

A Contributing Life
The 2013 National Report Card on
Mental Health and Suicide Prevention

Supplementary Paper 2:

A Contributing Life **the 2013 National** **Report Card** on Mental Health and Suicide Prevention

Technical Supplement

Prepared by: The Australian Institute of Health and Welfare, November 2013



Australian Government
National Mental Health Commission

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1 Introduction

The purpose of this Technical Supplement (the Supplement) is to provide additional information about the data sources cited in the National Mental Health Commission's 2013 National Report Card on Mental Health and Suicide Prevention (the Report Card).

The Supplement has three main sections. Firstly, an overview is presented of the various data sources, including national data collections and surveys, used in the preparation of the 2013 Report Card. A summary of the various information sources which have been used in the preparation of the 2013 Report Card organised by topic; including data quality caveats and clarifying information follows. Finally, data quality statements, where available, for the various national data collections cited in the Report Card have been included.

This Technical Supplement has been provided by the Australian Institute of Health and Welfare on behalf of the National Mental Health Commission.

2 Data Sources

A range of national collections and surveys have been used to prepare the Report Card. A brief summary of each of these is presented below, and further detailed information can be found in the respective data quality statement (see Section 3). In addition to the various national data collections and surveys, the National Mental Health Commission also undertook a number of reviews of the literature, both peer-reviewed and grey literature in compiling the 2013 Report Card. These literature reviews can be found on the National Mental Health Commission's website: <http://www.mentalhealthcommission.gov.au>

New Data in the 2013 Report Card

Chapter	Data	Reference	Page Number
Thriving, not just surviving	We know that in a year, almost 340,000 Australians will have both mental illness and a substance use disorder	47	57
Thriving, not just surviving	People who have mental health issues and a substance use disorder are twice as likely to be homeless as those who had one of these problems, and twice as likely to have been in prison or a correction facility	47	57
Thriving, not just surviving	Recent data from the Victorian Ambulance Service shows that of 5,993 callouts to people with depression between June 2012 and May 2013, alcohol was involved in 29 per cent, with drug use being present in 38 per cent.	54	58
Maintaining connections with family, friends, community and culture	All too often people with mental health difficulties experience this, and frequently raise stigmatising attitudes as their greatest concern.	11	74
Maintaining connections with family, friends, community and culture	The early findings of the Commission's own pilot online survey found that 23.3 per cent of respondents said that social discrimination 'got in the way' of them feeling connected to family, friends, culture or community.	11	77
Maintaining connections with family, friends, community and culture	Spending by states and territories on these programs alone came to \$16.4 million in 2010-2011,...	113	84
Maintaining connections with family, friends, community and culture	... with grants to non-government organisations totalling an extra \$19.65 million.	15	84
Ensuring effective care, support and treatment	We asked people in our National Contributing Life Project pilot surveys what helped and what hindered them in living a contributing life. The three most important things that have emerged from the early findings are: 1. relationships and connections 2. stigma and discrimination 3. a sense of personal control, including having enough money	11	94

Ensuring effective care, support and treatment	Recent research undertaken by Health Workforce Australia included a small-scale survey of 305 people who identified as peer workers. Of this sample, 18 per cent worked casually, 29 per cent full-time and 53 per cent part-time.	163	107
Something meaningful to do	“I’d like to learn more about helpful coping strategies, healthy lifestyles, and helpful things to challenge and change your thinking in a positive and healthy way.”	173	120
Something meaningful to do	“When you come to school it’s not just so you learn, it’s so you get ready for when you leave school and you have friends and people to talk to, and stuff – and your teachers.”	174	120
Something meaningful to do	“For example, services might want to take into account that young people are more likely to seek help from an online forum than a phone helpline survey, but that face-to-face help from friends and professionals is still preferred over asking for help on Facebook or Twitter.”	175	120
Something meaningful to do	“I feel normal – and like – there are other people going through similar things. I don’t feel alone about issues.”	173	120
Something meaningful to do	“PDHPE teaches certain aspects about what they [illnesses] are. It’s about the illness – not about how you can help, or the next step.”	175	120
Something meaningful to do	“If there had been someone around to help me when I was a teenager caring for a mentally ill mother I do think my life would have been so different ... I had some good teachers at school who knew that things were bad at home ... I didn’t need a school counsellor. I needed support and practical assistance to help with things like school books & uniform, a safe place to study.”	11	120
Something meaningful to do	“Kids need to be educated at school, when they are young, so that when problems arise they can talk about them openly instead of keeping them to themselves. I didn’t know what to look for. Signs that I took for being adolescence were signs of his depression. For years he suffered on his own.”	11	132
Feeling safe, stable and secure	In a 2012 survey 33 per cent of prisoners who had been told they had a mental health condition had been in prison five or more times, compared to 26 per cent of prisoners who had no condition.	46	138
Feeling safe, stable and secure	In New South Wales for example, there was a 25 per cent increase in the annual number of police incidents involving people with a mental health problem between 2008-2009 and 2011-2012. This period saw the number grow from about 22,000 incidents in 2007-2008 to around 30,000 in 2011-2012.	205	142
Feeling safe, stable and secure	Figure 11: Mental health history of prison entrants by the number of times previously in adult prison	46	147

Feeling safe, stable and secure	Figure 13: Mental health history of prison entrants by drug use, smoking status, and risk of alcohol-related harm	46	149
Preventing suicide	There are stark geographical inequalities in suicide rates which this year we show for the first time. Rates are more than twice as high in the Northern Territory (20.0 per 100,000) as in New South Wales and Victoria (8.5 and 9.5 per 100,000 respectively).	247	164
Preventing suicide	The map of suicide deaths in Australia at Figure 15 shows this regional variation for the period 2007-2011, with darker colours indicating a higher rate of deaths. People living in non-metropolitan areas are more likely to die by suicide than those living in capital cities,...	247	164
Preventing suicide	... and we know that men not living in major cities are almost twice as likely as their urban counterparts to die by suicide.	248	164
Preventing suicide	People who identified as lesbian, gay or bisexual reported suicidal thoughts during their lifetime at almost three times the rate of those identifying as straight, and suicidal plans or attempts during their lifetime at four times the rate.	47	166

National Cause of Death Data

Overview

The Australian Bureau of Statistics (ABS) publishes cause of death data annually. Death statistics published by the ABS are sourced from death registrations systems administered by the various state and territory Registrars of Births, Deaths and Marriages and supplemented by information from the National Coroners Information System.

Scope

The ABS deaths data includes information on any death which occurs in, or en route to Australia, including deaths of persons whose usual place of residence is overseas, and is registered with a state or territory Registry of Births, Deaths and Marriages.

The scope of the cause of death data includes:

- All deaths being registered for the first time.
- Deaths of temporary visitors to Australia (including visitors from Norfolk Island).
- Deaths that occurred within Australian Territorial waters.
- Deaths that occurred in Australian Antarctic Territories or other external territories (excluding Norfolk Island).
- Deaths that occurred in transit (i.e. on ships or planes) if registered in the state or territory of 'next port of call'.
- Deaths of Australian nationals employed overseas at Australian legations and consular offices (i.e. deaths of Australian diplomats while overseas) where able to be identified.
- Deaths that occurred in earlier years that have not previously been registered (late registrations).

Deaths data does not include information on:

- Still births/foetal deaths.
- Deaths of Australian residents which occur outside Australia.
- Repatriation of human remains of descendants whose death occurred overseas.
- Deaths of foreign diplomatic staff in Australia (where able to be identified).
- Deaths occurring on Norfolk Island.

Further information on National cause of death data can be found on the ABS website:
<http://www.abs.gov.au/ausstats/abs@.nsf/mf/3303.0/>

National Health Survey, 2007-08

Overview

The National Health Survey (NHS) was collected, processed, and published by the ABS. The NHS was conducted by the ABS from August 2007 to June 2008.

Scope

Approximately 20,800 people from all states and territories and across all age groups were included. One adult (aged 18 years or more) and one child (where applicable) for each sampled dwelling were included in the survey.

The survey was designed to obtain national benchmarks on a wide range of health issues, and to enable changes in health to be monitored over time. Information was collected about:

- The health status of the population
- Health-related aspects of lifestyle and other health risk factors
- The use of health services and other actions people had recently taken for their health

The NHS is conducted as a face-to-face interview in which the interviewer asks a series of questions, with or without the use of prompt cards in order to identify those respondents with a mental health disorder.

Further information on the NHS can be found on the ABS website:
[http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4364.0Main+Features12007-2008%20\(Reissue\)?OpenDocument](http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4364.0Main+Features12007-2008%20(Reissue)?OpenDocument)

National Health Survey, 2011-12

Overview

The National Health Survey (NHS) (also known as the Australian Health Survey 2011-12) was collected, processed, and published by the ABS. The NHS was conducted by the ABS from March 2011 to March 2012.

Scope

Approximately 20,400 people from all states and territories and across all age groups were included. One adult (aged 18 years or more) and one child (where applicable) for each sampled dwelling were included in the survey.

The survey was designed to obtain national benchmarks on a wide range of health issues, and to enable changes in health to be monitored over time. Information was collected about:

- The health status of the population
- Health-related aspects of lifestyle and other health risk factors
- The use of health services and other actions people had recently taken for their health

The NHS is conducted as a face-to-face interview in which the interviewer asks a series of questions, with or without the use of prompt cards in order to identify those respondents with a mental health disorder. The NHS 2011-12 collects data on diagnosed and undiagnosed self-reported mental and behavioural problems that have lasted or are expected to last for six months or more. Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.

Further information on the NHS can be found on the ABS website:
<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4364.0.55.001Main+Features12011-12?OpenDocument>

National Survey of Mental Health and Wellbeing, 2007

Overview

The National Survey of Mental Health and Wellbeing (NSMHWB) was conducted by the ABS from August to December 2007. This is the second national mental health and wellbeing survey, with the previous survey being conducted in 1997. Funding for this survey was provided by the Australian Government Department of Health (formerly the Department of Health and Ageing).

Scope

The survey collected information from approximately 8,800 Australians aged 16-85 years. The survey provides information on the prevalence of selected lifetime and 12-month mental disorders by three major disorder groups: Anxiety disorders (e.g. Social Phobia), Affective disorders (e.g. Depression) and Substance Use disorders (e.g. Alcohol Harmful Use). It also provides information on the level of impairment, the health services used for mental health problems, physical conditions, social networks and caregiving, as well as demographic and socio-economic characteristics.

Further information about the National Survey of Mental Health and Wellbeing can be found on the ABS website:

<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4326.0Main+Features12007?OpenDocument>

National Survey of Psychotic Illness, 2010

Overview

The 2010 survey was undertaken by the University of Western Australia, under contract to the Australian Government Department of Health. The second national survey of people with psychotic illness was undertaken to provide updated estimates of the number of people being treated for psychosis, and to determine who these people are, the health services they receive and the impact of these illnesses.

The second survey allows for the examination of how changes to public sector mental health services, administered by state and territory governments, have impacted on people's lives in the 12 years since the first survey.

Scope

The sample of the 2010 national survey included 1,825 adults with psychotic illnesses aged 18-64 years, who were in contact with public specialised mental health services between April 2009 and March 2010 inclusive, as well as those receiving mental health services from government-funded non-government organisations in March 2010. Two thirds of those in the sample were current clients of the public specialised mental health services, in March 2010.

The survey did not cover those people with psychotic illness who are treated only in the private sector by a private psychiatrist, psychologist or general practitioner. It also did not cover people who are currently experiencing a psychotic illness, but were not receiving any mental health services through either the public or private health systems.

Further information on the National Survey of Psychotic Illnesses can be found on the Department of Health website:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-p-psych10>

Prisoners in Australia, 2012

Overview

The National Prisoner Census is a census of all persons in the legal custody of adult corrective services in Australia, undertaken by the ABS, as at midnight on 30 June 2012.

Scope

The scope of the Prisoners in Australia report includes all persons remanded or sentenced to adult custodial corrective services agencies in each state and territory in Australia, including periodic detainees in the Australian Capital Territory; which is the situation where detainees are in custody for two consecutive days per week and remain at liberty for the rest of the week. It excludes people held in juvenile justice institutions, psychiatric custody and police custody. It is based on data extracted from administrative records held by the corrective services agencies in each state and territory. The Prisoners in Australia report provides information on the legal status, sentence details and demographic characteristics of Australian prisoners as at 30 June 2012.

Further information about the National Prisoner Census can be found on the ABS website:

<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4517.0Main+Features12012?OpenDocument>

Survey of Disability, Ageing and Carers, 2009

Overview

The Survey of Disability, Ageing and Carers (SDAC) 2009 was conducted by the ABS throughout Australia from April to December 2009. The primary objective of the survey was to collect information about people with disability, older people (i.e. those aged 60 years and over) and people who provide assistance to older people and people with disabilities.

Scope

The scope of SDAC was persons in both urban and rural areas in all states and territories, living in both private and non-private dwellings but excluding foreign diplomatic personnel, persons who usually reside outside of Australia, foreign Defence force members and their dependents and persons living in very remote areas.

The household sample included approximately 27,600 private dwellings and 200 non-private dwellings, and the cared-accommodation (includes group homes, health establishments and institutional settings) sample included approximately 1,100 establishments. The final sample comprised 64,213 persons for the household component and 9,470 for the cared-accommodation component.

Further information about the Survey of Disability, Ageing and Carers, 2009 can be found on the ABS website:

<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Main+Features12009?OpenDocument>

Prison Health Data Collection, 2012

Overview

The AIHW Prison Health Data Collection was conducted over a 2 week period in May 2012. Some data for indicators concerning communicable diseases, illicit drug use, and unprotected sex are sourced from the National Prison Entrants' Blood-borne Virus and Risk Behaviour Survey.

Scope

The AIHW Prison Health Data Collection collected data from 74 public and private prisons in all states and territories except Western Australia which was unable to provide data. In contrast to the ABS's Prisoners in Australia 2012 report, periodic detention centres and court cells administered by

corrective services were excluded, as were juvenile detention centres, immigration detention centres and secure psychiatric facilities.

During the data collection period, prison entrants, prison dischargees, prisoners in custody visiting the prison clinic, and prisoners taking prescribed medication were invited to participate in the data collection, with the option to refuse to give consent. There were 794 prison entrants from whom data were obtained in this data collection. Nine out of 10 (90%) were male, ranging from 79% in Victoria to 97% in South Australia.

