



Performance Indicators Report

December 2016

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



Queensland
Mental Health
Commission

Further information and feedback

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

Queensland Mental Health Commission
PO Box 13027, George Street QLD 4003

Phone: 1300 855 945

Email: info@qmhc.qld.gov.au



Translation

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding this report, you can contact us on 1300 855 945 and we will arrange an interpreter to effectively communicate the report to you.



Licence

This report is licensed by the State of Queensland (Queensland Mental Health Commission) under a Creative Commons Attribution (CC BY) 4.0 Australia licence.

To view a copy of this licence, visit
<http://creativecommons.org/licenses/by/4.0/>

In essence, you are free to copy, communicate and adapt this document, as long as you attribute the work to the Queensland Mental Health Commission.

© Queensland Mental Health Commission 2017

Published by the Queensland Mental Health Commission, February 2017

An electronic copy of this document is available at www.qmhc.qld.gov.au

Contents

Commissioner’s message	1
Acknowledgements	1
Executive summary	2
Performance indicator results 2016: at a glance	3
Performance indicator dashboard	5
Introduction	13
<i>Outcome 1</i>	
A population with good mental health and wellbeing	16
<i>Outcome 2</i>	
Reduced stigma and discrimination	20
<i>Outcome 3</i>	
Reduced avoidable harm	22
<i>Outcome 4</i>	
People living with mental health difficulties or issues related to substance use have lives with purpose	30
<i>Outcome 5</i>	
People living with mental illness and substance use disorders have better physical and oral health and live longer	36
<i>Outcome 6</i>	
People living with mental illness and substance use disorders have positive experiences of their support, care and treatment	42
Our next report	46
Appendix 1 – Sources of data	47
References	49

Commissioner's message

There has been, over many years, considerable discussion about how to measure mental health outcomes both internationally and nationally. Issues relating to reliability and cost have acted as barriers to continued efforts to measure outcomes in a wide range of areas, including whether people living with mental illness are living lives with purpose or harm associated with problematic alcohol and other drug use.

While complex, it is important. Measuring outcomes and monitoring progress enables us to assess whether our collective efforts are making a positive difference and to identify those areas which require greater focus and effort. It can also inform how we respond to those circumstances we cannot control which impact on mental health and wellbeing, such as drought and natural disasters.

It is with pleasure that I present the Queensland Mental Health Commission's second Performance Indicators Report. Our first report, published in December 2015 outlined the framework and the principles upon which measures were identified for each of the long-term outcomes in the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019*. Based on data which was available at that time, it also provided a baseline for progress in a number of key areas and identified gaps which required further attention.

This report builds on that framework with updates in areas where data has become available and fills some of the gaps identified in 2015. We will continue, in partnership with government, including the Queensland Government Statistician's Office, non-government organisations and the Queensland Mental Health and Drug Advisory Council during 2016–17 to continue to further develop and identify indicators for Queensland.



Dr Lesley van Schoubroek
*Acting Queensland Mental Health
Commissioner*



Acknowledgements

We pay our respects to Aboriginal and Torres Strait Islander Elders, past, present and future. We also acknowledge the important role played by Aboriginal peoples and Torres Strait Islanders as the First Nations people, their traditions, cultures and customs across Queensland. We also acknowledge people living with mental illness, mental health problems and problematic alcohol and other drug use, and their families and carers. We can all contribute to a society that is inclusive and respectful, where everyone is treated with dignity and is able to focus on wellness and recovery and lead fulfilling lives.

Executive summary

The *Performance Indicators Report 2016* (this report) is the Queensland Mental Health Commission's (the Commission) second report outlining the indicators and progress made towards achieving the six long-term outcomes set by the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* (the Strategic Plan).

It also provides a basis for monitoring progress towards achieving the shared goals of Action Plans developed that support implementation of the Strategic Plan, including the:

- *Early Action: Queensland Mental Health, Promotion, Prevention and Early Intervention Action Plan 2015–17* (Early Action Plan)
- *Queensland Suicide Prevention Action Plan 2015–17* (Suicide Prevention Plan)
- *Queensland Alcohol and Other Drugs Action Plan 2015–17* (Alcohol and Other Drugs Action Plan)
- *Queensland Rural and Remote Mental Health and Wellbeing Action Plan 2016–18* (Rural and Remote Plan)
- *Queensland Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan 2016–18*. (Aboriginal and Torres Strait Islander Plan)

This report focuses on those measures which influence the mental health and wellbeing of all Queenslanders, including those living with mental illness, mental health problems and problematic alcohol and other drug use.

The indicators and measures in this report build on the *2015 Performance Indicators Report* (the 2015 report) which set a framework and principles that the indicators and measures be meaningful and shared, appropriate and useful, feasible and cost effective, and robust.

The Commission in partnership with government and non-government stakeholders including the Queensland Government Statistician's Office and the Queensland Mental Health and Drug Advisory Council has continued to work towards updating data to provide an indication of progress as well as considering ways of addressing gaps in the data identified in the 2015 report.

This work has resulted in new indicators being included in this report: the age of first use of alcohol, tobacco and other drugs; intentional self-harm; and the proportion of people living with long-term mental health conditions who visit dental professionals and general practitioners.

Data collection and analysis is continually reforming. This has led to a number of indicators reported in 2015 changing, including indicators relating to mental health consumer experiences of treatment with the *Your Experience of Service (YES)* survey replacing the previously reported results from the *Consumer Perceptions of Care* survey.

This 2016 report includes selected measures about the mental health and wellbeing of all Queenslanders. Where differences between years, regions or groups are reported, they should not be considered to be statistically significant.

The Strategic Plan's outcomes can only be achieved through collective action by a wide variety of organisations and sectors. Implementation of these actions is monitored and progress reported in the Strategic Plan's *Annual Implementation Report 2015–16*.

The outcomes and indicators in this report will form an important basis for the review, due to commence in 2017 of the Strategic Plan and associated action plans the: *Queensland Early Action: Mental Health, Promotion, Prevention and Early Intervention Action Plan 2015–17*; *Queensland Suicide Prevention Action Plan 2015–17*; and *Queensland Alcohol and Other Drugs Action Plan 2015–17*.

Performance indicator results 2016: at a glance

The indicators included in this report show:

Outcome 1: Improved mental health and wellbeing

- The proportion of people in Queensland reporting high or very high psychological distress has increased (from 10.8 per cent in 2011–12 to 12.0 per cent in 2014–15). A similar increase was experienced nationally.

Outcome 2: Reduced stigma and discrimination

- A higher proportion of Queenslanders living with a mental health condition (31.7 per cent) experience discrimination or are treated unfairly than those not living with a mental health condition (15.0 per cent).

Outcome 3: Reduced avoidable harm

- The age standardised suicide rate in Queensland dropped slightly in 2014 (from 14.4 per 100 000 people in 2013 to 13.7 per 100 000 people) and increased again to 15.7 per 100 000 people in 2015. It continues to be higher than the national rate of 12.6 per 100 000 in 2015.
- Suicide rates fluctuate year to year and there is a need to consider the suicide rate over time. From 2011 to 2015 the average age standardised suicide rate for Queensland was 14.1 per 100 000 people.
- The age standardised suicide rate for Aboriginal and Torres Strait Islander Queenslanders decreased in 2014 (from 30.9 per 100 000 people in 2013 to 20.5 per 100 000 people in 2014) but then increased to 25.0 per 100 000 people in 2015.

- A higher proportion of Queenslanders drink alcohol at risky levels and smoke tobacco daily than the national proportion. Use of illicit drugs including crystal methamphetamine and misuse of pharmaceuticals is similar in Queensland and nationally.
- The average age Queenslanders first used alcohol and other drugs is similar to the national average at 17.0 years for alcohol, 15.9 years for smoking, and 19.3 years for illicit drug use.

Outcome 4: People living with mental health difficulties or issues related to substance use have lives with purpose

- Queenslanders, living with a mental health condition are less likely to be enrolled in study or be employed than those not living with a mental health condition.
- Similar proportions of people living with a mental health condition engage in unpaid volunteer work and participate in the community in Queensland and nationally.

Outcome 5: Better physical and oral health and live longer

- A higher proportion of Queenslanders living with mental/behavioural problems had cardiovascular disease (12.9 per cent compared to 5.8 per cent), 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).
- A higher proportion of people living with a mental health/behavioural problem smoke daily and were not participating in physical activity through sport or recreation in Queensland.

- Levels of obesity and risk of harm from alcohol consumption were similar for those living with a mental health/behavioural problem in Queensland.
- Similar proportions of Queenslanders living with a long-term mental health condition saw a dental professional (51.5 per cent in 2013–14 and 51.1 per cent in 2014–15), or a general practitioner (95.0 per cent in 2013–14 and 94.8 per cent in 2014–15), as those not living with a long-term mental health condition.

Outcome 6: People living with mental illness and substance use disorders experience positive experiences of their support, care and treatment

- Adults, children and adolescents receiving mental health inpatient and adults receiving extended treatment services in Queensland found their experience of care was acceptable, but highlighted the need for improvement.
- Most adults, children and adolescents receiving mental health treatment and support in the community and through ambulatory care had positive experiences of their care in 2015 in Queensland.
- While the number of paid consumer positions per 1 000 full-time equivalent (FTE) direct care positions employed in mental health services has reduced in Queensland (2.8 in 2012–13 to 1.8 in 2013–14), the number of paid carer positions per 1 000 FTE has increased (from 0.6 in 2012–13 to 1.1 in 2013–14). The national rate of consumer and carer FTE positions has not changed.

Our next report

The Commission, with the support of other government agencies and non-government organisations will continue to examine options to measure key areas, including measuring wellbeing and stigma associated with mental health problems, mental illness, suicide and problematic alcohol and other drug use having regard to the cost and feasibility of developing new measures.

The areas which the Commission will continue to seek new or improved data over the next year include:

Outcome 1: A population with good mental health and wellbeing

- wellbeing of all Queenslanders

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 suicide attempts
- suicide rates among diverse population groups including cultural groups and lesbian, gay, bisexual, transsexual, and intersex Queenslanders
- harm relating to alcohol and other drug use including new hepatitis C infections resulting from injecting drug use

Outcome 6: People living with mental illness and substance use disorders experience 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 December 2017 and a report on Aboriginal and Torres Strait Islander social and emotional wellbeing late in 2017.

