
12 Health management issues

CONTENTS

Indigenous data in the Health management issues chapter	272
Breast cancer	272
Framework of performance indicators	272
Early detection — participation rate of women from selected community groups in the BreastScreen Australia Program	275
Mental health	276
Impact of mental illness	276
Service use by Indigenous status of patient	277
Framework of performance indicators	278
Clinical mental health service use by special needs groups	281
Mortality due to suicide	283
Future directions for reporting on mental health management	285
Definitions of key terms and indicators	286
List of attachment tables	288
References	288

Attachment tables

Attachment tables are identified in references throughout this Indigenous Compendium by an 'A' suffix (for example, in this chapter, table 12A.3). As the data are directly sourced from the 2011 Report, the Compendium also notes where the original table, figure or text in the 2011 Report can be found. For example, where the Compendium refers to '2011 Report, p. 12.15' this is page 15 of chapter 12 of the 2011 Report, and '2011 Report, table 12A.2' is attachment table 2 of attachment 12A of the 2011 Report. A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

The Health management issues chapter (chapter 12) in the *Report on Government Services 2011* (2011 Report) reports on the management of breast cancer and mental health in Australia. Data are reported for Indigenous people for a subset of the performance indicators reported in that chapter — those data are compiled and presented here.

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). The Health management issues chapter in the 2011 Report reports on the management of breast cancer and mental health, which represent some activities of the Australian, State and Territory governments in health management.

Breast cancer detection and management services comprise a number of major components: primary care and community-based services, including general practitioner (GP) services and community-based women's health services; screening services; acute services based in hospitals, including both inpatient and outpatient services; private consultations for a range of disciplines; and post-acute services, including home-based and palliative care (DHS 1999). Relevant clinical disciplines include surgery, plastic and reconstructive surgery, pathology, radiation and medical oncology, nursing, diagnostic radiology, radiography, physiotherapy, allied health, and psychological and psychiatric services. Post-acute services include a range of further treatments, such as radiotherapy and chemotherapy (most of which take place on a same day or outpatient basis) and a range of follow up and palliative care services (DHS 1999).

Specialised mental health management services include a range of government and non-government service providers offering promotion, prevention, treatment and management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in

private practice, counsellors, Aboriginal health workers, Aboriginal mental health workers, public hospitals with specialised psychiatric units and stand-alone psychiatric hospitals all provide specialised mental health care. In addition, a number of health services provide care to mental health patients in a non-specialised health setting — for example, GPs, Aboriginal community controlled health services, public hospital emergency departments and outpatient departments, and public hospital general wards (as distinct from specialist psychiatric wards). Some people with a mental illness are cared for in residential aged care services.

Indigenous data in the Health management issues chapter

The Health management issues chapter in the 2011 Report contains the following data for Indigenous people:

- Participation rates of women screened by BreastScreen Australia
- Impact of mental illness
- Service use by Indigenous status of patient
- Mental health service use by special needs groups
- Mortality due to suicide

Breast cancer

Breast cancer is a disease whereby abnormal cells in the lobules (where milk is produced) or the ducts (which carry milk to the nipple) of the breast grow and multiply out of control (box 12.1). Breast cancer can be invasive or non-invasive. Non-invasive breast cancer remains in the ducts or lobules. Invasive breast cancer spreads beyond the ducts or lobules to invade surrounding breast tissue, and can spread to other parts of the body, or metastasize (AIHW 2009). If left untreated, most invasive cancers (tumours) are life-threatening (AIHW 2009).

