Australian Government
Australian Institute of Health and Welfare

AIHW

Dr Fiona Martin MP
Chair
Select Committee on Mental Health and Suicide Prevention
PO Box 6021
Parliament House
CANBERRA ACT 2600

Dear Dr Martin

Submission to Select Committee on Mental Health and Suicide Prevention

The Australian Institute of Health and Welfare (AIHW) welcomes the opportunity to provide a submission to the Select Committee on Mental Health and Suicide Prevention.

The AIHW is a nationally recognised independent information management agency. We are committed to using data to create information and statistics on a range of health and welfare topics and publish reports and online tables for everyone to access. We aim to inform good decisions—and improve the health and welfare of all Australians—through strong evidence that is timely, reliable, relevant and trusted.

We trust that you find this information useful. Should the committee have any queries about the information we have provided, or wish to seek additional information from the AIHW, please contact Mr Matthew James, Deputy Chief Executive Officer via telephone on 02 6244 1204 or email matthew.james@aihw.gov.au.

Yours sincerely

[redacted]

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23 March 2021

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Australian Institute of Health and Welfare

Submission

House of Representatives Select Committee on Mental Health and Suicide Prevention

March 2021

Introduction

The Australian Institute of Health and Welfare (AIHW) welcomes the opportunity to participate in the House of Representatives Select Committee on Mental Health and Suicide Prevention.

The AIHW is a national independent statutory agency established under the *Australian Institute of Health and Welfare Act 1987* (AIHW Act). The AIHW's purpose is to create authoritative and accessible information and statistics that inform decisions and improve the health and welfare of all Australians.

The AIHW currently performs the following key roles in the context of the health and welfare of Australians:

a. the development and collection of comprehensive data, including making this accessible to others
b. analysing and reporting on data (from national data collections that the AIHW has custody of, as well as other credible data sources)
c. developing and improving performance indicators and targets for national agreements
d. providing data linkage services that have been approved by the AIHW's Ethics Committee and
e. the development and maintenance of national metadata standards, housed in the AIHW's Metadata Online Repository (METeOR).

The AIHW Act enables the release of information for public benefit while protecting the identity of individuals and organisations and ensuring that data providers can be confident that the AIHW will adhere to data supply terms and conditions. As a statistical and information agency, the AIHW relies on strong data governance arrangements to retain the trust of our many data providers, data recipients and other stakeholders.

AIHW's mental health information activities

The AIHW has a long history of curating, analysing and reporting national mental health information. AIHW's Mental Health Unit, a multidisciplinary team of 18 people, leads AIHW's mental health information activities and currently undertakes the following activities:

a. Data curation, analysis and reporting of mental health-related expenditure and activity from the following data sets:
    - Admitted Patient Care National Minimum Data Set (APC NMDS)
    - National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD)
    - Mental Health Establishments National Minimum Data Set (MHE NMDS)
    - Community Mental Health Care National Minimum Data Set (CMHC NMDS)
    - Residential Mental Health Care National Minimum Data Set (RMHC NMDS)
    - National Seclusion and Restraint National Best Endeavours Data Set (SECREST NBEDS)

  - Medicare Benefits Schedule data set (MBS)
  - Pharmaceutical Benefits Scheme data set (PBS)
  - Disability Services National Minimum Data Set (Disability Services NMDS)
  - Specialist Homelessness Services (SHS) data collection
  - Your Experience of Service (YES) survey data set (currently only 3 jurisdictions).

b. Development, supply and reporting of key national performance indicators, including the Fifth National Mental Health and Suicide Prevention Plan, the Key Performance Indicators for Australian Public Mental Health Services and National Healthcare Agreement mental health-specific indicators.

c. Authoring and publishing our online *Mental Health Services in Australia* (MHSA) web product.

d. Technical and platform support for the National Mental Health Service Planning Framework (NMHSPF), a national population-based model that enables estimates of the resources required for mental health services for any selected population region in Australia.

e. Provision of secretariat support for three jurisdictional mental health committees: Mental Health Information Strategy Standing Committee (MHISSC), National Mental Health Performance Subcommittee and National Mental Health Dataset Subcommittee (NMHDS SC).

f. Management of the National Outcomes and Casemix Collection (NOCC) and the Australian Mental Health Outcomes and Classification Network (AMHOCN) on behalf of the Department of Health. AMHOCN is a consortium consisting of the University of Queensland, Health Education and Training Institute (HETI), and Strategic Data.

g. Assisting the Australian Government Department of Health in the curation, analysis and supply of the COVID-19 National Mental Health Services Reporting Dashboard and accompanying Jurisdictional Dashboard, which are produced fortnightly and are supplied to the Prime Minister, Minister for Health, Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention, National Suicide Prevention Advisor and National Federation Reform Council (when required).

The AIHW considers mental health to be a key focus in its reporting and includes mental health in reporting on children and young people, Aboriginal and Torres Strait Islander people, homelessness, drug and alcohol use and veterans, amongst others.

Importance of mental health to Australians

The importance of mental health to Australians both collectively and individually is undeniable. As Prime Minister, the Hon Scott Morrison MP observed following the release of the Productivity Commission's Mental Health Inquiry in November 2020: *"Mental health issues and suicide do not discriminate. It doesn't matter where you live, what you do for a living. 1 in 5 Australians will experience a mental health illness every year and half of us will be diagnosed during our lifetime…We will build a system of comprehensive coordinated and compassionate care…driven by evidence, by the data, enhancing our understanding of what is happening in our communities"* (Morrison 2020).

A considerable proportion of the Australian population will experience a mental illness at some time in their life whilst many others may experience mental health issues which can cause them distress and affect both their personal and working lives. The AIHW believes that access to effective, appropriate and high quality mental health care is of increasing importance.

As a national statistical agency, this submission will focus on the AIHW's experience in creating, analysing and reporting national mental health information and statistics that informs decisions and improves the health and welfare of all Australians.

Recent mental health reviews

The AIHW provided expert advice and support to number of recent reviews of mental health programs and services, including:

- Productivity Commission's Inquiry into Mental Health and
- Royal Commission into Victoria's Mental Health System.

During the COVID-19 pandemic, the AIHW has been working with a number of Australian Government agencies and jurisdictions to collate available data to inform decision making.

What the Productivity Commission said

The Inquiry considered how mental illness can affect all aspects of a person's quality of life including physical health, social participation, education, employment and financial status. In its submission to the Inquiry, the AIHW highlighted issues around the lack of data for specific demographic groups. Information on the mental health support needs and subsequent support provided to a number of specific sections of Australian society: Aboriginal and Torres Strait Islander people, Culturally and Linguistically Diverse people, Lesbian Gay Bisexual Transgender and Intersex (LGBTI) people, people with experience of suicide, refugees and victims of traumatic crime are not currently available for national reporting purposes.