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

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

Outlined here are the performance indicators based on currently available data for each outcome. It includes new indicators (#) and indicators which are replaced from those reported in 2015 as a result of changes in the way the Australian Bureau of Statistics defines and/or collects data (##).

Where appropriate a comparison is made with national data and outlines when we anticipate data will be available for updating our report against each indicator.

The dashboard identifies the baseline data from which progress is measured. Where data is provided for later years, after the baseline year, the dashboard provides an indication of change. It does not indicate whether the change is statistically significant.

Progress key:

BL Baseline data

● There is an indication there has been a positive change

● Little or no change

● There is an indication there has been a negative change

Outcome 1

A population with good mental health and wellbeing

Domains and performance indicators	Year	State status	State progress	National status	National progress	Next update
1.1 Mental health of all Queenslanders						
1.1.1 Age standardised percentage of people 18 years and over experiencing high or very high levels of psychological distress	2011–12	10.8	BL	10.8	BL	2019
	2014–15	12.0	●	11.8	●	
1.2 Levels of mental health problems and illness						
1.2.1 Percentage of people aged 15 years and over reporting they live with a mental health condition	2014	18.7	BL	18.2	BL	2019
1.2.2 Percentage of people aged 15 years and over who report they or someone close to them has experienced a mental illness as a personal stressor in the last 12 months	2014	13.7	BL	13.4	BL	2019

Outcome 2

Reduced stigma and discrimination

Domains and performance indicators	Year	State status	State progress	National status	National progress	Next update
2.1 Discrimination						
2.1.1 Percentage of people aged 15 years and over living with a mental health condition who have experienced any discrimination or been treated unfairly	2014	31.7	BL	29.1	BL	2019
2.1.2 Percentage of people aged 15 years and over living with a mental health condition who have experienced discrimination as a personal stressor	2014	6.7	BL	3.9	BL	2019

Outcome 3

Reduced avoidable harm

Domains and performance indicators	Year	State status	State progress	National status	National progress	Next update
3.1 Suicide						
3.1.1 Age standardised suicide rate per 100 000 people	2013	14.4	BL	10.9	BL	2017
	2014	13.7	●	12.0	●	
	2015	15.7	●	12.6	●	
3.1.2 Age standardised suicide rate for Aboriginal and Torres Strait Islander per 100 000 people	2013	30.9	BL	23.8	BL	2017
	2014	20.5	●	23.0	●	
	2015	25.0	●	25.5	●	
3.1.3 Age standardised suicide rate for areas outside greater Brisbane/capital cities per 100 000 people ##	2013	14.5	BL	13.0	BL	2017
	2014	15.8	●	14.7	●	
	2015	18.1	●	16.2	●	

Outcome 3

Reduced avoidable harm (continued)

Domains and performance indicators	Year	State status	State progress	National status	National progress	Next update
3.2 Alcohol and other drug-related harm						
3.2.1 Percentage of people aged 14 years and over who report drinking alcohol at life-time risky levels in the previous 12 months	2013	20.2	BL	18.2	BL	2018
3.2.2 Percentage of people aged 14 years and over who report drinking alcohol at single occasion risky levels in the previous 12 months	2013	40.6	BL	37.8	BL	2018
3.2.3 Percentage of people aged 14 years and over who smoke tobacco daily	2013	15.0	BL	12.8	BL	2018
3.2.4 Percentage of people aged 14 years and over who used an illicit drug in the previous 12 months	2013	15.5	BL	15.0	BL	2018
3.2.5 Percentage of people aged 14 years and over who misused pharmaceuticals in the previous 12 months	2013	4.8	BL	4.7	BL	2018
3.2.6 Average age of first use of alcohol #	2013	17.0	BL	17.2	BL	2018
3.2.7 Average age of first use of tobacco #	2013	15.9	BL	16.2	BL	2018
3.2.8 Average age of first use of any illicit drugs #	2013	19.3	BL	19.4	BL	2018
3.2.9 Number of hospitalisations due to harm associated with substance use 2015–16 #	2014–15	13 424	BL	NA	NA	2017
	2015–16	15 567	●	NA	NA	
3.3 Intentional Self-harm						
3.3.1 Age standardised rate of hospital separations per 100 000 persons as a result of intentional self-harm #	2014–15	216.1	BL	NA	NA	2017

Outcome 4

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

Domains and performance indicators	Year	State status	State progress	National status	National progress	Next update
4.1 Economic participation						
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	2011–12	79.4	BL	79.2	BL	2017
4.1.2 Age standardised percentage of people aged 16 to 64 years living with a mental/behavioural condition who were employed	2014–15	57.7	BL	61.7	BL	2017
4.1.3 Percentage of people aged 15 years and over living with a mental health condition who have undertaken unpaid volunteer work	2014	25.8	BL	30.9	BL	2019
4.2 Community participation						
4.2.1 Percentage of people aged 15 years and over living with a mental health condition and who participated in social groups	2014	44.4	BL	48.9	BL	2019
4.2.2 Percentage of people aged 15 years and over living with a mental health condition who participated in community support	2014	32.7	BL	34.5	BL	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	2014	14.1	BL	15.4	BL	2019
4.2.4 Percentage of people aged 15 years and over living with a mental health condition and attended cultural and leisure activities	2014	85.7	BL	82.8	BL	2019
4.3 Personal connections						
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	2014	12.5	BL	15.1	BL	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	2014	60.5	BL	61.5	BL	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	2014	92.1	BL	93.0	BL	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	Year	State status	State progress	National status	National progress	Next update
5.1 Long-term health conditions						
5.1.1 Age standardised percentage of people living with a mental/behavioural problem with cardiovascular disease	2011–12	12.9	BL	9.5	BL	2017
5.1.2 Age standardised percentage of people living with a mental/behavioural problem with cancer	2011–12	3.2	BL	3.5	BL	2017
5.1.3 Age standardised percentage of people living with a mental/behavioural problem with diabetes	2011–12	7.2	BL	6.6	BL	2017
5.1.4 Age standardised percentage of people living with a mental/behavioural problem with arthritis	2011–12	25.1	BL	26.9	BL	2017
5.1.5 Age standardised percentage of people living with a mental/behavioural problem with asthma	2011–12	15.5	BL	16.7	BL	2017
5.2 Risk factors						
5.2.1 Age standardised percentage living with a mental/behavioural problem who smoke daily	2011–12	25.7	BL	26.1	BL	2018
5.2.2 Age standardised percentage living with a mental/behavioural problem who are obese or overweight	2011–12	65.4	BL	67.0	BL	2018
5.2.3 Age standardised percentage living with a mental/behavioural problem who are at risk of long-term harm from alcohol consumption	2011–12	20.4	BL	21.3	BL	2018
5.3 Protective factors						
5.3.1 Percentage of people aged 15 years and over living with a mental health condition who participated in physical activity	2014	63.8	BL	65.1	BL	2019
5.3.1 Percentage of people living with a long-term mental health condition who saw a dental professional in the previous 12 months #	2013–14	51.5	BL	49.8	BL	2017
	2014–15	51.1	●	49.2	●	
5.3.2 Percentage of people living with a long-term mental health condition who saw a general practitioner in the previous 12 months #	2013–14	95.0	BL	95.4	BL	2017
	2014–15	94.8	●	95.0	●	

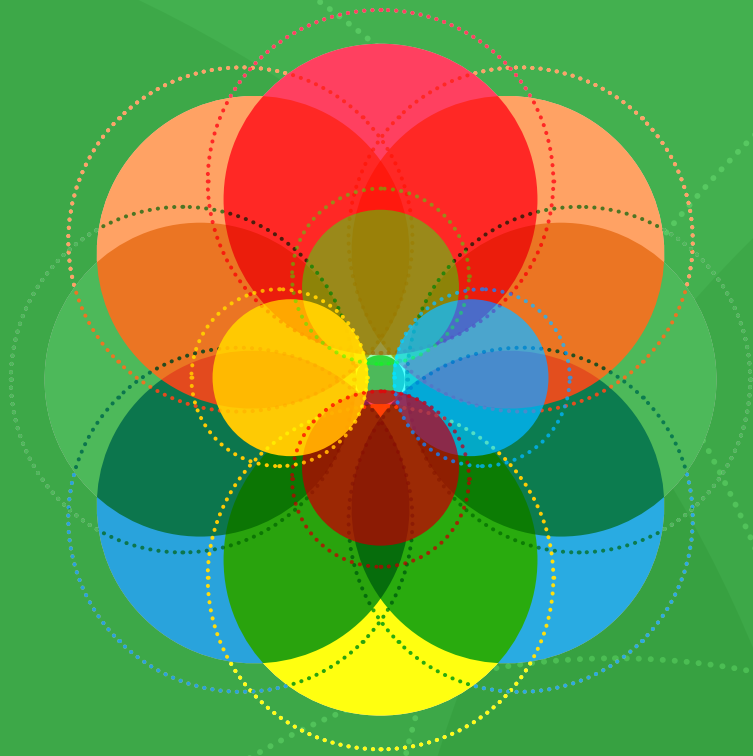
Outcome 6

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

Domains and performance indicators	Year	State status	State progress	National status	National progress	Next update
6.1 Consumer satisfaction						
6.1.1 Consumer overall satisfaction with adult mental health inpatient treatment and care ##	2015	5.9*	BL	NA	NA	2017
6.1.2 Consumer overall satisfaction with adult mental health extended treatment services ##	2015	5.8*	BL	NA	NA	2017
6.1.3 Consumer overall satisfaction with adult community mental health and ambulatory services ##	2015	7.8**	BL	NA	NA	2017
6.1.4 Consumer overall satisfaction with child and adolescent mental health inpatient treatment and care ##	2015	5.8*	BL	NA	NA	2017
6.1.5 Consumer overall satisfaction with child and adolescent community mental health and ambulatory care ##	2015	7.9**	BL	NA	NA	2017
6.2 Consumer and carer engagement						
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	2012–13	2.8	BL	2.7	BL	2017
	2013–14	1.8	●	2.7	●	
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	2012–13	0.6	BL	1.4	BL	2017
	2013–14	1.1	●	1.4	●	
6.3 Ability to access services						
6.3.1 Percentage of people aged 15 years and over experiencing a mental health condition and who have difficulty accessing service providers	2014	41.3	BL	38.0	BL	2019

* Rating of 5 to 6 means consumers have indicated an acceptable experience of care highlighting the need for improvement.