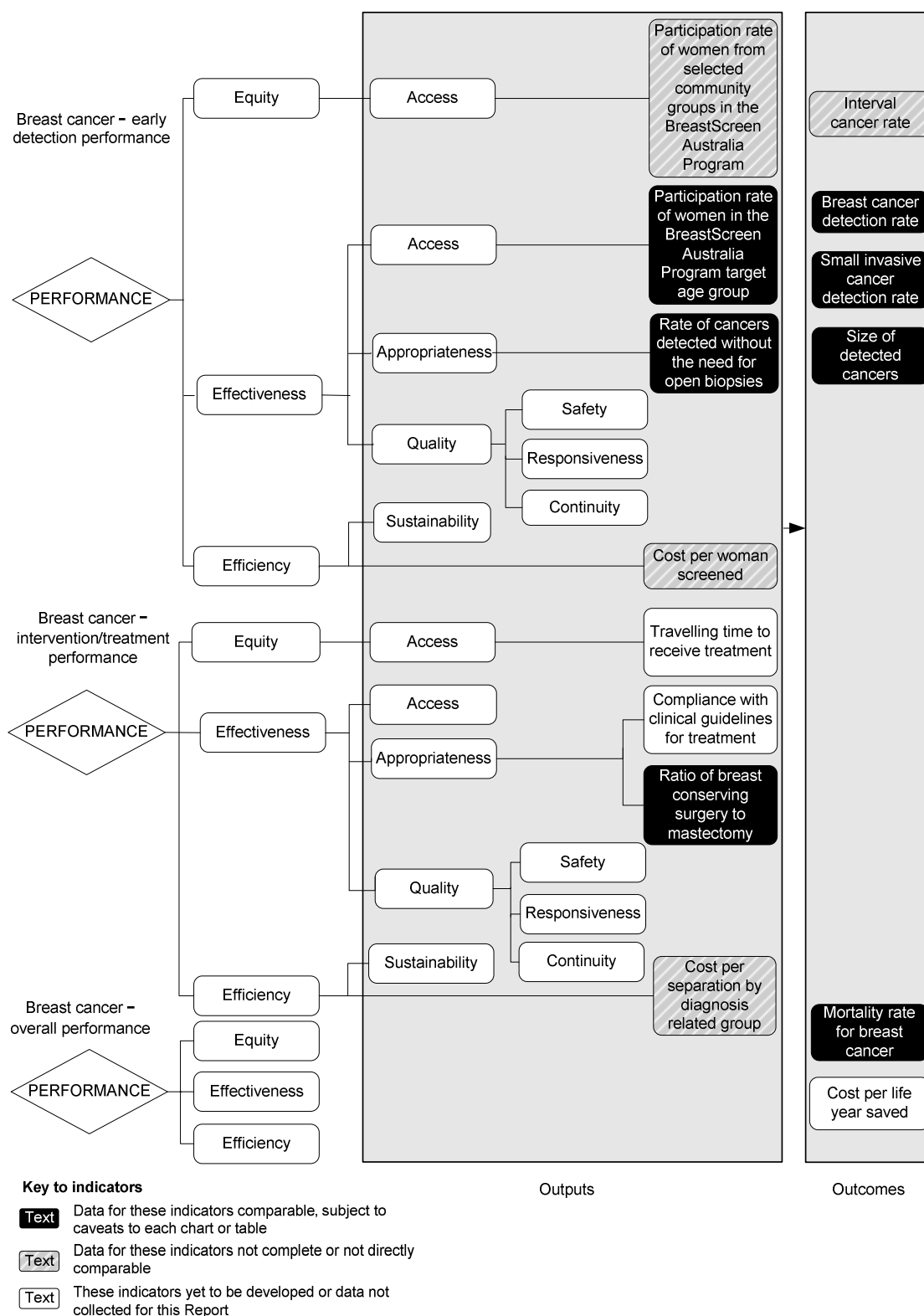
Framework of performance indicators

The breast cancer management performance indicator framework outlined in figure 12.1 is based on shared government objectives for managing the disease (2011 Report, box 12.2). Data for Indigenous people are reported for a subset of the performance indicators and are presented here. It is important to interpret these data in the context of the broader performance indicator framework. The framework shows which data are comparable. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

Indicator boxes presented throughout the chapter provide information about the reported indicators. As these are sourced directly from the 2011 Report, they might include references to data not reported for Indigenous people and therefore not included in this Compendium.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 12.1 Performance indicators for breast cancer detection and management



Source: 2011 Report, figure 12.7, p. 12.15.

Early detection — participation rate of women from selected community groups in the BreastScreen Australia Program

‘Participation rate of women from selected community groups in the BreastScreen Australia Program’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer through early detection strategies, in a manner that is equitable (box 12.1).

Box 12.1 Participation rate of women from selected community groups in the BreastScreen Australia Program

‘Participation rate of women from selected community groups in the BreastScreen Australia Program’ is defined as the proportion of the target population in each selected community group attending the screening program within a 24 month period.

Participation rates for community groups that are at, or close to, those for the total population indicate equitable access to early detection services.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Early detection is associated with reduced morbidity and mortality for women with breast cancer. Indigenous women, women from non-English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas can experience particular language, cultural and geographic barriers to accessing breast cancer screening.

