# 12 Mental health management

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| **Attachment tables** |
| Attachment tables are identified in references throughout this Indigenous Compendium by an ‘A’ prefix (for example, in this chapter, table 12A.1). As the data are directly sourced from the 2015 Report, the Compendium also notes where the original table, figure or text in the  2015 Report can be found. For example, where the Compendium refers to ‘2015 Report,  p. 12.1’ this is page 1 of chapter 12 of the 2015 Report, and ‘2015 Report, table 12A.1’ is attachment table 1 of attachment 12A of the 2015 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/research/recurring/report-on-government-services. |
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The Mental health management chapter (chapter 12) in the *Report on Government Services 2015* (2015 Report) reports on the management of mental health in Australia. Data are reported for Aboriginal and Torres Strait Islander 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 primary and community health services is reported in chapter 10 and the performance of public hospitals is reported in chapter 11.

### Aboriginal and Torres Strait Islander data in the Mental health management chapter

The Mental health management chapter or attachment in the 2015 Report contains the following data for Aboriginal and Torres Strait Islander Australians:

* age standardised rate of adults with high/very high levels of psychological distress
* GP mental health-related encounters (general and mental health specific)
* use of State and Territory specialised public mental health care reported, by service type
* new clients as a proportion of total clients under the care of State or Territory specialised public mental health services
* proportion of the population using State and Territory specialised public mental health services
* proportion of the population using MBSsubsidised mental health services
* proportion of young people (aged < 25 years) who had contact with MBS subsidised primary mental health care services
* rate of community follow up within first seven days of discharge from a psychiatric admission
* readmissions to hospital within 28 days of discharge
* recent drinkers lifetime and single occasion risk, people aged 14 years or older
* illicit drug use, people aged 14 years or older
* mortality due to suicide.

### Size and scope of sector

#### Prevalence of mental illness and high/very high levels of psychological distress

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 (2015 Report, table 12A.76). 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 (2015 Report, table 12A.76).

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 (2015 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 Australian Bureau of Statistics (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 (2105 Report, figure 12.5). People with disability or restrictive long term health condition and people in low socioeconomic areas also reported higher proportions of very high levels of psychological distress than other community groups (2015 Report,   
table 12A.9). In 2012‑13, 29.4 ± 2.1 per cent of Aboriginal and Torres Strait Islander 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.

#### Specialised admitted patient 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, contacts for community‑based ambulatory care and number of participants accessing the targeted community care (mental health) services funded by the Department of Social Services (DSS). Other service use data for the NGOs are not available.

Data on service use by Indigenous status are available, but comparisons are not necessarily accurate because Aboriginal and Torres Strait Islander patients are not always correctly identified (table 12A.25). Differences in rates of service use could also reflect other factors, including the range of social and physical infrastructure services available to Aboriginal and Torres Strait Islander Australians, and differences in the complexity, incidence and prevalence of illnesses between Aboriginal and Torres Strait Islander and non‑Indigenous Australians.

### 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 Aboriginal and Torres Strait Islander Australians are reported for a subset of the performance indicators and are presented here or in the attachment tables. 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 2015 Report. 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 2015 Report, chapter 1, 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 Aboriginal and Torres Strait Islander and ethnic status) (chapter 2).

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| Figure 12.1 Mental health management performance indicator framework |
| |  | | --- | | Figure 12.9 Mental health management performance indicator framework  More details can be found within the text surrounding this image. | |
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*Source*: 2015 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 Aboriginal and Torres Strait Islander Australians (box 12.2).