The Productivity Commission recommended that the role of the AIHW should be to:

- Lead the monitoring and reporting on the performance of mental health services (such as those provided by Non-Government Organisations, General Practitioners, and Medicare-related services).

The Productivity Commission outlined a number of other actions and recommendations for work by the AIHW, including:

Perinatal mental health data (Action 5.1)

The Productivity Commission noted that in order to determine current screening rates and prioritise interventions, better data are required and recommends:

- The AIHW should expand the Perinatal National Minimum Data Set, to include indicators of mental health screening in the weeks before and immediately after birth.
- State and territory governments should collect data on screening undertaken by maternal and child health nurses and provide these data to the AIHW.

- Using data from the AIHW, the National Mental Health Commission should commence monitoring and reporting on progress towards universal screening.

Children's Social and Emotional Wellbeing

Data gaps are also apparent in information collected about children's mental health and use of mental health services. The AIHW has laid the groundwork for a national indicator to assess children's wellbeing. The Productivity Commission recommends the Australian Government funding the AIHW to complete this work and roll out a national wellbeing indicator.

Regional Performance Data

The Productivity Commission recommends that the Australian, state and territory governments should authorise the AIHW to report all data relating to the performance of mental health and suicide prevention services at a regional level, as defined by Primary Health Network and Local Hospital Network regional boundaries, as well as at a state and territory and national level. The Productivity Commission recommended that the Australian Government continue to provide AIHW with additional resources to establish service performance reporting at the regional level and to make these data accessible to commissioning bodies and the public.

Non-Government support services

The Productivity Commission recommends Australian, State and Territory Governments should ensure that a national dataset on mental health-related Non-Government Organisation (NGO) services be established in all states and territories. These data should allow for analyses on how NGOs improve outcomes for consumers and enable accurate gap analysis and service planning. The Mental Health Non-Government Organisation Establishments National Best Endeavours Data Set (NBEDS) should be considered, however, it may need further development —for example, it could be more outcomes focused. The AIHW should be tasked and funded to lead this, to ensure nationally consistent data are collected where appropriate.

What the National Suicide Prevention Adviser said

Interim advice and 'in-principle' recommendations were provided by the National Suicide Prevention Adviser to the Prime Minister in August 2020 (NSPA 2020). It builds on the Initial findings submitted in November 2019 and outlines actions to deliver a more coordinated, comprehensive and compassionate approach to suicide prevention.

Interim advice discusses improved data and evidence to inform decision-making, including:

- Recommendation 5: All governments expand this investment in suicide data in a consistent and systematic approach, including collection and sharing of all relevant health and non-health data, to support policy decisions and agility to respond to emerging and shifting vulnerabilities. In particular:
    - all governments to work with the AIHW and remove barriers to the routine sharing of relevant data with the National Suicide and Self-Harm Monitoring System.
    - all governments to establish consistent definitions for suicide-related data (including agreed distinctions between self-harm and suicide attempts) and increase data capture for priority populations.

In the 2019–20 Budget, the Australian Government established the National Suicide and Self-Harm Monitoring System. The Department of Health is funding the AIHW to lead the development of this work. The AIHW is working in collaboration with the National Mental Health Commission. This system is discussed on page 15.

The system will improve the coherence, accessibility, quality and timeliness of national data and information on suicide, suicide attempts and self-harm and will inform the development of suicide and self-harm policy, as well as identify trends, emerging areas of concern and at-risk groups.

The system has already started quality improvement and linkage work on suicide data. Suicide registers are being established in states and territories that do not have any in place. The monitoring system will include data from crisis-lines, ambulance services, emergency departments and hospitals, state and territory suicide registers, and data sets from housing, justice and other areas of government.

During COVID-19, the AIHW has been working with other Australian Government agencies and jurisdictions to collate available data to inform decision making.

What the Victorian Royal Commission said

While the Royal Commission’s final report does not directly mention the AIHW in its recommendations to government, the Commission cited many AIHW publications. The Commission’s final report does recommend (Rec. 44) the establishment of a new Mental Health and Wellbeing Commission; and to enable the Commission to obtain data and information about mental health and wellbeing service delivery, system performance and outcomes, and other relevant information (State of Victoria 2021).

The AIHW provided support to the Commission while it undertook its inquiry into Victoria’s mental health system by linking Commonwealth and Victorian data, as data linkage custodians. As with the Royal Commission, the AIHW welcomes any opportunities to support the new Commission with these activities.

National mental health information

Australia has had a relatively long history of collecting and publishing national mental health information and statistics. Under the National Mental Health Strategy, which effectively commenced in 1992, there have been five National Mental Health Plans, with their associated data development, monitoring and reporting activities. As a result, the mental health sector is relatively rich in terms of the data that it collects and reports at the national level when compared with other Australian health and welfare sectors. However, the mental health sector's information activities necessarily reflect Australia's federated model of funding and delivery of the health and welfare sectors, and is fragmented. Consequently, there is no single 'unified information system' with consistent definitions and structure which policymakers and researchers can use to assess whether programs and support services are 'making a difference' and effectively supporting Australians living with mental ill health or experiencing mental health issues.

Rather, the current Australian mental health information landscape has evolved over time, and in 2021 is a mix of Australian and state and territory Government administrative data, a purpose-built national outcomes collection and survey data, supplemented by academic studies and evaluations commissioned for specific purposes. The sector has also been able to draw on five National Minimum Data Sets (NMDS) brought together by the AIHW (Admitted Patient, Emergency Department, Mental Health Establishment, Community Mental Health Care and Residential Mental Health Care) to guide its decision making. Over time, national collections have also been developed around restrictive practices, consumer experiences and outcomes. This matrix of mental health information has served the sector well over the years and is more advanced than most other health and welfare sectors. However, there are gaps in measurement and reporting in the mental health sector, which prevents Australia from comprehensively monitoring and reporting on programs and initiatives aimed at making a difference to peoples' lives, and determining whether desirable outcomes are being achieved. One of the challenges is that these data are not routinely integrated which makes it difficult to observe patterns of service use across sectors.

As previously noted, Australia's mental health information system is fragmented and reflects our federal system of government. Australia's Fifth National Mental Health Plan commits all governments to working together to achieve integration in planning and service delivery at a regional level. Should this aim be achieved, it will be easier to monitor a consumer's journey through the health and welfare system and the myriad of potential support providers and evaluate the effectiveness of respective interventions. A significant challenge though, from a data perspective, will be the reality that information support systems are expensive to design, implement and maintain and often have long lead times from conception to implementation.