In the 24 month period 2008 and 2009, the national age standardised participation rate for Indigenous women aged 50–69 (36.5 per cent) was below the total participation rate in that age group (55.2 per cent), although this can in part reflect under-reporting of Indigenous status in screening program records. For NESB women for the same 24 month period and age group, the national participation rate of 47.6 per cent was also lower than that of the national total female population (table 12.1). Care needs to be taken when comparing data across jurisdictions as there is variation in the collection of Indigenous and NESB identification data, and in the collection of residential postcodes data.

Table 12.1 Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2008 and 2009 (24 month period) (per cent)^{a, b}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Indigenous ^c	37.0	27.4	48.5	28.4	32.8	51.7	49.1	24.0	36.5
NESB ^d	52.7	32.6	68.9	65.1	55.4	34.8	15.7	24.7	47.6
Major cities and inner regional ^e	53.4	53.3	57.2	56.6	58.2	58.4	53.7	..	54.9
Outer regional, remote and very remote ^e	56.2	58	62.8	55.7	60.7	55.8	..	41.1	57.7
All women aged 50–69 years	54.0	53.0	58.4	56.7	58.6	57.4	53.8	41.3	55.2

^a First and subsequent rounds. ^b Rates are standardised to the 2001 Australian population standard. ^c Women who self-identify as being of Aboriginal and/or Torres Strait Islander descent. ^d NESB is defined as speaking a language other than English at home. ^e Remoteness areas are classified according to the Australian Standard Geographical classification (ASGC). The ASGC is a measure of the remoteness of a location from the services provided by large towns or cities. Not all remoteness areas are represented in each State or Territory. .. Not applicable.

Source: State and Territory governments (unpublished); ABS (2009) *Population by Age and Sex, Australian States and Territories, June 2009*, Cat. no. 3201.0; ABS (unpublished) *Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2021*, Cat. no. 3238.0; ABS (unpublished) *2006 Census of Population and Housing*; AIHW (unpublished) derived from State and Territory data; table 12A.1; 2011 Report, tables 12A.9-10 and 12A.12-13; 2011 Report, table 2.4, p. 12.18.

Mental health

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC and AIHW 1999). The World Health Organization (WHO) describes positive mental health as:

... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

There is a wide range of mental illnesses that can affect an individual's mental health, functioning and quality of life. Each mental illness is unique in terms of its incidence across the lifespan, causal factors and treatments.

Impact of mental illness

Mental illnesses contribute significantly to the total burden of disease and injury in Australia (13.3 per cent of the total burden in 2003) (Begg *et al.* 2007). The total burden comprises the amount of 'years' lost due to fatal events (years of life lost due to premature death) and non-fatal events (years of 'healthy' life lost due to

disability). Mental illness is also the leading cause of ‘healthy’ life years lost due to disability (24 per cent of the total non-fatal burden in 2003) (Begg *et al.* 2007).

Mental illness can affect an individual’s functioning and quality of life. According to the NSMHWB, in 2007, people with a lifetime mental disorder who had symptoms in the previous 12 months (20.0 ± 1.1 per cent of the total population), were significantly overrepresented in the populations who had high or very high levels of psychological distress — 57.1 ± 5.1 per cent and 79.6 ± 7.2 per cent of these populations respectively (ABS 2008).

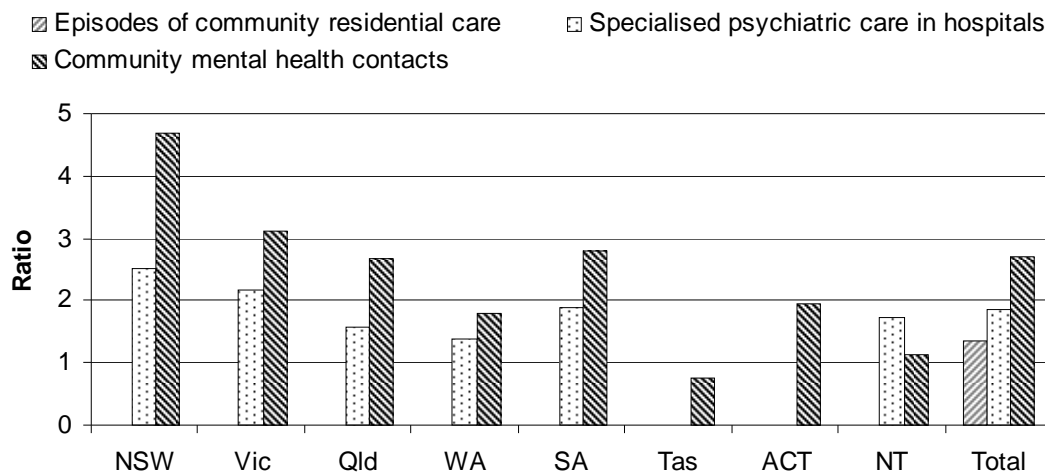
According to the 2007-08 National Health Survey (NHS), a significantly higher proportion of females reported high/very high levels of psychological distress than males in 2007-08 (14.4 ± 1.1 per cent compared with 9.6 ± 0.9 per cent) (2011 Report, table 12A.24). The proportion of high/very high levels of psychological distress was also higher for people aged 18–64 years, than for people aged 65 years or over (2011 Report, table 12A.24). The *National Aboriginal and Torres Strait Islander Health Survey* conducted in 2004-05 found that after adjusting for age, approximately 27 per cent of Indigenous people reported high levels of psychological distress (AHMAC 2008). This was more than twice the proportion for non-Indigenous adults (13 per cent).