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| Box 12.2 Mental health service use by selected community 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 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 mental health services.   The selected community groups reported are Aboriginal and Torres Strait Islander Australians, people from outer regional, remote and very remote locations and people residing in low socioeconomic areas. For MBS subsidised mental health services, data by socioeconomic status are reported by decile and quintile, 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 groups. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness. It also does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.  Data reported for 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 from 2012‑13 are not comparable to previous years’ data — previously data were restricted to counts of people receiving one or more service contact provided by community‑based ambulatory services, now they also includes people using inpatient and residential care services * incomplete for the current reporting period (subject to caveats). All required 2012‑13 data are not available for Victoria.   (continued next page) |
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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 from 2011‑12 by geographic location and Socio‑Economic Indexes for Areas (SEIFA) are not comparable to previous years’ data * complete for the current reporting period (subject to caveats). All required 2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
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The proportions of the population using State and Territory specialised public mental health services in 2012‑13, by selected community groups are reported in figure 12.2. The results are not available for Victoria.

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| Figure 12.2 Population using State and Territory specialised public mental health services, by selected community group, 2012‑13**a, b, c, d, e, f, g** |
| |  | | --- | | **Indigenous status** | | Figure 12.2 Population using State and Territory specialised public mental health services, by selected community group, 2012-13  Indigenous status  More details can be found within the text surrounding this image. | | **Geographic location** | | Figure 12.12 Population using State and Territory specialised public mental health services, by selected community group, 2012-13  Geographic location  More details can be found within the text surrounding this image. | | **SEIFA location** | | Figure 12.12 Population using State and Territory specialised public mental health services, by selected community group, 2012-13  SEIFA location  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 services provided by inpatient or community‑based ambulatory or residential services. c Data are not available for Victoria. d Industrial action during 2012‑13 in Tasmania has limited the available data quality and quantity of the community‑based ambulatory mental health care data; which represents a large proportion of the overall figures. e Disaggregation by remoteness area is based on a person’s usual residence, not the location of the service provider, except the NT for which the majority of the data were based on the location of the service. f The ACT does not have outer regional, remote or very remote locations. ACT data are not published for inner regional areas. Data for Quintile 1 are not published for the ACT. g The NT does not have major cities or inner regional locations. |
| *Source*: AIHW (unpublished), derived from data provided by State and Territory governments; State and Territory governments (unpublished) specialised mental health services data; tables 12A.36, 2015 Report, tables 12A.37–38; 2015 Report, figure 12.12, p. 12.27. |
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The proportions of the population using MBS subsidised mental health services, by selected community groups, are reported in figure 12.3 (data by socioeconomic status are available by decile and quintile at the national level only in 2105 Report, tables 12A.38 and 12A.40).

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| Figure 12.3 Population using MBS subsidised mental health services, by selected community group, 2012‑13**a, b, c, d** |
| |  | | --- | | **Indigenous status** | | Figure 12.3 Population using MBS subsidised mental health services, by selected community group, 2012-13  Indigenous status  More details can be found within the text surrounding this image. | | **Geographic location** | | **Figure 12.13 Population using MBS subsidised mental health services, by selected community group, 2012-13  Geographic location  More details can be found within the text surrounding this image.** | |
| 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 the Department of Veterans’ Affairs (DVA). The specific Medicare items included are detailed in 2105 Report,  table 12A.41. 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. |
| *Source*: AIHW (unpublished), derived from data provided by the Australian Government; Department of Health (unpublished) and Department of Veterans’ Affairs (DVA) (unpublished), Medicare Benefits Schedule (MBS) Statistics data; table 12A.36 and 2015 Report, table 12A.37; 2015 Report, figure 12.13,  p. 12.28. |
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### 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, Aboriginal and Torres Strait Islander 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, NGOs 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 disaggregations (see the attachment tables 12A.81–83 in 2015 Report for details) * complete for the current reporting period (subject to caveats). All required 2012 or  2008–2012 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
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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, Hancock and   
Kisely 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 International Classification of Diseases (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.

Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander Australians during the period 2008–2012, 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 Aboriginal and Torres Strait Islander Australians are incomplete and data for some jurisdictions are not published. Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander deaths across jurisdictions.