Outcome measurement

A key issue that the mental health sector, and the health and welfare sectors more generally, have been grappling with in recent years is outcome measurement i.e. how do we assess whether an intervention has made a difference or make more informed decisions about scarce resource allocation. In an ideal world we would be able to access information from the consumer or individual, a significant other, the clinician/provider and/or observe the impact of an intervention or mental health-related program. The reality is that outcome measures in the Australian context consist primarily of clinician-rated measures (Health of the Nation Outcome Scales [HoNOS]) in the National Outcomes and Casemix Collection (NOCC) managed by the Australian Mental Health Outcomes and Classification Network (AMHOCN) which in turn is managed by the AIHW on behalf of the Australian Government. However, clinician measures alone are not considered sufficient by many stakeholders who advocate that a spectrum of measures, including patient-rated outcome measures and measures of recovery that are meaningful to both consumers and clinicians, should be available to better assess the effectiveness of mental health services.

Data linkage can assist in the assessment of outcomes. Some outcomes are not observed or cannot be observed while a program is operating as they require generational change. Early childhood education is a good example—some of main benefits of early childhood education are not apparent until participants are teenagers. It can be possible to observe the subsequent impact of programs and policies through data linkage. The Chicago Longitudinal Study has demonstrated the impact of early childhood education by linking existing administrative data. A similar approach would be possible for mental health as high quality early intervention may result in better employment and education outcomes. Through data linkage, it would be possible to assess whether particular types of assistance have a positive impact on key outcomes such as employment compared with a control group.

Mental health information development

AIHW notes that, from its inception, Australia's Mental Health Strategy has included a program of mental health information development to establish a mental health information culture to support the Strategy. The national approach adopted has been instrumental in delivering the contemporary mental health information landscape with some notable achievements, including a national mental health consumer experience of care measure (Your Experience of Service [YES]) and a national restrictive practice data collection.

In 2018, the AIHW was engaged by the Australian Government Department of Health, in conjunction with the then Australian Health Ministers' Advisory Council's Mental Health Principal Committee (MHPC) and its Mental Health Information Strategy Standing Committee (MHISSC), to author a Third Edition of the National Mental Health and Suicide Prevention Information Priorities (the Information Priorities). The Information Priorities articulate the kind of mental health information landscape that Australia aspires to over the next ten years: personalised, comprehensive and connected. AIHW hopes to work with MHISSC and other stakeholders to further develop Australia's mental health information systems to support the identified initiatives.

International approaches

AIHW has had the opportunity to participate in a number of international mental health benchmarking exercises through the World Health Organization (WHO) and International Initiative for Mental Health Leadership (IIMHL), a collaboration of nine countries: Australia, England, Canada, the Netherlands, New Zealand, Republic of Ireland, Scotland, USA and Sweden. AIHW's observation is that the mental health challenges facing other countries are not dissimilar to our own, though the models of care can be markedly different between countries which makes international benchmarking challenging. AIHW's additional observations include:

- Australia is leading the way in some aspects of monitoring and reporting e.g. National Outcome and Casemix Collection and national restrictive practice data collection.
- Australia's reporting reflects inherent structural barriers in our health system: relatively strong reporting of state and territory services but more limited reporting for other sectors e.g. primary care, office-based care.
- Australia shares similar challenges with most other western countries in measuring and reporting on mental health interventions, the use and efficacy of psychotropic medication and broader outcome measurement.

Data linkage

National Integrated Health Services Information (NIHSI) – Analysis Asset (AA)

The AIHW has worked with the Australian Government Department of Health and state and territory health authorities to create the National Integrated Health Services Information (NIHSI) Analysis Asset (AA). The NIHSI AA contains de-identified data from 2010–11 onwards on admitted patient care services (in public and private hospitals where available), emergency department services and outpatient services in public hospitals for all participating states and territories, along with Medicare Benefits Schedule data, Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data, Residential Aged Care data and National Deaths Index data. The incorporation of data into the NIHSI AA will be staged and will be dependent on timing of receipt of the required data.

The creation of the linkage infrastructure supporting the NIHSI provides an opportunity to link existing mental health data sets with other pertinent health and welfare datasets and should be considered as a priority.

The National Disability Data Asset

The AIHW is working with Australian Government and state partners to deliver the Pilot phase of the National Disability Data Asset (NDDA). The NDDA is a joint integrated data project aiming to bring together Australian Government and state data to provide new insights for the future development of policy for people with disability. The NDDA commenced with an 18-month Pilot between the Australian, New South Wales, Victorian, South Australian, and Queensland Governments. The Pilot's focus is on bringing together Commonwealth and state data in five high priority projects (test cases). The test cases focus on the following themes: early childhood; justice; education to employment; mental health;

and how linked administrative data can support an outcomes framework under the new National Disability Strategy.

The key purposes of the test cases is to demonstrate the potential of the linked data to inform and drive disability policy as well as serving as key pilots for shaping the design and implementation of an enduring asset which is able to both support research initiatives and improve outcomes for people with disability.

The test case *Services and supports for people with disability and mental health issues*, led by the Victorian Government Department of Human Services investigates the impacts of service and support programs for people living with disability with mental health issues and psychosocial disabilities (and their families). The test case aims to provide baseline data for government policy development and to inform service, program planning and reporting on what services and supports people with disability and mental health issues have used. It also aims to better understand the relationship between the use of supports and the impact on outcomes.

Data gaps/limitations

Despite the relative richness of the Australian mental health information landscape, there are opportunities in the mental health sector for more comprehensive mental health data to flow more swiftly to the national level, particularly in areas where there have been substantial investment e.g. Better Access, headspace and NDIS. In addition, there are known data gaps in a number of areas which should be filled as a matter of priority to give a more comprehensive view of the sector's activity and the mental health-related support being given to Australians:

- **General Practitioners.** The mental health-related Medicare Benefits Schedule (MBS) items are currently the only source of national data on mental health-related services provided by general practiioners (GPs). Not all mental health-related GP encounters are billed using mental health-specific MBS items—so these items are an underestimate of total mental health-related GP activity, which a Royal Australian College of General Practitioners (RACGP) survey suggests are in the top three reasons for a patient's visit.
- **Primary Health Networks.** Data on the activity of Primary Health Networks—collected under the Department of Health's Primary Mental Health Care Minimum Data Set—are not yet available for reporting.
- **National Disability Insurance Scheme.** In 2018–19, around 230,000 people used National Disability Agreement (NDA) specialist disability support services. However, data on the supports accessed under the NDIS by people with psychosocial disability are not currently available for reporting.
- **Mental Health NGOs.** There is currently no nationally consistent data on the workforce or activities of mental health non-government organisations (NGOs) to inform policy, practice and planning of their activities. This is a notable data gap as NGOs play an important role in providing non-clinical mental health-related services to people living with mental illness, their families and carers. Information about numbers of peer and consumer workers employed in the sector and their activity are currently unavailable.
- **Specific Demographic Groups.** Information on the mental health support needs and subsequent support provided to a number of specific sections of Australian society: Aboriginal and Torres Strait Islander people, Culturally and Linguistically Diverse people, Lesbian Gay Bisexual Transgender and Intersex (LGBTI) people, people with experience of suicide, refugees and victims of traumatic crime are not currently available for national reporting purposes.
- **Suicide prevention data.** Information on suicide deaths and attempts is needed by a range of stakeholders so that they can more effectively target their suicide prevention activities.