Service use by Indigenous status of patient

Data on service use by the Indigenous status of patients are available, but comparisons are difficult because Indigenous patients are not always correctly identified. Differences in rates of service use could also reflect other factors, including the range of social and physical infrastructure services available to Indigenous people, and differences in the complexity, incidence and prevalence of illnesses.

Combined data for the jurisdictions for which data are available, show that Indigenous people were 1.4 times more likely to have an episode of community residential care, 1.8 times more likely to receive specialised psychiatric care in hospitals (both public and private hospitals) and 2.7 times more likely to have a community mental health contact than non-Indigenous people (figure 12.2). Table 12A.2 contains further information on use of these services by Indigenous status. Data for episodes of community residential care by Indigenous status are not available across jurisdictions for 2007-08.

Figure 12.2 Ratio of Indigenous to non-Indigenous specialised mental health service use, 2007-08^{a, b, c, d, e, f}



^a Data for episodes of community residential care by Indigenous status are not available across jurisdictions for 2007-08. National data should be interpreted with caution due to the varying quality and completeness of Indigenous identification across jurisdictions. ^b Data for community mental health contacts should be interpreted with caution. Across jurisdictions, the data quality and completeness of Indigenous identification varies or is unknown. Data were reported by the following states and territories to be of acceptable quality: Queensland, WA, Tasmania, the ACT and the NT. ^c The ratio is equal to the service use rate (episodes, contacts or separations) for Indigenous people divided by the service use rate for non-Indigenous people. Data for non-Indigenous include people whose Indigenous status was 'not stated'. ^d Data for specialised psychiatric care in hospitals includes both public and private hospitals (except for the NT that are for public hospitals only). ^e Queensland does not fund community residential services, but funds a number of campus-based and non-campus-based extended treatment services. ^f Data by Indigenous status are not published for Tasmania and the ACT for specialised psychiatric care in hospitals.

Source: AIHW (2010) *Mental Health Services in Australia 2007-08*, Mental health series no. 12, Cat. no. HSE 88, (internet only tables); table 12A.2; 2011 Report, figure 12.25, p. 12.51.