** Rating of 7 to 8 means that most consumers have positive experiences of their care.



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

Achieving long-term outcomes can be challenging, particularly when they are influenced by a wide variety of factors. Only through continual improvement, informed by evidence and lived experience, can we ensure our efforts to improve the mental health and wellbeing of Queenslanders are effective.

Combined with research and the views of the community, particularly those with a lived experience, their families, carers, and support persons, performance indicators enhance transparency and accountability. They also help us to understand what has worked and where we should direct our collective actions towards achieving our shared vision that Queensland is:

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.

Our vision guides work being undertaken as part of the *Queensland Mental Health Drug and Alcohol Strategic Plan 2014–2019* (the Strategic Plan) to achieve six long-term outcomes:

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 guide actions being taken as part of the Strategic Plan including in associated whole-of-government action plans, the:

- *Early Action: Queensland Mental Health, Promotion, Prevention and Early Intervention Action Plan 2015–17* (Early Action Plan)
- *Queensland Suicide Prevention Action Plan 2015–17* (Suicide Prevention Plan)
- *Queensland Alcohol and Other Drugs Action Plan 2015–17* (Alcohol and Other Drugs Action Plan)
- *Queensland Rural and Remote Mental Health and Wellbeing Action Plan 2016–18* (Rural and Remote Plan)
- *Queensland Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan 2016–18* (Aboriginal and Torres Strait Islander Plan).

Responsibility for realising this vision and achieving these outcomes including those linked to the associated Action Plans 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, our collective efforts are making a positive and long-term difference to improving the mental health and wellbeing of Queenslanders and to inform our future actions.

A shared commitment to measure and report on progress

The Strategic Plan commits the Commission to identifying performance indicators to measure progress toward improving mental health and wellbeing (Shared Commitment to Action 8). The commitment involves:

- identifying robust performance indicators to help measure, monitor and report on progress towards achieving the vision and outcomes set out in the Strategic Plan and, together with other information, identify areas for future action
- reporting in a meaningful manner to Queenslanders on the progress of reforms to the mental health, alcohol and other drugs service system.

This is being achieved by:

- identifying and using existing data sets that can help measure progress
- addressing information gaps by developing new data sets where feasible and examining existing data sets by further disaggregation
- aligning performance indicators to goals and targets set at a whole-of-government level.

Setting the framework – the 2015 report

In 2015, the Queensland Mental Health Commission published its first Performance Indicators Report (the 2015 report) which defined and proposed indicators to measure progress towards achieving six long-term outcomes for Queensland.

The 2015 report provides an important foundation for monitoring progress towards improved outcomes for Queenslanders. It was developed by a Reference Group which comprised representatives from the following government and non-government organisations:

- Queensland Treasury (the Queensland Government Statistician's Office)
- Department of the Premier and Cabinet
- Queensland Health – Prevention Division
- Queensland Health – Chief Psychiatrist (Clinical Excellence Division)
- Queensland Voice
- Queensland Alliance for Mental Health Inc.
- Queensland Network of Alcohol and other Drug Agencies
- Queensland Council of Social Service
- Queensland Mental Health and Drug Advisory Council.

Defining each outcome

Each of the Strategic Plan's six long-term outcomes is broad in nature and is influenced by a wide variety of factors.

Two outcomes address the needs of all Queenslanders: a population with good mental health and wellbeing and reduced avoidable harm. The remaining four outcomes focus on the needs of people living with mental illness and problematic substance use. All outcomes involve many elements and are broken down into domains to ensure all parts of the outcome are being considered.

Principles for identifying performance indicators

As indicated in the 2015 report there is considerable research about how to choose the right performance indicators and measures for performance. The United Kingdom developed FABRIC (focused, appropriate, balanced, robust, integrated and cost effective) as an appropriate performance framework tool¹. The principles identified also informed the Australian Capital Territory Government's Performance Framework². The Commission continues to research and seek expert advice on performance measurement to inform this work.

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 the identification and development of 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.

About this report

This report uses the framework established in 2015 based on the same definition of the Strategic Plan's six long-term outcomes and the principles identified and agreed by the Reference Group.

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

- *Australian Health Survey*, Australian Bureau of Statistics (ABS)
- *Causes of Death*, ABS
- *General Social Survey*, ABS
- *National Minimum Data Sets for Mental Health*, Australian Institute of Health and Welfare
- *National Drug Strategy Household Survey detailed report, 2013*, Australian Institute of Health and Welfare
- *Report on Government Services (ROGS) Steering Committee for the Review of Government Service Provision.*
- *Queensland Hospital Admitted Patient Data Collection (QHAPDC)*, Queensland Health
- *Your Experience of Service*, Queensland Health.

It is important to note many of the publicly available data sets have limitations. 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.

What is new

This report outlines updated data where it has become available providing a basis to commence measuring progress in a number of areas, including levels of psychological distress, suicide and the rate at which consumers and carers are employed in the public health system. It gives an indication whether positive change is occurring, however at this stage it is not possible to assess how sustainable these changes are or whether they are statistically significant, because tests for significance were not conducted. Continued monitoring will be required over time to ensure improvements continue to be measured.

Suicide rates reported in 2015 have been updated to reflect revisions made by the Australian Bureau of Statistics and changes in its geography standard relating to suicide rates in rural and remote communities. This report also uses the recently administered Your Experience of Service which replaces the consumer satisfaction data reported in 2015.

New indicators are included in this report:

- the average age of first use of alcohol, tobacco and illicit drug use,
- hospitalisations associated with substance use
- hospitalisation for intentional self-harm
- people living with a long-term mental health condition who have visited dental professionals or general practitioners.



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 community³.

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 opportunities⁴.

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 wellbeing⁵.

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, drought, migration and the many other changes in life circumstances that can occur⁶.

It impacts, and is influenced by, many factors in our lives including educational outcomes, employment, our ability to parent and to withstand life challenges⁶.

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 and associated Action Plans

All Shared Commitments to Action in the Strategic Plan support improved mental health and wellbeing of Queenslanders. This outcome, however, is supported primarily by 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

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 ABS. In the absence of a more appropriate measure, monitoring and reporting psychological distress was considered to meet all of 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

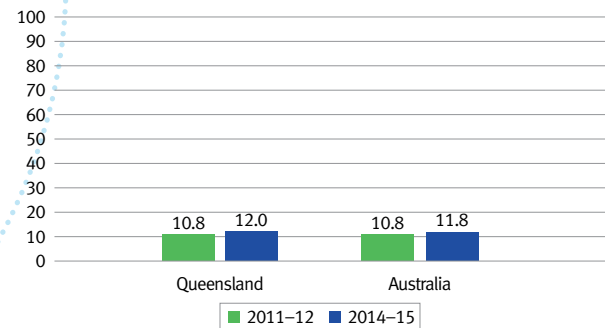
A robust and reliable population-level measure of overall wellbeing of Queenslanders is currently not available. The feasibility and cost effectiveness of developing a wellbeing measure for Queensland will be considered. This will be examined by the Reference Group further in 2017.

These performance indicators do not include the number of people living with problematic alcohol and other drug use as alcohol and other drug use and its 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 reporting high or very high levels of psychological distress



Source: ABS 4364.0, National Health Survey, 2011-12 and 4364.0.55.001 *National Health Survey: First Results*, 2014-15.

What it is

Age standardised percentage of people aged 18 years and over experiencing high or very high levels of psychological distress is 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 in that year.

In 2014-15 there was a slight increase in the proportion of people experiencing psychological distress in Queensland (12.0 per cent) and nationally (11.8 per cent). Further monitoring over time will be required to determine whether any trend (positive or negative) exists.

What it doesn't tell us

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

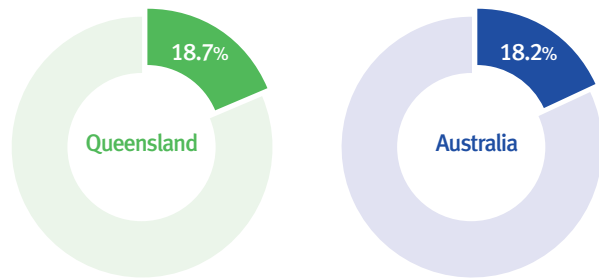
When we will next report progress

It is anticipated that progress on levels of psychological distress will be updated in 2019.

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 similar proportion of Queenslanders (18.7 per cent) and Australians (18.2 per cent) reported experiencing a mental health condition.

What it doesn't tell us

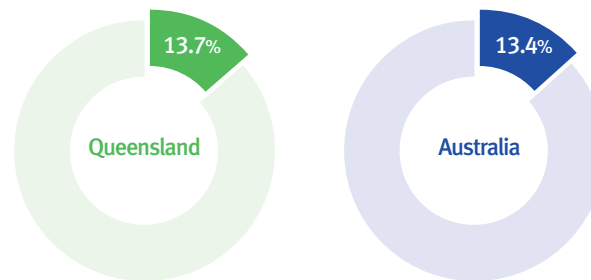
It focuses on elements of mental ill-health only, which cannot alone be considered a performance indicator of overall wellbeing. The data combines both diagnosed and self-perceptions and therefore may not provide an accurate picture of the proportion of Queenslanders actually experiencing a diagnosed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

When we will next report progress

The next *General Social Survey* is due to be conducted in 2018 and we anticipate providing an update on this 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

People aged 15 years and over who report that they, or someone close to them, in 2014, 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 including dementia, depression, substance use and anxiety disorders.

What it tells us about Queensland

In 2014, a similar proportion of Queenslanders (13.7 per cent) and Australians (13.4 per cent) reported experiencing mental illness as a personal stressor.

