



# Performance indicators

## December 2015

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*Queensland Mental Health, Drug and Alcohol  
Strategic Plan 2014–2019*



### Further information and feedback

We value the views of our readers and invite your feedback on this report.

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### Translation

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## Commissioner's message

Improving mental health and wellbeing is a long-term prospect that can be achieved only through systemic change and collective actions taken by all levels of governments, the non-government sector, private industry and communities. Our efforts must include not only the health and mental health sectors but also those sectors which influence the social and economic conditions in which Queenslanders live. Many of these conditions are dynamic and some are beyond our control, for example natural disasters and drought. It is important however that we measure and monitor progress to inform our responses to these events and issues.

It is also important that we acknowledge the voice of those with a lived experience in this work. Many of the performance indicators are informed by those who are living with mental health problems, mental illness and problematic substance use through satisfaction surveys and national surveys capturing many of the conditions which influence good mental health and wellbeing, such as experiences of discrimination.

The performance indicators outlined in this report, together with research and the views of those with a lived experience, their families and carers and other stakeholders will help drive and direct future work to improve outcomes for all Queenslanders living with mental health problems, mental illness and problematic alcohol and other drug use.

I would like to thank those who have supported and contributed to the development of this report. Work will continue into the future to identify gaps and consider developing new measures in important areas.



**Dr Lesley van Schoubroeck**  
*Queensland Mental Health  
Commissioner*



# Executive summary

Measuring progress towards achieving outcomes is essential to direct our actions and is the foundation for good accountability and transparency. It is also an important element in guiding the collective action of many government agencies, non-government organisations and the community towards improving mental health and wellbeing.

The *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* (the Strategic Plan) includes a commitment (Shared Commitment to Action 8: Indicators to measure progress towards improving mental health and wellbeing) to identify and report on performance indicators measuring progress towards achieving six long-term outcomes:

1. A population with good mental health and wellbeing
2. Reduced stigma and discrimination
3. Reduced avoidable harm
4. People living with mental health difficulties or issues related to substance use have lives with purpose
5. People living with mental illness and substance use disorders have better physical and oral health and live longer
6. People living with mental illness and substance use disorders have positive experiences of their support, care and treatment

There has been considerable discussion nationally and internationally about how best to measure these and similar outcomes over many years. This report outlines the steps that have been taken in Queensland to commence identifying and reporting on performance indicators focused on better outcomes for people living with mental health problems, mental illness and problematic substance use.

Led by the Queensland Mental Health Commission in partnership with a number of organisations including the Office of the Government Statistician and non-government peak organisations, performance indicators were identified based on four principles—that they are meaningful and shared, appropriate and useful, feasible and cost effective, and robust.

This report outlines performance indicators based on data currently available, including comparisons to national levels where appropriate, and when we will be able to next report on progress. It also outlines links to the Strategic Plan's Shared Commitments to Action which support progress towards achieving the six long-term outcomes. Further information on the Strategic Plan's implementation is outlined in the *Implementation Annual Report 2014–15*.

## Performance indicator results 2015

Available data indicates that Queenslanders use illicit drugs and experience mental health problems at similar levels to other Australians.

However, Queenslanders experience higher rates of suicide, risky alcohol consumption and daily tobacco smoking. A greater proportion of Queenslanders living with mental health conditions are unemployed, experience discrimination and have cardiovascular disease (a major risk factor for early death) compared to other Queenslanders.

On a positive note, a greater proportion of those living with mental health conditions participate in the community, for example through community support groups or political and civic groups, than other Queenslanders.

## Our next report

Suitable performance indicators, based on data currently available, could not be identified to measure progress for a number of domains. Our next steps will involve considering the feasibility and cost effectiveness of either developing performance indicators or sourcing data in the following areas:

### *Outcome 1:* A population with good mental health and wellbeing

- Wellbeing of all Queenslanders
- Social and emotional wellbeing of Aboriginal and Torres Strait Islander Queenslanders
- The mental health and wellbeing of people living in rural and remote Queensland

### *Outcome 2:* Reduce stigma and discrimination

- Stigma experienced by people living with mental illness, mental health problems and problematic alcohol and other drug use

### *Outcome 3:* Reduced avoidable harm

- Levels of self-harm
- Levels of suicide attempts
- Suicide rates among diverse population groups including cultural groups and Lesbian, Gay, Bisexual, Transgender and Intersex Queenslanders
- Average age Queenslanders first use alcohol and other drugs
- Harm relating to alcohol and other drug use including new hepatitis C infections resulting from injecting drug use

### *Outcome 6:* Consumers have positive experiences of their support, care and treatment

- Service user satisfaction with alcohol and other drug services

The Commission will release its next performance indicators report in 2016–17. The report will provide an update where new data is available and will also outline steps taken and progress to address gaps.

The graphic features a central square with a small circle inside, surrounded by overlapping circles and squares in various shades of blue and green. The text 'Performance indicator dashboard' is centered over this graphic.

# Performance indicator dashboard

## *Outcome 1*

A population with good mental health and wellbeing

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## *Outcome 2*

Reduced stigma and discrimination

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## *Outcome 3*

Reduced avoidable harm

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## *Outcome 4*

People living with mental health difficulties or issues related to substance use have lives with purpose

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## *Outcome 5*

People living with mental illness and substance use disorders have better physical and oral health and live longer

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## *Outcome 6*

People living with mental illness and substance use disorders have positive experiences of their support, care and treatment

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Performance indicators outlined here are identified based on currently available data for each outcome, where an appropriate measure has been identified, and comparing relevant populations in Queensland and nationally.

The State status column provides current Queensland data related to each indicator. The National status column indicates the comparable data at the national level where it is available and relevant. The progress update column provides the year in which we anticipate reporting new data based on expectation of pending release dates. Where a status report is noted as NA, this indicates the data is not applicable.

### Outcome 1

#### A population with good mental health and wellbeing

Domains and performance indicators	State status	National status	Progress update
<b>1.1 Mental health of all Queenslanders</b>			
<b>1.1.1</b> Age standardised percentage of people 18 years and over experiencing high or very high levels of psychological distress	10.8	10.8	2019
<b>1.2 Levels of mental health problems and illness</b>			
<b>1.2.1</b> Percentage of people aged 15 years and over reporting that they live with a mental health condition	18.7	18.2	2019
<b>1.2.2</b> Percentage of people aged 15 years and over who report that they, or someone close to them, has experienced a mental illness as a personal stressor in the last 12 months	13.7	13.4	2019

## Outcome 2 Reduced stigma and discrimination

Domains and performance indicators	State status	National status	Progress update
<b>2.1 Discrimination</b>			
<b>2.1.1</b> Percentage of people aged 15 years and over living with a mental health condition who have experienced any discrimination or been treated unfairly	31.7	29.1	2019
<b>2.1.2</b> Percentage of people aged 15 years and over living with a mental health condition who have experienced discrimination as a personal stressor	6.7	3.9	2019

## Outcome 3 Reduced avoidable harm

Domains and performance indicators	State status	National status	Progress update
<b>3.1 Suicide</b>			
<b>3.1.1</b> Age standardised suicide rate per 100,000 people	14.3	10.7	2016
<b>3.1.2</b> Age standardised suicide rate for Aboriginal and Torres Strait Islander per 100,000 people	30.9	23.8	2016
<b>3.1.3</b> Age standardised suicide rate for areas outside of Brisbane and urban areas per 100,000 people	17.1	NA	TBC
<b>3.2 Alcohol and other drug-related harms</b>			
<b>3.2.1</b> Percentage of people aged 14 years and older who report drinking alcohol at life-time risky levels	20.2	18.2	2018
<b>3.2.2</b> Percentage of people aged 14 years and older who report drinking alcohol at single occasion risky levels	40.6	37.8	2018
<b>3.2.3</b> Percentage of people aged 14 years and older who smoke tobacco daily	15.0	12.8	2018
<b>3.2.4</b> Percentage of people aged 14 years and older who recently used an illicit drug	15.5	15.0	2018
<b>3.2.5</b> Percentage of people aged 14 years and older who recently misused pharmaceuticals	4.8	4.7	2018



## Outcome 4

### People living with mental health difficulties or issues related to substance use have lives with purpose

Domains and performance indicators	State status	National status	Progress update
<b>4.1 Economic participation</b>			
4.1.1 Age standardised percentage of people aged 16 to 30 years living with a mental/behavioural condition, who were employed and/or enrolled in study	79.4	79.2	2018
4.1.2 Age standardised percentage of people aged 16 to 64 years living with a mental/behavioural condition who were employed	57.7	61.7	2018
4.1.3 Percentage of people aged 15 years and over living with a mental health condition who have undertaken unpaid volunteer work	25.8	30.9	2019
<b>4.2 Community participation</b>			
4.2.1 Percentage of people aged 15 years and older living with a mental health condition and who participated in social groups	44.4	48.9	2019
4.2.2 Percentage of people aged 15 years and over living with a mental health condition who participated in community support groups	32.7	34.5	2019
4.2.3 Percentage of people aged 15 years and over living with a mental health condition who participated in civic or political groups	14.1	15.4	2019
4.2.4 Percentage of people aged 15 years and over living with a mental health condition and attended cultural or leisure activities	85.7	82.8	2019

Domains and performance indicators	State status	National status	Progress update
<b>4.3 Personal connections</b>			
4.3.1 Percentage of people aged 15 years and over living with a mental health condition and who had face-to-face contact with family and friends outside the household daily	12.5	15.1	2019
4.3.2 Percentage of people aged 15 years and over living with a mental health condition and who had face-to-face contact with family and friends outside the household at least once a week	60.5	61.5	2019
4.3.3 Percentage of people aged 15 years and over living with a mental health condition and who were able to get support in times of crisis	92.1	93.0	2019