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| Figure 12.4 Suicide rates, by Indigenous status, 2008–2012**a, b, c, d, e, f** |
| |  | | --- | | Figure 12.4 Suicide rates, by Indigenous status, 2008-2012  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 Aboriginal and Torres Strait Islander Australians are affected by differing levels of coverage of deaths of Aboriginal and Torres Strait Islander people across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Aboriginal and Torres Strait Islander and non‑Indigenous data. d Deaths with a ‘not stated’ Indigenous status are excluded. e Causes of death data for 2008−2010 have undergone revisions and are now considered final. Causes of death data for 2011 have been revised and are subject to further revisions. Causes of death data for 2012 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 has been included for these five states and territories only as there is evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis. |
| *Source*:ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.84; 2015 Report, figure 12.33, p. 12.64. |
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### 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 Aboriginal and Torres Strait Islander 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. |
| **Comparability** | Data are considered comparable if (subject to caveats) they can be used to inform an assessment of comparative performance. Typically, data are considered comparable when they are collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data. |
| **Completeness** | Data are considered complete if all required data are available for all jurisdictions that provide the service. |
| **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. |
| **Mortality rate  from suicide** | The proportion of the population who die as a result of suicide. |
| **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/research/recurring/report-on-government-services).

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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.19** | GP mental health-related encounters (general and mental health specific), 2012-13 |
| **Table 12A.25** | Specialised mental health care reported, by Indigenous status |
| **Table 12A.34** | New clients as a proportion of total clients under the care of State or Territory specialised public mental health services, by selected characteristics, 2012-13 |
| **Table 12A.36** | Proportion of people receiving clinical mental health services by service type and Indigenous status |
| **Table 12A.45** | Proportion of young people (aged < 25 years) who had contact with MBS-subsidised primary mental health care services, by selected characteristics (per cent) |
| **Table 12A.54** | Rate of community follow up within first seven days of discharge from a psychiatric admission, by State and Territory, by Indigenous status and remoteness |
| **Table 12A.57** | Readmissions to hospital within 28 days of discharge, by selected characteristics, 2012-13 |
| **Table 12A.65** | Recent drinkers lifetime and single occasion risk, people aged 14 years or older, by social characteristics, 2013 (per cent) |
| **Table 12A.74** | Illicit drug use, people aged 14 years or older, by social characteristics (per cent) |
| **Table 12A.84** | Suicide deaths, by Indigenous status, 2008–2012 |

### References

ABS (Australian Bureau of Statistics) 2010, *Causes of Deaths, Australia 2008*, Cat. no. 3303.0, Canberra.

—— 2012, *Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys*, Australia, 2007‑08, Cat. no. 4817.0.55.001, Canberra.

Coghlan, R., Lawrence D., Holman D. and Jablensky A. 2001, *Duty to Care: Physical Illness in People with Mental Illness*, University of Western Australia, Perth.

DoHA (Department of Health and Ageing) 2010, *National Mental Health Report 2010: Summary of 15 years of reform in Australia’s Mental Health Services under the National Mental Health Strategy 1993–2008*, Australian Government, Canberra.

DHAC (Australian Government Department of Health and Community Services) and AIHW 1999, *National Health Priority Areas Report: Mental Health 1998*,   
AIHW Cat. no. PHE 13, Canberra.

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

Lawrence, D., Hancock, K. and Kisely S. 2013, ‘The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers’, *British Medical Journal*, Vol. 346.

Morgan, V., Waterreus, A., Jablensky, A., Mackinnon, A., McGrath, J., Carr, V., Bush, R., Castle, D., Cohen, M., Harvey, C., Galletly, C., Stain, H., Neil, A. McGorry, P., Hocking, B., Shah, S., Saw, S. 2011, *People Living With Psychotic Illness 2010, Report on the Second Australian National Survey*, Australian Government, Canberra.

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

WHO (World Health Organization) 2001, *Strengthening mental health promotion*, Fact sheet no. 220, Geneva.