What it doesn't tell us

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

When will we next report progress

The next *General Social Survey* is due to be conducted in 2018 and we anticipate providing an update on this 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 alcohol and other drug use, stigma and discrimination can hinder recovery. It can affect people long after their mental health symptoms have 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 the Early Action Plan and Shared Commitment to Action 3 – *Targeted responses in priority areas*, and in particular work to implement the *Queensland Alcohol and Other Drugs Action Plan 2015–17* (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 in the last 12 months. Both are nationally comparable and are considered to be reliable.

Addressing gaps in monitoring this outcome

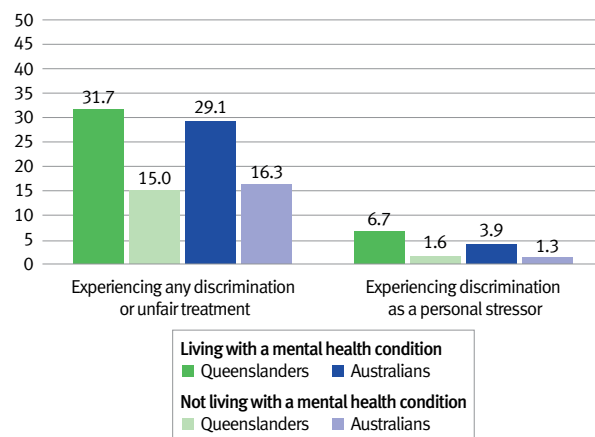
Data that provides a direct measure of stigma by exploring beliefs, thoughts and attitudes towards people experiencing mental health problems, all mental illnesses and problematic drug use is currently not available. Further consideration will be given regarding the feasibility and cost effectiveness 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 any discrimination or unfair treatment

2.1.2 Experience of discrimination as a personal stressor

Percentage of people 15 years and over 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 reported having ever 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 as well as perceived mental health problems such as feeling depressed, anxious, stressed or 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 (15.0 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) with a mental health condition (6.7 per cent compared to 1.6 per cent). A higher proportion of Queenslanders both living with or without a mental health condition, have experienced discrimination or unfair treatment than national proportions.

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 they have been discriminated against or treated unfairly, so this indicator is likely to under-represent actual discrimination. This indicator also does not tell us about the levels of stigma and discrimination experienced by people living with problematic alcohol and other drug use.

When we will next report progress

The next *General Social Survey* is due to be conducted in 2018 and we anticipate providing an update on this 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. This outcome encompasses three types of harm:

Suicide: when a person dies as a result of harming themselves with the intention of ending their life.

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

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

Why it is important

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 legal and illegal drugs becomes dependent, many people experience harms that can result in injury, disability and in some cases death.

Self-harm: People who self-harm are experiencing poor mental health and wellbeing and in some instances mental illness. While not generally involving suicidal intent, those who engage in this behaviour may be at increased risk of suicide or accidental death.

Links to the Strategic Plan

Indicators relating to suicide rates are an important indicator to assess whether we are making progress towards achieving the Suicide Prevention Plan's shared goal to reduce suicide and its impact on Queenslanders.

The alcohol and other drug harms data is an important basis for measuring progress towards achieving preventing and reducing the adverse impact of alcohol and other drugs through the Alcohol and Other Drugs Action Plan.

Indicators for intentional self-harm assists us to understand the levels of mental health and wellbeing and is supported through implementation of the Early Action Plan.

Performance indicators

Based on available data this report outlines the results from the following performance indicators across three 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

3.2.6 Age of first use of alcohol

3.2.7 Age of first use of tobacco

3.2.8 Age of first use of an illicit drug

3.2.9 Hospitalisation due to harm associated with substance use

3.3 Intentional self-harm

3.3.1 Hospitalisation for intentional self-harm

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 reports on deaths confirmed by coroners as being suicides and enables comparison between Queensland and national figures.

Alcohol and other drug-related harm

While levels of alcohol and other drug use does not give us an indication of harm, it is however the best data that is currently available.

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 draft *National Drug Strategy 2016–2025*.

This report includes the average age people first use alcohol, tobacco and illicit drugs. This is an important indicator as the age when a young person starts using these drugs can increase the risk of harm and future adult use.

Intentional self-harm

Data relating to intentional self-harm is difficult to collect as it relies on a person indicating they had intentionally harmed themselves or on a clinician making an assessment. In this report we have relied on data collected by hospitals and relates to people who are hospitalised. This data does not provide an assessment of the extent of intentional self-harm in the community.

Addressing gaps in monitoring this outcome

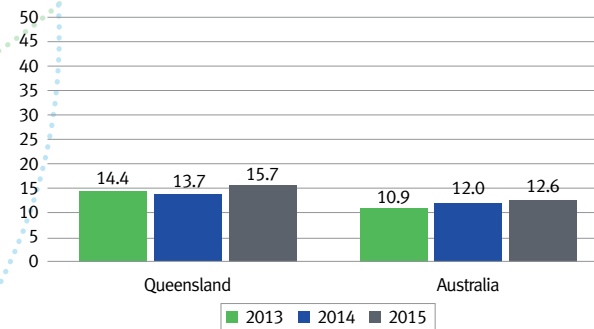
Suicide

Suicide data through both the Queensland Suicide Register and also reported by the ABS are reliable. However, as a death needs to be confirmed as a suicide (based on a coroner's findings) there are delays, with confirmed suicide rates usually reported two-to-three years after they occur. The ABS does not report on suicide rates for people from culturally and linguistically diverse backgrounds or lesbian, gay, bi-sexual, transsexual or intersex Queenslanders.

3.1 Suicide

3.1.1 Queensland suicide rate

Age standardised suicide rate per 100 000



Source: ABS 3303.00, *Causes of Death*, 2015.

What it is

The age standardised suicide rates per 100 000 people in 2013, 2014 and 2015 in Queensland and Australia based on deaths which are confirmed to be suicides by coroners.

What it tells us about Queensland

The suicide rate in Queensland dropped slightly in 2014 (from 14.4 per 100 000 people in 2013 to 13.7 per 100 000 people) and increased again to 15.7 per 100 000 people in 2015. It continues to be higher than the national rate of 12.6 per 100 000 in 2015.

Suicide rates fluctuate year to year and there is a need to consider the suicide rate over time. From 2011 to 2015 the average age standardised suicide rate for Queensland was 14.1. The national average age standardised suicide rate was 11.4 from 2011 to 2015.

What it doesn't tell us

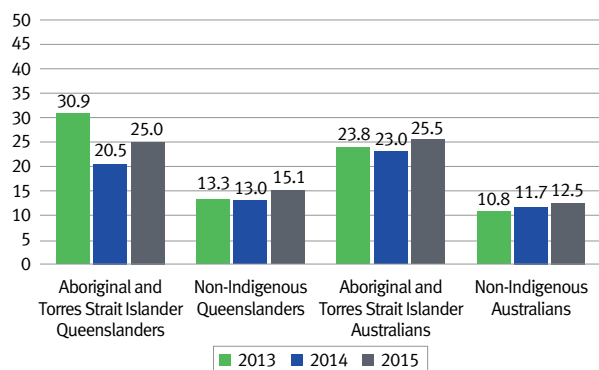
This data does not tell us about the circumstances of those who have died by suicide and therefore, it does not enable targeted strategies to reduce the suicide rate. The rates may be under-reported as some deaths cannot be confirmed as being the result of self-harm with the intention of ending a person's life.

When we will next report on progress

The ABS *Causes of Death* publication is reported annually. We will next report on progress in 2017.

3.1.2 Aboriginal and Torres Strait Islander suicide rate

Age standardised suicide rate per 100 000 people for Aboriginal and Torres Strait Islanders



Source: ABS 3303.00, *Causes of Death*, 2015.

What it is

The age standardised rate of Aboriginal peoples and Torres Strait Islanders who have died by suicide per 100 000 people in 2013, 2014 and 2015 in Queensland and Australia based on deaths which are confirmed to be suicides by coroners. Suicide data reported at the national level is based on data from New South Wales, Queensland, South Australia, Western Australia and the Northern Territory.

What it tells us about Queensland

In 2015, the Aboriginal and Torres Strait Islander suicide rate in Queensland was 25.0 per 100 000 people, slightly lower than the national Indigenous rate of 25.5 per 100 000.

The Aboriginal and Torres Strait Islander suicide rate in Queensland has fluctuated the past three years (30.9 per 100 000 people in 2013, 20.5 per 100 000 people in 2014, and 25.0 per 100 000 people in 2015). Despite these fluctuations, Aboriginal peoples and Torres Strait Islanders in Queensland are at least 1.6 times more likely to die by suicide than non-Indigenous Queenslanders.

What it doesn't tell us

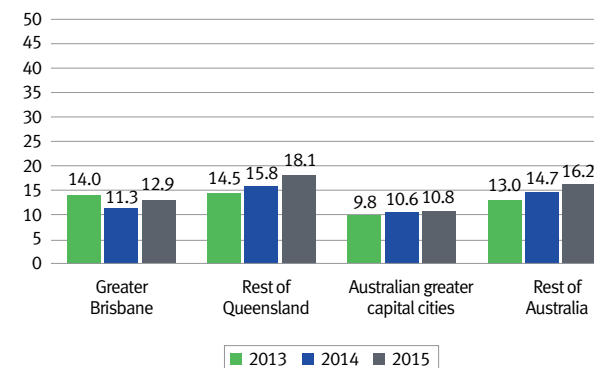
This data does not tell us about the circumstances of those who have died by suicide and therefore does not enable targeted strategies to reduce the suicide rate. The rates may be under-reported as some deaths cannot be confirmed as being the result of self-harm with the intention of ending a person's life.

When we will next report on progress

The ABS *Causes of Death* publication is reported annually. We will next report on progress in 2017.

3.1.3 Age standardised suicide rate for Greater Brisbane and rest of Queensland

Age standardised suicide rate per 100 000 people for Greater Brisbane and rest of Queensland



Source: ABS 3303.00, *Causes of Death*, 2015.