### Outcome 5

#### People living with mental illness and substance use disorders have better physical and oral health and live longer

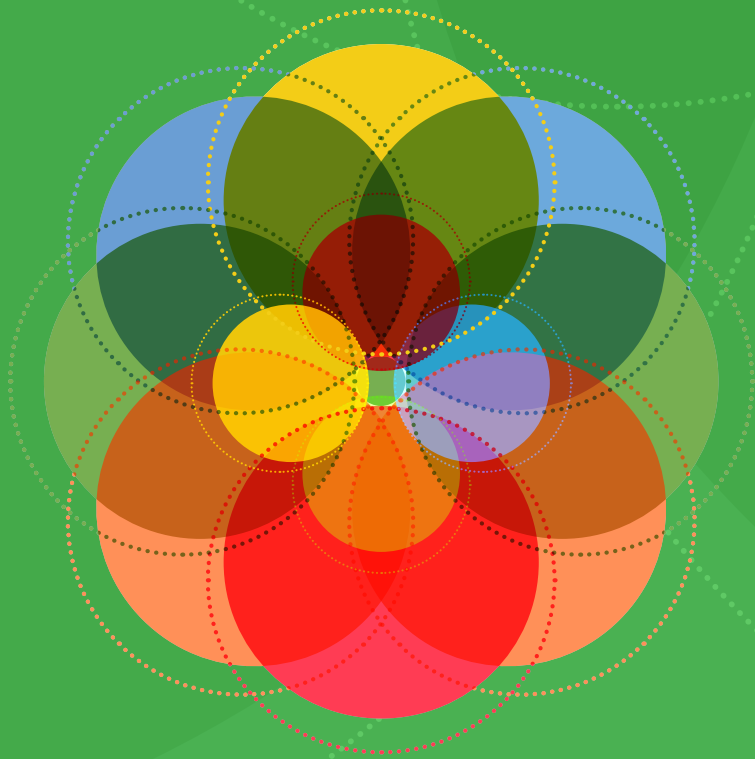
Domains and performance indicators	State status	National status	Progress update
<b>5.1 Long-term health conditions</b>			
5.1.1 Age standardised percentage of people living with a mental/behavioural problem with cardiovascular disease	12.9	9.5	2018
5.1.2 Age standardised percentage of people living with a mental/behavioural problem with cancer	3.2	3.5	2018
5.1.3 Age standardised percentage of people living with a mental/behavioural problem with diabetes	7.2	6.6	2018
5.1.4 Age standardised percentage of people living with a mental/behavioural problem with arthritis	25.1	26.9	2018
5.1.5 Age standardised percentage of people living with a mental/behavioural problem with asthma	15.5	16.7	2018
<b>5.2 Risk factors</b>			
5.2.1 Age standardised percentage of people living with a mental/behavioural problem who smoke daily	25.7	26.1	2018
5.2.2 Age standardised percentage of people living with a mental/behavioural problem who are obese or overweight	65.4	67.0	2018
5.2.3 Age standardised percentage of people living with a mental/behavioural problem who are at risk of long-term harm from alcohol consumption	20.4	21.3	2018
<b>5.3 Protective factors</b>			
5.3.1 Percentage of people aged 15 years and over living with a mental health condition who participated in physical activity	63.8	65.1	2019

### Outcome 6

#### People living with mental illness and substance use disorders have positive experiences of their support, care and treatment

Domains and performance indicators	State status	National status	Progress update
<b>6.1 Consumer satisfaction</b>			
6.1.1 Consumer satisfaction with public community mental health services (index score)*	7.5	NA	2016
<b>6.2 Consumer and carer engagement</b>			
6.2.1 Number of paid full-time equivalent (FTE) consumer workers per 1,000 FTE direct care, consumer and carer staff in mental health services	2.8	2.7	2016
6.2.2 Number of paid full-time equivalent carer workers per 1,000 FTE direct care, consumer and carer staff in mental health services	0.6	1.4	2016
<b>6.3 Ability to access services</b>			
6.3.1 Percentage of people aged 15 years and over experiencing a mental health condition and who have difficulty accessing service providers	41.3	38.0	2019

\* See Indicator 6.1 for details.



## Our shared vision for Queensland

*A healthy and inclusive community, where people living with mental health difficulties or issues related to substance use have a life with purpose and access to quality care and support focused on wellness and recovery, in an understanding, empathic and compassionate society.*

# Introduction

It is often said that we value what we measure. Measuring outcomes is an important part of the evidence we need to enable us to set goals and inform our shared understanding of what we seek to collectively achieve. Together with research and the views of the community, particularly those with a lived experience, their families and carers, it helps us to identify areas where progress is being made and where further work is needed.

Over many years leaders in the mental health sector have called for better measurement and reporting of outcomes for people living with mental illness across a wide spectrum of areas. In 2013, the Council of Australian Governments' Expert Reference Group developed *National Targets and Indicators for Mental Health Reform*. This work identified six domains, targets and indicators. Efforts to identify indicators and measures and to measure progress continue at the national level.

The *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* adapted these targets and domains as outcomes and expanded their scope to include issues relating to problematic alcohol and other drug use. The Strategic Plan's six long-term outcomes are:

## Outcome 1

A population with good mental health and wellbeing

## Outcome 2

Reduced stigma and discrimination

## Outcome 3

Reduced avoidable harm

## Outcome 4

People living with mental health difficulties or issues related to substance use have lives with purpose

## Outcome 5

People living with mental illness and substance use disorders have better physical and oral health and live longer

## Outcome 6

People living with mental illness and substance use disorders have positive experiences of their support, care and treatment

These outcomes are reflected in the Strategic Plan's vision for Queensland:

*A healthy and inclusive community, where people living with mental health difficulties or issues related to substance use have a life with purpose and access to quality care and support focused on wellness and recovery, in an understanding, empathic and compassionate society.*

Responsibility for realising this vision and achieving these outcomes does not belong to any one agency. Rather they are to be achieved through the collective effort of many organisations, all levels of government, the non-government sector, private enterprise and the broader community.

Many factors, including those that are often outside the control of governments and other stakeholders, influence whether progress is made towards achieving these outcomes, for example natural disasters and droughts. However we do need to know whether, and to what extent, collective efforts are making a positive and long-term difference to improving the mental health and wellbeing of Queenslanders.

## A shared commitment to measure and report on progress

The Strategic Plan committed to identify performance indicators to measure progress toward improving mental health and wellbeing. The commitment seeks to:

- identify robust performance indicators to help measure, monitor and report on progress towards achieving the Strategic Plan's vision and outcomes and, together with other information, identify areas for future action
- meaningfully report to Queenslanders on the progress of reforms to the mental health, alcohol and other drugs service system.

This is to be achieved by:

- Identifying and using existing data sets that can help measure progress
- Addressing information gaps by developing new data sets where feasible
- Aligning performance indicators to any goals and targets set at the whole-of-government level.

The first stage of this work to identify and report on performance indicators commenced in 2014–15 and involved establishing and identifying:

- Principles that would be used to identify performance indicators
- Existing measures that could be used to report progress
- Areas where further work could be undertaken to address gaps in data.

This work was led by the Commission in partnership with government and non-government organisations including:

- Queensland Treasury (the Office of the Government Statistician)
- Department of the Premier and Cabinet
- Queensland Health
- Chief Psychiatrist
- Queensland Voice
- Queensland Alliance for Mental Health Inc.
- Queensland Network of Alcohol and other Drug Agencies
- Queensland Council of Social Services
- Queensland Mental Health and Drug Advisory Council.

This report outlines steps taken to identify performance indicators for each outcome and reports on measures where data is currently available, including making comparisons with national data where available. It also identifies areas where additional work is needed to further develop or source performance indicators and measures.

# Identifying the performance indicators

## Defining each outcome

Each of the six long-term outcomes included in the Strategic Plan are broad in nature and are influenced by a wide variety of factors. A number of them address the needs of all Queenslanders—for example a population with good mental health and wellbeing and reduced avoidable harm—while others focus on the needs of people living with mental illness and problematic substance use. Some outcomes involve many elements and were broken down into domains to ensure all parts of an outcome are being considered.

## Principles for identifying performance indicators

There is considerable research about how to choose the right performance indicators and measures for performance. The United Kingdom developed FABRIC as an appropriate performance framework tool<sup>1</sup>. The principles identified (focused, appropriate, balanced, robust, integrated and cost effective) also informed the Australian Capital Territory Government's Performance Framework<sup>2</sup>.

Based on FABRIC and on the Strategic Plan's Shared Commitment to Action 8 the following principles were adopted by the Reference Group and were used to guide identifying, developing and reporting on performance indicators for Queensland:

- **Meaningful and shared:** aligned to the Strategic Plan's objective to improve mental health and wellbeing and to the outcomes. Where change is not likely to be seen immediately, other measures which contribute to progress towards achieving the outcomes may be identified. To support collective action, system managers and stakeholders will ideally have a common understanding and ownership of the performance indicators and measures.
- **Appropriate and useful:** stakeholders, particularly those developing policies and planning services, and service providers are likely to use the performance indicators to monitor progress and inform future action. To measure progress the performance indicators and measures must be reported regularly. Consideration will be given to the currency and frequency of available data. Ideally data will be collected and reported in a timely manner to enable it to inform actions and responses.
- **Feasible and cost effective:** Wherever possible the performance indicators will be measurable through existing data sets and sources. New data sets and sources may be developed where necessary on consideration of the benefits and costs.
- **Robust:** the measures should be valid, reliable, consistent, credible and comparable nationally and over time.

## Applying the principles

Available data sources were identified and assessed against the criteria. Outlined in this report are those performance indicators and measures that most satisfied the principles. The main sources of data were (see Appendix 1):

- *Australian Health Survey*, Australian Bureau of Statistics (ABS)
- *Causes of Death*, ABS
- *Consumer Perceptions of Care Statewide Report 2014*, Queensland Health
- *General Social Survey*, ABS
- *National Minimum Data Sets for Mental Health*, Australian Institute of Health and Welfare (AIHW)
- *The National Drug Strategy Household Survey, detailed report 2013*, AIHW
- *Report on Government Services 2015 (ROGS 2015)*, Steering Committee for the Review of Government Service Provision
- *Suicides Australia*, ABS

It is important to note that many of the publicly available data sets have limitations. While all, except the consumer perceptions of care, include a national comparison, many rely on self-reporting and cannot be broken down to focus solely on people living with a mental illness or people experiencing problematic alcohol and other drug use. How the principles were applied, and areas of further work, are outlined throughout this report under each of the outcome areas.