Further information about the AIHW Prison Health Data Collection 2012 can be found on the AIHW website: <http://www.aihw.gov.au/publication-detail/?id=60129543948>

National Aboriginal and Torres Strait Islander Health Survey, 2004-05

Overview

The ABS 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) was conducted to provide information about the health of Indigenous Australians, by remoteness, and at the national and state/territory levels; allow for the relationships across the health status, risk factors and health related behaviour of Indigenous Australians; provide comparisons over time about the health of Indigenous Australians; and provide comparisons with results for the non-Indigenous population from the National Health Survey.

Scope

This survey, which was conducted in remote and non-remote areas throughout Australia, was designed to collect a range of information from Indigenous Australians about health-related issues, including health status, risk factors and actions, and socio-economic circumstances.

The 2004-05 NATSIHS sample covered usual residents of private dwellings only. Usual residents are those people who usually live in a particular dwelling and regard it as their own or main home.

Non-Indigenous people were not eligible for selection in the NATSIHS, although if they were a parent or guardian of an Indigenous child they may have been involved as a spokesperson for the child.

A total of 10,044 Aboriginal and Torres Strait Islander adults and children from across Australia were surveyed in the NATSIHS, which was conducted from August 2004 to July 2005. In addition, 395 Indigenous Australians were enumerated in the 2004-05 NHS sample of 25,906 persons. The Indigenous results included in this ABS publication are based on the combined sample of 10,439 Indigenous Australians, comprising 5,757 adults and 4,682 children.

Further information about the National Aboriginal and Torres Strait Islander Health Survey, 2004-05 can be found on the ABS website:

<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4715.0Main+Features12004-05?OpenDocument>

National Surveys of Mental Health Literacy and Stigma

Overview

The 2011 survey was undertaken by Nicola Reavley and Anthony Jorm, from the University of Melbourne, under contract to the Australian Government Department of Health. The aim of the National Survey of Mental Health Literacy and Stigma was to assess whether there have been changes in recognition, treatment beliefs, stigmatising attitudes and other aspects of mental health literacy. Previous similar surveys (in 1995, 2003-4 and 2006) have focused on depression and schizophrenia. The inclusion of vignettes (a short character sketch) for social phobia and post-traumatic stress disorder (PTSD) in the general community survey, and PTSD and depression with suicidal thoughts in

the youth survey allowed for the introduction of baseline assessments of mental health literacy and stigma for these disorders.

Scope

The survey had two components: a general community survey covering those aged 15+ and a youth survey involving those aged 15 to 25 years. The general community survey involved computer-assisted telephone interviews with a national sample of 6019 respondents and the youth survey involved similar interviews with 3025 young people. The surveys were carried out between January and May 2011.

The interviews were based on a vignette of a person with a mental disorder. Respondents were then asked a series of questions to assess their recognition of the disorder in the vignette, help-seeking intentions, beliefs about interventions, beliefs and intentions about first aid, beliefs about causes and risk factors, beliefs about outcomes, beliefs about prevention, stigmatising attitudes, exposure to mental disorders, psychological distress, awareness of mental health-related organisations, media exposure and socio-demographic characteristics.

Further information about National Survey of Mental Health Literacy and Stigma can be found on the University of Melbourne Population Mental Health Group website:

http://pmhg.unimelb.edu.au/research_settings/general_community

The Longitudinal Study of Australian Children

Overview

Growing Up in Australia: the Longitudinal Study of Australian Children (LSAC) is a nationally representative longitudinal study of child and adolescent development. It is conducted in partnership between the Department of Social Services, the Australian Institute of Family Studies and the ABS. The study began in 2004 and follows approximately 10,000 families from around Australia. The study is investigating the contribution of children's family, social, learning, economic and cultural environments to their development and wellbeing. A major aim of the study is to guide government policies and programs aimed at supporting the wellbeing of children and their families. In particular, the study will aid the development of early intervention and prevention strategies.

Scope

The LSAC involves a representative sample of children from urban and rural areas of all states and territories of Australia. Participants were randomly selected from the Medicare database and invited to join the study. Data are collected from two cohorts every 2 years. The first cohort comprised 5,000 children aged 0–1 years in 2004, and the second cohort comprised 5,000 children aged 4–5 years in 2004. From Wave 3, the study design allows for comparison between the cohorts at the same ages.

Information is collected about various aspects of children's development including physical and mental health, social adjustment, cognitive development, school achievement, and experiences at home, school and local communities. Socio-economic and other contextual information is also collected.

Further information about LSAC on the Growing Up in Australia: the Longitudinal Study of Australian Children website:

<http://www.growingupinaustralia.gov.au/>

Other Data Sources

In addition to the various national data collections and surveys mentioned above, the Commission has undertaken a comprehensive review of the academic literature, both peer-reviewed and grey literature, in compiling the Report Card.

A detailed review of each of these data sources is beyond the scope of this Supplement. However, a brief overview of selected sources, in particular those which contributed facts and figures, is provided in this section. For those sources not covered here, a full list of references can be found in the reference section of the Report Card. Additionally, the literature review commissioned to inform the 2013 Report Card can be found on the National Mental Health Commission's website:

<http://www.mentalhealthcommission.gov.au>

Mental Health Council of Australia

The Mental Health Council of Australia (MHCA) completed a survey of 756 carers in 2010 which was published in the Mental Health Carers Report 2010.

Inspire Foundation National Survey 2012

The 2012 National Survey was completed by 5,238 visitors to the Australian ReachOut.com website between May and July 2012. The participants were non-professional users of the site aged 25 years and below.

Mental Health Peer Workforce Survey

The Health Workforce Australia (HWA) Mental Health Peer Workforce Study included a number of site visits and telephone interviews with organisations across Australia employing mental health peer workers. HWA also conducted an online survey of mental health peer workers which was completed by 305 respondents, with the study results to be published in late 2013.

Mission Australia Youth Survey 2012

In 2012, Mission Australia conducted its 11th annual survey of young people. The survey aimed to identify both the values and issues of concern to young people. In 2012, 15,351 young Australians aged 15-19 years participated in the survey.

Young People in Custody Health Survey

The 2009 NSW Young People in Custody Health Survey (YPICHS) was conducted by Justice Health NSW to gain a picture of the health status of young people in juvenile detention across NSW. A baseline survey includes a health questionnaire, physical examination, offending behaviour and psychological assessment, with follow-up surveys at 3, 6 and 12 months. A total of 361 young people participated in the survey.

NSW Inmate Health Survey

The 2009 NSW Inmate Health Survey was conducted by Justice Health NSW using a stratified random sample of all inmates from 30 adult correctional centres. Of the 1,166 inmates randomly selected and invited to participate, 996 agreed, equating to a response rate of 85.4%. Women and Indigenous people were over-represented in the sample to ensure better estimates of health issues for these populations. Of the 996 participants, 312 (31%) self-identified as being of Indigenous origin.

3 Report Card Data Points and Graphs

The purpose of this section is to provide further technical information about data that is presented as either discrete data points or graphs in the 2013 Report Card.

This section presents a summary of selected information sources which have been used in the preparation of the 2013 Report Card, organised by chapter, in the same order as presented in the Report Card. Where appropriate, data quality issues and/or clarifying information have also been provided.

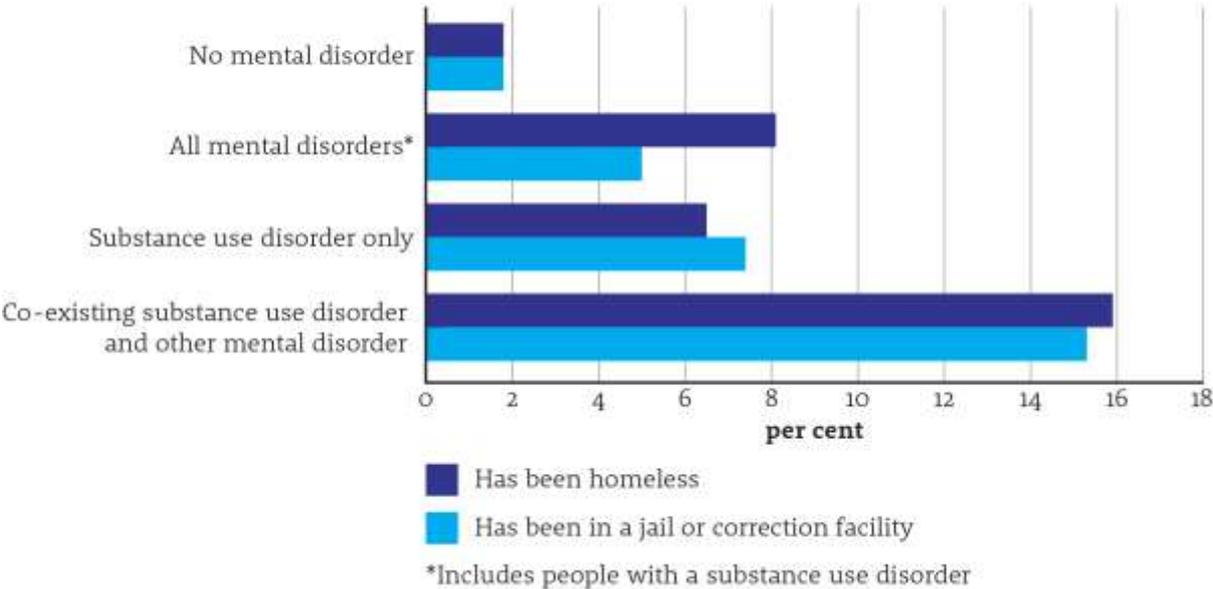
Thriving, Not Just Surviving

Page 57: National Survey of Mental Health and Wellbeing

The previously described 2007 National Survey of Mental Health and Wellbeing (NSMHWB) included questions which related to respondents with and without a mental health and/or substance use disorder who identified as having ever been homeless or in a correctional facility.

The following figure is presented on page 57 in the Report Card and is sourced from 2007 NSMHWB data.

Figure 1: Percentage of people who have ever been homeless or in a correctional facility, by mental health status



Source: 2007 National Survey of Mental Health and Wellbeing

The following table presents the data which was sourced to produce the above figure.

Ever been homeless or in a correctional facility	Co-existing substance use disorder and other mental disorder (%)*	Substance use disorder only (%)*	All mental disorders* (%)	No mental disorder (%)
Has been homeless	15.9	6.5	8.1	1.8
Has been in a jail or correctional facility	15.3	7.4	5	1.8

* These estimates have a relative standard error between 25% and 50% and should be interpreted with caution.

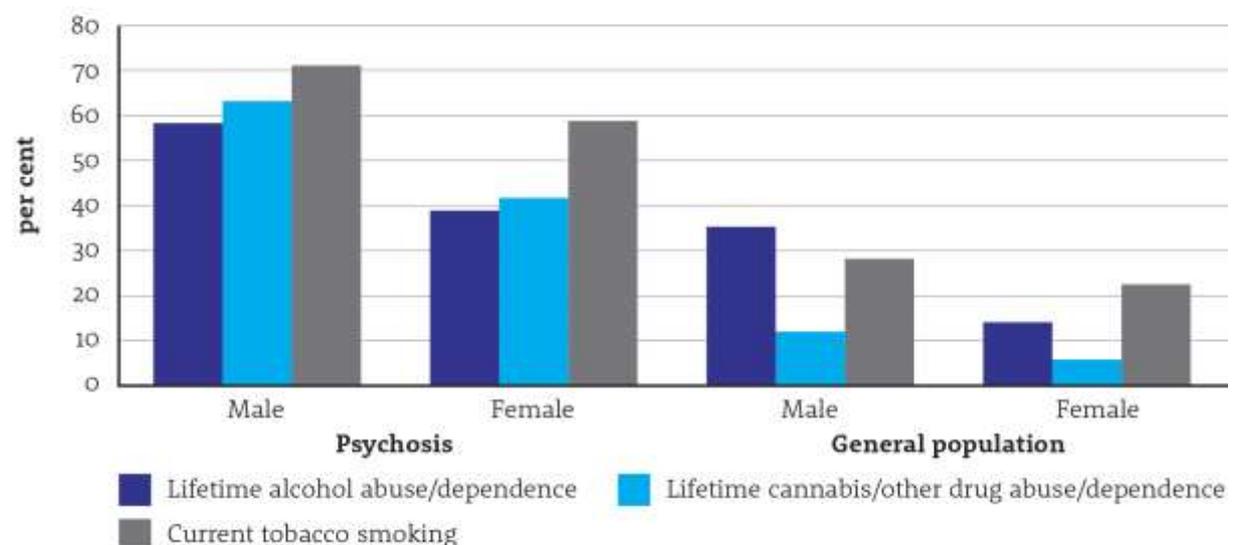
Notes:

- Estimates are for people aged between 16–85 years.
- 12-month diagnoses of mental disorders were derived based on lifetime diagnosis and the presence of symptoms of a disorder in the 12 months prior to the survey interview. Assessment of mental disorders are based on the definitions and criteria of the World Health Organization's (WHO) International Classification of Diseases, Tenth Revision (ICD-10).
- 'Homeless' refers to a person who at some point in their lives was homeless, i.e. they slept in public places, homeless shelters, a tent, an abandoned building or 'couch surfed' because they had no other choice.

Page 59: National Survey of Mental Health and Wellbeing and National Survey of Psychotic Illness

Information on substance use among people with a psychotic illness compared to the general population has been sourced from two national surveys: the *2007 National Survey of Mental Health and Wellbeing* and the *National Survey of Psychotic Illness 2010*. The following figure is presented on page 59 of the 2013 Report Card and is sourced from data from both of these surveys.

Figure 2: Drug use by people living with a psychotic illness compared with the general population



Sources: 2007 National Survey of Mental Health and Wellbeing and 2010 National Psychosis Survey

The following table presents the data which was sourced to produce the above figure.

Alcohol and other drug use	Psychosis ^{1 a,b}		General population ²	
	Male (%)	Female (%)	Male (%)	Female (%)
Lifetime ^c alcohol abuse/dependence	58.3	38.9	35.3	14.1
Lifetime ^c cannabis/other drug abuse/dependence	63.2	41.7	12	5.8
Current tobacco smoking	71.1	58.8	28.2	22.5

(a) Random sample of 1825 Australians with an ICD-10 psychotic illness in contact with public specialised mental health services in March 2010 and the eleven months prior.

(b) The survey collected information from approximately 8,800 Australians aged 16-85 years.

(c) 'Lifetime dependence' refers to abuse or dependence at some point in their lifetime.

Sources: (1) Data from the *National Survey of Psychotic Illness 2010*; (2) Data from the *2007 National Survey of Mental Health and Wellbeing*.