Relevant data and information aligned to the committee's terms of reference

There is no single 'master data set' relating to mental health. National data typically comes from a variety of sources, including:

- administrative data sourced from the systems used to manage healthcare delivery, such as patient administration systems in hospitals
- patient-reported data sourced directly from patients
- clinician-reported data sourced from tools used by clinicians in providing care and
- population surveys, such as prevalence and national health surveys.

Information in the national mental health data landscape is illustrated in Figure 1 (page 20).

The AIHW publishes *Mental health services in Australia* (MHSA), which provides a picture of the national response of the health and welfare service system to the mental health care needs of Australians. MHSA is updated progressively throughout each year as data becomes available.

In addition to work related specifically to mental health, the AIHW also has a long history of publishing periodic, 'compendium' reports which bring together a wide range of health and welfare data sources needed to better understand the wellbeing of children and young people, including information about mental health and wellbeing. Our next report, *Australia's Youth*, is scheduled to be published in May 2021, and follows on from previous products including the National Youth Information Framework (NYIF) indicators data portal, Young Australians: their health and wellbeing. Australia's children follows on from previous products, including Children's Headline Indicators and A picture of Australia's children report series.

These compendium reports provide an overview of how children and young people in Australia are faring, using a common people-centred framework and established measures. In addition, they include a summary of related data gaps, which can support national improvements in data and reporting.

Specific populations of interest

Current data cannot identify particular communities more at risk for mental illness (e.g. people from culturally and linguistically diverse backgrounds and people identifying as lesbian, gay, bisexual, transgender, gender diverse, intersex and queer). Improving data on specific communities is a key step in informing service delivery, identifying trends and gaps, and evaluating service access and program effectiveness. Better data are also needed including on rates of mental illness, services delivered and outcomes, to support efforts to improve the mental health of Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander people

There is a substantial difference in the burden of mental health on Aboriginal and Torres Strait Islander people compared with non-Indigenous Australians. In 2011, the years of healthy life lost per 1,000 due to mental and substance use disorders among Indigenous Australians was 2.4 times the rate for non-Indigenous Australians (57.8 compared with 23.6) (AIHW 2016). In 2018–19 an estimated 24% (187,500) of Indigenous Australians reported a mental health and behavioural condition and 31% reported high or very high levels of psychological distress (ABS 2019). Furthermore, Indigenous Australians' suicide rates have ranged from 1.4 to 2.3 times that of non-Indigenous Australians between 2001 and 2019 (AIHW 2020a). Preliminary data from 2019 find an age-standardised rate of 27.1 per 100,000 for Indigenous Australians compared with 12.7 per 100,000 for non-Indigenous Australians (AIHW 2020a).

The AIHW established the Indigenous Mental Health and Suicide Prevention program in 2019. The program's activities align with Action 13 of the Fifth National Mental Health and Suicide Prevention Plan (to strengthen the evidence base needed to improve mental health services and outcomes for Aboriginal and Torres Strait Islander people) and Closing the Gap Target 14 (People enjoy high levels of social and emotional wellbeing).

A primary output is the Indigenous Mental Health and Suicide Prevention Clearinghouse, which is being launched in 2021. The objectives of the Clearinghouse refer to Action 13.1 of the Fifth National Plan to improve the evidence base of what works and does not work relating to Indigenous mental health and suicide prevention. The Clearinghouse will provide a repository of commissioned and publicly available resources on government-funded programs implemented to address mental health and suicide prevention, the status of program evaluations, quality of evaluation evidence and the issues that impact on the social and emotional wellbeing of Indigenous Australians.

In addition, the program addresses key evidence limitations and gaps on Indigenous mental health and suicide prevention. Central to these limitations are the quality, currency and completeness of available data sources and options to enhance or link existing data collections. Three projects responding to these data limitations include the:

- linkage of mental health data sets to the National Integrated Health Services Information Analysis Asset (NIHSI AA), which links de-identified admitted patient care, emergency department and outpatient services, residential aged care, MBS, PBS and National Deaths Index data. This work would allow for improvement to the data quality of Aboriginal and Torres Strait Islander self-identification information and provide deeper insight into the use of mental health services by Aboriginal and Torres Strait Islander people
- assessment of existing data sources used to populate the 24 performance indicators outlined in the Fifth National Mental Health and Suicide Prevention Plan
- identification of achievable strategies to enhance Indigenous suicide data that complement current data enhancement activities and improve the tracking of Indigenous suicide.

The second stream of work focuses on improving Indigenous suicide prevalence estimates, historically affected by the aforementioned data availability and quality issues as well as the small number of suicide incidences that can produce variable estimates. Modelling work is being undertaken to map more accurate prevalence estimates of Indigenous suicide and the effect of intersecting protective and risk factors on suicide outcomes.

The third stream contributes to building a more comprehensive picture of Indigenous Australians' access to and contact with mental health and related services. Mental health service access will be examined in relation to physical access and how this varies geographically and patterns of service contact and suicide outcomes.

Veterans' mental health

The Department of Veterans' Affairs (DVA) and the AIHW have established a strategic partnership; working together to build a knowledge base that supports the health and wellbeing of Australia's veterans across a range of areas.

Since 2016, the work undertaken by DVA and the AIHW has taken a coordinated, whole-of-population approach to monitoring and reporting on the status and needs of veterans and their families.

During this time, the AIHW has released a number of publications on veterans' health and welfare, including the flagship report *Australia's health 2020*. This report contains a chapter on the health of serving and ex-serving Australian Defence Force (ADF) personnel (people who are currently serving or have previously served at least 1 day in a regular capacity or as a member of the active or inactive reserves).

Australia's health 2020 found more than 1 in 5 (22%) men who had ever served in the ADF reported a mental or behavioural condition (for example, anxiety and mood disorders, or problems with alcohol) in the Australian Bureau of Statistics (ABS) 2017–18 National Health Survey, which is very similar result to Australians that did not serve (18%). Rates of self-reported high or very high psychological distress were also similar across these two groups (about 12%) (ABS 2019a).