# 1

## A population with good mental health and wellbeing

### What we mean by mental health and wellbeing

The World Health Organisation defines mental health as a state in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community<sup>3</sup>.

There has been considerable debate both within Australia and internationally about how to define wellbeing. Subjective wellbeing, that is how people assess their own wellbeing, is often described in terms of satisfaction with their lives and sometimes includes an assessment of happiness. Objective wellbeing considers the conditions in which we live for example educational and employment opportunities<sup>4</sup>.

Individuals can experience poor mental health and wellbeing with or without experiencing mental illness. It is also possible to live with mental illness and experience good mental health and wellbeing<sup>5</sup>.



## Why it is important

All of us, whether we are living with a mental illness or problematic drug use, experience varying levels of mental health and wellbeing. Mental health and wellbeing is the foundation to thriving and prosperous individuals, families, communities and the economy. People with higher levels of mental health and wellbeing are healthier, better able to take care of their own needs, are more productive and resilient in the face of challenges such as unemployment, natural disasters, migration and the many changes in life circumstances that can occur<sup>6</sup>.

It impacts, and is influenced by, many factors in our lives including educational outcomes, employment, our ability to parent and to withstand life challenges such as natural disasters and droughts<sup>7</sup>.

For people living with mental illness and problematic drug use, good mental health and wellbeing is the foundation for recovery.

## Links to the Strategic Plan

All Shared Commitments to Action support improved mental health and wellbeing of Queenslanders. This outcome is supported primarily by Shared Commitment to Action 2 (Improved awareness, prevention and early intervention) and the *Early Action: Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan 2015–17* (the Early Action Plan).

## Performance indicators

Based on available data, this report outlines the results for the following performance indicators under two domains:

### 1.1 Mental health of all Queenslanders

#### 1.1.1 Psychological distress

### 1.2 Levels of mental health problems and illness

#### 1.2.1 Prevalence of mental health conditions

#### 1.2.2 Experience of mental illness as a personal stressor

## Why these performance indicators

There is no current nationally-accepted way of measuring mental health or wellbeing. Instead psychological distress has been used and reported by organisations such as the Productivity Commission and the Australian Bureau of Statistics. In the absence of a more appropriate measure, monitoring and reporting psychological distress was considered to best meet the principles.

While mental health and wellbeing is different from mental illness or diagnosed mental health conditions, it was considered appropriate to identify the number of Queenslanders who are living with mental health conditions and mental illness as a personal stressor. Importantly, the indicator relating to a mental health condition includes both diagnosed mental illness and feelings of stress and depression.

## Addressing gaps in monitoring this outcome

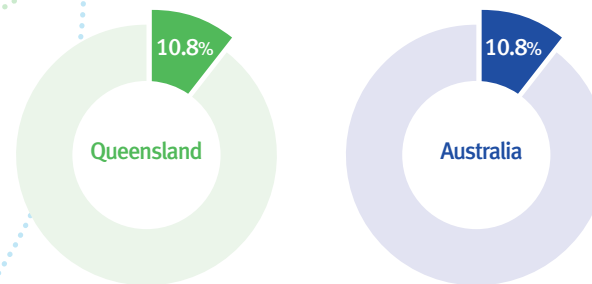
A robust and reliable population-level measure of overall wellbeing of Queenslanders is currently not available. The feasibility and cost effectiveness of developing a wellbeing measure for Queensland will be considered.

The performance indicators do not include the number of people living with problematic alcohol and other drug use. Alcohol and other drug use and harms is reported under Outcome 3.

## 1.1 Mental health of all Queenslanders

### 1.1.1 Psychological distress

Age standardised percentage of people aged 18 years and over experiencing high or very high levels of psychological distress, 2011–12



Source: ROGS (2015) Table 12A.10, ABS (unpublished) 4364.0, *National Health Survey, 2011–12*

#### *What it is*

Age standardised percentage of people aged 18 years and over experiencing high or very high levels of psychological distress based on self-reported negative emotional states experienced in the preceding 30 days and based on the Kessler Psychological Distress Scale (K10). High or very high levels of psychological distress may indicate that a person needs professional help regarding mental health problems.

#### *What it tells us about Queensland*

In 2011–12, 10.8 per cent of Queenslanders aged 18 years and over experienced high or very high levels of psychological distress. The same proportion of people nationally experienced high or very levels of psychological distress.

#### *What it doesn't tell us*

It does not tell us that a person needs professional help, which is an assessment that should be made by practitioners. The performance indicator relies on self-reported levels of psychological stress and may therefore be under or over reported.

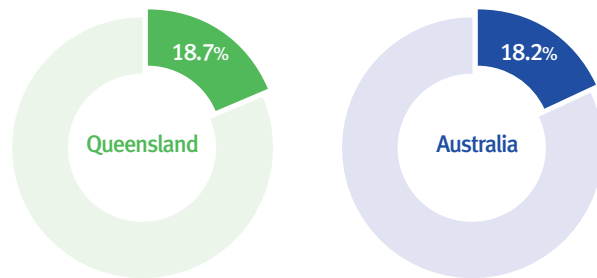
#### *When we will next report progress*

It is anticipated that progress on levels of psychological distress will be updated in 2019 when new data is expected to become available.

## 1.2 Levels of mental health problems and illness

### 1.2.1 Prevalence of mental health conditions

Percentage of people aged 15 years and over who report living with a mental health condition, 2014



Source: ABS 4159.0, *General Social Survey*, 2014

#### What it is

Percentage of people aged 15 years and over who self-report experiencing a mental health condition. A mental health condition refers to clinically-recognised emotional and behavioural disorders, and perceived mental health problems such as feeling depressed, feeling anxious, stress and sadness.

#### What it tells us about Queensland

In 2014, a slightly higher proportion of Queenslanders (18.7 per cent) reported experiencing a mental health condition than the national percentage (18.2 per cent).

#### What it doesn't tell us

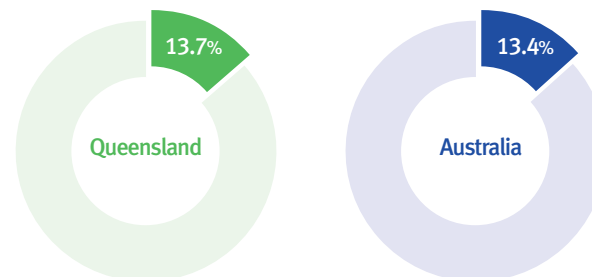
It focuses on elements of mental ill-health only, which cannot alone be considered a performance indicator of overall wellbeing. The data combines both diagnosed conditions and self-perceptions and therefore may not provide an accurate picture of the number or rate of Queenslanders actually experiencing a mental health condition.

#### When we will next report progress

The *General Social Survey* is collected every four years and reported in the following year. It was last conducted in 2014 and reported in 2015. The survey is next due to be conducted in 2018 and we anticipate next reporting on this indicator in 2019.

### 1.2.2 Experience of mental illness as a personal stressor

Percentage of people aged 15 years and over who report mental illness as a personal stressor, 2014



Source: ABS 4159.0, *General Social Survey*, 2014

#### What it is

Percentage of people aged 15 years and over who report that they, or someone close to them, have experienced mental illness as a stressor in the previous 12 months. Mental illness is not defined as part of the data collection tool however tends to include organic mental health conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions (e.g. dementia, depression, substance use and anxiety disorders).

#### What it tells us about Queensland

In 2014, a higher proportion of Queenslanders (13.7 per cent) reported experiencing mental illness as a personal stressor in the last 12 months than the national proportion (13.4 per cent).

#### What it doesn't tell us

The data is self-reported and therefore relies on the accuracy of individual reports and perceptions.

#### When we will next report progress

The *General Social Survey* (GSS) is collected every four years and reported in the following year. It was last conducted in 2014 and reported in 2015. The survey is next expected to be conducted in 2018 and we anticipate next reporting on this indicator in 2019.



## Reduced stigma and discrimination

### What we mean by stigma and discrimination

This outcome focuses on stigma and discrimination experienced by people living with mental health problems, mental illness and problematic alcohol and other drug use.

**Stigma** refers to beliefs, thoughts and attitudes about a particular group of people based on their actual or perceived characteristics.

**Discrimination** refers to behaviour and can include processes of exclusion, restriction or unfavourable treatment based on a personal attribute or trait. A person will not always know they are experiencing discrimination.

### Why it is important

Stigma and discrimination impact on the mental health and wellbeing of all Queenslanders. Stigma can also affect whether a person is willing to seek help and discrimination can impact on whether they receive help. For people living with mental health problems, mental illness and problematic drug use, stigma and discrimination can hinder recovery. It can affect people long after their mental health symptoms are resolved.

### Links to the Strategic Plan

All Shared Commitments to Action support improved mental health and wellbeing of Queenslanders. This outcome is supported primarily by Shared Commitment to Action 2 (Improved awareness, prevention and early intervention) and the Early Action Plan, and Shared Commitment to Action 3 (Targeted responses in priority areas), and in particular the whole-of-government *Queensland Alcohol and Other Drugs Action Plan 2015–17* (the Alcohol and Other Drugs Action Plan).

## Performance indicators

Based on available data, this report outlines the results for the following performance indicators:

### 2.1 Discrimination

#### 2.1.1 Experience of discrimination or unfair treatment

#### 2.1.2 Experience of discrimination as a personal stressor

## Why these performance indicators

These performance indicators provide a population-wide measure of self-reported experience of any discrimination focusing in the last twelve months. Both are nationally comparable and are considered to be reliable.