What it is

The age standardised rate of people who have died by suicide per 100 000 people in 2013, 2014 and 2015 for those living in Greater Brisbane and the Rest of Queensland. The data is based on deaths which are confirmed to be suicides by coroners.

What it tells us about Queensland

In 2013, the suicide rate for greater Brisbane and the rest of Queensland were similar at 14.0 and 14.5 per 100 000 people. However, in 2014 the rate of suicide in Greater Brisbane declined to 11.3 per 100 000 people while the Rest of Queensland increased to 15.8 per 100 000 people. The increase has continued into 2015 when the suicide rates for Rest of Queensland was 18.1 per 100 000 people. A similar trend also occurred nationally.

What it doesn't tell us

This data does not tell us about the circumstances of those who have died by suicide and therefore does not enable targeted strategies to reduce the suicide rate. It also does not provide a break down by remote, rural and regional areas as reported in the 2015 report. The rates may be under-reported as some deaths cannot be confirmed as being the result of self-harm with the intention of ending a person's life.

When we will next report on progress

The ABS *Causes of Death* publication is reported annually. We will next report on progress in 2017.

3.2 Alcohol and other drug-related harm

3.2.1 Alcohol consumption at life-time risky levels

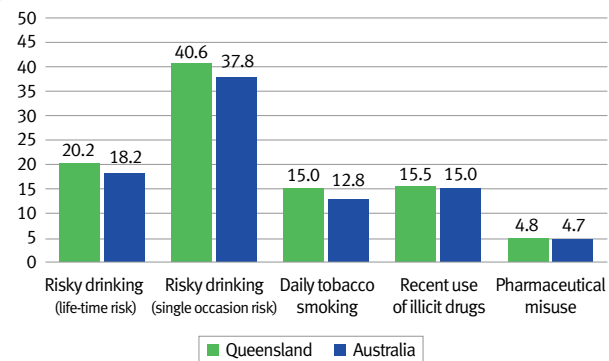
3.2.2 Alcohol consumption at single occasion risky levels

3.2.3 Daily tobacco smoking

3.2.4 Illicit drug use

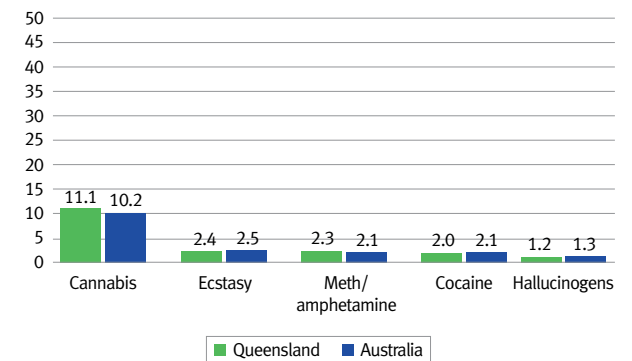
3.2.5 Misuse of pharmaceuticals

Percentage of people aged 14 years and over who reported using alcohol and other drugs, 2013



Source: Australian Institute of Health and Welfare (AIHW), *National Drug Strategy Household Survey*, 2013.

Percentage of people aged 14 years and over who reported use of illicit drugs in previous 12 months, 2013



Source: AIHW, *National Drug Strategy Household Survey*, 2013.

What it is

The percentage of people aged 14 years or over who report drinking alcohol at life-time risky levels and single occasion risky levels, illicit drugs (by type) and misused pharmaceuticals in the last 12 months. It includes those who report currently smoking tobacco on a daily basis.

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 (15.0 per cent compared to 12.8 per cent).

A similar proportion of Queenslanders reported using illicit drugs (15.5 per cent) compared to all Australians (15.0 per cent) and 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 survey is reliant 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. The data does not tell us whether the alcohol or drug use has actually resulted in harm.

When we will next report on progress

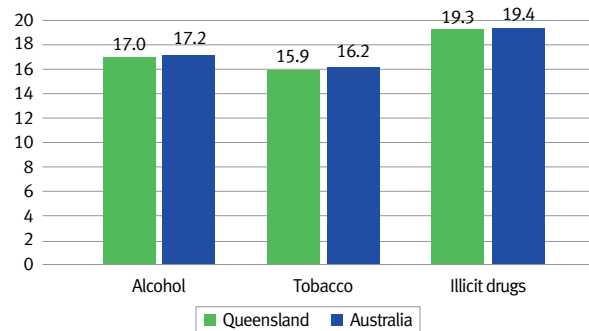
The 2016 *National Drug Strategy Household Survey* has commenced and results will be publicly available in 2017. We anticipate reporting on progress in 2018.

3.2.6 Age of first use of alcohol

3.2.7 Age of first use of tobacco

3.2.8 Age of first use of illicit drugs

Average age of first use of alcohol, tobacco and illicit drug use, 2013



Source: AIHW, *National Drug Strategy Household Survey*, 2013.

What it is

The average age at which people, who were aged 14 years of age or over, reported having first consumed a full serve of alcohol and who reported being a recent drinker (consumed at least a full serve of alcohol in the previous 12 months) or reported being an ex-drinker (consumed a full serve of alcohol during their life-time but not in the previous 12 months).

The average age at which people, who were aged 14 years or over, reported having first full cigarette and who are reported being a smoker (smoked daily, weekly or less than weekly) or reported being an ex-smoker (smoked at last 1 000 cigarettes in their life-time and reported no longer smoking).

The average age at which people, who were aged 14 years and over, reported having first used an illicit drug or misused pharmaceuticals.

What it tells us about Queensland

The average age that people first drink alcohol, smoke tobacco or use illicit drugs is similar in Queensland and nationally.

In 2013, the average age a person first used alcohol in Queensland was 17.0 years of age. In the same year, the average of first use of tobacco was 15.9 years in Queensland and 16.2 years nationally. First age of illicit use of drugs is considerably higher than that of alcohol and tobacco with the average age a person over 14 first uses an illicit drug being 19.3 years in Queensland and 19.4 nationally.

What it doesn't tell us

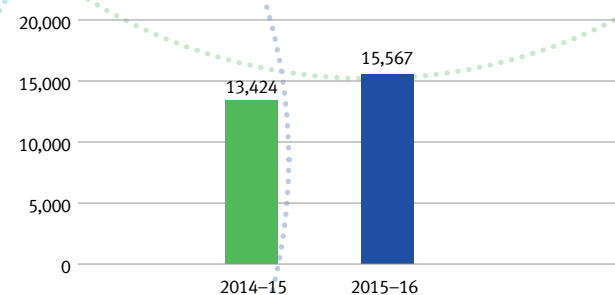
This provides us with no information on the amount of alcohol, tobacco or illicit drug used or whether the person used the drug once, irregularly or regularly.

When we will next report on progress

The 2016 *National Drug Strategy Household Survey* has commenced and results will be publicly available in 2017. We anticipate reporting on progress in 2018.

3.2.9 Hospitalisations for harm associated with substance use

Number of hospital separations in Queensland relating to alcohol and drug harm in 2014–15



Source: Queensland Hospital Admitted Patient Data Collection (QHAPDC), Queensland Department of Health, 2016 (unpublished data).

What it is

The number of hospital separations in Queensland public and private hospitals in 2014–15 and 2015–16 where a person was admitted for treatment relating to alcohol and other drug use. This includes alcohol and other drug intoxication and withdrawal and treatment for alcohol and other drug dependence and disorders. A hospital separation occurs when a person who was admitted to hospital: is discharged; dies while in hospital; has a change in their care type during a hospital stay; or they are transferred to another hospital.

What it tells us about Queensland

The number of separations from hospital related to harm resulting from alcohol and other drug use increased by 16.0 per cent from 13 424 in 2014–15 to 15 567 in 2015–16.

What it doesn't tell us

It does not tell us about the number of people who were hospitalised in Queensland as it does not count individuals. It does not tell us whether the increase is a result of increasing harms or increased access to services and supports.

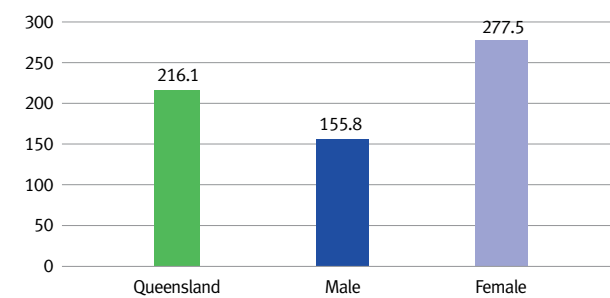
When we will next report on progress

We anticipate providing an update on this indicator in 2017.

3.3 Intentional self-harm

3.3.1 Hospitalisation for intentional self-harm

Age standardised rate of hospital separations in Queensland for intentional self-harm per 100 000 people, 2014–15



Source: QHAPDC, Queensland Department of Health, 2016 (unpublished data).

What it is

The age standardised rate of separations from hospital where a person has been admitted for treatment due to intentional self-harm per 100 000 people in 2014–15. The term intentional self-harm includes: self-poisoning from exposure to a variety of agents; and harm caused by certain actions or using certain tools; or as a consequence of a previous self-harm event. It includes suicide attempts. A hospital separation occurs when a person: is discharged from care; dies while in hospital; or is transferred to another hospital where they continue treatment or recuperation. A hospital separation occurs where there is a change in a person's type of care during a stay in hospital, for example from acute care to sub-acute care.

What it tells us about Queensland


In 2014–15, the rate of hospital separations in Queensland for all types of self-harm was 216.1 per 100 000 people. The rate of hospital separations for females was much higher (277.5 per 100 000) than for males (155.8 per 100 000).

What it doesn't tell us

It does not tell us about extent of self-harm in the community as it does not include people who receive treatment in public or private emergency departments or through general practice, community-based primary care or public community health services. As the data reports on separations from hospital, it does not tell us the number of people who have been admitted to hospital for intentional self-harm as one person can have multiple hospital separations arising from the same incident of self-harm. The severity and the impact of the intent to self-harm on the person themselves, their families and carers cannot be assessed based on this data or whether the treatment was effective and the person recovered.

When we will next report on progress

It is anticipated that Queensland Health will provide this data to the Commission on an annual basis and we will next be able to report on this indicator in 2017.