Notes:

- It should be noted that the results from the *National Survey of Psychotic Illness 2010* cannot be statistically compared to results from the *2007 National Survey of Mental Health and Wellbeing*, as there are significant differences in collection methodology, research questions, scope/coverage rules and population benchmarks between each study. See national data collections section above for further information.
- The rationale behind presenting these results in a single figure is to provide the reader with an indication as to the relative differences in alcohol and drug use across these groups.

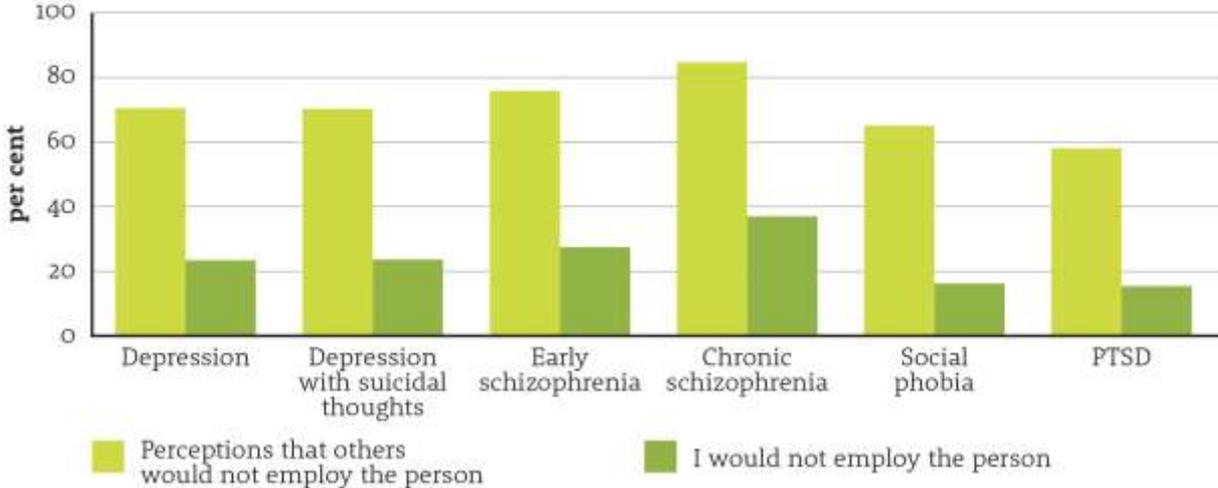
Maintaining Connections with Family, Friends, Community and Culture

Page 75: National Survey of Mental Health Literacy and Stigma

The previously described 2011 National Survey of Mental Health Literacy and Stigma included questions regarding attitudes towards employing someone with various mental health disorders.

The following figure is presented on page 75 in the Report Card and is sourced from the 2011 National Survey of Mental Health Literacy and Stigma data.

Figure 3: Attitudes to employing someone with varying mental health disorders



Source: Reavley, N.J., Jorm, A.F. (2011) National Survey of Mental Health Literacy and Stigma.

The following table presents the data which was sourced to produce the above figure.

Attitude	Depression	Depression with suicidal thoughts	Early schizophrenia	Chronic schizophrenia	Social phobia	PTSD
Perceived attitudes of others (others would not employ the person)	70.5	70.3	75.9	84.7	65.1	58.1
Personal attitudes (I would not employ the person)	23.4	23.6	27.5	37	16.2	15.4

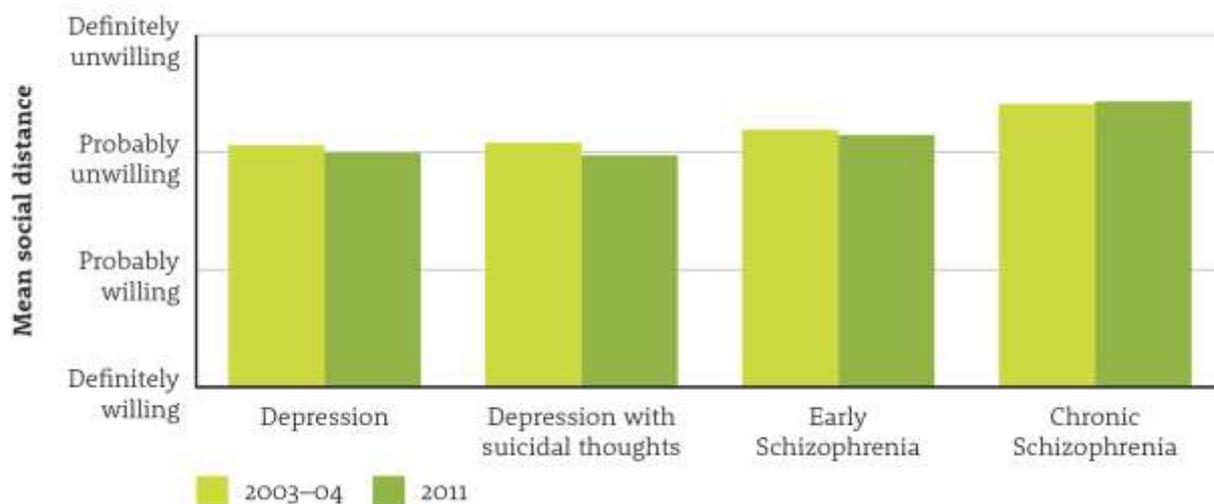
Note:

- Computer assisted telephone interviews were conducted with respondents. The interviews were based on a vignette of a person with a mental disorder. After being presented with the vignette, respondents were asked a series of questions about the vignette, including questions about stigmatising attitudes.

Page 76: National Mental Health Report

The following figure is presented on page 76 in the Report Card and is sourced from the 2013 National Mental Health Report, based on data from the 2003-2004 Australia-Japan Partnership Mental Health Literacy Survey and the 2011 National Survey of Mental Health Literacy and Stigma.

Figure 4: Reported desire to keep a social distance from people with selected mental illnesses



Source: 2013 National Mental Health Report

The following table presents the data which was sourced to produce the above figure.

Year	Depression	Depression with suicidal thoughts	Early Schizophrenia	Chronic Schizophrenia
2003-04	9.4	9.5	10	11
2011	9.1	9	9.8	11.1

Notes:

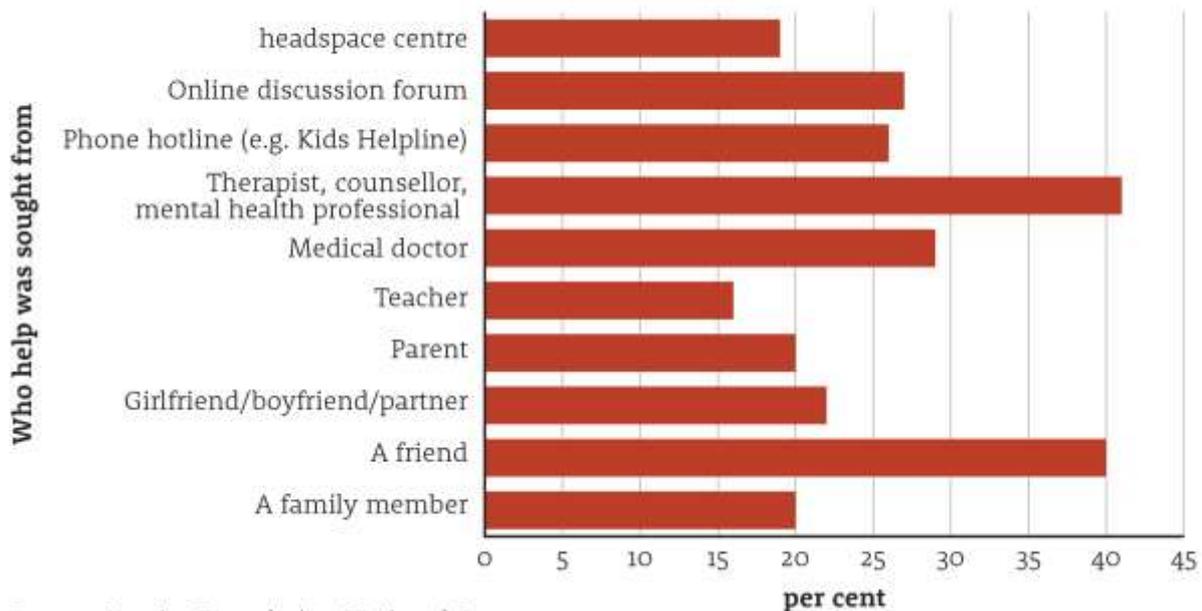
- Computer assisted telephone interviews were conducted with respondents. The interviews were based on a vignette of a person with a mental disorder. After being presented with the vignette, respondents were asked a series of questions about the vignette.
- Self-reported willingness to have contact with the person described in the vignette was measured using a 5-item scale. The items were rated according to the person's willingness to (1) move next door to (John/Jenny); (2) spend an evening socializing with (John/Jenny); (3) make friends with (John/Jenny); (4) working closely with (John/Jenny) on a job; (5) have (John/Jenny) marry into their family. Each item was rated on a 4-point scale ranging from 'definitely willing' to 'definitely unwilling'. The mean of these ratings is the mean social distance score.

Ensuring Effective Care, Support and Treatment

Page 101: Inspire Foundation National Survey

The previously described 2012 ReachOut.com National Survey included questions on whether respondents were 'more or less likely to talk to or access support' from a list of social and professional sources for help. Figure 5 below, included on page 101 in the Report Card, presents the responses given by young people experiencing high or very high levels of psychological distress who had not previously accessed help from professional sources.

Figure 5: Where people experiencing high or very high psychological distress are more likely to go for help



Source: Inspire Foundation National Survey 2012.

The following table presents the data which was sourced to produce the above figure.

Who help was sought from	Per cent
A family member	20
A friend*	40
Girlfriend/boyfriend/partner*	22
Parent	20
Teacher	16
Medical doctor*	29
Therapist, counsellor, mental health professional*	41
Phone hotline (e.g. Kids Helpline)*	26
Online discussion forum	27
Headspace centre*	19

Notes:

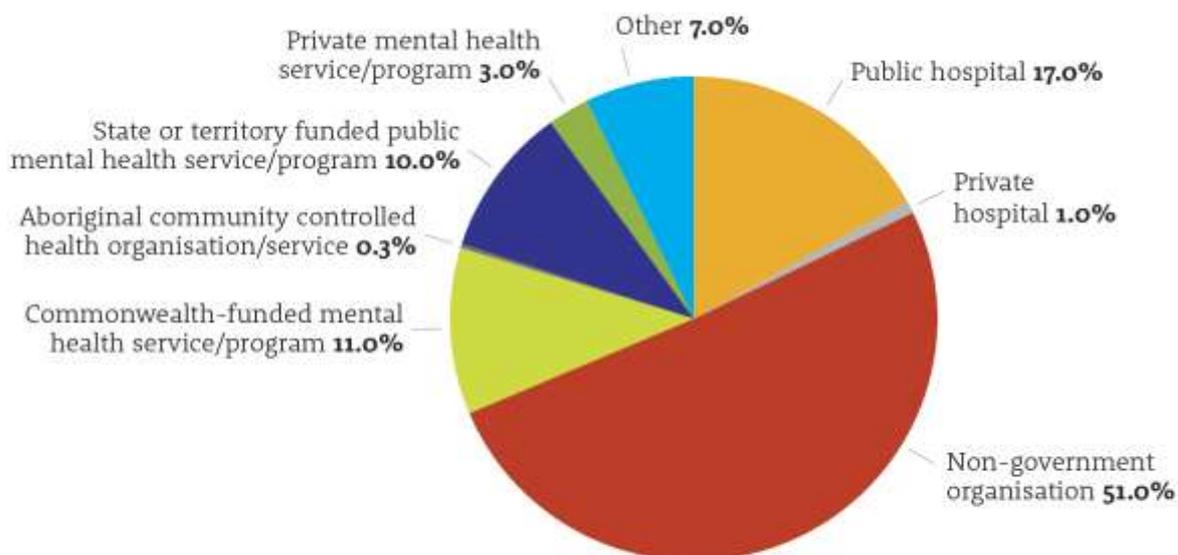
- *Repeat ReachOut.com visitors with high or very high psychological distress were significantly more likely than new visitors with high or very high psychological distress to report they were "more likely" to seek help from this source after visiting ReachOut.com (p <0.05)

Page 107: Mental Health Peer Worker Survey

The following figure is presented on page 107 of the Report Card and is sourced from Health Workforce Australia Mental Health Peer Workforce Survey data.

N.B. This data has not previously been publically available.

Figure 6: Mental health peer workers by service type



Source: Health Workforce Australia (Unpublished)

The following table presents the data which was sourced to produce the above figure.

Service type	Per cent
Public hospital	17
Private hospital	1
Non-government organisation	51
Commonwealth-funded mental health service/program	11
Aboriginal community controlled health organisation/service	0.3
State or territory funded public mental health service/program	10
Private mental health service/program	3
Other	7

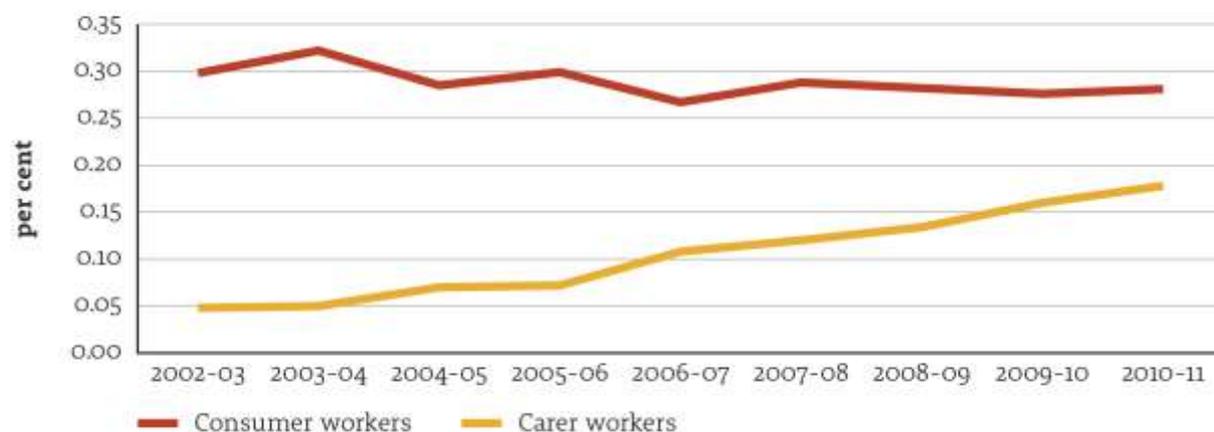
Notes:

- Peer workers have lived experience of mental illness or of supporting someone with a mental illness and work in roles that provide support to people with mental health issues.