Framework of performance indicators

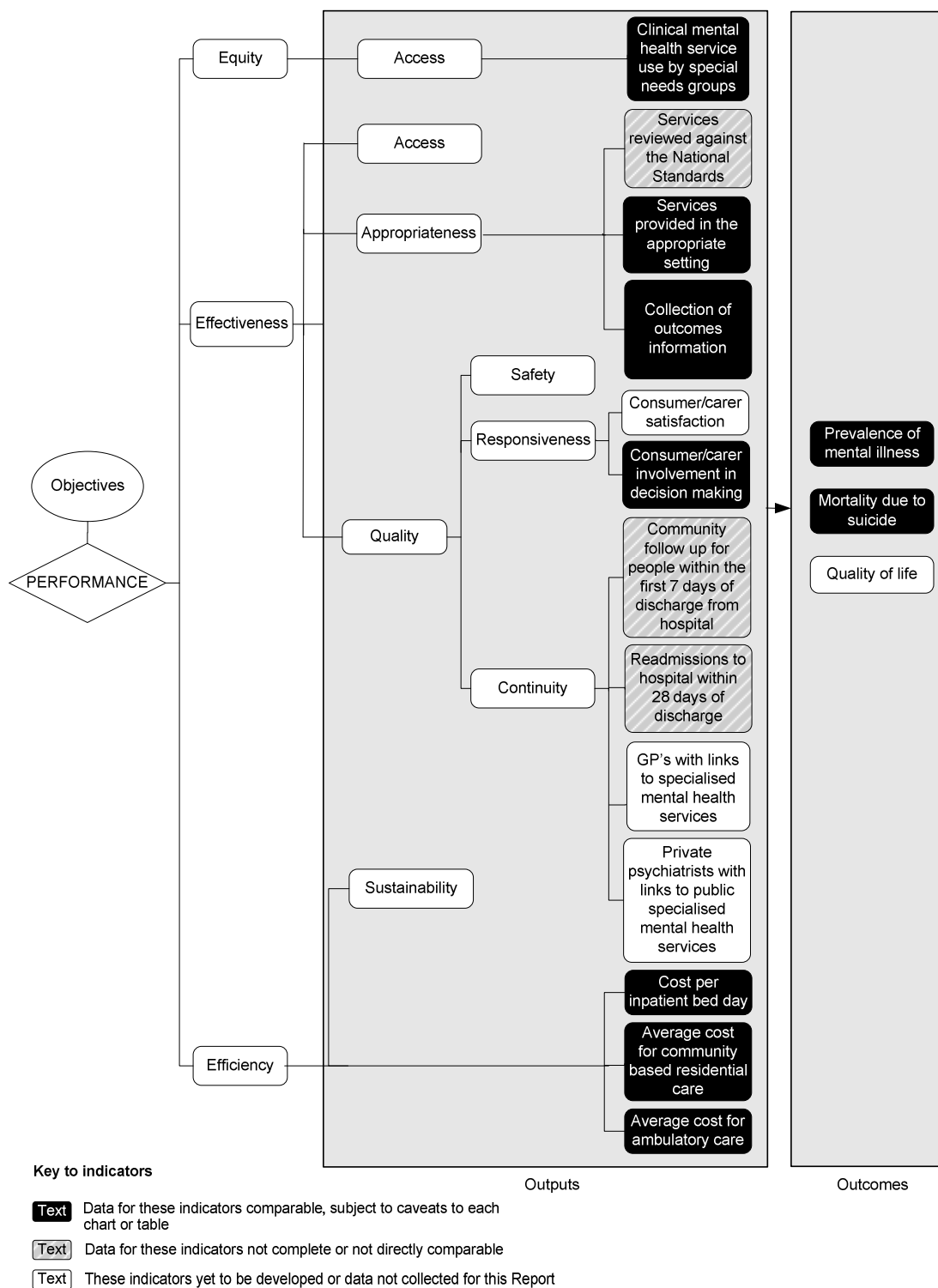
The mental health management performance indicator framework outlined in figure 12.3 draws on governments' broad objectives for national mental health policy, as encompassed in the NMHS and the COAG National Action Plan on Mental Health (2011 Report, box 12.18). Data for Indigenous people are reported for a subset of the performance indicators and are presented here. It is important to interpret these data in the context of the broader performance indicator framework. The framework shows which data are comparable. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

Indicator boxes presented throughout the chapter provide information about the reported indicators. As these are sourced directly from the 2011 Report, they might include references to data not reported for Indigenous people and therefore not included in this Compendium.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Over the period 2004–2009, the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being 2004–2009* (the Social and Emotional Well Being Framework) provided a basis for action by all governments and communities to improve the social and emotional well being and mental health needs of Indigenous people. Ongoing monitoring is provided under the *Aboriginal and Torres Strait Islander Health Performance Framework*. This framework includes 71 performance indicators that measure progress against closing the gap in Indigenous health outcomes. Of these indicators, two relate specifically to social and emotional well being. The performance indicators are reported on biennially.

Figure 12.3 Performance indicators for mental health management



Source: 2011 Report, figure 12.29, p. 12.58.

Clinical mental health service use by special needs groups

‘Clinical mental health service use by special needs groups’ is an indicator of governments’ objective to provide mental health services in an equitable manner, including access to services by special needs groups such as Indigenous people (box 12.2).

Box 12.2 Clinical mental health service use by special needs groups

‘Clinical mental health service use by special needs groups’ is defined by two measures:

- proportion of the Indigenous population using State and Territory mental health services, compared with the proportion for the non-Indigenous population.
- proportion of the Indigenous population using MBS-funded ambulatory mental health services provided by private psychiatrists, GPs and allied health providers (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers), compared with the proportion for the non-Indigenous population.