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 wellbeing⁷.

Links to the Strategic Plan

All Shared Commitments to Action support improved mental health and wellbeing of Queenslanders. This outcome is supported primarily by the Early Action Plan and the Alcohol and Other Drugs Action Plan. Work as part of Shared Commitment to Action 4 – *A responsive and sustainable community sector* and Shared Commitment to Action 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 across 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 Weekly 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 ABS 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

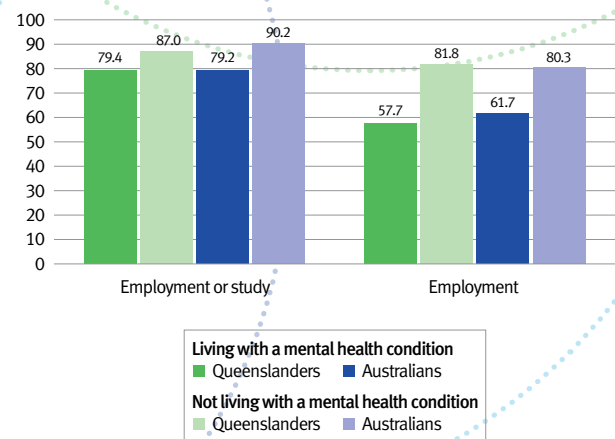
There are a considerable number of performance indicators under this outcome which do not differentiate between those with mental health problems, those living with mental illness and people experiencing problematic alcohol and drug use. Many data sets used as performance indicators also refer to mental 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 of people engaged 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 or without a mental health 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 reported living with or without a mental or health condition 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 works one hour to less than 35 hours a week). It includes those who worked for a minimum of one hour a week in their own business or without pay in a family business.

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 health condition aged 16 to 30 years were less likely to be employed or enrolled in study (79.4 per cent) than other Queenslanders in the same age group (87.0 per cent). This was similar to Australians living with a mental health condition aged 16 to 30 years (79.2 per cent).

In 2011–12, a much smaller proportion of people living with a mental health condition 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 health conditions who were employed (61.7 per cent).

What it doesn't tell us

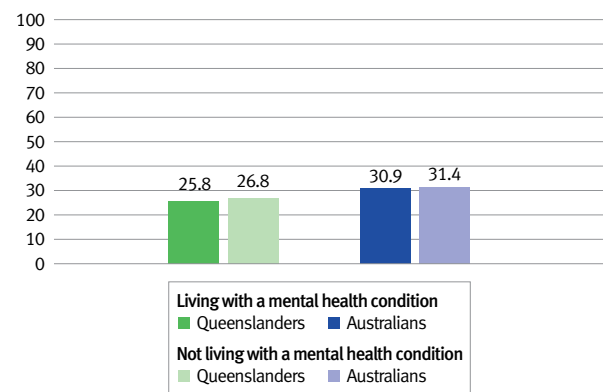
The data does not indicate the proportion of people completing their study or how long they have held employment or how appropriate the employment is. The enrolment in study and employment data is collected from people who are actively engaged with a mental health service provider, so comparison with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

When we will next report on progress

The next Report on Government Services (ROGS) to include this indicator is expected to be released in 2017. We anticipate updating this indicator in 2017.

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 it is

The percentage of people aged 15 years and over in 2014 who report living with a mental health condition, and have undertaken unpaid voluntary work in the last 12 months through an organisation. A person is identified as having a mental health condition if they report that they had experienced a clinically-recognised emotional and behavioural disorder, and perceived mental health problems such as feeling depressed, anxious, stressed or sadness. A person is engaged in volunteering if they have willingly provided unpaid work in the form of time, service or skills to an organisation or group in Australia.

What it tells us about Queensland

In 2014, while 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). Overall, a smaller proportion of Queenslanders volunteered compared to the proportion nationally.

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 next *General Social Survey* is due to be conducted in 2018 and we anticipate providing an update on this in 2019.

4.2 Community participation

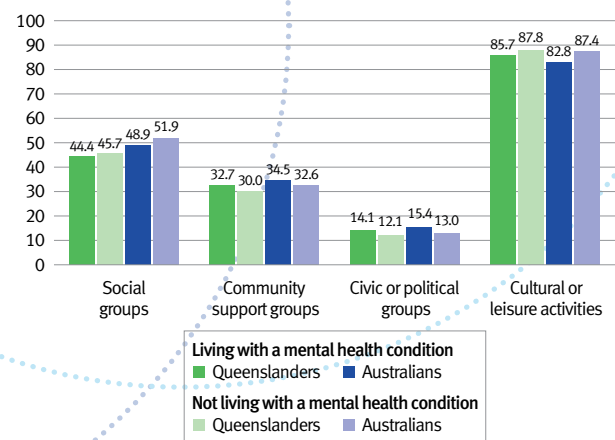
4.2.1 Participation in social groups

4.2.2 Participation in community support groups

4.2.3 Participation in civic or political groups

4.2.4 Attending cultural and leisure events

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 or attended cultural or leisure activities in the last 12 months.

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

What it tells us about Queensland

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

- 44.4 per cent participating in social groups compared to 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 to 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 next due to be conducted in 2018 and we anticipate reporting on this indicator in 2019.

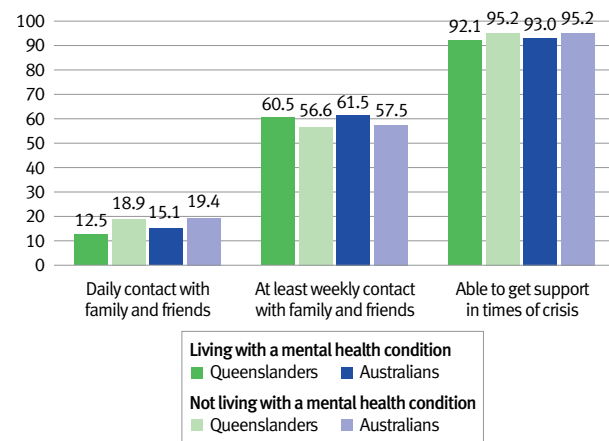
4.3 Personal connections

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 Ability 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 (every day or 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, anxious, stressed or sadness.

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 but less likely to have face-to-face contact on a daily basis.

In 2014, 12.5 per cent of Queenslanders living with a mental health condition reported having face-to-face contact with family and friends every day and 60.5 per cent at least once a week. The difference at a national level is similar to the Queensland percentage, 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 to 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 next *General Social Survey* is due to be conducted in 2018 and we anticipate providing an update on this in 2019.



5

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*⁹. 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 less⁹.

Reduced life expectancy is not directly caused by mental illness. However a number of factors, including the effects of some medications used to treat mental illness can increase the risk of experiencing health conditions, including diabetes and cardiovascular disease, which result in lower life expectancy^{9,10}. Stigma associated with mental illness, can also lead to social isolation and reduced ability to participate in sport and recreation and contribute to increased smoking and alcohol consumption.

Systemic barriers to people living with a mental illness accessing health care have also been identified by researchers as a significant contributor to reduced life expectancy⁸.

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

The performance indicators for this outcome include two new indicators relating to visits to dental professionals and general practitioners.

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 Physical activity through sport and recreation

5.3.2 Visits to dental professionals

5.3.3 Visits to general practitioners

Why these performance indicators

It is not possible to measure life expectancy at this stage. The indicators have been chosen as they enable us to monitor and address risk and protective factors relating to physical health and therefore life expectancy.

5.1 Long-term health conditions

5.1.1 Cardiovascular disease

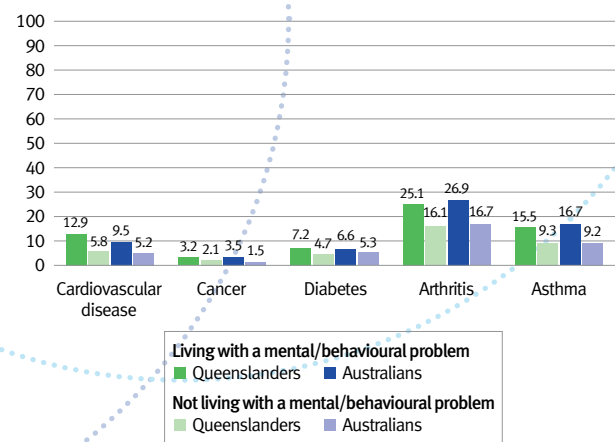
5.1.2 Cancer

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 or 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 (for example: dementia, depression, substance use and anxiety disorders).

What it tells us about Queensland

In 2011–12, 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, in 2011–12, 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).

Early results from the ABS *National Health Survey* 2014–15 indicate that in 2014–15 a greater proportion of Queenslanders (based on non-age standardised percentages) living with a mental or behavioural conditions reported living with a long-term health condition of heart, stroke, and vascular disease; diabetes; arthritis; and/or asthma, than Queenslanders not living with a mental or behavioural condition.

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 occur along with long-term health conditions.

When we will next report on progress

The Report on Government Services (ROGS) is expected to report age standardised percentages in 2017. This will enable us to make a more accurate comparison in future years. We therefore anticipate next reporting progress on this indicator in 2017 after the ROGS is published.

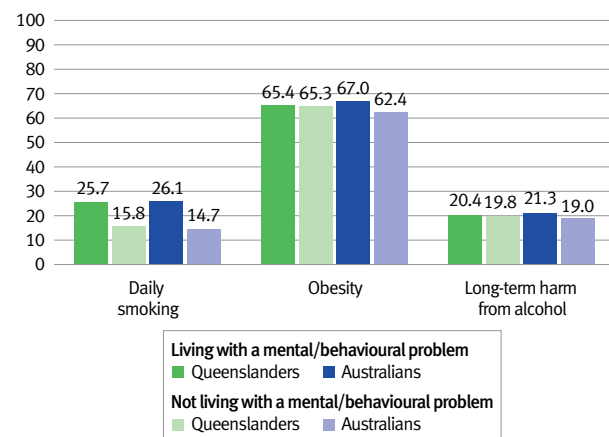
5.2 Risk factors

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 of people living with mental/behaviour problems who smoked tobacco daily, were obese or overweight, and/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 (for example: dementia, depression, substance use and anxiety disorders).