Page 108: Mental health services in Australia report

The following figure is presented on page 108 in the Report Card from data published in Mental Health Services in Australia 2013. The data is sourced from the Department of Health and Ageing, National Survey of Mental Health Services Database (2002-03 to 2004-05) and National Mental Health Establishments Database (2005-06 to 2010-11).

Figure 7: Consumer and carer peer workers as a proportion of the direct care mental health workforce



Source: AIHW Mental health services in Australia 2013

The following table presents the data which was sourced to produce the above figure.

Year	Consumer workers (%)	Carer workers (%)
2002-03	0.30	0.05
2003-04	0.32	0.05
2004-05	0.29	0.07
2005-06	0.30	0.07
2006-07	0.27	0.11
2007-08	0.29	0.12
2008-09	0.28	0.13
2009-10	0.28	0.16
2010-11	0.28	0.18

Notes:

- The definition of these categories was modified from ‘consultants’ to ‘mental health workers’ for the 2010-11 collection, in order to capture a variety of contemporary roles. Caution is therefore required when interpreting time series data.
- Mental health carer workers are employed (or engaged via contract) on a part-time basis specifically for their expertise developed from their experience as a mental health carer. Mental health carer workers include the job titles of, but not limited to, carer consultants, peer support workers, carer representatives and carer advocates. Roles that mental health carer workers may perform include, but are not limited to, mental health policy development, advocacy roles and carer support roles.
- Mental health consumer workers are employed (or engaged through contracts) on a part-time or full-time basis specifically due to the expertise developed from their lived experience of mental illness. Mental health consumer workers include the job titles of, but not limited to, consumer consultants, peer support workers, peer specialists, consumer companions, consumer representatives, consumer project officers and recovery support workers. Roles that mental health consumer workers may perform include, but are not limited to, participation in mental health service planning, mental health service evaluation and peer support roles.

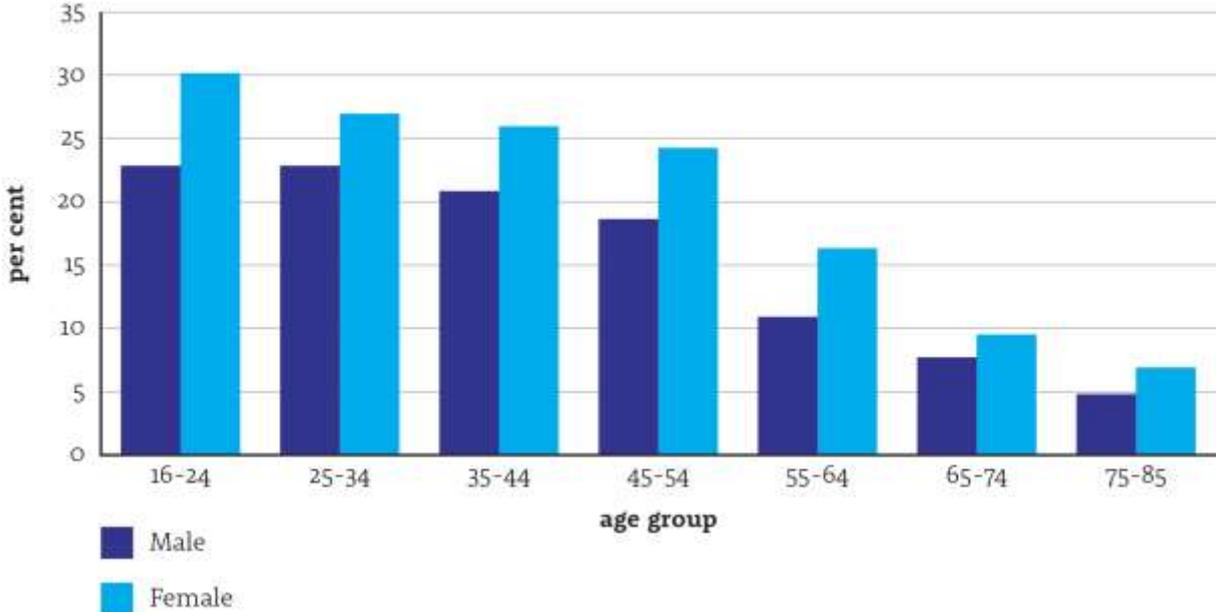
Something Meaningful To Do

Page 119: National Survey of Mental Health and Wellbeing

The previously described 2007 National Survey of Mental Health and Wellbeing (NSMHWB) included questions used to measure the prevalence of mental disorders in the community.

The following figure is presented on page 119 in the Report Card and is sourced from the 2007 NSMHWB data.

Figure 9: Prevalence of mental disorders by age group



Source: ABS National Survey of Mental Health and Wellbeing 2007

The following table presents the data which was sourced to produce the above figure.

Age group	Males	Females
16-24	22.8	30.1
25-34	22.8	26.9
35-44	20.8	25.9
45-54	18.6	24.2
55-64	10.9	16.3
65-74	7.7	9.5
75-85*	4.8	6.9

* These estimates have a relative standard error between 25% and 50% and should be interpreted with caution.

Notes:

- To estimate the prevalence of specific mental disorders, the 2007 National Survey of Mental Health and Wellbeing used the World Mental Health Survey Initiative version of the World Health Organization's Composite International Diagnostic Interview, version 3.0 (WMH-CIDI 3.0). Data is published in the 2007 NSMHWB according to the ICD-10 classification system.
- 12-month diagnoses were based on lifetime diagnosis and the presence of symptoms of that disorder in the 12 months prior to the survey interview.

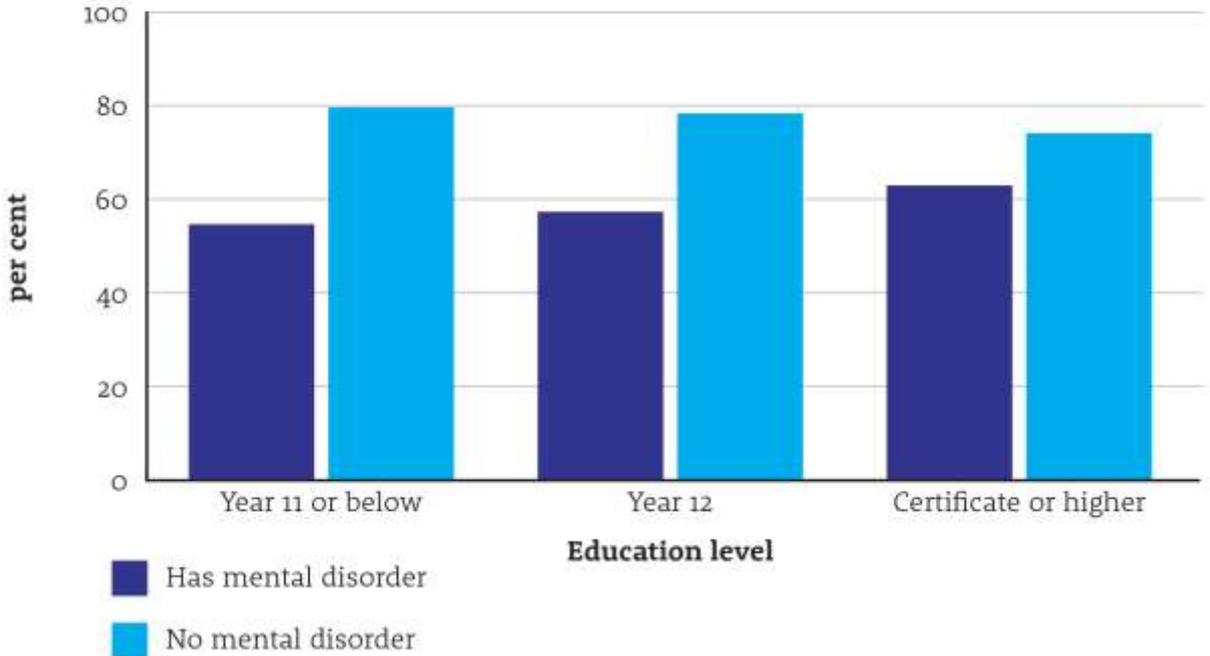
Page 127: National Health Survey

The previously described 2011-12 National Health Survey (NHS) included questions on engagement in employment and education.

The following figure is presented on page 127 in the Report Card and is sourced from the 2011-12 NHS data.

N.B. This data has not previously been publically available.

Figure 10: People aged 15-24 years who are fully engaged in employment and/or education by highest level of education and mental health status



Source: ABS National Health Survey 2011-12

The following table presents the data which was sourced to produce the above figure.

	Year 11 or below	Year 12	Certificate or higher
Has mental disorder	55.4	58.1	63.8
No mental disorder	80.7	79.4	75.1

Notes:

- Non-school qualification refers to educational attainments other than those of pre-primary, primary or secondary education. Includes 'Certificate I or II', 'Certificate III or IV', and 'Certificate not further defined' and higher qualifications.
- 'Fully engaged' comprises people who are engaged through full-time study for a qualification (including school), full-time employment, or part-time study for a qualification (including school) & part-time employment. 'Employed full time' are persons who are employed full time irrespective of whether they are also studying. 'Studying full time' are persons who are studying full time irrespective of whether they are also employed part time or not in the labour force. 'Unemployed' are persons who are unemployed irrespective of whether they were also studying part time.

- 'Education Level' refer to the level of education qualification completed. 'Level not determined' is not included. 'Year 11 or below' includes never attended school. 'Certificate or higher' includes 'Certificate I or II', 'Certificate III or IV', 'Certificate not further defined', Diploma, Advanced diploma, Bachelor degree and higher qualifications. For the purpose of this table, all non-school qualifications have been grouped together and treated higher than all school years.
- For the 15-17 age group in particular, most people are still in high school and may not yet have completed year 11 or 12. However if they are studying full time, they will be included in 'Fully engaged'.
- The concept of being fully engaged in employment, study or training is commonly used in the literature. Because there are a broad range of mental health conditions with varying levels of severity and duration, for some people with mental health conditions, being partially engaged may in fact be an excellent outcome. Also, informal work such as voluntary work or unpaid domestic activities are not included. It also does not capture descriptive measure of the employment or study, such as autonomy or working conditions.
- The NHS 2011-12 is designed to measure health information and aims to collect a comprehensive range of health related information and some demographics. The survey asked respondents about a broad range of topics (such as health risk factors, health related actions, income sources, etc.), in addition to the education, labour force and mental health information included in the attached tables. The NHS is not designed specifically for people with mental health conditions and will not, for example, include people who are in institutions.

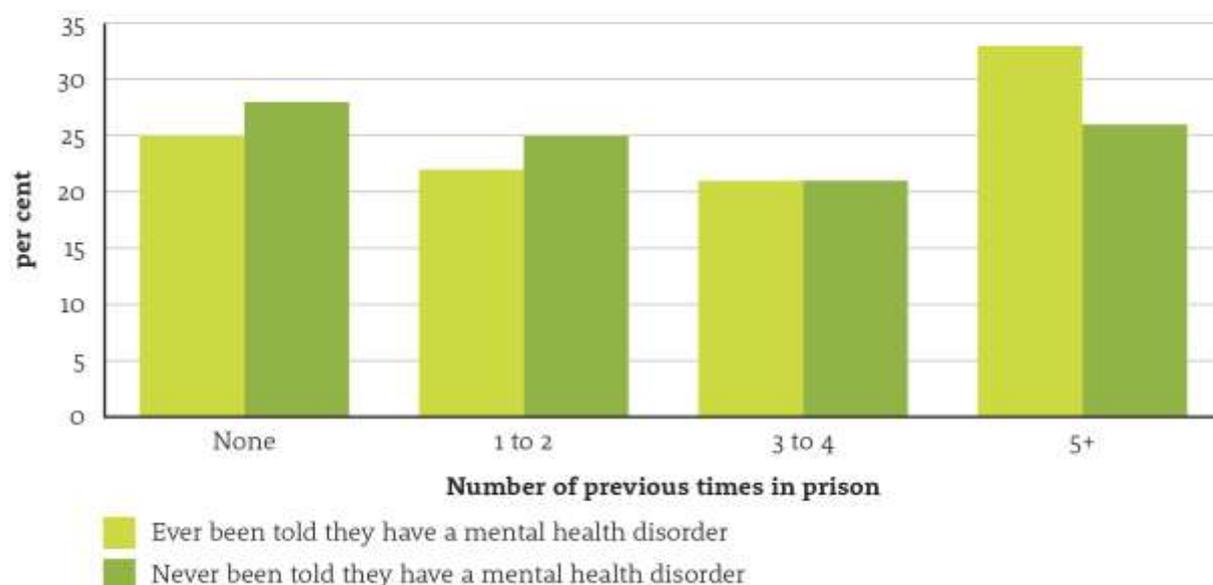
Feeling Safe, Stable and Secure

Page 147: Prison Health Data Collection

The following figure is presented on page 147 in the Report Card and is sourced from previously described 2012 AIHW Prison Health Data Collection.

N.B. This data has not previously been publically available.

Figure 11: Mental health history of prison entrants by the number of times previously in adult prison



Source: AIHW analysis of Prison Health Data Collection 2012 (Unpublished).

The following table presents the data which was sourced to produce the above figure.