## Addressing gaps in monitoring this outcome

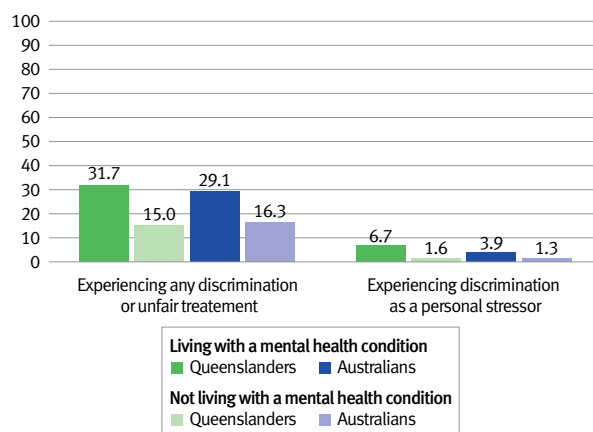
Data that provides a direct measure of stigma by exploring beliefs, thoughts and attitudes towards people experiencing mental health problems, all mental illnesses and problematic drug use is currently not available. Further consideration will be given to the feasibility and cost-effectiveness of developing a measure for stigma relating to mental health problems, mental illness and problematic alcohol and other drug use.

## 2.1 Discrimination

### 2.1.1 Experience of discrimination or unfair treatment

### 2.1.2 Experience of discrimination as a personal stressor

Percentage of people 15 years and older experiencing discrimination, 2014



Source: ABS (unpublished) 4159.0, *General Social Survey*, 2014

#### What it is

The percentage of people aged 15 years and over who report having experienced some form of discrimination or having been treated unfairly, or experienced discrimination (other than for ethnic or cultural reasons) as a personal stressor in the last 12 months.

A mental health condition is one which is a clinically-recognised emotional and behavioural disorder, and perceived mental health problems such as feeling depressed, feeling anxious, stress and sadness. The data was self-reported by the respondent.

#### What it tells us about Queensland

In 2014, a greater proportion of Queenslanders who identified as living with a mental health condition reported experiencing discrimination and unfair treatment (31.7 per cent) than those who did not identify as living with a mental health condition (15 per cent). They were also more likely than other Australians living with a mental health condition (29.1 per cent) to have reported experiencing discrimination or being treated unfairly.

In 2014, a greater proportion of Queenslanders living with a mental health condition (6.7 per cent) also reported experiencing discrimination as a personal stressor than other Queenslanders (1.6 per cent). The Queensland proportions are higher than the national percentage for both those living with or without a mental health condition.

#### What it doesn't tell us

It is difficult to determine from the data whether the discrimination experienced by people is directly related to their mental health status. It should also be noted that a person will not always know that they have been discriminated against or treated unfairly, so this indicator is likely to under-represent actual discrimination.

#### When we will next report progress

The *General Social Survey* is collected every four years and reported in the following year. It was last conducted in 2014 and reported in 2015. The survey is next expected to be conducted in 2018 and we anticipate next reporting on this indicator in 2019.



## Reduced avoidable harm

### What we mean by reduced avoidable harm

This outcome focuses on reducing avoidable harm associated with intentional self-harm, suicide and problematic use of alcohol, tobacco and other drugs.

Harm includes physical and psychological harms for those experiencing mental health problems, mental illness and problematic alcohol and other drug use. This outcome encompasses three types of harm:

**Self-harm:** when a person intentionally harms themselves without the intention of ending their life.

**Suicide:** when a person dies through self-harm with the intention of ending their life.

**Alcohol and other drug-related harms:** when a person experiences problems associated with use of a drug, defined as including alcohol, tobacco, illegal (also known as 'illicit') drugs, pharmaceuticals and other substances that alter brain function, resulting in changes in perception, mood, consciousness, cognition and behaviour.

## Why it is important

**Self-harm:** People who self-harm are experiencing mental health problems and in some instances mental illness. Self-harm is defined as intentional bodily injury without the intention of ending life. While not generally involving suicidal intent, those who engage in this behaviour may be at increased risk of suicide.

**Suicide:** Suicide has a significant impact on the lives of many including family, friends, work colleagues and the broader community.

**Alcohol and other drug-related harms:** While not everyone who uses drugs becomes dependent, many people experience harms that can result in injury, disability and in some cases death.

## Links to the Strategic Plan

All Shared Commitments to Action support improved mental health and wellbeing of Queenslanders. This outcome is supported primarily by Shared Commitment to Action 2 (Improved awareness, prevention and early intervention) and the Early Action Plan. Shared Commitment to Action 3 (Targeted responses in priority areas) also supports this outcome, in particular actions to implement the Suicide Prevention Action Plan and the Alcohol and Other Drugs Action Plan. The development of a new Mental Health, Drug and Alcohol Services Plan under Shared Commitment to Action 7 will also contribute to reduced avoidable harm.

## Performance indicators

Based on available data this report outlines the results from the following performance indicators in two domains:

### 3.1 Suicide

3.1.1 Queensland suicide rate

3.1.2 Queensland Aboriginal and Torres Strait Islander suicide rate

3.1.3 Queensland suicide rate for regional, rural and remote communities

### 3.2 Alcohol and other drug-related harms

3.2.1 Alcohol consumption at life-time risky levels

3.2.2 Alcohol consumption at single occasion risky levels

3.2.3 Daily tobacco smoking

3.2.4 Illicit drug use

3.2.5 Misuse of pharmaceuticals

## Why these performance indicators

### Suicide

Performance indicators for suicide include data on the number of Queenslanders who suicide and the suicide rate. National data is available from the Australian Bureau of Statistics which allows comparison between Queensland and national figures.

### Alcohol and other drug-related harms

Data relating to drug use is collected through the triennial *National Drug Strategy Household Survey*. Due to the nature of drug use this collection is considered the most reliable way of identifying the number of people using drugs and the extent of use. It includes levels of risky alcohol consumption, daily tobacco smoking, use of illicit drugs and other drugs such as pharmaceuticals. This also aligns with the *National Drug Strategy 2010–2015* (the National Drug Strategy) and the revised draft *National Drug Strategy 2016–2025* (revised National Drug Strategy).

## Addressing gaps in monitoring this outcome

### Self-harm

At this stage there is no reliable or widely-accepted way of measuring levels of self-harm in Queensland. Hospital and Health Services and the Queensland Ambulance Service currently collect some data about hospitalisation as a result of self-harm. Further work to explore issues associated with data collection methodology will be undertaken.

### Suicide

Suicide data through both the Queensland Suicide Register and also reported by the ABS is reliable. However as a death needs to be confirmed as a suicide (based on a Coroner's findings) there are lags in time, with confirmed suicide rates usually reported two to three years after they occur. The Commission has committed to developing an Information and Data Sharing Network which will consider enhancing current data including providing data about unconfirmed suicides as part of the Suicide Prevention Action Plan.

Currently there is no nationally agreed way of measuring or reporting suicide attempts. This also forms part of the Commission's commitment under the Suicide Prevention Action Plan. The Commission will also investigate the most appropriate and timely way to report on the age standardised suicide rates for children and young people.

### Alcohol and other drug-related harms

The current proportion of people using alcohol and other drugs is not an indicator of harm, as not everyone who uses alcohol and other drugs will experience harm. Whether a person experiences harm is often influenced by the age a person uses or is exposed to alcohol and other drugs, how often it is used, and the quantity used. While the current performance indicators include risky alcohol consumption likely to lead to harm, and daily smoking which is a high risk factor for disease, the current performance indicators do not accurately reflect harms or risk of harm relating to the use of other drugs including illicit drugs.

To address this issue, the Commission will identify options to monitor and report on levels of harm, for example hospitalisation due to drug use, new hepatitis C infection rates related to injecting drug use, and overdoses of all drugs including alcohol.

While the *National Drug Strategy Household Survey 2013* reports average age of first use at a national level, a breakdown at the state level is currently not available. The Commission will be working with the stakeholders to identify and report on the average age Queenslanders first use alcohol and other drugs.

The revised National Drug Strategy identifies a number of performance indicators of harm which are also not available at the state level including drug-related burden of disease.



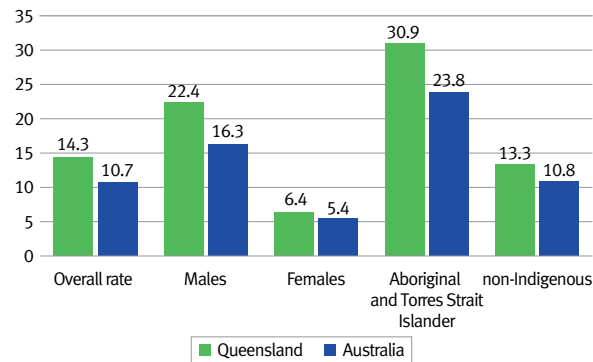
## 3.1 Suicide

### 3.1.1 Queensland suicide rate

### 3.1.2 Queensland Aboriginal and Torres Strait Islander suicide rate

### 3.1.3 Queensland suicide rate for regional, rural and remote communities

Age standardised suicide rate per 100,000 people, 2013



Source: ABS 3303.0, *Causes of Death*, 2013

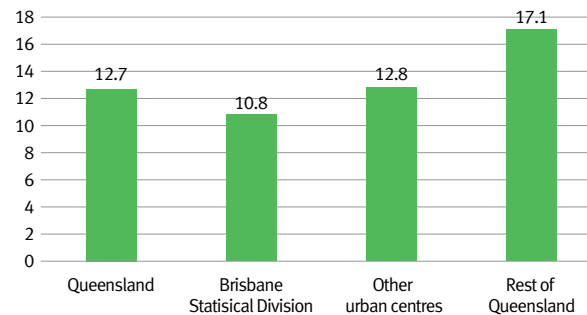
#### What it is

The age standardised suicide rates per 100,000 people in 2013 in Queensland including suicide deaths of people who identify as Aboriginal and Torres Strait Islander. The second graph indicates the suicide rate by geographic location in 2006–2010.