Interpretation of this indicator is ambiguous. This indicator does not measure access according to need, that is, according to the prevalence of mental illness across special needs groups. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

Data for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

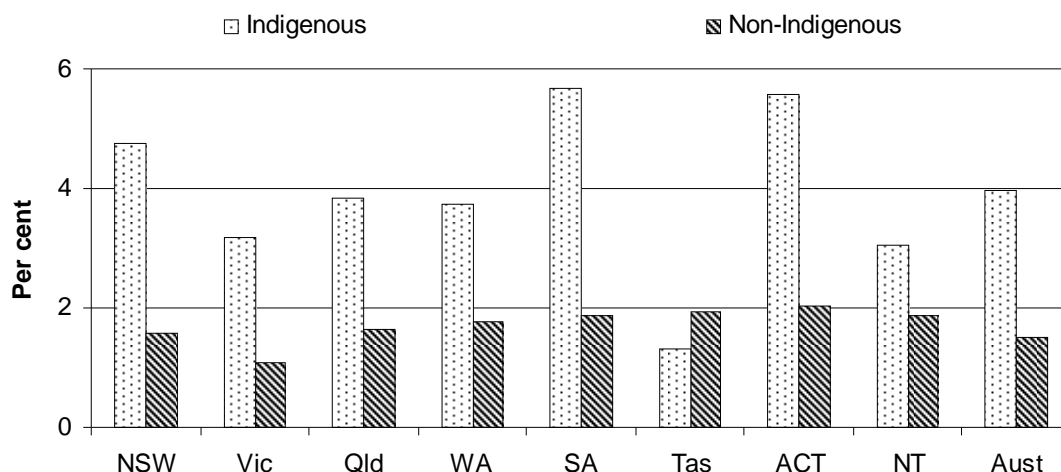
Nationally, the proportion of the population using State or Territory mental health services in 2008-09 is higher for Indigenous people, than for non-Indigenous people (figure 12.4).

These results, which are based on State and Territory governments’ community mental health care data, should be interpreted with care, whereby:

- people receiving only admitted and/or residential services from State and Territory mental health services are not included in the proportion of people accessing services or in rates of service use
- there is no identifier to distinguish ‘treatment’ versus ‘non-treatment’ service contacts in the community mental health care data set

- jurisdictions differ in their collection and reporting of community mental health care data — there are variations in local business rules and in the interpretation of the national definitions.

Figure 12.4 Population using State and Territory mental health services, by Indigenous status, 2008-09^{a, b}

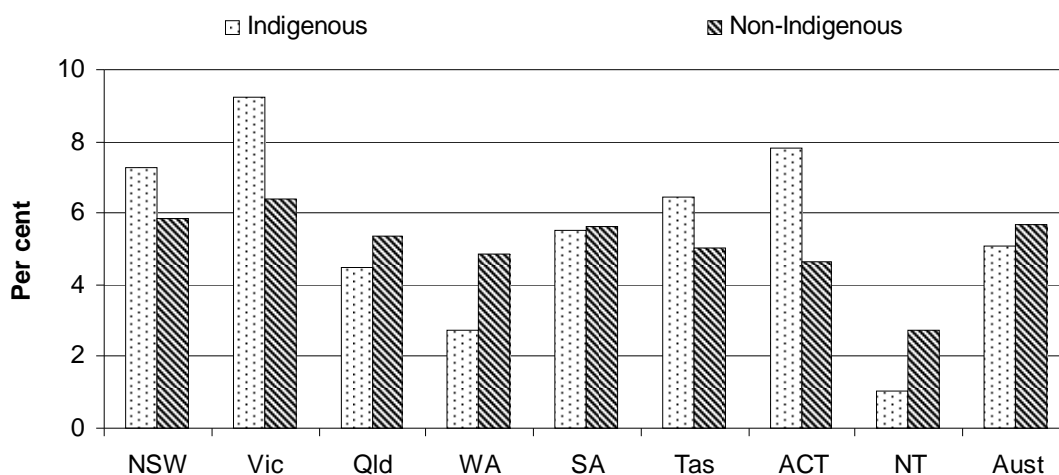


^a Proportions are age-standardised to the Australian population as at 30 June 2001. ^b Counts for State and Territory mental health services are counts of people receiving one or more service contacts provided by public sector community mental health services. SA and Tasmania submitted data that were not based on unique patient identifiers or data matching approaches. Therefore, caution needs to be taken when making jurisdictional comparisons.

Source: State and Territory governments (unpublished) CMHC data; table 12A.3; 2011 Report, figure 12.30a, p. 12.61.