Addressing the development and management of mental disorders such as depression, post-traumatic stress disorder, other anxiety disorders and alcohol dependence for the veteran community has been identified as a priority for the Australian Government (DVA 2015). There are limited data available about the current prevalence of mental disorders among the Australian population, but further information will be available from the Intergenerational Health and Mental Health Study 2020–21 (ABS 2019b), the 2021 ABS Census, and through linkage projects utilising data assets held by the AIHW and the ABS' MADIP data sets.

DVA and the AIHW continue to increase the range of data available about veterans, and collaborate on how best to describe the information. Targeted research aims to bridge the gaps in knowledge on veterans to better understand current needs, anticipate emerging needs, and improve the services that best support those needs.

Work is also underway to build a more comprehensive profile of the welfare of Australia's veterans, as well as their families. As outlined in the AIHW's A profile of Australia's Veterans 2018 report; previous research efforts have been primarily health focused. With AIHW and DVA broadening its scope on wellbeing, research will also look to address key information gaps in the areas of education, employment, justice, housing, safety, finance and social support and their relationship to mental health conditions and preventive strategies.

First responders

In the last few years, Australia has faced several major natural disasters and public health crises that have required protracted and unprecedented efforts from the nation's 80,000[1] to 120,000 (Lawrence et al. 2018) employed Emergency Services Workers (ESWs). Every day, these 'first responders'—paid and volunteers—are exposed to stressful, traumatic and life-threatening events that can have immediate and lifelong effects on their mental health and wellbeing. The aftermath of the 2019–20 bushfires and the ongoing COVID-19 pandemic have highlighted the importance of accurate, relevant and timely data to ensure that the current and changing health and welfare needs of ESWs are met. Currently, there is no single data source that provides a comprehensive picture of ESWs and their mental health and wellbeing.

The Department of Home Affairs engaged the AIHW to examine the availability and suitability of current data sets relating to ESW mental health. These data are required to support the development and ongoing monitoring of mental health indicators for the First Mental Health National Action Plan for ESWs, including volunteers (the NAP). The objective of the NAP is to lower suicide rates and improve mental health outcomes. To measure these objectives, robust, complete data across states and territories relating to suicide and mental health indicators will be required.

There are a number of data sources that provide information about ESWs, or mental health and wellbeing, or suicide, however there is no single data source that provides a comprehensive picture of all three elements together for ESWs, including volunteers. There are numerous data gaps and opportunities to enhance available information to maximise the use of existing data sources, develop existing data sources and explore data linkage opportunities.

Suicide and self-harm

The Australian Government has invested $15 million over 3 years from 2019–2022 and has established the National Suicide and Self-Harm Monitoring Project to improve the quality, timeliness and comprehensiveness of suicide and self-harm data across Australia. This monitoring project is being implemented by the AIHW with the National Mental Health Commission, the Australian Government Department of Health and an Expert Advisory Group including representation from people with lived experience of suicide and suicide prevention service providers.

The National Suicide and Self-Harm Monitoring Project launched its initial publication on 29 September 2020, which has been designed to be used by groups such as service providers, researchers and communities to increase their awareness and understanding of suicide and self-harm. In addition, the project will include a separate State and Territory Analytics Portal to assist policy and program development and evaluation in Australian Government and state and territory governments by allowing detailed analysis of multiple data sources to target suicide prevention activities in response to emerging trends.

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[1] ABS 2016. Census of Population and Housing, TableBuilder

Regular updates to Government on COVID-19

AIHW has been assisting the Australian Government Department of Health's Mental Health Division to curate, analyse and report COVID-19 mental health-related activity data on a weekly basis since 16 April 2020. The data are reported within Government, including to the States and Territories via the Departments of Health and Prime Minister and Cabinet. Data reported include Medicare Benefit Schedule, Australian Government funded Help Lines, headspace, suspected suicide information from a number of jurisdictions and analysis of emerging research and key messages. This reporting will expand to include more detailed data from the states and territories.

Public website and State and Territory Information Portal

Public website

The reporting of suicide and self-harm statistics and information on the AIHW website represents only one part of the National Suicide and Self-harm Monitoring Project. It brings together, for the first time, data on suicide, intentional self-harm and suicidal behaviours from existing national morbidity (hospitalisation) and mortality data sources and national survey data. New national data from state and territory ambulance services is included, attained specifically through this project, from the National Ambulance Surveillance System (NASS).

The web-based format for Suicide and self-harm monitoring includes interactive data visualisations and geospatial mapping to illustrate and explore the statistics as well as text to assist with their interpretation and clarification of the limitations of the data.

State and Territory Information Portal

This will involve the development of a secure analytics portal for policy evaluation, service planning and service activities by data custodians and approved users, such as Primary Health Networks. This portal will have the potential to bring together a greater range of administrative and service level data and at greater detail than the public website, including national morbidity, mortality and ambulance attendance data as well as data on risk and protective factors.

Data development activities

Suicide registers

One of the key goals of the system is to facilitate more timely data on suspected deaths by suicide from jurisdictions. The AIHW has established arrangements with jurisdictions to supply regular, up-to-date data on suspected suicides. Data from these registers will not be publicly available unless the relevant jurisdiction decides to release data. These data exist to inform the deliberations of the Coroner and may be provided to Australian, state and territory government officials for the purposes of tailoring interventions, policy and program settings. Such data are incomplete and extremely sensitive.

Registers currently exist in Queensland (established in 1990), Victoria (2012), Western Australia (2010) and Tasmania (2017). The AIHW has been obtaining timely data from several suicide registers to inform reporting to governments.

New South Wales will have established a suicide register by October 2020. The AIHW is working with State Coroners and department of health officials in South Australia, the Australian Capital Territory and the Northern Territory to establish suicide registers in these jurisdictions. If all of these jurisdictions establish registers then registers will exist in every state and territory. Detailed planning with South Australia and the Australian Capital Territory include the establishment of project teams within their Coroners Courts to progress this work.

National ambulance data

A lack of national ambulance attendance data has been a significant gap in service-level data for populations at risk of suicide. The AIHW has contracted Turning Point through Monash University to develop the National Ambulance Surveillance System (NASS) for self-harm and mental health related attendances. The NASS is a novel and world-first public health monitoring system for mental health, alcohol and drug harms, and self-harm (including suicidal behaviours) with components funded by the Department of Health, Department of Health and Human Services (Victoria) and the AIHW. For this project, Turning Point will collect, code and improve nationally consistent data on ambulance attendances to self-harm (deaths by suicide, suicide attempts, suicidal ideation and self-injury) and mental health-related incidents, including demographics (age, sex), mechanism of injury, mental illness symptoms, alcohol and drug intoxication, transport to hospital status and history of self-harm. Importantly, coding of historical data from 2018 and 2019 for available jurisdictions will be undertaken to provide baseline data for ongoing quarterly reporting. Quarterly collated data will flow back to states and territories to assist with service planning and program delivery and will also be used for regular monitoring on Suicide and self-harm monitoring.