What it tells us about Queensland

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

Similar proportions of Queenslanders living with or without mental/behavioural health problems 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 (67.0 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 to those who were 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, consume alcohol at risky levels or are obese or overweight.

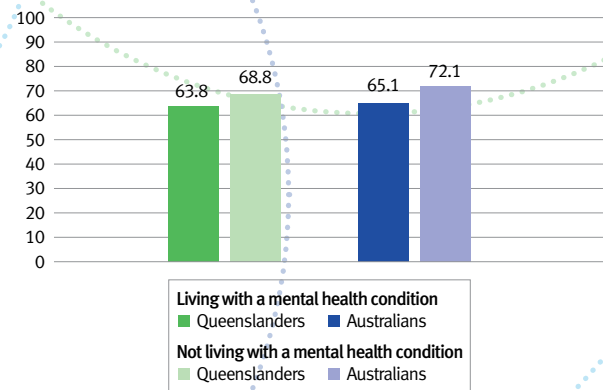
When we will next report progress

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 Engagement in sport or recreation

Percentage of people engaging 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 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, anxious, stressed or 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 exercise 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

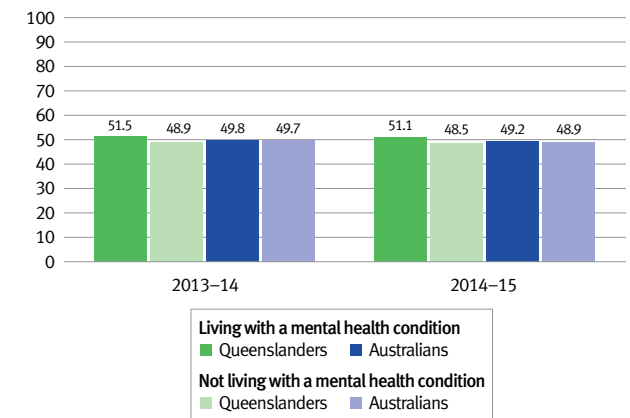
The data does not provide detail about the nature and extent to which people benefit from their participation in activities outside the household.

When we will next report on progress

The next *General Social Survey* is due to be conducted in 2018 and we anticipate providing an update on this in 2019.

5.3.2 Visit to a dental professional

Percentage of people aged 15 years and over who saw a dental professional in 2013–14 and 2014–15



Source: ABS 4839.0, *Patient Experiences in Australia*, 2013–14 and 2014–15 (unpublished data).

What it is

The percentage of people aged 15 years and over who reported living with a long-term mental health condition and who saw a dental professional in the previous 12 months. Dental professionals include dentists, dental hygienists and dental specialists such as periodontists, orthodontists, and endodontists. A long-term mental health condition, including depression or anxiety, is a self-reported condition which has lasted or is likely to last six months or more.

What it tells us about Queensland

Nearly the same proportion of Queenslanders living with a long-term mental health condition reported seeing a dental professional in the past 12 months in 2013–14 (51.5 per cent) and 2014–15 (51.1 per cent).

What it doesn't tell us

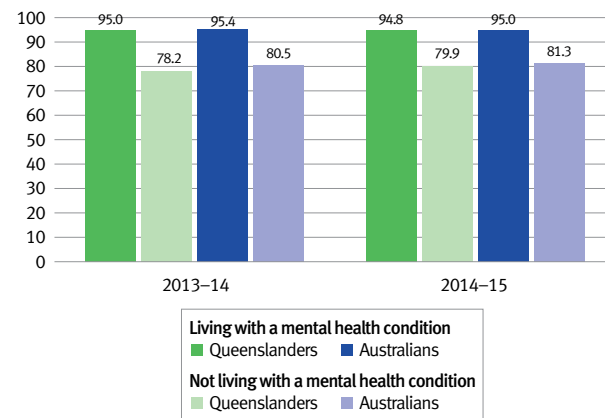
The data does not provide us with detail about the reason or number of times a person saw a dental professional, the nature or outcome of the dental care provided, or the self-assessed health status of the people who saw a dental professional.

When we will next report on progress

The *Patient Experience Survey* is conducted every financial year and we anticipate we will next report on this indicator in 2017.

5.3.3 Visit to a general practitioner

Percentage of people aged 15 years and over who saw a general practitioner in 2013–14 and 2014–15



Source: ABS 4839.0, *Patient Experiences in Australia*, 2013–14 and 2014–15 (unpublished data).

What it is

The percentage of people aged 15 years and over who reported living with a long-term mental health condition and who saw a general practitioner in the previous 12 months. A long-term mental health condition, including depression or anxiety, is a self-reported condition which has lasted or is likely to last six months or more.

What it tells us about Queensland


The proportion of Queenslanders living with a long-term mental health condition who visited a general practitioner (95.0 per cent in 2013–14 and 94.8 in 2014–15) was considerably higher than the proportion who are not living with a long-term mental health condition (78.2 per cent in 2013–14 and 79.9 per cent in 2014–15).

What it doesn't tell us

The data does not provide us with detail about the reason, which may include getting a repeat prescription for medication or number of times a person saw a general practitioner, the nature or outcome of the health care provided, or the general health status of the people who saw a general practitioner.

When we will next report on progress

The *Patient Experience Survey* is conducted every financial year and we anticipate we will next report on this indicator in 2017.



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 include public mental health and alcohol and other drug services both 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 services 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 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 included developing best practice principles for consumer, family and carer engagement in mental health and alcohol and other drug services, and promoting lived experience in the mental health sector.

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

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.

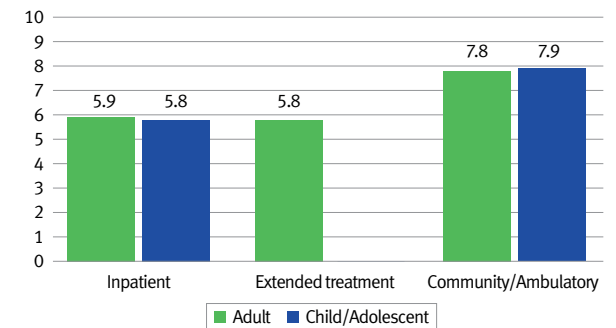
Addressing gaps in monitoring this outcome

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 experience with mental health services

Consumer overall experience of care from Queensland public mental health service organisations, 2015



Source: Queensland Department of Health, *Your Experience of Service Survey*, 2016 (unpublished).

What it is

An overall rating of the experiences of consumers aged 13 years and over about the care and treatment they received in public specialised mental health care services through the *Your Experience of Service (YES)* survey. Consumers were asked to rate their experiences by answering the following question (Question 26 of the YES Survey): Overall how would you rate your experience of care with this service in the last three months. Consumer experiences recorded through the survey uses a scale zero to 10 scale as follows:

- **Scores of 9 to 10** – the vast majority of consumers have very positive experiences of care
- **Scores of 7 to 8** – most consumers have positive experiences of care
- **Scores of 5 to 6** – consumers who score in this range indicate only acceptable experiences of care highlighting the need for improvement
- **Scores of less than 5** – the majority of consumers have negative experiences of their care.

What it tells us about Queensland

In 2015, consumers in community-based services generally indicated a better experience of care than those in bed-based services (inpatient or extended treatment).

What it doesn't tell us

These scores provide an overall experience rating only and do not enable a national comparison or a comparison between individual services. It does not include the views of consumers who: did not participate in the survey, were accessing services outside the collection period, or were accessing services outside the public specialised mental health services (including those receiving treatment through the private sector). A national comparison is not available at this stage as the YES survey has not been implemented by all Australian states and territories. It also does not tell us about particularly vulnerable groups and their experiences of care, such as Aboriginal peoples and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds or people who identify as lesbian, gay, bi-sexual, transgender or intersex.

When we will next report on progress

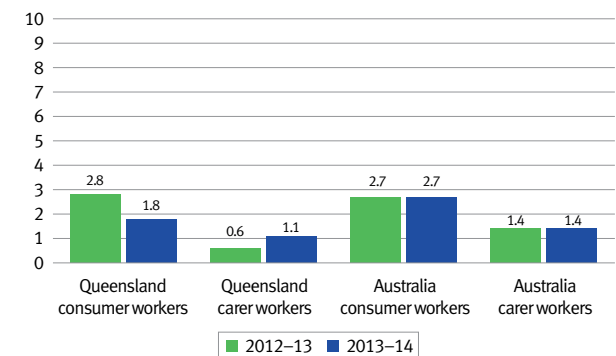
We anticipate reporting on progress for this indicator in 2017.

6.2 Consumer and carer engagement

6.2.1 Paid consumer workers

6.2.2 Paid carer workers

Paid mental health consumer and carer workers per 1 000 full-time equivalent positions direct care staff, 2012–13 and 2013–14



Source: ROGS (2015) Table 12A.52, AIHW (unpublished) derived from the MHE NMDS and ROGS (2016) Table 12A.53, 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 staff (including consumer and carer staff) in specialised mental health services managed or funded by state or territory health authorities. In Queensland these positions are employed by Queensland Health specialist mental health services.

What it tells us

In Queensland there were 2.8 paid FTE consumer workers per 1 000 FTE direct consumer and carer staff in 2012–13 and 1.8 per 1 000 FTE in 2013–14. The Australian rate of 2.7 consumer workers per 1 000 FTE remained unchanged in 2012–13 and 2013–14.

What it doesn't tell us

The data does not include all consumer and carer positions funded by Hospital and Health Services but which are working in the non-government sector. It also does not include consumer or carer positions employed in the private hospitals.

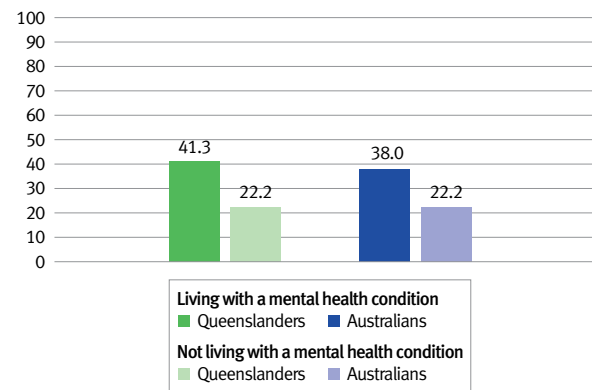
When we will next report on progress

This data was published as part of the ROGS which provides information on the equity, effectiveness and efficiency of government services in Australia. We will report on this indicator when ROGS is published in 2017.