#### What it tells us about Queensland

In 2013 the Queensland suicide rate (14.3 per 100,000 people) was greater than the Australian rate (10.7 per 100,000 people). As the number of people who suicide fluctuates each year it is important to also consider rates over time. Between 2006 and 2010 the Queensland age standardised rate of suicide was 12.7 per 100,000 people compared to the Australian rate of 10.7 over the same period.

Age standardised suicide rate by geographic region per 100,000 people, 2006–2010



Source: ABS 3309.0, *Suicides Australia*, 2010

Suicide rates were higher in 2013 for Indigenous Queenslanders at 30.9 per 100,000 compared with the non-Indigenous rate at 13.3 per 100,000. This is higher than the national rate of 23.8 per 100,000 for Aboriginal and Torres Strait Islander peoples.

Males were also more likely to suicide than females both in Queensland and nationally. Suicide rates for Queensland males were 22.4 per 100,000 compared to the suicide rate for females which was 6.4 per 100,000. Female figures are consistent with the national rate however the rate of males suiciding in Queensland is higher than the national rate of 16.3 per 100,000.

Queenslanders living in Brisbane (10.8 per 100,000 people) and other urban centres (12.8 per 100,000 people) were also less likely to suicide than those living in the rest of Queensland (17.1 per 100,000 people).

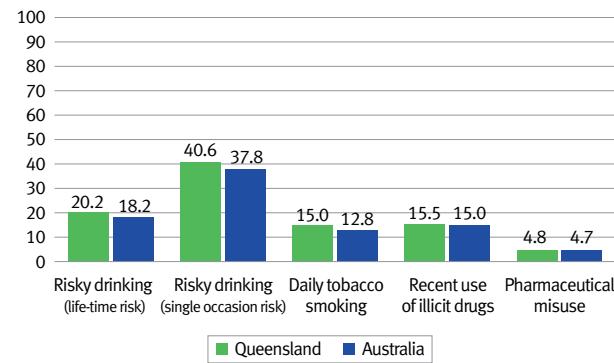
#### When we will next report on progress

The ABS *Causes of Death* publication is reported annually. There is a lag time in reporting due to the need for suicides to be confirmed by the Coroner. We will next report on progress in 2016–17 when updated data becomes available. The ABS *Suicides Australia* report is not a regular publication and further investigations will need to be undertaken to determine when or if the report will be published in the future.

## 3.2 Alcohol and other drug-related harm

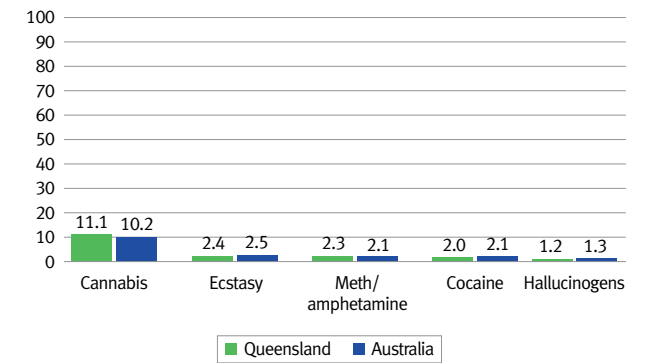
- 3.2.1 Alcohol consumption at life-time risky levels
- 3.2.2 Alcohol consumption at single occasion risky levels
- 3.2.3 Daily tobacco smoking
- 3.2.4 Illicit drug use
- 3.2.5 Misuse of pharmaceuticals

Percentage of people aged 14 years and older who reported using drugs in the past 12 months, 2013



Source: AIHW, National Drug Strategy Household Survey, 2013

Percentage of people aged 14 years and older who reported recent use of illicit drugs, 2013



Source: AIHW, National Drug Strategy Household Survey, 2013

### *What it is*

The percentage of people aged 14 years or older who report drinking alcohol at life-time risky levels and single occasion risky levels, daily tobacco smoking, recent use of illicit drugs (by type) and misused pharmaceuticals.

### *What it tells us about Queensland*

In 2013, Queenslanders reported drinking alcohol at risky levels which put them at life-time risk (20.2 per cent) and single occasion risk (40.6 per cent) above the national percentage (18.2 per cent and 37.8 per cent respectively). A higher proportion of Queenslanders also reported smoking tobacco daily than the national percentage (15 per cent compared to 12.8 per cent).


There was no significant difference in the proportion of Queenslanders who reported using illicit drugs (15.5 per cent) than the national percentage (15 per cent) or misusing pharmaceuticals (4.8 per cent compared to 4.7 per cent). In relation to illicit drugs the greatest proportion of people reported using cannabis (11.1 per cent in Queensland) compared to any other illicit drug.

### *What it doesn't tell us*

The *National Drug Strategy Household Survey* relies on people disclosing their use of what are in some cases illegal drugs, and therefore results about those drugs may be under-reported. The survey was also not administered in institutional settings, hostels, motels, to homeless people or in foreign languages.

### *When we will next report on progress*

The *National Drug Strategy Household Survey* is conducted every three years. The next survey is expected to be undertaken in 2016 with results publicly available in 2018. We anticipate reporting on progress in 2018–2019.



People living with mental health difficulties or issues related to substance use have lives with purpose

## What we mean by a life with purpose

A life with purpose is one where a person is engaging in meaningful activities including community participation, social engagement, education, training and employment. This outcome focuses on those living with mental illness and problematic alcohol and other drug use.

## Why it is important

Living a life with purpose is fundamental to recovery. Being connected to community, family and friends, engaging in meaningful activities and participating in education, training and employment can offer hope and enable people to achieve their aspirations. Being able to live a life with purpose supports good mental health and wellbeing<sup>8</sup>.

## Links to the Strategic Plan

All Shared Commitments to Action support improved mental health and wellbeing of Queenslanders. This outcome is supported primarily by Shared Commitment to Action 2 (Improved awareness, prevention and early intervention) and the Early Action Plan. Shared Commitment to Action 3 (Targeted responses in priority areas) also supports this outcome through the Alcohol and Other Drugs Action Plan. Work as part of Shared Commitments to Action 4 (A responsive and sustainable community sector) and 5 (Integrated and effective government responses) will also contribute to achieving this outcome.

## Performance indicators

Based on available data this report outlines results against the following performance indicators in three domains:

### 4.1 Economic participation

4.1.1 Employment or enrolment in study

4.1.2 Employment

4.1.3 Volunteering

### 4.2 Community participation

4.2.1 Participation in social groups

4.2.2 Participation in community support groups

4.2.3 Participation in civic or political groups

4.2.4 Attending cultural or leisure activities

### 4.3 Personal connections

4.3.1 Daily face-to-face contact with family or friends

4.3.2 At least weekly face-to-face contact with family or friends

4.3.3 Ability to get support in times of crisis

## Why these performance indicators

This data collected by the Australian Bureau of Statistics as part of the *Australian Health Survey* and the *General Social Survey* provides an overview of participation and community connectedness across a range of domains.

## Addressing gaps in data

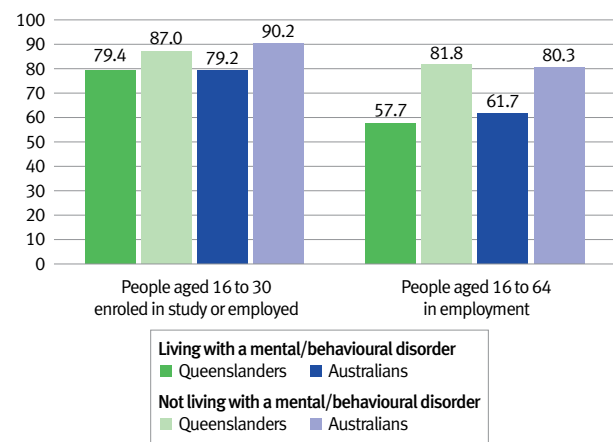
There are a considerable number of performance indicators under this outcome which do not differentiate between those with mental health problems, those living with mental illness and people experiencing problematic drug use. Many data sets used as performance indicators also refer to mental health problems or mental health conditions. The definition in many cases includes substance use, however it is not clear whether this refers to substance use disorder or includes those who may be experiencing problematic drug use but are not dependent or living with a mental illness.

## 4.1 Economic Participation

### 4.1.1 Employment or enrolment in study

### 4.1.2 Employment

#### Age standardised percentage in study or employment, 2011–12



Source: ROGS (2015) Table 12A.87, ABS unpublished 4364.0, *Australian Health Survey* (2011–12 NHS component), 2011–13.

#### What it is

The age standardised percentage of people aged 16 to 30 years who reported living with a mental or behavioural condition, and who were employed and/or were enrolled for study in a formal secondary or tertiary qualification (full or part-time).

The age standardised percentage of people aged 16 to 64, who are employed either on a full-time basis (where the person usually works 35 hours or more a week), or on a part-time basis (where the person usually works one hour to less than 35 hours a week).

A person is considered to be living with a mental health condition if they self-report mental or behavioural problems that have lasted for six months, or which they expect to last for six months or more. It includes organic mental conditions, alcohol and other drug conditions, mood conditions and other mental or behavioural conditions (for example dementia, depression, substance use and anxiety disorders).

#### What it tells us about Queensland

In 2011–12, Queenslanders living with a mental/behavioural disorder were less likely to be employed or enrolled in study (79.4 per cent) than other Queenslanders (87 per cent). There was no significant difference, however, with the national percentage (79.2 per cent).

In 2011–12, a much smaller proportion of people living with mental/behavioural disorders were employed in Queensland (57.7 per cent) compared to those without (81.8 per cent). This was also less than the national proportion of people living with mental/behavioural disorders who were employed (61.7 per cent).