Suicide and self-harm monitoring includes the initial results of the National Ambulance Surveillance System (2019) from New South Wales, Victoria, Tasmania and the ACT (see Ambulance attendances, self-harm behaviours and mental health for further information). Data for 2020 are also presented for Victoria. Data supplies from additional participating jurisdictions will be available over the remainder of 2020 and 2021.

Embedding of psychosocial risk factors in the National Mortality Database

Suicide and self-harm monitoring includes information from a pilot study that enhanced the national Australian Bureau of Statistics (ABS) Causes of Death data set, by coding psychosocial risk factors for all coroner-referred deaths (including deaths by suicide) registered in 2017, via a comprehensive manual review of reports included in the NCIS (see Psychosocial risk factors and suicide for more information). The AIHW is working with the ABS to code and embed psychosocial risk factors in future national mortality data sets.

Coding of 2018 risk factors included in police, autopsy, toxicology and coroner’s reports for deaths where the underlying cause of death is Intentional self-harm, has been completed. Coding of 2019 data is underway.

Data integration

The AIHW has begun analysing data obtained from the Multi-Agency Data Integration Project (MADIP) to evaluate whether educational attainment or employment status are associated with deaths by suicide. Initial summary analysis are reported in Suicide and self-harm monitoring (see Social factors and suicide). Further analysis of MADIP will include determination of the effect of other social determinants (for example, housing tenure, household composition or income) on suicide risk.

The AIHW has also been working with the Australian Government Department of Health along with state and territory health departments to develop the National Integrated Health Services Information Analysis Asset (NIHSI AA). This data asset includes mortality data together with information from hospital admissions, Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) and residential aged care data. This analysis asset will enable examination of service-use patterns and the demographic profiles of those using (and, by inference, those not using) health services. The AIHW will analyse the NIHSI AA to report on the service use of people in their last 12 months of life, including those who died by suicide. The potential insights from this project and analysis of other integrated data assets will greatly enhance our understanding of people-centred service use and modifiable risk factors for suicide.

Developmental evaluation

The AIHW has engaged the University of Melbourne (led by Professor Jane Pirkis of the Centre for Mental Health) to evaluate the National Suicide and Self-harm Monitoring Project. The evaluation will be conducted alongside the development and implementation of the system from 2020 to 2021 to advise and shape the ongoing project and inform future needs and decisions.

Collaboration with the Australian National University

The AIHW has engaged the Australian National University (ANU) Centre for Social Research and Methods (CSRM) to provide advice on the methodological challenges and statistical issues of monitoring suicide and self-harm and to conduct complex modelling on deaths by suicide. The ANU CSRM will also, in collaboration with the AIHW, undertake data analysis of existing data on suicide and self-harm to identify trends, differences by population sub-group and opportunities for improvements in data collection.

In addition, the AIHW has collaborated with the ANU CSRM on the design, analysis and reporting of data collected through the Life in Australia Panel, with a specific focus on tracking mental health, substance use, social and financial outcomes during the COVID-19 pandemic. The AIHW is partnering with ANU CSRM on surveys in May, August and November 2020. This data set will allow for comparisons of outcomes with those of previous data collections throughout 2019 and 2020 (see COVID-19).

Veterans' suicide prevention

There is ongoing concern in the Australian community about suicide in serving and ex-serving ADF personnel. In particular, ex-serving ADF personnel have historically faced an increased risk of suicide. Reducing the rate of serving and ex-serving suicide is a priority for the Australian Government.

Recent government inquiries have highlighted the need to improve the integration of service responses to meet the health and wellbeing needs of serving and ex-serving ADF personnel (JSCFADT 2015). The need to invest in prevention and early intervention strategies to improve health and wellbeing outcomes for these groups has also been highlighted. The Australian Government has introduced further suicide prevention and mental health support services for serving and ex-serving ADF personnel and their families (AG 2017).

AIHW produces an annual ongoing suicide monitoring report which provides information on the level of suicide among serving and ex-serving ADF personnel.

On 5 February 2020, the Prime Minister announced the establishment of a National Commissioner for Defence and Veteran Suicide Prevention (National Commissioner) to inquire into suicides among serving and ex-serving ADF members. As a first priority, the National Commissioner will undertake an Independent Review of Past ADF and Veteran Suicides (the Review). The National Commissioner will be supported by expert technical assistance from the Australian Commission on Safety and Quality in Health Care (ACSQHC) and the AIHW. The Review will predominantly focus on deaths by suicide among ADF members and veterans who have had one day or more of service since 1 January 2001, where the death occurred between 1 January 2001 and 31 December 2018 and will identify and investigate the risk and protective factors relevant to past deaths by suicide among ADF members and veterans. The analysis of the Review will build on existing work in the AIHW annual ongoing monitoring program, incorporating data linkage from a wider array of sources.

Physical health

In the last decade, there has been growing recognition of the complex interrelationship between physical and mental health. The substantial physical health burden experienced by many people with a mental illness has a direct impact on not only their life expectancy but also quality of life. The evidence suggests that significant barriers to physical health monitoring and treatment persist for this population group, which raises serious questions of equity in health care provision. Improving the physical health of people with mental illness has been identified as one of the key priority areas in the Fifth National Mental Health and Suicide Prevention Plan.

Currently, national administrative collections include little data about physical health of mental health consumers, with the exception of some diagnosis data for admitted patients. The most information comes from the National Health Survey conducted every 3 years by the ABS. Although the existing data is limited, it does demonstrate the physical health gap between people with mental illness and the general population.

Performance measurement and reporting can help drive improvements to services to ensure that quality physical care is included in the treatment of people with mental illness.

Psychosocial disability

Psychosocial disability is a term used to describe the disability experience of people with impairments and participation restrictions related to mental health conditions. These include loss of, or reduced ability to function, think clearly, experience full physical health and manage social and emotional aspects of their lives (NDIA2019).

In 2018–19, around 230,000 people used NDA specialist disability support services. Of NDA service users, psychosocial was the most common disability group (32% as a primary disability and 46% including primary and other significant disability) (AIHW 2020b).

At 31 December 2019, there were around 339,000 active NDIS participants with approved plans. Of those active NDIS participants at 31 December 2019, one of the most common disability groups is psychosocial disability (9.1%)(NDIA 2020).