Nationally, the proportion of the population using MBS-funded ambulatory mental health services is lower for Indigenous people than for non-Indigenous people (figure 12.5).

Figure 12.5 Population using MBS-funded ambulatory mental health services, by special needs groups, 2008-09^{a, b}



^a Proportions are age-standardised to the Australian population as at 30 June 2001. ^b MBS services are those specific mental health services provided under Medicare. The specific Medicare items included are detailed in table 12A.37 of the 2011 Report.

Source: DoHA (unpublished) Medicare Statistics data; table 12A.3; 2011 Report, figure 12.31a, p. 12.62.

Further data on the use of State and Territory mental health services and MBS-funded ambulatory mental health services are in tables 12A.4 and 12A.5.

Mortality due to suicide

‘Mortality due to suicide’ is an indicator of governments’ objective under the NMHS to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk (box 12.3).

Box 12.3 Mortality due to suicide

'Mortality due to suicide' is defined as the suicide rate per 100 000 people. The suicide rate is reported for Indigenous and non-Indigenous people.

A low or decreasing suicide rate per 100 000 people is desirable.

While mental health services contribute to reducing suicides, other government services also have a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by severe mental illness, some of whom have either attempted, or indicated the intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government departments, non-government organisations and other special interest groups. Any impact on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including education, housing, justice and community services agencies.

Many factors outside the control of mental health services can influence a person's decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with an increased risk of suicidal behaviour. Other factors that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often a combination of these factors can increase the risk of suicidal behaviour.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

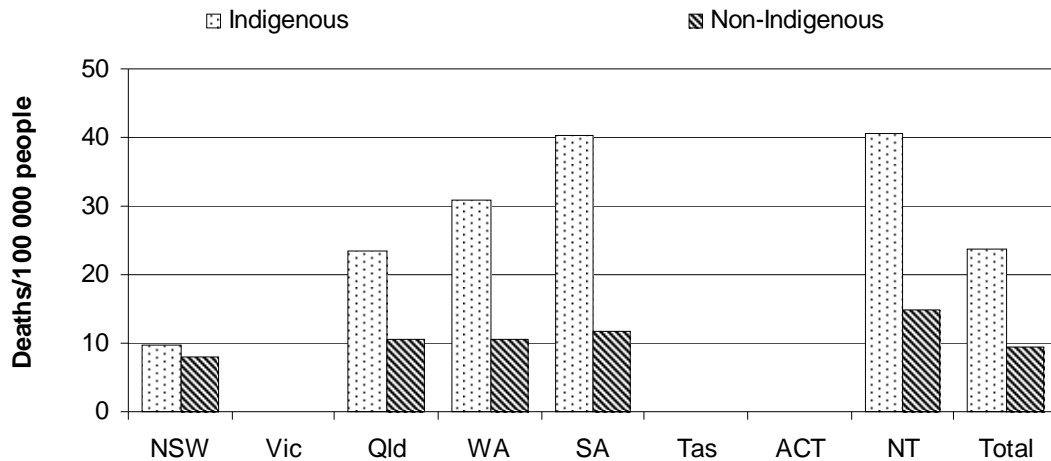
People with a mental illness are at a higher risk of suicide than are the general population. They are also at a higher risk of death from other causes, such as cardiovascular disease (Coghlan *et al.* 2001; Joukamaa *et al.* 2001; Sartorius 2007).

Indigenous suicide rates are presented for NSW, Queensland, WA, SA and the NT (figure 12.6). After adjusting for differences in the age structure of the two populations, the suicide rate for Indigenous people during the period 2004–2008, for the reported jurisdictions, was higher than the corresponding rate for non-Indigenous people.

Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some jurisdictions are not published. Indigenous people are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The rate calculations have not been adjusted for differences in the completeness of

identification of Indigenous deaths across jurisdictions. The Health preface discusses the quality of Indigenous mortality and other data.

Figure 12.6 Suicide rates, by Indigenous status, 2004–2008^{a, b, c, d}



^a Indigenous population figures are based on ABS's *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians* (series B, 2006 base). There are no comparable population data for the non-Indigenous population. The non-Indigenous population figures are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care. Rates are calculated on an age standardised basis. ^b Data for Victoria, Tasmania and the ACT are not reported due to varying coverage in the identification of Indigenous deaths in death registrations. ^c Causes of death data for 2007 have been revised and are subject to further revisions. Causes of death data for 2008 are preliminary and subject to a revisions process. ^d Total relates to the jurisdictions for which data are reported: NSW, Queensland, WA, SA and the NT.