#### What it doesn't tell us

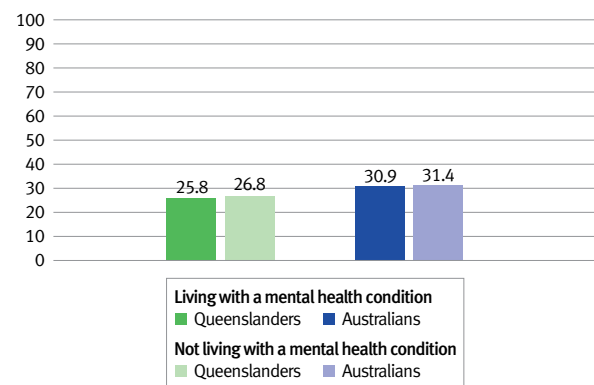
The data does not indicate the proportion of people completing their study or how long they have held employment. The enrolment in study and employment data is collected from people who are actively engaged with a mental health service provider, so comparison with prevalence data for mental health issues would need to be treated with caution.

#### When we will next report on progress

This data was sourced from the *Australian Health Survey* which is next expected to be undertaken in 2015–16 with results expected in 2017. We anticipate reporting on progress in 2018.

### 4.1.3 Volunteering

Percentage of people aged 15 years and over engaged in volunteering, 2014



Source: ABS (unpublished) 4159.0, *General Social Survey*, 2014

#### What is it

The percentage of people aged 15 years and over in 2014 who reported living with a mental health condition, and have undertaken unpaid voluntary work in the last 12 months through an organisation. People who engaged in the survey self-identified whether they had experience of a clinically-recognised emotional and behavioural disorder, and perceived mental health problems such as feeling depressed, feeling anxious, stress and sadness.

#### What it tells us about Queensland

In 2014, a smaller proportion of Queenslanders living with a mental health condition undertook unpaid volunteer work (25.8 per cent) than other Queenslanders (26.8 per cent) but the difference was not significant. Overall a smaller proportion of Queenslanders volunteered than other Australians.

#### What it doesn't tell us

The data does not indicate the nature and extent of the volunteer work. It does not provide detail which may allow analysis of the quality of the working experience or the extent to which it may facilitate access to paid work.

#### When we will next report on progress

The *General Social Survey* is collected every four years and reported in the following year. It was last conducted in 2014 and reported in 2015. The survey is next expected to be conducted in 2018 and we anticipate next reporting on this indicator in 2019.

## 4.2 Community participation

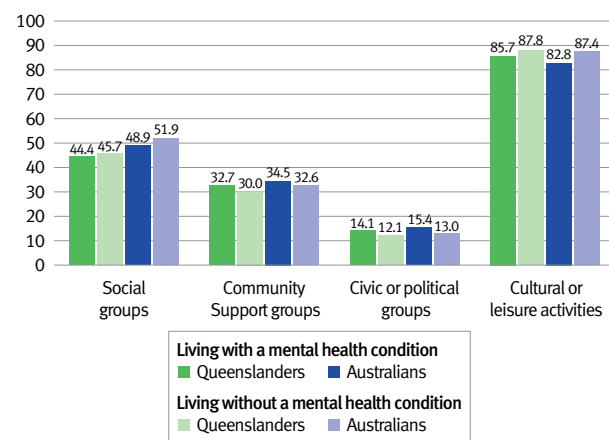
### 4.2.1 Participation in social groups

### 4.2.2 Participation in community support groups

### 4.2.3 Participation in civic or political groups

### 4.2.4 Attending cultural or leisure activities

Percentage of people aged 15 years and over participating in the community, 2014



Source: ABS (unpublished) 4159.0, *General Social Survey*, 2014

#### What it is

Percentage of people aged 15 years and over who report living with a mental health condition and are involved in social groups, community support groups, civic or political groups and attended cultural or leisure activities in the last 12 months.

A person is identified as living with a mental health condition if they report that they experience clinically-recognised emotional and behavioural disorders, and perceived mental health problems such as feeling depressed, feeling anxious, stress and sadness.

#### What it tells us about Queensland

In 2014, Queenslanders living with mental health conditions were less likely to participate in the community with:

- 44.4 per cent participating in social groups compared with 45.7 per cent of people who do not experience mental health conditions.
- 85.7 per cent attending cultural or leisure activities compared to 87.8 per cent of those who do not experience mental health conditions.

However, a greater proportion participated in community support groups than Queenslanders not living with a mental health condition (32.7 per cent compared with 30.0 per cent) and in civic or political groups (14.1 per cent compared to 12.1 per cent).

#### What it doesn't tell us

The data does not provide detail about the nature and extent to which people benefit from their participation in activities outside the household.

#### When we will next report on progress

The *General Social Survey* is collected every four years and reported in the following year. It was last conducted in 2014 and reported in 2015. The survey is next expected to be conducted in 2018 and we anticipate next reporting on this indicator in 2019.



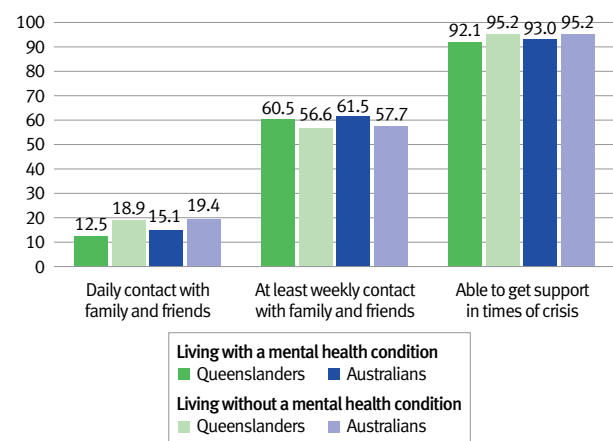
## 4.3 Personal connections

### 4.3.1 Daily face-to-face contact with family or friends

### 4.3.2 At least weekly face-to-face contact with family or friends

### 4.3.3 Able to get support in times of crisis

Percentage of people aged 15 years and over having personal connections, 2014



Source: ABS (unpublished) 4159.0, *General Social Survey*, 2014

#### What it is

The percentage of people aged 15 years and over who reported living with a mental health condition, who frequently (everyday, at least once a week) had face-to-face contact with family or friends outside the household and who were able to access support outside of their household in times of crisis.

A mental health condition is self-reported and includes experiences of clinically-recognised emotional and behavioural disorders, and perceived mental health problems such as feeling depressed, feeling anxious, stress and sadness. It includes mental health conditions such as depression, feeling depressed, behavioural and emotional disorders, and feeling anxious.

#### What it tells us about Queensland

In 2014, Queenslanders experiencing mental health conditions were more likely than other Queenslanders to have at least weekly face-to-face contact with family and friends outside of their home (60.5 per cent compared with 56.6 per cent) but less likely to have face-to-face contact on a daily basis (12.5 per cent compared with 18.9 per cent).

The difference at a national level is similar to the Queensland percentages except there appears to be more daily contact between those living with mental health conditions and their family and friends outside the household.

Queenslanders living with a mental health condition felt they were less likely to be able to access support at times of crisis. In 2014, 92.1 per cent of people with mental health conditions felt they were able to get support from people outside the household at a time of crisis compared with 95.2 per cent of Queenslanders who do not experience mental health problems. This is similar to the national percentages.

#### What it doesn't tell us

The data does not indicate the quality and nature of the contact or support they received and whether it is supporting recovery and improved mental health and wellbeing.

#### When we will next report on progress

The *General Social Survey* is collected every four years and reported in the following year. It was last conducted in 2014 and reported in 2015. The survey is next expected to be conducted in 2018 and we anticipate next reporting on this indicator in 2019.



15

People living with mental illness and substance use disorders have better physical and oral health and live longer

## What we mean by better physical and oral health and living longer

This outcome refers to the life expectancy, physical and oral health of people experiencing mental illness, including substance use disorders.

Unlike the outcome of reduced avoidable harm which focuses on reducing harm for the whole community, this outcome focuses on the difference in health outcomes for people who live with mental illness and mental health problems.

## Why it is important

The most recent information on life expectancy was undertaken in Western Australia by The University of Queensland and The University of Western Australia entitled: *The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers*<sup>9</sup>. It indicated that between 1985 and 2005, males living with mental illness were expected to live 15.9 years less than other males, and females 12 years less<sup>10</sup>.

## Links to the Strategic Plan

This outcome is supported primarily by actions taken to implement Shared Commitment to Action 6 (More integrated health service delivery).

## Performance indicators

Based on available data, this report outlines results on the following performance indicators:

### 5.1 Long-term health conditions

#### 5.1.1 Cardiovascular disease

#### 5.1.2 Cancer

#### 5.1.3 Diabetes

#### 5.1.4 Arthritis

#### 5.1.5 Asthma

### 5.2 Risk factors

#### 5.2.1 Daily smoking

#### 5.2.2 Obesity

#### 5.2.3 Risk of long-term harm from alcohol

### 5.3 Protective factors

#### 5.3.1 Participated in physical activity

## Why these performance indicators

Reduced life expectancy is not directly caused by mental illness. Research indicates that physical health conditions such as cancer, cardiovascular disease and diabetes are the major contributor to lowered life expectancy. High levels of alcohol, tobacco and other drug use as well as poor diets and lower levels of exercise are significant factors<sup>11</sup>. There is also a need to address systemic barriers to people living with a mental illness accessing health care<sup>12</sup>.

## Addressing gaps in monitoring this outcome

The ABS collects data relating to dental visits and health checks but is not available at the state level. Investigations will be undertaken to determine whether Queensland data can be obtained and reported.

## 5.1 Long-term health conditions

### 5.1.1 Cardiovascular disease

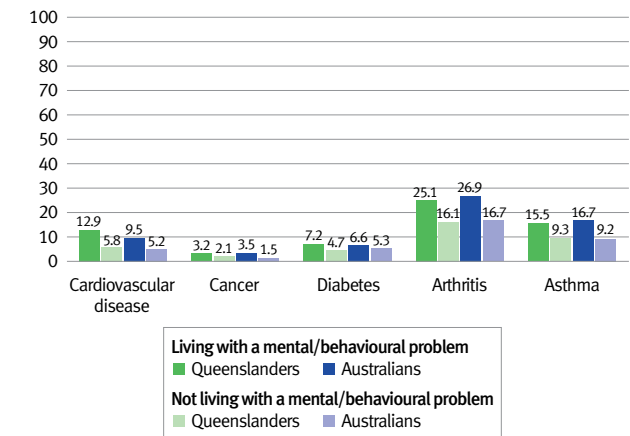
### 5.1.2 Cancer

### 5.1.3 Diabetes

### 5.1.4 Arthritis

### 5.1.5 Asthma

## Age standardised percentage of people with long-term health conditions, 2011–12



Source: ROGS (2015) Table 12A.86, ABS unpublished 4364.0, Australian Health Survey (2011–12 NHS component), 2011–13

### What it is

The age standardised percentage of people who lived with mental/behaviour problems and the following long-term health conditions: cardiovascular disease, cancer, diabetes, arthritis and asthma.