Number of previous times in prison	Ever been told they have a mental health disorder*	Never been told they have a mental health disorder
Never	25	28
1 to 2	22	25
3 to 4	21	21
5+	33	26

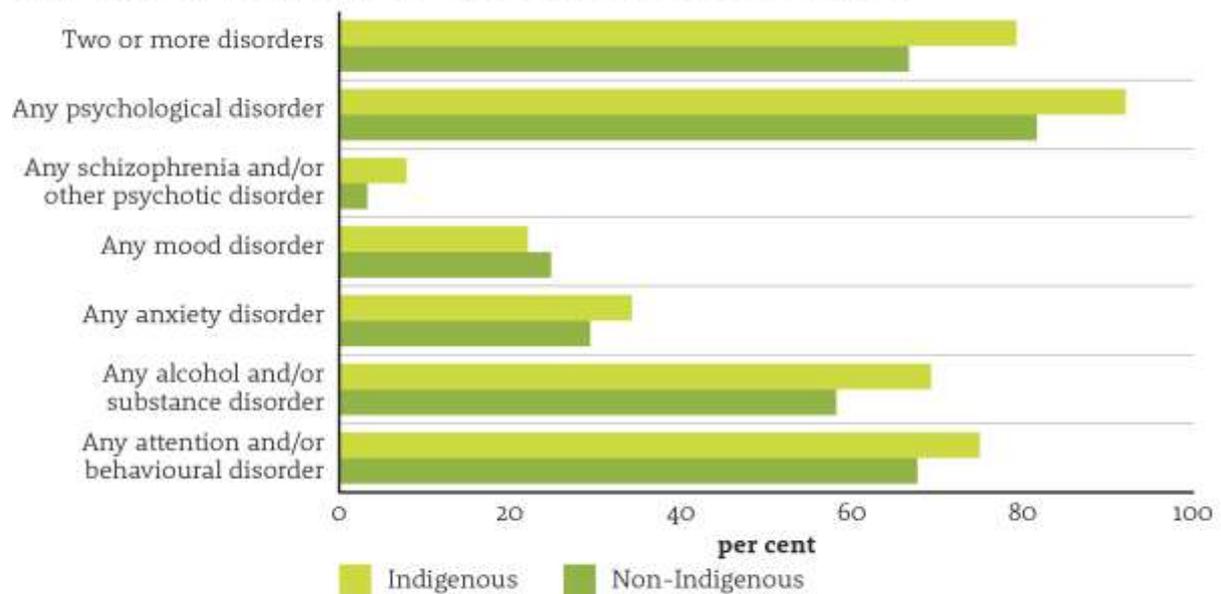
Notes:

- * Proportion of prison entrants who report that they have been told by a doctor, psychiatrist, psychologist or nurse that they have a mental health disorder (including drug and alcohol abuse).

Page 148: Young People in Custody Health Survey

The following figure is presented on page 149 in the 2013 Report Card and is sourced from the previously described 2009 Young People in Custody Health Survey (YPICHS) baseline survey.

Figure 12: People in juvenile detention in NSW with a mental illness



Source: 2009 NSW Young People in Custody Health Survey

The following table presents the data which was sourced to produce the above figure.

Disorder	Indigenous	Non-Indigenous
Any attention and/or behavioural disorder	75.0	67.7
Any alcohol and/or substance disorder	69.3	58.2
Any anxiety disorder	34.3	29.4
Any mood disorder	22.1	24.8
Any schizophrenia and/or other psychotic disorder	7.9	3.3
Any psychological disorder	92.1	81.7
Two or more disorders	79.3	66.7

Notes:

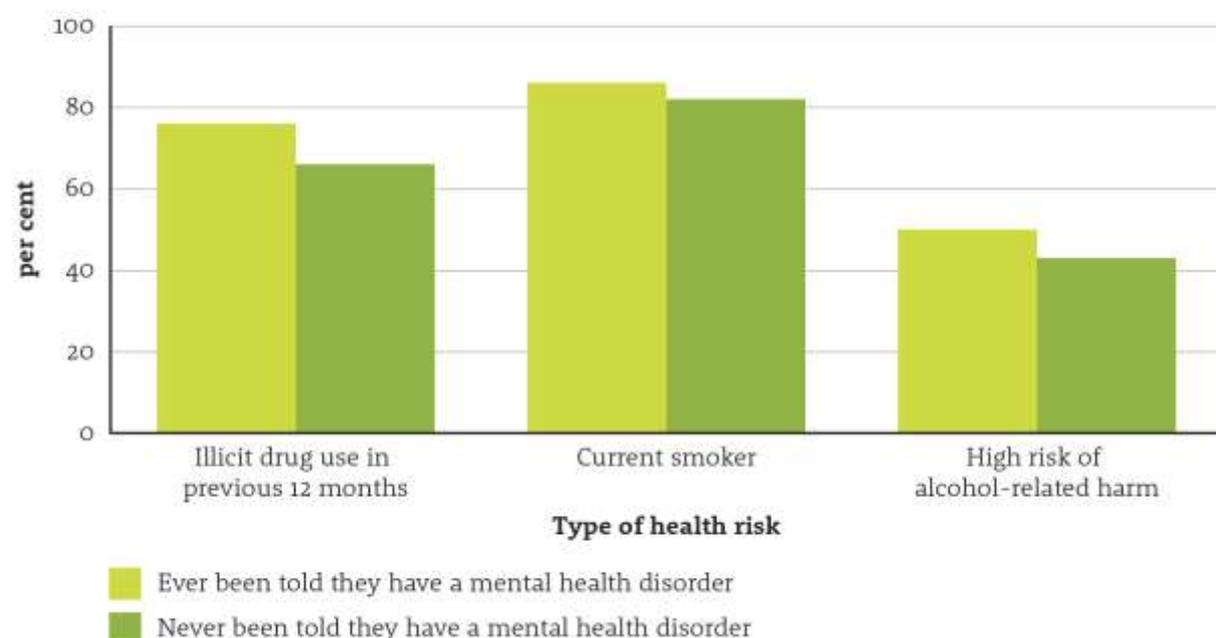
- A total of N=361 young people participated in the survey, which represented 80% of all young people in custody and 95% of young people approached to participate in the study. The sample was 88% male, 48% of Indigenous origin, with an average age of 17 years.
- Aboriginal young people were significantly more likely than non-Aboriginal young people to have an attention or behavioural disorder (75% vs 65%) or an alcohol or substance use disorder (69% vs 58%).

Page 149: Prison Health Data Collection

The following figure is presented on page 149 in the Report Card and is sourced from 2012 AIHW Prison Health Data Collection.

N.B. This data has not previously been publically available.

Figure 13: Mental health history of prison entrants by drug use, smoking status, and risk of alcohol-related harm



Source: AIHW analysis of Prison Health Data Collection 2012 (Unpublished).
 The following table presents the data which was sourced to produce the above figure.

Drug use	Ever been told they have a mental health disorder*	Never been told they have a mental health disorder
Illicit drug use in previous 12 months	76	66
Current smoker	86	82
High risk of alcohol-related harm	50	43

Notes:

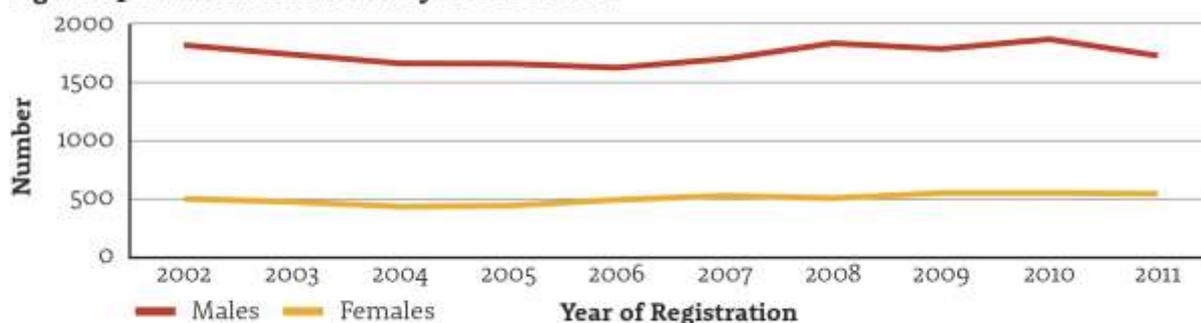
- * Proportion of prison entrants who report that they have been told by a doctor, psychiatrist, psychologist or nurse that they have a mental health disorder (including drug and alcohol abuse).
- High risk of alcohol-related harm represents the proportion of prison entrants who received a consumption score of at least 6 on the Alcohol Use Disorders Identification Test (AUDIT-C), indicating a risk of alcohol-related harm.

Preventing Suicide

Page 163: Cause of death data

The following figure is presented on page 163 in the Report Card and is sourced from ABS Cause of Death data.

Figure 14: Number of suicides by sex 2002-2011



Source: ABS Cause of death 2011

The following table presents the data which was sourced to produce the above figure.

Sex	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Males	1,817	1,737	1,661	1,658	1,624	1,699	1,833	1,785	1,867	1,727
Females	503	477	437	444	494	530	508	552	553	546

Notes:

- The number of deaths that are registered in any year will be different to the number of deaths that actually occurred in that year. Counts of specific causes of death (including suicide) based on year of occurrence are available in the ABS Year of Occurrence data cube.
- The proportion of suicide deaths that occur in a previous reference period (year of registration) can impact the overall count of suicide deaths, along with coronial investigations not being finalised and the revisions process undertaken by the ABS.
- All causes of death data from 2006 onward are subject to a revisions process—once data for a reference year are ‘final’, they are no longer revised. See Explanatory Notes 29–33 and Technical Note ‘Causes of Death Revisions’ in both the Causes of Death, Australia, 2010 and in Causes of Death, Australia, 2011 (cat. 3303.0).

Page 165: Cause of death data

The following figure is presented on page 163 in the Report Card and is sourced from ABS Cause of Death data.

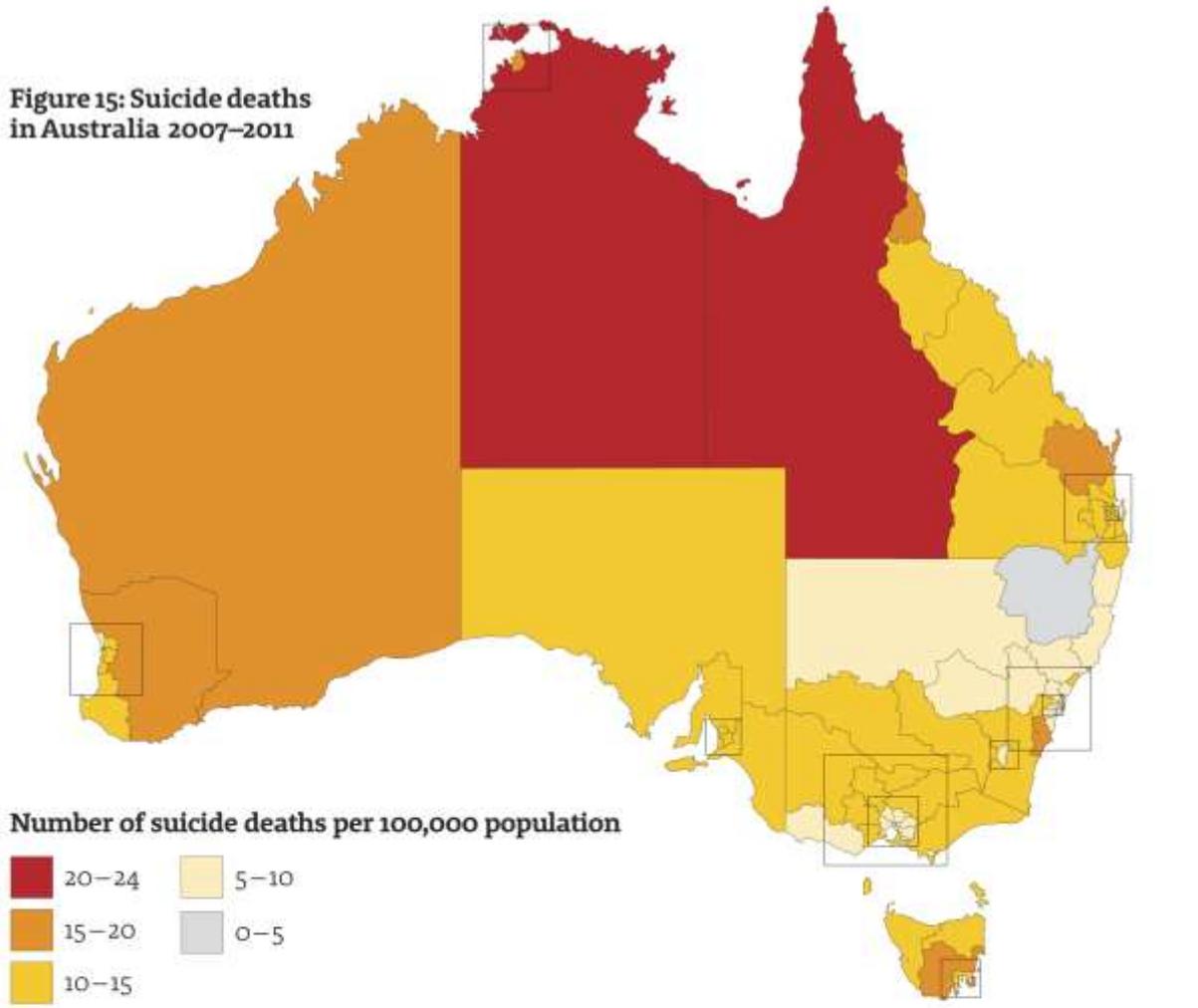
N.B. This presentation of suicide data has not previously been publically available.

Notes:

- The map presents aggregated suicide data for 2007-2011 reported at the Australian Standard Geographical Classification (ASGC) Statistical Area 4 level (SA4). More information on the ASGC can be found on the ABS website.
[http://abs.gov.au/websitedbs/D3310114.nsf/home/Australian+Standard+Geographical+Classification+\(ASGC\)](http://abs.gov.au/websitedbs/D3310114.nsf/home/Australian+Standard+Geographical+Classification+(ASGC))
- All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are ‘final’, they are no longer revised. Affected data in this table are: 2006-2009 (final), 2010 (revised), 2011 (preliminary). See Explanatory Notes 29-33 and Technical Notes, Causes of Death Revisions, 2006 in Causes of Death, Australia, 2010 (cat. 3303.0) and Causes of Death Revisions, 2009 and 2010 in Causes of Death, Australia, 2011 (cat. 3303.0).
- Age-standardised death rate per 100,000 population standardised against the 2001 Australian standard population.
- State and Territory totals include deaths where the individual’s usual residence could be attributed to a state or territory but not a specific Statistical Area 4.

- Care needs to be taken in interpreting figures relating to suicide. See Explanatory Notes 92–95 in Causes of Death, Australia, 2011 (cat. 3303.0).
- Data cells with small values have been randomly assigned to protect the confidentiality of individuals. As a result, some totals will not equal the sum of their components. Cells with a zero value have not been affected by confidentialisation.