People with psychosocial disability (disability related to mental health conditions) are the most likely disability group to avoid situations because of their disability. An estimated 2 in 3 (67% or 413,000) people aged 15 and over, with psychosocial disability living in households, avoided situations in the last year, compared with 1 in 4 (25% or 277,000) with sensory and speech disability (ABS 2019a).

Females (35% or 610,000) with disability, living in households, were more likely to avoid situations because of their disability in the past year than males (31% or 475,000). This is more pronounced for females with psychosocial disability (69% or 231,000) compared with 64% (or 182,000) males (ABS 2019a).

People with psychosocial disability are also more likely to experience discrimination because of their disability. Around 1 in 4 (24% or 149,000) people aged 15 and over, living in households, with psychosocial disability experienced disability discrimination in the last year, compared with 1 in 17 (7.5% or 82,000 people) with sensory and speech disability (ABS 2019a).

People with psychosocial disability also account for the highest proportion of disability discrimination complaints the Australian Human Rights Commission (AHRC) receives. A total of:

- 32% of complaints are by people with psychosocial disability
- 18% are by people with physical disability
- 9.3% are by people with intellectual or learning disability
- 9.0% are by people with sensory disability (AHRC 2019).

Consumer experience of mental health services

Information about consumer-rated experiences of care in public specialised mental health services utilises the nationally developed Your Experience of Service (YES) survey. The YES survey aims to help Australian mental health services and consumers work together to build better services. The project was a national initiative funded by the Australian Government Department of Health and managed by the Victorian Department of Health and Human Services in conjunction with the MHISSC. Implementation of the YES survey and national reporting of the data is a key action under the Fifth Plan (CHC 2017).

Currently 3 jurisdictions—New South Wales, Queensland and Victoria—have implemented the YES survey and are contributing to the Your Experience of Service National Best Endeavours Data Set (YES NBEDS). Data are reported annually in the Consumer perspectives of mental health care on MHSA.

Safety and quality

Ensuring the safety of people using mental health and suicide prevention services is fundamental to a rights-based approach to treatment, care and support. Reporting has a key role to play in improving safety in clinical settings.

Data on the use of restrictive practices, including seclusion (when a person is confined alone in a room or area where free exit is prevented) and restraint (when a person's freedom of movement is restricted by physical or mechanical means) in specialised mental health public hospital acute service units, is reported in the Restrictive practices section of MHSA.

Data are also reported on the treatment of people on an involuntary basis under legislated state and territory Mental Health Acts in public acute and psychiatric hospitals, residential mental health services, and community mental health care services.

Funding

Information on recurrent expenditure (running costs) for mental health-related services in Australia is reported in MHSA. Health expenditure (what was spent) and health funding (funding provided and who provided the funds) are distinct but related concepts essential to understanding the financial resources used by the health system. Data on expenditure and funding, calculated in both current and constant prices, are derived from a variety of sources, and published in the Expenditure on mental health-related services section on MHSA.

Workforce

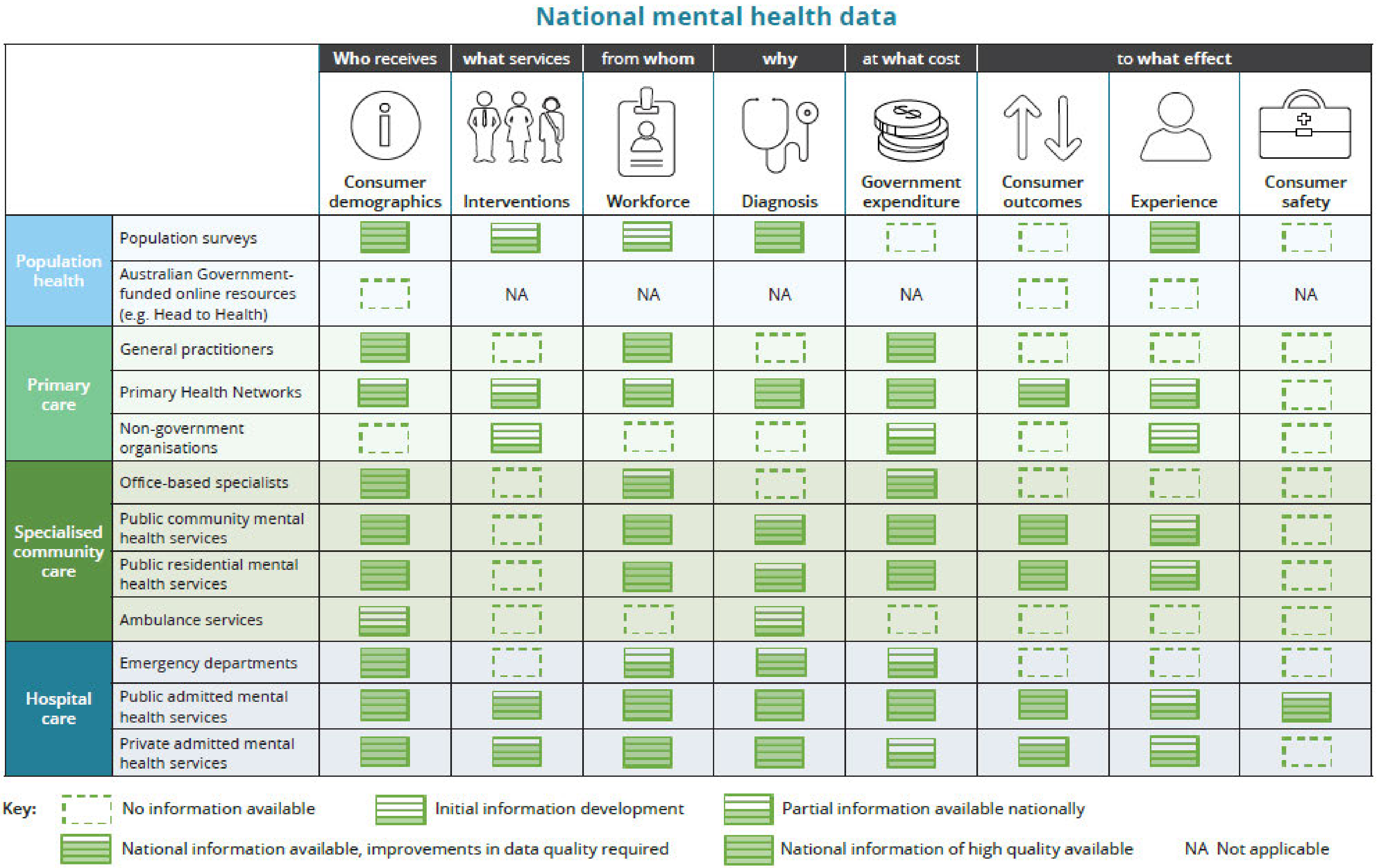
Maintaining an informed, committed and supported workforce is an important component of ensuring a responsive and effective mental health system. Additional data on the workforce, particularly involving mental health workers with lived experience (peer workers) and the experiences of mental health workers, will support efforts to plan and deliver quality services.