A person is considered to be living with a mental/behavioural problem if they self-report a problem that has lasted for six months, or which they expect to last for six months or more. It includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions (e.g. dementia, depression, substance use and anxiety disorders).

## 5.2 Risk factors

### What it tells us about Queensland

The proportion of Queenslanders with cardiovascular disease was greater than the national percentage for those living with mental/behavioural problems (12.9 per cent compared to 9.5 per cent) as well as for Queenslanders not living with mental/behavioural problems (5.8 per cent).

In relation to all other long-term health conditions, a higher proportion of Queenslanders living with mental/behavioural problems had cancer (3.2 per cent compared to 2.1 per cent); diabetes (7.2 per cent compared to 4.7 per cent); arthritis (25.1 per cent compared to 16.1 per cent); and asthma (15.5 per cent compared to 9.3 per cent).

### What it doesn't tell us

This indicator does not tell us why a greater proportion of people living with mental or behavioural problems also experience long-term health conditions. It also doesn't tell us the type of mental or behavioural conditions that are most likely to co-occur with long-term health conditions.

### When we will next report on progress

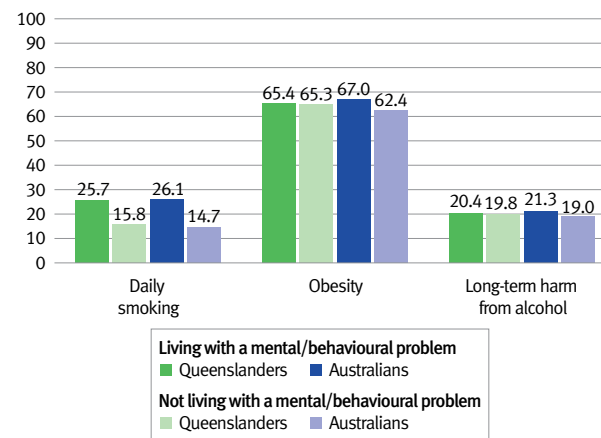
This data was sourced from the *Australian Health Survey* which is next expected to be undertaken in 2015–16 with results expected in 2017. We anticipate reporting on progress in 2018.

### 5.2.1 Daily smoking

### 5.2.2 Obesity

### 5.2.3 Long-term harm from alcohol

Age standardised percentage of people experiencing risk factors, 2011–12



Source: ROGS (2015) Table 12A.85, ABS unpublished 4364.0, *Australian Health Survey* (2011–12 NHS component), 2011–13

### What it is

The age standardised percentage living with mental/behavioural problems who smoked any substance daily, were obese or overweight; or who consumed alcohol at levels that place them at long-term risk of harm.

A person is considered to be living with a mental/behavioural problem if they self-report a problem that has lasted for six months, or which they expect to last for six months or more. It includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions (e.g. dementia, depression, substance use and anxiety disorders).

### What it tells us about Queensland

In 2011–12, a greater proportion of Queenslanders who experienced mental or behavioural problem smoked daily (25.7 per cent) than those who did not live with a mental or behavioural problem (15.8 per cent). The proportion however was slightly less than people living with mental/behavioural problems nationally.

There was no significant difference in the proportion of Queenslanders with or without a mental/behavioural health problem who were obese or overweight (65.4 per cent compared to 65.3 per cent). However a lower proportion of people living with mental/behavioural problems in Queensland were obese compared to the national percentage (67 per cent).

A similar proportion of Queenslanders who experienced mental/behavioural conditions were at risk from long-term harm from alcohol, at 20.4 per cent, compared with those who did not, at 19.8 per cent. The proportion was slightly lower than the national percentage for people living with mental/behavioural conditions (21.3 per cent).

#### What it doesn't tell us

It does not tell us the reasons why a greater proportion of people living with mental/behavioural conditions smoke or consume alcohol at risky levels. It also does not tell us why a slightly higher proportion is obese or overweight.

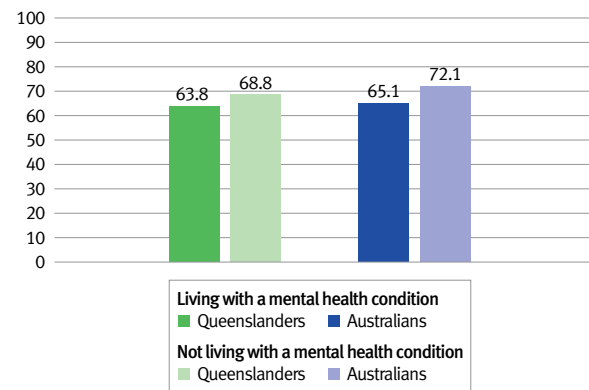
#### When we will next report progress

This data was sourced from the *Australian Health Survey* which is due to be next undertaken in 2015–16 with results expected in 2017. We anticipate reporting on progress in 2018.

## 5.3 Protective factors

### 5.3.1 Participated in physical activity

Percentage of people who participated in physical activity through sport or recreation, 2014



Source: ABS (unpublished) 4159.0, *General Social Survey*, 2014

#### What it is

The percentage of people aged 15 years and over who reported living with a mental health condition and who participated in any physical activities for sport or exercise or recreation in the previous 12 months. A person identified as living with a mental health condition if they reported that they experienced clinically-recognised emotional and behavioural disorders, and perceived mental health problems such as feeling depressed, feeling anxious, stress and sadness.

#### What it tells us about Queensland


In Queensland in 2014, people aged 15 years and over living with a mental health condition were less likely to engage in physical activity through sport or recreation (63.8 per cent) than those who did not live with a mental health condition (68.8 per cent). The proportion was lower in Queensland than the national percentage for both those living with a mental health condition and those who were not.

#### What it doesn't tell us

The data does not provide detail about the nature and extent to which people benefit from their participation in activities outside the household.

#### When we will next report on progress

The *General Social Survey* is collected every four years and reported in the following year. It was last conducted in 2014 and reported in 2015. The survey is next expected to be conducted in 2018 and we anticipate next reporting on this indicator in 2019.



People living with  
mental illness  
and substance use  
disorders have  
positive experiences  
of their support,  
care and treatment

## What we mean by support, care and treatment

Support, care and treatment includes public mental health and alcohol and other drug services within hospitals, rehabilitation centres and in the community. This outcome however focuses on services beyond the health system and includes access to other supports critical to recovery including housing, disability and employment.

## Why it is important

In some cases access to services and positive experiences can reduce the duration and severity of mental illness and mental health problems and is the foundation for recovery. Having a positive experience also means that people are more likely to remain engaged with services including alcohol and other drug services. Consumer and carer participation in the development, planning, delivery and evaluation of mental health services has been a focus area for the *National Standards for Mental Health Services*.

## Links to the Strategic Plan

This outcome is supported primarily by Shared Commitment to Action 1 (Engagement and leadership priorities for individuals, families and carers). Specific projects include developing best practice standards for consumer, family and carer engagement in mental health and alcohol and other drug services.

## Performance indicators

Based on available data this report outlines the following performance indicator results:

### 6.1 Consumer satisfaction

#### 6.1 Consumer satisfaction with mental health care

### 6.2 Consumer and carer engagement

#### 6.2.1 Paid consumer workers

#### 6.2.2 Paid carer workers

### 6.3 Access to services

#### 6.3.1 Difficulty accessing services

## Why these performance indicators

Consumer perceptions of mental health care and treatment can inform future improvements, with high levels of satisfaction with services demonstrating effectiveness. There is also growing evidence that consumer and carer involvement in mental health treatment and care can have a positive effect on consumer experiences and further support recovery.

The inclusion of paid consumer and carer worker positions, including peer worker roles, in the mental health system is considered an indicator of quality service provision that supports a recovery-focused approach.

## Addressing gaps in monitoring this outcome

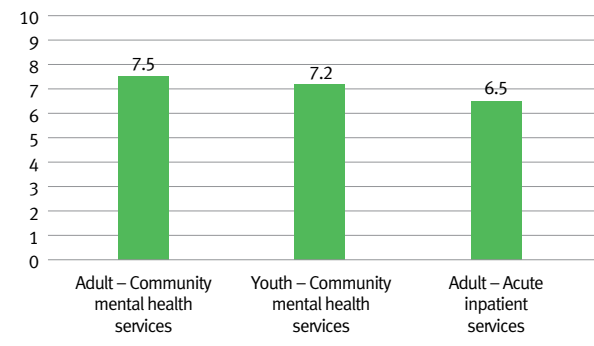
Data exploring consumer perceptions of care across Queensland is currently collected by Hospital and Health Services and reported by the Queensland Health in the annual *Consumer Perceptions of Care Statewide report*. In 2015, this survey will be replaced by the national *Your Experience of Service (YES)* survey.

There is currently no state-wide mechanism to assess the experiences of people who access alcohol and other drug services or how long they remain engaged with these services and the reason for support ending. Consideration will be given to the feasibility and cost effectiveness of developing a measure regarding service-user satisfaction with alcohol and other drug services.

## 6.1 Consumer satisfaction

### 6.1.1 Consumer satisfaction with mental health care

Average Consumer Satisfaction Index scores, 2014



Source: Queensland Health, *Consumer Perceptions of Care Statewide report 2014*.

### What it is

The *Consumer Perceptions of Care Statewide report 2014* is based on the views of consumers who received treatment and care from the Queensland public mental health system. Consumers are invited to respond anonymously to a survey. In 2014, 10,504 consumers were offered a survey and 4,616 responded (44 per cent).