Source: ABS (unpublished) *Causes of Deaths, Australia*; Cat. no. 3303.0; table 12A.6; 2011 Report, figure 12.49, p. 92.

Future directions for reporting on mental health management

Similar to previous years, a key challenge for improving the reporting of mental health management is improving the reporting of effectiveness and efficiency indicators for Indigenous people.

Definitions of key terms and indicators

General practice	The organisational structure in which one or more GPs provide and supervise health care for a 'population' of patients. This definition includes medical practitioners who work solely with one specific population, such as women's health or Indigenous health.
Health management	The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.
Separation	An episode of care for an admitted patient, which can be a total hospital stay, or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care.
Breast cancer Radiation therapy	The use of high energy radiation from X-rays, gamma rays, neutrons, and other sources to kill cancer cells and shrink tumours. Radiation can come from a machine outside the body (external beam radiation therapy) or from materials called radioisotopes. Radioisotopes produce radiation and can be placed in or near the tumour or in the area near cancer cells. This type of radiation treatment is called internal radiation therapy, implant radiation, interstitial radiation or brachytherapy. Systemic radiation therapy uses a radioactive substance (such as a radiolabelled monoclonal antibody) that circulates throughout the body.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than it would otherwise be found.
Mental health Acute services	Services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short term treatment. Acute services can: <ul style="list-style-type: none">• focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric illness for whom there has been an acute exacerbation of symptoms• target the general population or be specialised in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, and forensic mental health services.
General mental health services	Services that principally target the general adult population (18–65 years old) but that can provide services to children, adolescents or older people. Includes, therefore, those services that cannot be described as specialised child and adolescent, older people's or forensic services. <p>General mental health services include hospital units whose principal function is to provide some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, post-natal depression, anxiety disorders).</p>

Mental illness	A diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental illness.
Mental health promotion	Actions taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the 'coping' capacity of communities, families and individuals by giving power, knowledge, skills and necessary resources.
Mental illness prevention	Interventions that occur before the initial onset of a illness to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and mental illnesses.
Mortality rate from suicide	The percentage of the population who die as a result of suicide.
Outpatient services — community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They can include outreach or domiciliary care as an adjunct to services provided from the centre base.
Outpatient services — hospital-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. They can include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Psychiatrist	A medical practitioner with specialist training in psychiatry.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services, as well as other necessary professional services.
Stand-alone psychiatric hospitals	Health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under the management control of a general hospital. A health establishment that operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus can also be a stand-alone hospital if the following criteria are not met: <ul style="list-style-type: none"> • a single organisational or management structure covers the acute care hospital and the psychiatric hospital • a single employer covers the staff of the acute care hospital and the psychiatric hospital • the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus • the patients of the psychiatric hospital are regarded as patients of the single integrated health service.

List of attachment tables

Attachment tables for data within this chapter are contained in the attachment to the Compendium. These tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.1 is table 1 in the health management issues attachment). Attachment tables are provided on the Review website (www.pc.gov.au/gsp).

Breast cancer

Table 12A.1 Participation rates of Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)

Mental health

Table 12A.2 Specialised mental health care reported, by Indigenous status, 2007-08

Table 12A.3 Proportion of people receiving clinical mental health services by service type and Indigenous status

Table 12A.4 Community mental health service contacts provided by public sector community mental health services

Table 12A.5 Rate of ambulatory mental health services provided, by sex, Indigenous status, remoteness and SEIFA

Table 12A.6 Suicide deaths, by Indigenous status

References

ABS 2008, *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, Cat. no. 4326.0, Canberra.

AHMAC (Australian Health Ministers' Advisory Council) 2008, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2008*, AHMAC, Canberra.

AIHW (Australian Institute of Health and Welfare) 2009, *BreastScreen Australia Monitoring Report 2005-2006*, Cancer series no. 48, Cat. no. CAN 44, Canberra.

Begg, S., Vos, T., Barker, B., Stevenson, C., Stanley, L. and Lopez, A. 2007, *The burden of disease and injury in Australia, 2003*, Cat. no. PHE 82, AIHW, Canberra.

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

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

DHS (Department of Human Services Victoria) 1999, *Breast Disease Service Redevelopment Strategy. A Report by the Breast Care Implementation Advisory Committee 1999–2003*, Victorian Government Publishing Service, Melbourne.

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

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

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