A variety of health and social care professionals, including psychiatrists, psychologists, nurses, GPs and social workers, provide a range of mental health-related services to Australians. The National Health Workforce Data Set (NHWDS) comprises data about employed registered health professionals collected through annual registration surveys administered by the Australian Health Practitioner Regulation Agency (AHPRA) since 2010. Data on the size and selected characteristics of the workforce is available for the following health care professionals who work principally in mental health care and related areas:

- psychiatrists
- mental health nurses
- psychologists.

Data on the Australian mental health workforce are published in the Mental health workforce section of MHSA. Data on staffing in state and territory services are published in the Specialised mental health care facilities section.

Figure 1: Information in the national mental health data assets



National mental health data

		Who receives	what services	from whom	why	at what cost	to what effect		
		Consumer demographics	Interventions	Workforce	Diagnosis	Government expenditure	Consumer outcomes	Experience	Consumer safety
Population health	Population surveys	▤	▤	▤	▤	⬚	⬚	▤	⬚
	Australian Government-funded online resources (e.g. Head to Health)	⬚	NA	NA	NA	NA	⬚	⬚	NA
Primary care	General practitioners	▤	⬚	▤	⬚	▤	⬚	⬚	⬚
	Primary Health Networks	▤	▤	▤	▤	▤	▤	▤	⬚
	Non-government organisations	⬚	▤	⬚	⬚	▤	⬚	▤	⬚
Specialised community care	Office-based specialists	▤	⬚	▤	⬚	▤	⬚	⬚	⬚
	Public community mental health services	▤	⬚	▤	▤	▤	▤	▤	⬚
	Public residential mental health services	▤	⬚	▤	▤	▤	▤	▤	⬚
	Ambulance services	▤	⬚	⬚	▤	⬚	⬚	⬚	⬚
Hospital care	Emergency departments	▤	⬚	▤	▤	▤	⬚	⬚	⬚
	Public admitted mental health services	▤	▤	▤	▤	▤	▤	▤	▤
	Private admitted mental health services	▤	▤	▤	▤	▤	▤	▤	⬚

Key: ⬚ No information available ▤ Initial information development ▤ Partial information available nationally
▤ National information available, improvements in data quality required ▤ National information of high quality available NA Not applicable

Evidence-based policy and decision making

Australia's national mental health landscape is relatively data rich compared with other health and welfare sectors due to the strong leadership provided via the former AHMAC's mental health committees over the life of the National Mental Health Strategy. It relies heavily on state and territory administrative health data sets which are necessarily designed to facilitate and monitor the provision of services to mental health consumers rather than to evaluate and assess the outcomes of specific interventions and associated mental health-related programs. Administrative health data sets have universal coverage, are data rich and systematic. They also have known jurisdictional differences in data elements, coding criteria and database storage.

The known limitations inherent to administrative data sets can make data extraction, linkage and merging of different mental health data sets challenging in the absence of a nationally agreed linkage methodology (Mazzali et al. 2016). The multiplicity of data sets also means that Data Custodian responsibilities are dispersed across a variety of organisations and individuals which can significantly impact on the timeliness of data flows.

There are a number of key parts of the health and welfare sector for which there is very limited information about the support being provided to Australians experiencing mental ill health and mental health issues. The existing administrative data sets could also be further refined to enhance their utility i.e. better identifiers, more comprehensive information about interventions and consumer outcomes. These deficiencies should be systematically addressed by Australian governments, through existing committees and processes, in order to provide health and welfare sector decision makers (Health ministers, Primary Health Networks, state and territory departments and agencies – such as Local Hospital Districts, Local Hospital Networks) with the comprehensive, high quality data they need to assess whether Australians with mental health issues are getting the necessary treatment and support that they need to lead contributing lives.

Monitoring, reporting and analysing the performance of mental health services

A substantial number of health and welfare stakeholders report on their mental health-related activities: government departments, mental health commissions, corporate and individual service providers and academic institutions. At the national level, no single entity currently has the responsibility or authority to analyse, monitor and report on performance of mental health services across the health and welfare sector at the national level. AIHW's online *Mental Health Services in Australia* report, funded by the Australian Government Department of Health, is an omnibus report which brings together a wide range of data from across the health and welfare sector in a 'one-stop shop' format. Other national mental health reporting entities include:

- Productivity Commission – *Review of Government Services*
- National Mental Health Commission – *Monitoring Mental Health and Suicide Prevention Reform: National Report* and *Fifth National Mental Health and Suicide Prevention Plan Progress Report*

- The Australian Commission on Safety and Quality - *Australian Atlas of Healthcare Variation*
- The Australian Private Hospital Association - *Private Psychiatric Hospitals Data Reporting and Analysis Service Report*.

Consideration could be given to rationalising the multitude of mental health-related reporting activities in the interests of creating a simpler, authoritative system.

What other outcomes should be measured and reported on?

The issue of outcome measurement has been the subject of robust discussion in the mental health sector for a number of years. In particular, the sector has been concerned about the extent to which it is able to measure a person's clinical and personal recovery and how it can improve outcome measurement e.g. participation, work and study. AIHW is of the view that the National Mental Health Commission's concept of a Contributing Life has merit and could be used to guide further enhancement of existing outcome measurement in the mental health sector. In addition, AIHW makes the following observations:

- Australia has a long-standing program of outcome monitoring through public mental health services. However, there is a need to expand outcome measurement to cover private office-based care (GPs (who deliver the bulk of care), psychiatrists, psychologists), and NGO providers.
- Consumer-rated outcomes are a key component of outcomes measures, in line with consumer's dictum of 'nothing about us without us'. Work is underway through the MHISSC to develop a nationally consistent measure of consumer-rated outcomes.
- Data on broader outcomes around social participation (housing, employment, community participation) are only available from large national surveys run by the ABS, which are unlikely to include the people for whom monitoring is most needed (people with low prevalence, high impact conditions). Data on housing, employment, and other measures of recovery should be collected on people in touch with specialised services, either public or private.
- Work is underway to develop a version of Living in the Community Questionnaire that could be used to survey the population under care. There is likely to be buy-in from states and territories to implement it but mechanisms are needed to deliver the survey through the private sector and collate data nationally.

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