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, anxious, stressed or 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 next *General Social Survey* is next due to be conducted in 2018 and we anticipate providing an update on this in 2019.

Our next report

The Commission will release its next Performance Indicators report in December 2017. The report will provide an update where new data is available and will also outline steps taken and progress to address gaps.

Over the next year, the Commission will work with the Reference Group and other 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 the feasibility and cost effectiveness of developing new indicators and measures.

The areas which the Commission will continue to seek new or improved indicators over the coming year include:

Outcome 1: A population with good mental health and wellbeing

- Wellbeing of all Queenslanders

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 suicide attempts
- Suicide rates among diverse population groups including cultural groups and lesbian, gay, bisexual, transsexual, and intersex Queenslanders
- Harm relating to alcohol and other drug use including new hepatitis C infections resulting from injecting drug use

Outcome 6: People living with mental illness and substance use disorders experience positive experiences of their support, care and treatment

- Service user satisfaction with alcohol and other drug services

This report will also inform ongoing reform and the review of the Strategic Plan due to commence in 2017.

Appendix 1

Sources of data

Australian Health Survey, Australian Bureau of Statistics (ABS)

The *Australian Health Survey 2011–13* (AHS) comprises three separate surveys the:

- *National Health Survey 2011–12* (NHS)
- *National Nutrition and Physical Activity Survey 2011–12* (NNPAS)
- *National Health Measures Survey 2011–12* (NHMS).

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).

National Health Survey, ABS

The *National Health Survey 2014–15* (NHS) was formerly known as the Australian Health Survey, National Health Survey. The NHS 2014–15 reflects a return to the three yearly NHS time series. The NHS survey was conducted throughout Australia from July 2014 to June 2015 from a sample of approximately 14 700 private dwellings across Australia. Urban and rural areas in all states and territories were included, while very remote areas of Australia and discrete Aboriginal and Torres Strait Islander communities were

excluded. Within each selected dwelling one adult (18 years and over) and one child (0–17 years) were randomly selected for inclusion in the survey. This data was based on 831 100 people in Queensland having a mental and/or behavioural problem and 3 777 300 people in Queensland not having a mental and/or behavioural problem.

In 2014–15 a module specifically dedicated to mental and behavioural conditions was included in the NHS to collect information on cognitive, organic and behavioural conditions. In previous NHS cycles, mental and behavioural conditions were collected in a module that included a wide range of long-term health conditions. The number of people who reported having a mental and behavioural condition in 2014–15 has increased since the 2011–12 NHS, potentially due to the greater prominence of mental and behavioural conditions in the new module. Data on mental and behavioural conditions for 2014–15 is therefore not comparable with data in previous National Health Surveys.

Causes of Death, ABS

The *Causes of Death* publication present statistics on the number of deaths, for reference year, by state and territory of Australia, sex, selected age groups, and cause of death classified to the World Health Organisation's International Classification of Diseases (ICD). Version 10 of the ICD was introduced from the 1999 reference year. Causes of death are presented in the publication in a number of different ways including: by underlying cause, leading causes and multiple causes. Data is also presented for deaths of Aboriginal and Torres Strait Islander persons, and for suicide deaths. The 2014 data presented in this publication is preliminary data and will be subject to a revision process. Revised 2013 and final 2012 Causes of Death data are also presented in this publication by underlying cause of death.

General Social Survey, ABS

The 2014 *General Social Survey* (GSS) collected data on a range of social issues from March to June 2014 from 12 932 private dwellings throughout urban and rural areas in all states and territories. Information was obtained from one person aged 15 years or over in each selected household.

National Drug Strategy Household Survey, Australian Institute of Health and Welfare

The *National Drug Strategy Household Survey* (NDSHS) collects information on alcohol and tobacco consumption, and illicit drug use among the general population in Australia. It also surveys people's attitudes and perceptions relating to tobacco, alcohol and other drug use. Survey findings relate mainly to people aged 14 years or over. The 2013 NDSHS collected information from almost 24 000 people across Australia. The 2013 survey consisted solely of a self-completion drop-and-collect method which occurred from 31 July to 1 December 2013. The scope of the survey was residential households and excluded institutional settings, hostels, motels and homeless people. Foreign language interviews were not conducted. The 2016 NDSHS is currently being conducted with results anticipated to be released in mid-late 2017. Previous surveys were conducted in 1985, 1988, 1991, 1993, 1995, 1998, 2001, 2004, 2007, 2010 and 2013.

National Minimum Data Set for Mental Health, Australian Institute of Health and Welfare

A national minimum data set (NMDS) is a minimum set of data elements agreed for mandatory collection and reporting at the national level. The NMDS for mental health are:

- **Mental Health Establishment NMDS** which includes all specialised mental health services managed or funded by state or territory health authorities. The concept of a specialised mental health service is not dependent on the inclusion of the service within the state or territory mental health budget. Services funded by government from non-mental health specific budgets are considered in-scope for collection if they meet the definition of a specialised mental health service.
- **Community mental health care NMDS** which includes data about mental health service contacts provided by specialised mental health services for patients/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those residents in 24 hour staffed specialised residential mental health services. The scope covers all ambulatory units that deliver clinical care and are administered or funded by state and territory governments.

Patient Experiences in Australia, ABS

Patient Experiences in Australia provides information from the *Patient Experience Survey* which is a part of the *Multipurpose Household Survey* (MPHS) conducted throughout Australia each financial year. This survey is conducted annually and collects data on access and barriers to a range of health care services, including general practitioners, medical specialists, dental professionals, imaging and pathology tests, hospital admissions and emergency department visits. It includes data from people who accessed health services in the previous 12 months and also includes data from people who did not access health services, and enables analysis of health service information in relation to particular population groups. Data is also collected on aspects of communication between patients and health professionals.

For the MPHS, the scope was restricted to people aged 15 years and over who were usual residents of private dwellings and included households residing in urban, rural, remote and very remote parts of Australia, except the Indigenous Community Strata.

The following were out of scope for the MPHS:

- members of the Australian permanent defence forces
- certain diplomatic personnel of overseas governments
- overseas citizens resident in Australia
- members of non-Australian defence forces (and their dependants)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, nursing homes, homes for people with disabilities, prison and people living in discrete Indigenous communities.

Queensland Hospital Admitted Patient Data Collection

The Queensland Hospital Admitted Patient Data Collection (QHAPDC) contains state-wide data capturing information about patients separated (an inclusive term meaning, discharged, died, transferred or statistically separated) from any hospital permitted to admit patients. QHAPDC data is also used to substantiate the number of patient days (occupied bed days) for public and private patients in declared public hospitals, licensed private hospitals, and day surgery units.

Report on Government Services, Steering Committee for 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. This report has used both the 2015 and 2016 reports.

Your Experience of Service survey

The *Your Experience of Service* (YES) survey instrument is designed to gather information from consumers about their experiences of care. Queensland Health implements the YES survey as an annual 'snapshot' collection with a collection period of four weeks for most services, but with an extended period of six weeks for rural and remote services and child and adolescent inpatient units. Queensland Health excludes children under the age of 13 years from participating in the survey.

Over the period of 18 May to 14 June 2015, 8 576 adults were offered an opportunity to under the YES survey with 2 834 or 33 per cent responding. More than 1 000 adolescents (1 191) were offered the opportunity to undertake the YES survey, with 546 or 45.9 per cent responding. At the time of the survey there were 20 public mental health service organisations across Queensland, 17 of which participated in the YES collection.

References

- 1 National Audit Office. Choosing the right FABRIC. London; 2001 [retrieved 22 February 2015]. Available from: www.nao.org.uk/wp-content/uploads/2013/02/fabric.pdf.
- 2 Australian Capital Territory Government. Organisational Performance Measurement and Reporting Guide. Canberra: Chief Minister and Treasury; 2013 [retrieved 22 February 2015]. Available from: www.cmd.act.gov.au/__data/assets/pdf_file/0003/435405/preformreportguide.pdf.
- 3 World Health Organisation. Mental health: Strengthening our response. 2014. Fact sheet 220 [retrieved 29 June 2015]. Available from: www.who.int/mediacentre/factsheets/fs220/en/.
- 4 Drabsch T. Measuring wellbeing: Briefing Paper No. 4/2012. NSW Parliamentary Research Service; 2012 [retrieved 4 November 2016]. Available from: <https://www.parliament.nsw.gov.au/researchpapers/Documents/measuring-wellbeing/Wellbeing.pdf>.
- 5 Tudor K. Mental Health Promotion: Paradigms and Practice. London: Routledge; 1996.
- 6 Gallup Healthways. State of global wellbeing: Results of the Gallup Healthways Global Wellbeing Index. Sydney; 2014 [retrieved 3 September 2015]. Available from: www.healthwaysaustralia.com.au/pdf/Gallup_Healthways_State_of_Global_Well-Being_Report.pdf.
- 7 Commonwealth of Australia. A national framework for recovery oriented mental health services: Policy and theory. Canberra: Australian Health Ministers' Advisory Council; 2013.
- 8 Lawrence D, Hancock KJ, Kisely S. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. *The British Medical Journal*. 21 May 2013; 346: f2539.
- 9 Cohn T. Metabolic monitoring for patients on antipsychotic medications. *Psychiatric Times* [Internet], 2013 December 20 [retrieved 11 October 2016]. Available from: www.psychiatrictimes.com/metabolic-disorders/metabolic-monitoring-patients-antipsychotic-medications.
- 10 Better Health Channel. Metabolic syndrome. Victoria State Government [Internet], 2014 [retrieved 11 October 2016]. Available from: www.betterhealth.vic.gov.au/health/conditionsandtreatments/metabolic-syndrome.