Figure 15: Suicide deaths in Australia 2007–2011

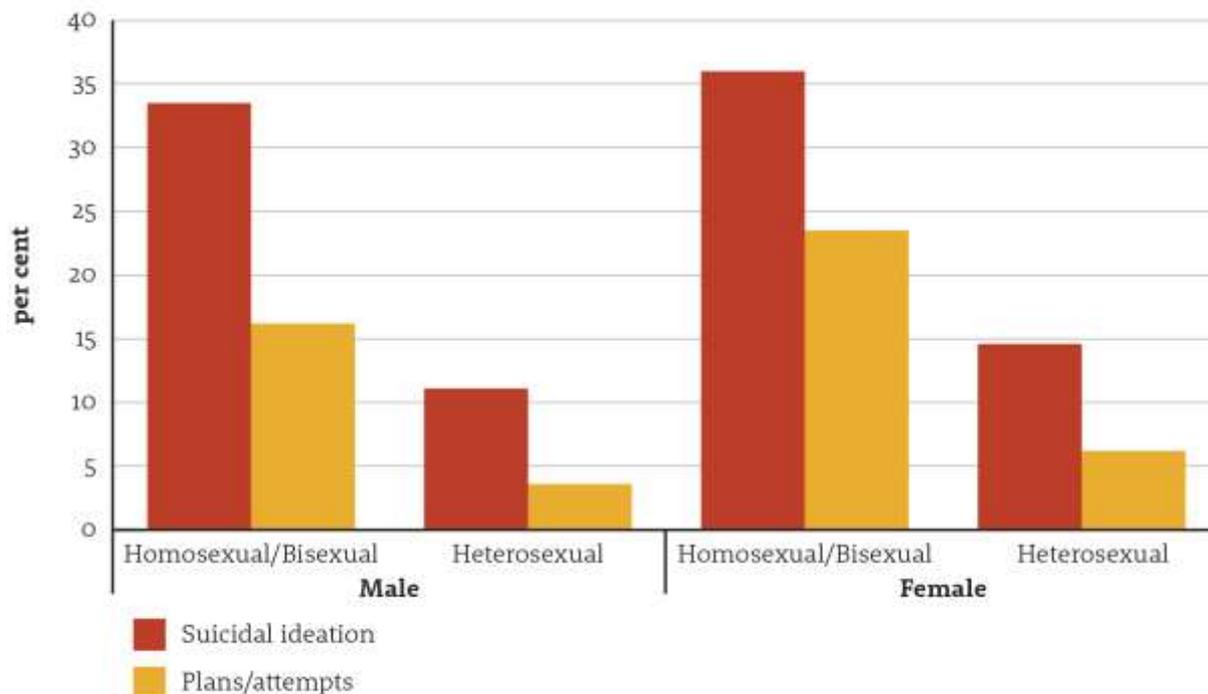


Based on ASGS Statistical Area 4. © Commonwealth of Australia 2013

Page 167: National Survey of Mental Health and Wellbeing

The following figure is presented on page 167 in the Report Card and is sourced from ABS 2007 NSMHWB data.

Figure 16: Suicidal ideation and behaviours in lifetime by Sex and Sexual orientation



Source: ABS. Analysis of 2007 NSMHWB (Unpublished)

The following table presents the data which was sourced to produce the above figure.

Suicidal ideation/behaviour	Male		Female	
	Homosexual / Bisexual	Heterosexual	Homosexual / Bisexual	Heterosexual
Suicidal ideation	33.5	11.1	36.0	14.6
Plans / Attempts	16.2	3.6	23.5	6.2

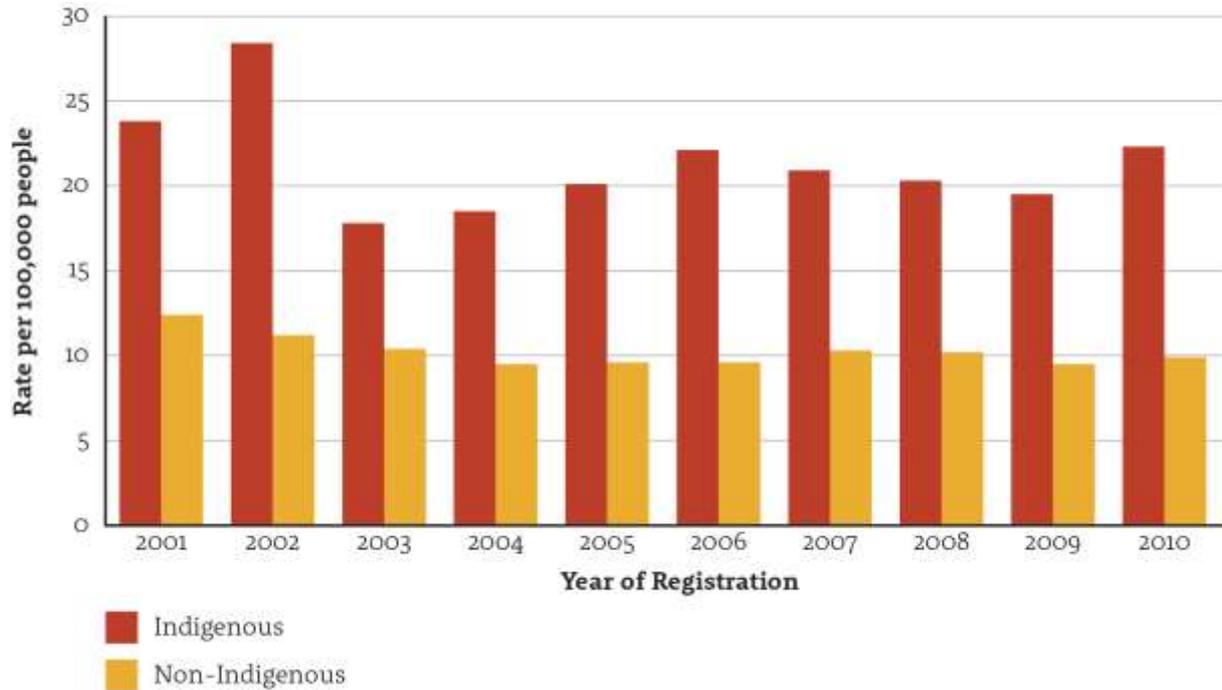
Notes:

- Suicidal ideation included people who had serious thoughts about committing suicide in the 12 months prior to the survey interview.
- Plans/attempts included people who had suicide plans or attempts in the 12 months prior to the survey interview.

Page 173: Cause of death data

The following figure is presented on page 173 in the Report Card and is sourced from ABS Suicides Australia 2010, based on ABS Causes of Death data.

Figure 17: Suicide rate for Indigenous and non-Indigenous populations, NSW, Qld, SA, WA and NT



Source: ABS Suicides Australia, 2010

Notes:

- Data are based on five jurisdictions for which the quality of Indigenous identification in mortality data is considered acceptable (NSW, Qld, SA, WA and NT only). Care should be taken when interpreting Aboriginal and Torres Strait Islander causes of death, particularly with regard to year-to-year changes. See Technical Note: Registration of outstanding deaths, Queensland, 2010, from the Deaths, Australia, 2010 publication (cat. no. 3302.0), and Explanatory Note 103 in the Causes of Death 2010 publication (cat. no. 3303.0).

4 Data Quality Statements

The purpose of a data quality statement is to provide an overview of the particular data collection and any known data quality issues.

This section provides a series of available data quality statements for selected national data collections which have been referenced in the 2013 Report Card.

National Survey of Mental Health and Wellbeing, 2007

Mental health measure

12-month mental disorder

Assessment of mental disorders is based on an international survey instrument, the Composite International Diagnostic Interview (CIDI), developed by the World Health Organization (WHO) for use by participants in the World Mental Health Survey Initiative.

The primary focus of the diagnostic modules is on the assessment of a lifetime mental disorder. This is based on the time when the respondent had the most symptoms or the worst period of this type. Where a number of symptoms were identified across a lifetime, the respondent was asked about the presence of symptoms in the 12 months prior to the survey interview. To be included in the 12-month prevalence rates, people must have met the criteria for lifetime diagnosis and had symptoms in the 12 months prior to interview.

Psychological distress

The Kessler Psychological Distress Scale-10 (K10) is used to provide broad information about people's social and emotional wellbeing. The K10 is a non-specific psychological distress scale consisting of 10 questions designed to measure levels of negative emotional states experienced by people in the four weeks prior to interview.

Institutional environment

The 2007 National Survey of Mental Health and Wellbeing (SMHWB) is processed and published by the ABS. The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. This framework ensures the ABS' impartiality and independence from political influence, and the confidentiality of respondents.

For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.

Relevance

Mental disorder (12-month and lifetime)

The SMHWB provides information about the prevalence of selected high-prevalence mental disorders in the Australian population aged 16–85 years; the level of impairment associated with these disorders; physical conditions; and the use of health services, such as consultations with health practitioners or visits to hospital. The survey also provides information on the strength of social networks, caring responsibilities and a range of socio-economic and demographic characteristics.

The SMHWB 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 SMHWB was not designed to measure the prevalence of all mental health conditions, therefore some severe mental disorders, such as schizophrenia, were not collected.

The 2007 survey was designed to provide data that were internationally comparable, rather than to provide comparisons with the 1997 SMHWB. The survey was also designed to provide estimates of the prevalence of mental disorders at a national rather than state/territory level.

Psychological distress

The Kessler Psychological Distress Scale-10 (K10) is a scale of non-specific psychological distress. Adults aged 18 years and over were asked questions about negative emotional states experienced in the 4 weeks prior to interview.

Based on research from other population studies, a very high level of psychological distress may indicate a need for professional help.

Timeliness

The SMHWB was conducted in 1997 and 2007.

Results from the 2007 survey were released ten months after the completion of enumeration, in the publication *National Survey of Mental Health and Wellbeing: Summary of Results* (cat. no. 4326.0).

Accuracy Estimates from the 2007 SMHWB are subject to sampling and non sampling errors. Sampling error is the difference between the published estimates, derived from a sample of persons, and the value that would have been produced if all persons in scope of the survey had been included.

The Relative Standard Error (RSE) is a measure of the size of the sampling error affecting an estimate; that is, the error introduced by basing estimates on a sample of the population rather than the full population. Estimates should be considered with reference to their RSEs. Estimates with an RSE between 25% and 50% should be used with caution, and those with an RSE greater than 50% are considered too unreliable for general use.

Non-sampling errors are inaccuracies that occur because of imperfections in reporting by respondents and interviewers, as well as errors made in coding and processing the data.

The SMHWB was designed primarily to provide estimates at the national level. Due to the higher than expected non-response rate, the RSEs for all estimates are somewhat larger than originally designed. Broad estimates may be available at the state level for the larger states, e.g. New South Wales. However, users should exercise caution when using estimates at this level due to high sampling errors.

An extensive range of non-response analyses were undertaken to ascertain, what, if any bias, may appear in the survey data. Analysis included comparisons of the characteristics of people who did and did not complete the personal interview, a small sample/short-form intensive Non-Response Follow-Up Study, and comparisons to existing ABS data. For more information on non-response, refer to the Explanatory Notes (cat. no. 4326.0).

Coherence The 2007 SMHWB was the second survey of this type conducted by the ABS, with the previous survey conducted in 1997. Care should be exercised when comparing data between surveys as there were a number of changes to the scope, design, collection, methodology and content. Details of the changes between these surveys are outlined in Appendix 2 of the SMHWB Users' Guide (cat. no. 4326.0).

Estimates derived from the SMHWB using the Composite International Diagnostic Interview (CIDI) will differ from those collected in the NHS long-term conditions measure.

The version of the Kessler Psychological Distress Scale (K10) used in the National Health Survey differs slightly from that used in the SMHWB. Care should therefore be taken in any comparisons made between the surveys. This difference is explained in greater detail in the Use of Kessler Psychological Distress Scale information paper (cat. no. 4817.0.55.001).

Accessibility The main products available from this survey are:

- *National Survey of Mental Health and Wellbeing: Summary of Results, 2007* (Cat. no. 4326.0)
- *National Survey of Mental Health and Wellbeing: Users' Guide, 2007* (Cat. no. 4327.0)
- *Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded Confidentialised Unit Record Files, 2007* (Cat. no. 4326.0.30.001)
- *Technical Manual: National Survey of Mental Health and Wellbeing, Confidentialised Unit Record Files* (Cat. no. 4329.0).

Further information may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level.

Interpretability The *National Survey of Mental Health and Wellbeing: Summary of Results* (Cat. no. 4326.0) includes explanatory material to aid the interpretation of the survey results. More detailed information is available in the *National Survey of Mental Health and Wellbeing: Users' Guide* (Cat. no. 4327.0).

Data gaps/issues The SMHWB was last collected in 2007.

Due to differences in collection methods, data regarding the type of professional help for mental health for which a perceived need exists are not directly comparable between the 1997 and 2007 surveys. In 1997, these data are presented with categories 'Social intervention' and 'Skills training'. In 2007, these categories were disaggregated to 'Help to sort out housing or money problems', 'Help to improve ability to work, or use time in other ways', 'Help to improve ability to look after self or home', and 'Help to meet other people for support or company'. This change in collection method may have had an unquantifiable impact on the comparability of estimates.

An issue in the 1997 survey in which responses from those who indicated that they had not been

abnormally happy or excited, but had been unusually irritable, were not coded to the computer file during the Computer Assisted Interview. This issue was resolved for the 2007 survey. As this issue may have slightly underestimated the prevalence of affective disorders in the 1997 survey, its resolution may have introduced differences in prevalence rates between the 1997 and 2007 surveys.

Changes to survey design between the 1997 and 2007 Surveys of Mental Health and Wellbeing may impact comparability:

1. The 2007 survey collected information from people aged 16-85 years, while the 1997 survey collected information on people aged 18 years and over. In 2007, overseas visitors who had been working or studying in Australia for the 12 months prior to the survey or were intending to do so were included in the scope. In 1997, overseas visitors were excluded.

2. The diagnoses of mental disorders for the 2007 survey are based on the CIDI 3.0, while the 1997 survey diagnoses were based on an earlier version of the CIDI (version 2.1). The CIDI 3.0 differs from earlier versions as it:

- has a number of expanded modules;
- incorporates changes to diagnostic algorithms and sequencing; and
- utilises a diagnostic 'screener'.

For example, the number of questions asked about scenarios which may have triggered a Post-Traumatic Stress Disorder (PTSD) increased substantially, from 10 questions in 1997 to 28 questions in 2007. Additionally, the 1997 survey excluded people who said their extremely stressful or upsetting event was only related to:

- bereavement;
- chronic illness;
- business loss;
- marital or family conflict; or
- a book, movie or television show.

3. The 2007 diagnostic criteria differed from 1997. In the 2007 SMHWP, to be included in the 12-month prevalence rates, people must have met the criteria for lifetime diagnosis and had symptoms in the 12 months prior to interview. However, in the 1997 SMHWP, diagnostic criteria were assessed solely on respondents' experiences in the 12 months prior to the survey interview.

4. A number of other differences exist between the diagnostic assessment criteria utilised in the 1997 and 2007 surveys. For an explanation of these differences, see Chapter 4 of the National Survey of Mental Health and Wellbeing: User Guide, 2007 (Cat. No. 4327.0).