The *Consumer Perceptions of Care Statewide* report used a Consumer Satisfaction Index (CSI) which summarises responses to each item or group of items on a scale of 0 to 10 as follows:

- **Scores of 9 to 10** are exceptional indicating that the majority of consumers recorded very positive perceptions of their care.
- **Scores of 7 to 8** are commendable with most consumers recording positive perceptions of care.
- **Scores of 5 to 6** are moderate indicating there is wide variance in consumer perceptions, with consumers recording both positive and negative perceptions about their care.
- **Scores of less than 5** are inadequate indicating that the vast majority of consumers recorded negative perceptions of their care.

### What it tells us about Queensland

Adults in community mental health services reported an average satisfaction rating of 7.5, indicating an experience of mental health services in the commendable range. This was slightly lower for young peoples' experience of community mental health services (7.2). Average satisfaction with adult acute inpatient services was lower still at 6.5, between the moderate and the commendable range.

### What it doesn't tell us

These scores provide an overall satisfaction rating only and do not enable a national comparison. Further, consumers are not required to participate in the survey and consequentially the results do not provide us with a complete picture of consumer satisfaction in Queensland.

### When we will next report on progress

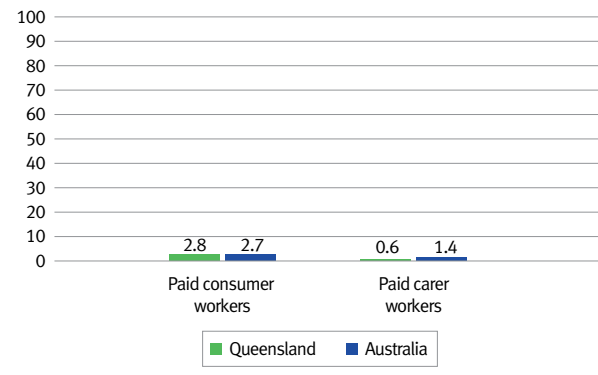
In 2015, the *Consumer Perceptions of Care Survey* will be replaced by the national YES survey. At this stage it is not compulsory for all service providers to administer the YES survey tool.

## 6.2 Consumer and carer engagement

### 6.2.1 Paid consumer workers

### 6.2.2 Paid carer workers

**Paid consumer and carer worker positions per 1,000 full-time equivalent positions, 2012–13**



Source: ROGS (2015) Table 12A.52, AIHW (unpublished) derived from the MHE NMDS

### What it is

The number of paid full-time equivalent (FTE) consumer and carer workers per 1,000 paid, direct care, consumer and carer staff (FTE).

### What it tells us

In 2012–13 there were 2.8 per 1,000 FTE paid consumer workers in the Queensland health system. This is consistent with the national rate at 2.7 per 1,000 FTE.

However the rate of paid carer workers in Queensland (0.6 FTE per 1,000) was half the national rate (1.4 FTE per 1,000).

### What it doesn't tell us

The data does not provide detail that would allow further analysis of the nature of consumer and carer paid positions.

### When we will next report on progress

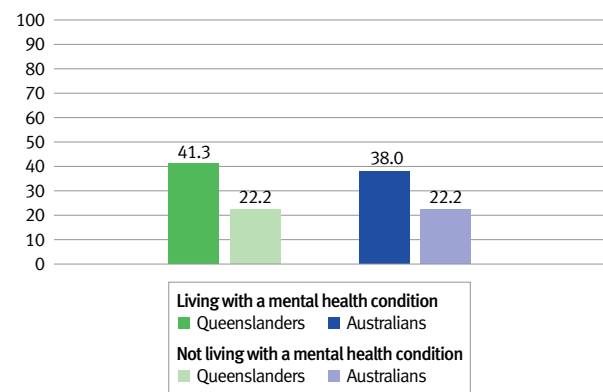
This data was published as part of the ROGS which provides information on the equity, effectiveness and efficiency of government services in Australia. It is published on an annual basis and was last published in 2015.



## 6.3 Ability to access services

### 6.3.1 Difficulty accessing services

Percentage of people aged 15 years and over experiencing difficulty accessing services, 2014



Source: ABS (unpublished) 4159.0, *General Social Survey*, 2014

#### *What it is*

Percentage of people aged 15 years and over who experienced a mental health condition and had difficulty accessing service providers. Mental health conditions refers to clinically-recognised emotional and behavioural disorders, and perceived mental health problems such as feeling depressed, feeling anxious, stress and sadness. A service includes dentists, doctors, employment services, family assistance, hospitals, Medicare and mental health services.

#### *What it tells us about Queensland*

In 2014, a greater proportion of Queenslanders experiencing a mental health condition (41.3 per cent) reported having difficulty accessing services than people who do not experience a mental health condition (22.2 per cent).

#### *What it doesn't tell us*

The data does not provide enough detail to determine the nature and extent of barriers related to service provider access or the type of service that people are having the greatest difficulty accessing.

#### *When we will next report progress*

The *General Social Survey* is collected every four years and reported in the following year. It was last conducted in 2014 and reported in 2015. The survey is next expected to be conducted in 2018 and we anticipate next reporting on this indicator in 2019.

## Conclusion

Over the next year, the Commission will work with key stakeholders to identify and consider other data sources which may support a better understanding regarding the mental health and wellbeing of all Queenslanders and in particular those living with mental health problems, mental illness and problematic alcohol and other drug use. This will involve considering the gaps in current data and considering the feasibility and cost effectiveness of developing new data sets including measuring the wellbeing of all Queenslanders, levels of stigma, suicide rates among different cultural groups and the social and emotional wellbeing of Aboriginal and Torres Strait Islander Queenslanders.

This report will also inform our priorities in implementing the Strategic Plan. It highlights the need to focus on increasing employment and supporting those living with mental health problems and mental illness to have better physical health.

Work will continue towards reducing Queensland's suicide rate, in particular the levels of suicide among vulnerable groups including Aboriginal and Torres Strait Islander peoples and those living in rural and remote communities. Work will also continue to reduce harms related to the use of alcohol, tobacco and other drugs in Queensland.

# Appendix 1

## Key survey tools

### **Australian Health Survey, Australian Bureau of Statistics (ABS)**

The *Australian Health Survey 2011–13* (AHS) comprises three separate surveys, the: *National Health Survey (NHS) 2011–12*; *National Nutrition and Physical Activity Survey (NNPAS) 2011–12*; and *National Health Measures Survey (NHMS) 2011–12*.

The 2011–12 NHS and NNPAS collected information by face-to-face interview (and by telephone for the second NNPAS interview) from usual residents of private dwellings in urban and rural areas of Australia, covering about 97 per cent of people living in Australia. People surveyed were those identified as an adult within each sampled private dwelling and a usual resident of that dwelling. Private dwellings are houses, flats, home units, caravans, garages, tents and other structures being used as a place of residence at the time of the survey.

The AHS is conducted every three to five years (2001, 2004–05, 2007–08, 2011–13). It is expected that the next AHS will be conducted in 2015–16 with results known in 2017.

### **Causes of Death, ABS**

The *Causes of Death* report contains statistics on causes of death for Australia based on deaths registered. The report has been published annually since 1993.

### **Consumer Perceptions of Care Statewide Report 2014, Queensland Health**

The *Consumer Perceptions of Care Statewide report 2014* (CPoC) surveys consumers who have used the public mental health system in four areas: adult acute inpatient, adult extended treatment, adult community, youth community and family of youth community. Each survey includes questions which relate to quality and appropriateness of services, access to services, general satisfaction, outcomes and overall perceptions of care.

In 2016 the CPoC survey will be replaced by the national *Your Experience of Service* survey. While this will enable us to compare consumer satisfaction nationally, it will not be compulsory for all Hospital and Health Services in Queensland to participate.

### **General Social Survey, Australian Bureau of Statistics**

The *2014 General Social Survey* (GSS) collected data on a range of social issues from the same person to enable analysis of the interrelationships in social circumstances and outcomes, including multiple advantage and disadvantage experienced by that individual.

The GSS is collected every four years (2002, 2006, 2010, 2014) and reported in the following year. The GSS is due to be conducted again in 2018 with results published in 2019.

### **National Minimum Data Sets for Mental Health, Australian Institute of Health and Welfare**

*National Minimum Data Sets* are those that are agreed to be collected and reported nationally. Collection and reporting is mandatory. The *National Minimum Data Sets for Mental Health* are:

- *Admitted Patient Mental Health Care* focusing on people who have been admitted to psychiatric hospital or designated psychiatric units in acute hospitals.
- *Community Mental Health Care* focusing on specialised mental health services for consumers, other than those admitted to psychiatric hospitals or designed psychiatric units in acute care hospitals.
- *Residential Mental Health Care* focusing on episodes of residential care for people in all government funded residential mental health care services.

### **The National Drug Strategy Household Survey detailed report 2013, Australian Institute of Health and Welfare, 2013**

The *National Drug Strategy Household Survey* (NDSHS) is the leading survey of licit and illicit drug use in Australia. The 2013 survey was the 11th conducted under the auspices of the *National Drug Strategy 2010–2015*. The NDSHS is conducted and reported every three years (1985, 1988, 1991, 1993, 1995, 1998, 2001, 2004, 2007 and 2010).

### **Report on Government Services, Steering Committee for the Review of Government Service Provision**

The annual *Report on Government Services* (ROGS) provides information on the equity, effectiveness and efficiency of government services in Australia and is available at [www.pc.gov.au/research/ongoing/report-on-government-services/2015](http://www.pc.gov.au/research/ongoing/report-on-government-services/2015)

### **Suicides Australia, ABS**

The *Suicides Australia* report contains summary statistics on deaths registered in Australia between 2001 and 2010 where the underlying cause of death was determined as intentional self-harm. Data is reported based on the year the death was registered not the year the death occurred. It does not seek to report suicide data annually but includes an analysis over multiple years. The report is not published regularly.

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