National Health Survey, 2011-12

Measure

Mental and behavioural conditions

The National Health Survey (NHS) 2011-12 collected information on long-term health conditions (conditions that had lasted or were expected to last for six months or more). Mental and behavioural conditions were identified through self-reported information on long-term health conditions.

Psychological distress

The Kessler Psychological Distress Scale-10 (K10) is used to provide broad information about people's social and emotional wellbeing. The K10 is a non-specific psychological distress scale consisting of 10 questions designed to measure levels of negative emotional states experienced by people in the four weeks prior to interview.

Socio-economic information

In addition to health related information, the NHS 2011-12 collected a range of socio-economic information for respondents over 15 years, such as labour force status, whether currently studying, highest year of school completed and highest non-school educational attainment.

Institutional environment

The NHS was collected, processed, and published by the Australian Bureau of Statistics (ABS) as part of the Australian Health Survey. The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. These ensure the ABS' impartiality and independence from political influence, and the confidentiality of respondents.

For more information on the institutional environment of the ABS, including the legislative

obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.

Relevance

Mental and behavioural conditions

The 2011-12 NHS collected information to describe various aspects of the health status of the Australian population, with a focus on long-term conditions including mental and behavioural conditions. To enable the prevalence of current long-term conditions to be established, supplementary information was collected as part of the process of determining whether a reported condition was current and long-term. Current long-term conditions are defined as medical conditions (illnesses, injuries or disabilities) which were current at the time of the survey and which had lasted at least six months, or which the respondent expected to last for six months or more.

Up to six long-term mental and behavioural problems could be recorded. Conditions such as behavioural or emotional disorders, dependence on drugs or alcohol, feeling anxious or nervous, depression, and feeling depressed were identified on prompt cards with more general questions about long-term conditions. Other mental health conditions were collected when respondents were asked to identify any other long-term conditions they had. These conditions were identified by a mental health conditions coding list in the instrument.

For each mental and behavioural condition reported, respondents were also asked whether a doctor, nurse or other health professional had told them they had the condition, and if so, how old they were when they were told. Additional data were then collected for diagnosed, long-term mental health conditions. These include: consultations in taken in the 2 weeks prior to the interview, consultations with GPs, specialists and other health professionals in the 12 months prior to the survey, time off work or study for the conditions.

While the NHS collects a range of demographic and socio-economic information, the collection or output of these measures is not designed specifically for people with mental health conditions. Further information about this survey, such as the scope and response rates, is available in the Explanatory Notes and Users Guide.

People reporting mental health conditions that were not diagnosed by a medical professional are also included in the prevalence estimates. This has several important implications:

- The terminology used by respondents to describe conditions is more likely to be non-medical terminology. This has implications for the accuracy of the classification of the condition assigned through the coding process, and ultimately for use/interpretation of the survey results. In some areas it may also result in the loss of important distinctions in the data; for example “feeling depressed” and “clinical depression” are grouped under a single condition code.
- Respondents may not have reported behavioural conditions such as dependence on alcohol, or have not considered this to be a medical condition.

Psychological distress

The Kessler Psychological Distress Scale-10 (K10) is a scale of non-specific psychological distress. Adults aged 18 years and over were asked questions about negative emotional states experienced in the 4 weeks prior to interview. A very high level of psychological distress may indicate a need for professional help.

Timeliness

The NHS is conducted every three years over a 12 month period, with most recent data available for 2011-12. First results from the 2011-12 NHS, including mental health condition prevalence were released in October 2012. Updated results, including actions related to mental health conditions, were released in June 2013.

Accuracy

Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were not included in the survey. Urban and rural areas in all states and territories were included, while Very Remote areas of Australia and discrete Aboriginal and Torres Strait Islander communities (and the remainder of the Collection Districts in which these communities were located) were excluded. These exclusions are unlikely to affect national estimates, and will only have a minor effect on aggregate estimates produced for individual states and territories, except the Northern Territory where the population living in Very Remote areas accounts for around 23% of persons. The 2011-12 NHS response rate was 85%. NHS data are weighted to account for non-response.

The NHS provides:

- relatively detailed estimates for each State, ACT and Australia
 - relatively detailed estimates for capital city/balance of State areas within each State,
 - broad level estimates for regions within the larger States, and
 - estimates for those characteristics which are relatively common, and sub-populations
-

which are relatively large and spread fairly evenly geographically.

Estimates from the 2011-12 NHS are subject to sampling and non-sampling errors.

The Relative Standard Error (RSE) is a measure of the size of the sampling error affecting an estimate; that is, the error introduced by basing estimates on a sample of the population rather than the full population. Estimates should be considered with reference to their RSEs. Estimates with an RSE between 25% and 50% should be used with caution, and those with an RSE greater than 50% are considered too unreliable for general use.

Non-sampling errors are inaccuracies that occur because of imperfections in reporting by respondents and interviewers, as well as errors made in coding and processing data. One potential source of non-sample error may be the way that respondents report mental health conditions. The reported prevalence of mental illness is complex and dynamic, and is a function of respondent knowledge and attitudes, which in turn may be affected by the availability of health services and health information, public education and awareness, accessibility to self-help, etc. Although it is not possible to quantify non-sampling error, every effort is made to reduce it to a minimum.

Coherence

The Australian Health Survey: Users' Guide 2011-12 (cat. no. 4363.0.55.001) provides information to assist users of the data to understand both the nature of the survey and its potential to meet their data needs. It may also assist in understanding the relationship between data variables within the dataset.

The methods used to construct the measures are consistent and comparable with other collections and with international practice.

Long-term health conditions described in this publication are classified to a classification developed for use in the NHS (or variants of that classification), based on the International Classification of Diseases (ICD). Estimates for people with mental health conditions will differ to the National Survey of Mental Health and Wellbeing (SMHWB) (cat. no. 4326.0) which used the World Health Organization's Composite International Diagnostic Interview (CIDI) to estimate the prevalence of lifetime and 12-month mental disorders.

The definitions of employment, unemployment and the labour force are consistent with those used in ABS labour force surveys.

Accessibility

Health data is accessible in a variety of formats on the ABS website (under catalogue number 4363).

Data from the National Health Survey, 2011-12 is also available through the TableBuilder Advanced product. Data obtained in the survey but not presented in the TableBuilder may also be available from the ABS, on request, as statistics in tabulated form.

The ABS observes strict confidentiality protocols as required by the Census and Statistics Act (1905). This may restrict access to data at a very detailed level.

Interpretability

Information to aid interpretation in a variety of forms is available from the ABS website:

- Australian Health Survey: Users' Guide, 2011-13 (cat. no. 4363.055.001)
- Australian Health Survey: Glossary, 2011-13
- National Health Survey Questionnaire
- Australian Health Survey Data item list

Data gaps/issues

Understanding the comparability of data from the 2011-12 NHS with data from previous cycles is important when interpreting apparent changes in health characteristics over time.

While the 2011-12 NHS is deliberately the same or similar in many ways to the 2007-08 survey, there are important differences in sample design and coverage, survey methodology and content, definitions and classifications between the surveys. These differences will affect the degree to which data are directly comparable between the surveys, and hence the interpretation of apparent changes in health characteristics over the 2007-08 to 2011-12 periods.

Comparability between the 2007-08 and 2011-12 National Health Surveys: Prevalence information about long-term mental health problems may not be directly comparable between surveys as additional conditions were added to the prompt cards. In particular, depression was added to the prompt card for other long term conditions. This is likely to have increased the prevalence of depression. Changes in community perceptions of mental illness/problems, together with changes in the identification of illness and the treatment of conditions (e.g. institutional versus community care) may also have affected the degree to which certain conditions were identified in the survey.

Users should also note that the version of K10 used in the NHS is slightly different to that used in the SMHWB (see Kessler Psychological Distress Scale, in Other Scales and Measures, National

Prisoners in Australia, 2012

Measure	Aboriginal and Torres Strait Islander Adult Prisoners ABS collects counts from corrective service agencies of the number of people in correctional institutions and a range of characteristics including Indigenous status.
Institutional environment	<p>The management of adult persons in custody and those on remand is the responsibility of state and territory corrective services agencies. Information on these persons is recorded by the corrective services agency for operational and case management purposes. Corrective services statistics published by the Australian Bureau of Statistics (ABS) are based on data extracted from these administrative records for all states and territories.</p> <p>Within the ABS, corrective services statistics are produced by the National Corrective Services Statistics Unit (NCSSU). The NCSSU operates under the auspices of an Inter-Governmental Agreement between the Commonwealth and the Corrective Services Ministers of each of the states and territories. One of the major functions of the Unit is to compile, analyse, publish and disseminate nationally comparable corrective services statistics.</p> <p>For information on the institutional environment of the Australian Bureau of Statistics (ABS), including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.</p>
Relevance	The Prisoner Census provides statistics on all persons in the legal custody of adult corrective services in each state and territory in Australia, as at 30 June. These statistics describe the characteristics of prisoners, their sentence length, the most serious offence/charge for which offenders are imprisoned, and provide a basis for measuring change over time.
Timeliness	Data from the Prisoner Census is released annually in Prisoners in Australia (cat. no. 4517.0) and accompanying data cubes within approximately 6 months of the reference period. Each release includes data for the current reference year, along with 10 year time series for some data items.
Accuracy	<p>The Prisoner Census is based on a snapshot of all prisoners taken as at midnight on 30 June of each year. The data is extracted from each state and territory's prisoner management information system. As it is a census the data is not subject to sampling error. Non-sampling errors can arise from inaccuracies in recording by corrective services agencies, when the data is extracted, processed and disseminated. The ABS has limited influence over any errors associated with data recorded by external sources. The ABS does provide a collection manual which outlines the scope, coverage, counting rules and data item definitions for the Prisoner Census to minimise data extraction errors. Efficient processing and editing procedures are in place within the ABS to minimise processing and reporting errors.</p> <p>Revisions to data may be made when new information about the accuracy of previously published data has been identified.</p>
Coherence	<p>The Prisoner Census is taken on 30 June each year. Due to differing scope and counting rules, the data may not be comparable to those published in other national and state/territory publications.</p> <p>In order to ensure consistency in the data for each state and territory, prisoner census statistics are compiled according to national standards and classifications. However, some differences still occur due to state and territory legislative and procedural requirements or to limitations of the various administrative data bases that are used to extract the data.</p> <p>In all states and territories except Queensland, persons are considered adults if aged 18 years and over. In Queensland persons are considered adults if aged 17 years and over.</p> <p>Statistics for persons held in custody are presented by the state or territory in which they were held and this may not be the state or territory in which they were sentenced.</p> <p>The Prisoner Census is limited in scope to persons remanded or sentenced to adult custodial corrective services agencies, therefore does not include people serving community service orders or those held under the authority of juvenile justice agencies.</p> <p>A number of legislative and administrative system changes have occurred over time and the statistical impact of these changes is detailed in the Explanatory Notes.</p>

Accessibility If the required information is not available from the Prisoners in Australia (cat. no. 4517.0) publication or Data Cubes, the National Centre for Crime and Justice Statistics within the ABS may be able to help you with a customised service to suit your needs. Email: <crime.justice@abs.gov.au>.

Interpretability The Prisoners in Australia publication contains detailed Explanatory Notes, Appendices and a Glossary which provide information on the data sources, counting rules, terminology, classifications and other technical aspects associated with these statistics.

To assist in the comparison of the prisoner populations across states and territories, imprisonment rates are included in the publication. Indigenous imprisonment rates, both crude and age-standardised, are included to allow for meaningful comparisons of the Indigenous and non-Indigenous prisoner populations.

Causes of Death, Australia 2011

Measure **Prevalence of suicides**

ABS data on suicide deaths are sourced from the state and territory Registrars of Births, Deaths and Marriages and supplemented by information from the National Coroner's Information System (NCIS).

Institutional environment Death statistics published by the ABS are sourced from death registrations systems administered by the various state and territory Registrars of Births, Deaths and Marriages and supplemented by information from the National Coroners Information System (NCIS). It is a legal requirement of each state and territory that all deaths are registered. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred. As part of the registration process, information on the cause of death is either supplied by the medical practitioner certifying the death on a Medical Certificate of Cause of Death, or supplied as a result of a coronial investigation.

For information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.

Relevance Death statistics are one of the components in the production of estimates of natural increase (the difference between numbers of births and deaths) used as a component of population change in the calculation of population estimates of Australia and the states and territories. Death statistics are also essential in the analysis of morbidity and mortality in Australia. Trends in mortality are used in the development of assumptions of future levels of mortality for population projections.

Causes of Death, Australia (cat. no. 3303.0) contains statistics for deaths and mortality in Australia disaggregated by underlying cause, leading cause and multiple causes. Data refer to deaths registered during the calendar year shown, unless otherwise stated. Statistics on demographic characteristics of the deceased such as age at death, sex, place of usual residence, marital status, Indigenous status and country of birth are included.

Data quality depends on the procedures being followed at every stage of collection and processing of statistical information. The quality of multiple cause of death data is particularly dependent on the contribution that doctors and coroners make when recording information about a death. When analysing multiple causes of death data, it is important to note that some conditions present at death will not be identified, effectively leading to under-reporting of associated causes and conditions. The extent to which under-reporting of multiple causes of death occurs is unknown and there may be differences in the likelihood of particular conditions being identified.

Suicides, Australia (cat. No. 3309.0) contains additional information where the underlying cause of death was determined as Intentional self-harm. To be classified as a suicide, a death must be recognised as being due to other than natural causes.

Timeliness Death records are provided electronically to the ABS by individual Registrars on a monthly basis for compilation into aggregate statistics on a quarterly and annual basis.

Quarterly estimates of deaths on a preliminary basis are published five to six months after the reference period in Australian Demographic Statistics (cat. no. 3101.0), and revised 21 months after the end of each financial year. Annual estimates on a year of registration basis are generally published within eleven months of the end of the reference year in Deaths, Australia (cat. no. 3302.0).

One dimension of timeliness in death registrations data is the interval between the occurrence

and registration of a death. As a result, a small number of deaths occurring in one year are not registered until the following year or later.

Accuracy

Information on deaths is obtained from a complete enumeration of deaths registered during a specified period and are not subject to sampling error. However, deaths data sources are subject to non-sampling error which can arise from inaccuracies in collecting, recording and processing the data.

Sources of non-sample error include:

- completeness of an individual record at a given point in time;
- completeness of the dataset (e.g. impact of registration lags, processing lags and duplicate records);
- extent of coverage of the population (whilst all deaths are legally required to be registered, some cases may not be registered for an extended time, if at all); and
- lack of consistency in the application of questions or forms used by data providers, both through time and between different jurisdictions.

Every effort is made to minimise error by working closely with data providers, the careful design of forms, training of processing staff, and efficient data processing procedures.

Although it is considered likely that most deaths of Aboriginal and Torres Strait Islander (Indigenous) Australians are registered, a proportion of these deaths are not registered as Indigenous. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred and may differ from the self-identified Indigenous origin of the deceased. Forms are often not subject to the same best practice design principles as statistical questionnaires, and respondent and/or interviewer understanding is rarely tested. Over-precise analysis of Indigenous deaths and mortality should be avoided.

All coroner certified deaths registered after 1 January 2006 are now subject to a revisions process. In this round of reporting, 2007, 2008 and 2009 data is final, 2010 data is revised and 2011 data is preliminary. Data for 2010 and 2011 is subject to further revisions. Prior to 2006 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 (e.g. a coroner certified death was yet to be finalised by the Coroner), less specific ICD codes were assigned as required by the ICD coding rules. The revision process enables the use of additional information relating to coroner certified deaths, as it becomes available over time. This results in increased specificity of the assigned ICD-10 codes.

Revisions will only impact on coroner certified deaths, as further information becomes available to the ABS about the causes of these deaths. See Technical Note: Causes of Death Revisions 2009 and 2010 and in Causes of Death, Australia, 2011 (cat.no. 3303.0).

Coherence

The international standards and recommendations for the definition and scope of deaths statistics in a vital statistics system are set out in the Principles and Recommendations for a Vital Statistics System Revision 2, published by the United Nations Statistical Division (UNSD). Consistent with the UNSD recommendations, the ABS defines a death as the permanent disappearance of all evidence of life at any time after live birth has taken place. In addition, the UNSD recommends that the deaths to be counted include all deaths "occurring in every geographic area and in every population group comprising the national area". For the purposes of Australia, this includes all deaths occurring within Australia as defined by the Australian Statistical Geographical Standard (ASGS) that applies at the time.

Registration of deaths is compulsory in Australia under relevant state/territory legislation. However, each state/territory Registrar has its own death registration form. Most data items are collected in all states and territories and therefore statistics at a national level are available for most characteristics. In some cases, different wording of questions asked on the registration form may result in different answers, which may affect final figures.

Use of the supporting documentation released with the statistics is important for assessing coherence within the dataset and when comparing the statistics with data from other sources. Changing business rules over time and/or across data sources can affect consistency and hence interpretability of statistical output.

Accessibility

Deaths data is available in a variety of formats on the ABS website under the 3302.0 product family.

The formats are:

- Main Features, which contains summary commentary;
- an Adobe PDF of the publication; and
- data cubes (in Microsoft Excel spreadsheet format)

Further information may be available on request. The ABS observes strict confidentiality protocols as required by the Census and Statistics Act (1905). This may restrict access to data at a

very detailed level.

Interpretability Deaths statistics are generally straightforward and easy to interpret. It should be noted, however, that changes in numbers of deaths over time can be due to a number of factors including changes in mortality and changes in the size and age/sex structure of the population. For this reason, deaths data needs to be considered in relation to the size of the relevant population(s) through the use of mortality rates.

Information of mortality rates, as well as data sources, terminology, classifications and other technical aspects associated with the statistics presented in these publications can be found under category numbers 3303.0 and 3309.0.

Data gaps/issues Issues for data on intentional self-harm (suicide):

1. The number of deaths attributed to suicide for 2011 is expected to increase as data is subject to the revisions process, see Explanatory Notes 29-33 and Technical Notes, Causes of Death Revisions 2009 and 2010 in Causes of Death, Australia, 2011 (cat. no. 3303.0) See also the Accuracy section, above.
 2. In addition to the revisions process, new coding guidelines were applied for deaths registered from 1 January 2007. The new guidelines improve data quality by enabling deaths to be coded to suicide if evidence indicates the death was from intentional self-harm. Previously, coding rules required a coroner to determine a death as intentional self-harm for it to be coded to suicide. However, in some instances the coroner does not make a finding on intent. Under the new coding guidelines, in addition to coroner-determined suicides, deaths may also be coded to suicide following further investigation of information on the NCIS. See Explanatory Notes 93 and 94 in Causes of Death, Australia, 2011 (cat. no. 3303.0) for a more detailed discussion on how the change to coding guidelines may influence the number of deaths coded to suicide.
 3. For processing of deaths registered from 1 January 2007, revised instructions for ABS coders were developed in order to ensure consistency in the coding of suicide deaths and compliance with the revised notes for coding to the undetermined intent categories. At the time that the ABS ceases processing, each coroner's record on the NCIS will have a status of 'open' or 'closed'. The NCIS case status impacts on how deaths are coded with regard to suicides. With the introduction of the revisions process for all deaths registered from 1 January 2006, additional information received by the ABS may lead to a more specific cause of death code being assigned.
 4. Suicide deaths of children are an extremely sensitive issue for families and coroners. The number of child suicides registered each year is small and is likely to be underestimated, more so than for other age groups.
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Survey of Disability, Ageing and Carers, 2009

Mental health measure **Psychological disability**
The 2009 Survey of Disability, Ageing and Carers (SDAC) collects information on people who identify having a psychological disability which is defined as either a long-term mental illness or conditions for which help or supervision is required, or a nervous or emotional condition that restricts everyday activities.

Institutional environment The SDAC is collected, processed, and published by the ABS. The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. This framework ensures the ABS' impartiality and independence from political influence, and the confidentiality of respondents. This framework ensures the ABS' impartiality and independence from political influence, and the confidentiality of respondents.

For information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, see ABS Institutional Environment (available www.abs.gov.au).

Relevance The 2009 Survey of Disability, Ageing and Carers (SDAC) collects information to:

- measure the prevalence of disability in Australia
- measure the need for support of older people and those with a disability
- estimate the number of and provide information about people who provide care to older people and people with disabilities
- provide a demographic and socio-economic profile of people with disabilities, older people and carers compared with the general population.

The SDAC contains the most comprehensive and accurate measure of disability produced by the ABS, using 125 questions to collect information on any conditions people may have, whether these conditions cause restrictions, and the nature and severity of any restrictions. Long term conditions data is self-reported.

Timeliness

The SDAC was conducted throughout Australia from April to December 2009, with data from the survey released twelve months after the completion of enumeration. The ABS has been conducting similar surveys on a five to seven year basis since 1981.

Results from the 2009 survey were released ten months after the completion of enumeration, in the publication Disability, Ageing and Carers: Summary of Findings (cat. no. 4430.0).

Accuracy

The 2009 SDAC was designed to provide reliable estimates at the national level and for each state and territory.

Dwellings in each state and territory were selected at random using a multi-stage area sample. The sample for the 2009 SDAC consisted of approximately 31,900 private dwellings, 1,150 health establishments (cared accommodation) and 360 other non-private dwellings. After sample loss, the sample included approximately 27,600 private dwellings, 1,100 health establishments and 200 other non-private dwellings.

Estimates from the 2009 SDAC are subject to sampling and non-sampling errors. Sampling error is the error associated with taking a sample of dwellings rather than going to all dwellings in Australia. The sampling error is measured by the relative standard error (RSE), the standard error expressed as a percentage of the estimate.

Non-sampling errors can occur in any data collection, whether based on a sample or a full count such as a census. Sources of non-sampling error include non-response, errors in reporting by respondents or recording answers by interviewers, and errors in coding or processing of data. Every effort was made to reduce the non-sampling error by careful design and testing of questions, training interviewers, follow-up of respondents and extensive editing and quality control procedures at all stages of data processing.

Coherence

The 2009 SDAC is the sixth survey of disability conducted by the ABS, with similar surveys conducted in 1981, 1988, 1993, 1998 and 2003. Much of the content of the six disability surveys is comparable, however there are some differences as later surveys have attempted to obtain better coverage of disability, specific tasks and activities previously considered too sensitive for a population survey and identification of primary carers. For the 2003 survey, the inclusion of questions relating to unmet need for and receipt of assistance with cognition or emotion provided a better perspective on assistance needs and requirements for both physical and psychological needs. Further enhancements to measuring unmet need were added in the 2009 survey.

Results from the 1998 and 2003 SDAC were published in Disability, Ageing and Carers, Australia: Summary of Findings, 2003 (cat. no. 4430.0, previous issue) and Disability, Ageing and Carers, Australia: Summary of Findings, 1998 (cat. no. 4430.0, previous issue).

Supporting documentation released with the survey data can assist in understanding the relationships between data variables within the dataset and in comparisons with data from other sources.

Accessibility

The main products available from this survey are:

- Disability, Ageing and Carers: Summary of Findings, 2009 (Cat. no. 4430.0)
- Disability, Ageing and Carers: User Guide, 2009 (Cat. no. 4431.0.55.001)
- Microdata: Disability, Ageing and Carers, Australia, 2009 (Cat. no. 4430.0.30.002)
- Information Paper: Disability, Ageing and Carers, Basic CURF, Australia, 2009 (Cat. no. 4430.0.00.001)

Further information may be available on request. The ABS observes strict confidentiality protocols as required by the Census and Statistics Act (1905). This may restrict access to data at a very detailed level.

Interpretability

The Disability, Ageing and Carers, Australia: Summary of Findings (Cat. no. 4430.0) includes explanatory material to aid the interpretation of the survey results. More detailed information is available in the Disability, Ageing and Carers: User Guide, 2009 (Cat. no. 4431.0.55.001).

National Prisoner Health Data Collection

Overview The NPHDC is the only national source of information on the health of prisoners in Australia, covering a broad range of health issues and social determinants of health. Paper-based data collection forms are completed in the context of routine health assessments and service provision, by prison health services.

Institutional environment The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management Board, and accountable to the Australian Parliament through the Health and Ageing portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The Australian Institute of Health and Welfare Act 1987, in conjunction with compliance to the Privacy Act 1988 (Cth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website <www.aihw.gov.au>.

The AIHW has been maintaining the NPHDC since 2009.

Relevance Scope and coverage
A prison entrant is classed as a person aged at least 18, entering full-time prison custody, either on remand (awaiting a trial or sentencing) or on a sentence. Prisoners who have been transferred from one prison to another are not included as entrants.

A prison dischargee is a full-time prisoner aged at least 18, who expects to be released from prison within the 4 weeks following the time of interview.

Prisoners aged at least 18 years, held in full-time custody in correctional facilities in Australia are in scope for the clinic and medication components of the NPHDC.

Police cells, court cells, periodic detention, juvenile correctional facilities and immigration detention centres are out of scope for all components of the NPHDC.

Reference period

The NPHDC was conducted over a 2-week period in May 2012. Entrants, discharge, and clinic data cover the whole 2-week period, and medications data cover 1 day in this 2-week period. Some indicators cover entire the 2011–12 financial year.

Coverage

In 2012, data were collected from all states and territories except Western Australia.

Statistical standards

Australian Standard Classification of Countries (ASCC) and Australian Standard Classification of Languages (ASCL) were used as the code frame for questions on country of birth and main language spoken at home.

Timeliness Data were collected over a 2-week period in May 2012 (14–27 May), and provided to the AIHW. The NPHDC has been conducted 3 times: 2009, 2010 and 2012. The exact timing of the data collection and how often it will be conducted in the future is not yet confirmed.

Accuracy Participation rate
The participation rate for entrants in 2012 was 70%; indicating that 3 out of 10 prison entrants did not provide data on entry to prison, with variation among the states and territories. However, estimates which consider those who were not approached suggest a participation rate for entrants of about 60%. The participation rate for dischargees was 55% in 2012; indicating that just under

half of prisoners exiting prison did not contribute to the data collection. Estimates which consider those who were not approached suggest a participation rate for dischargees of about 28%. 2012 was the first year that the discharge component of the data collection had been implemented, so lower participation rates were expected. Entrant non-participants were predominantly male (81%) but females were overrepresented (19%) compared with those who did participate (10%). The proportion of non-Indigenous non-participants was similar to participants (65% and 63%, respectively). Sex and age profiles for dischargee participants and non-participants were very similar; but a slightly higher proportion of non-participants were Indigenous (35% compared with 31%).

Indigenous data

Identification of Indigenous status was generally good in each state and territory, with unknown rates under 10%. The proportion of Indigenous participants in the entrants and discharge data were slightly higher than the reported proportion of the prisoner population on 30 June 2012.

Coherence

The indicators that constitute the NPHDC were developed by the AIHW with the assistance and advice of the National Prisoner Health Information Committee (NPHIC) and are influenced by policy relevance in monitoring key aspects of prisoner health. The data collection has been conducted in 2009, 2010 and 2012.

New data items were added in the 2012 NPHDC to the entrants, clinic and establishments collections. Also, the discharge component of the collection was introduced. Existing data items had minimal or no changes from previous years.

Comparison of data from previous years is difficult because the participating jurisdictions have changed, and therefore comparisons at the national level should be used with caution. Comparisons between years at the jurisdictional level may be more appropriate. Trend data for those states and territories which have participated in all three data collections would also be possible.

Accessibility

The AIHW website provides prisoner health data which can be downloaded free of charge. Reports including The health of Australia's prisoners, and thematic bulletins, are published and are available on the AIHW website where they can be downloaded without charge. Users can request data not available online or in reports via the Child Welfare and Prisoner Health Unit, Australian Institute of Health and Welfare on (02) 6244 1000 or via email to <prisoner.health@aihw.gov.au>. A fee may be charged for substantial requests on a cost-recovery basis. General enquiries about AIHW publications can be made to the Communications, Media and Marketing Unit on (02) 6244 1032 or via email to <info@aihw.gov.au>.

Interpretability

Most of the data in the NPHDC are self-report rather than diagnostic health data. Reports such as The health of Australia's prisoners have a 'method' section in the Introduction chapter, where technical information may be found.

The denominator for indicators sourced from the clinic and medication data is the total number of prisoners in custody at 30 June for the relevant year. Some indicators in the NPHDC relate to 12 months of data (number of pregnant prisoners in custody, number of prisoners taking medication for hepatitis C, number of notifications of sexually transmitted infections). To provide an appropriate denominator for these indicators, jurisdictions provide data on the number of prisoners received into prison and released from prison, during the same 12-month period. This is a more appropriate denominator for these indicators, as it provides a more accurate representation of the number of prisoners over a 12-month period than the ABS 30 June snapshot.

A Contributing Life
**The 2013 National Report Card on
Mental Health and Suicide Prevention**

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Australian Government
National Mental Health Commission