

## 1.17 Social and emotional wellbeing

*The social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples expressed as a percentage by age group, age-standardised rate and ratio*

### Data sources

Data for this measure come from:

- National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)
- National Aboriginal and Torres Strait Islander Social Survey (NATSISS)
- Australian Institute of Health and Welfare (AIHW) National Hospital Morbidity Database
- AIHW National Mortality Database
- AIHW Community Mental Health Care Database
- Western Australian Aboriginal Child Health Survey
- Bettering the Evaluation and Care of Health (BEACH) survey.

#### **National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)**

The 2004–05 NATSIHS collected information from 10,439 Indigenous Australians of all ages. This sample was considerably larger than the supplementary Indigenous samples in the 1995 and 2001 National Health Surveys. The survey was conducted in remote and non-remote areas of Australia and collected a range of information from Indigenous Australians about health-related issues including health-related actions, health risk factors, health status, socioeconomic circumstances and women's health. It is planned to repeat the NATSIHS at six-yearly intervals, with the next NATSIHS to be conducted in 2010–11. Selected non-Indigenous comparisons are available through the 2004–05 National Health Survey (NHS).

#### **National Aboriginal and Torres Strait Islander Social Survey (NATSISS)**

The 2002 NATSISS collected information from 9,400 Indigenous Australians across all states and territories of Australia. The sample covered persons aged 15 years or over who were usual residents of private dwellings. It collected information on a wide range of subjects including family and culture, health, education, employment, income, financial stress, housing, and law and justice. The 2002 NATSISS is the second national social survey of Indigenous Australians conducted by the ABS. Selected non-Indigenous comparisons are available through the 2002 General Social Survey (GSS). The ABS plans to conduct the NATSISS every 6 years. The next survey is planned for 2008.

#### **Western Australian Aboriginal Child Health Survey**

This survey was a large-scale investigation into the health of 5,289 Western Australian Aboriginal and Torres Strait Islander children aged 0–17 years. It was undertaken in 2001 and 2002 by the Telethon Institute for Child Health Research in conjunction with the Kulunga Research Network. The survey has been the first to gather comprehensive health, educational and developmental information on a population-based sample of Aboriginal and Torres Strait Islander children and their families and communities.

## **Bettering the Evaluation and Care of Health (BEACH) survey**

Information about encounters in general practice is available from the BEACH survey which is conducted by the AIHW and the University of Sydney. Information is collected from a random sample of approximately 1,000 general practitioners (GPs) from across Australia each year. A sample of 100 consecutive encounters is collected from each GP.

The number of Indigenous patients identified in the BEACH survey is likely to be underestimated. This is because some GPs might not ask about Indigenous status, or the patient may choose not to identify (AIHW 2002). The estimates presented here are also derived from a relatively small sample of GP encounters involving Indigenous Australians.

Due to a late inclusion of a 'not stated' category of Indigenous status in 2001–02, (before which not stated responses were included with non-Indigenous encounters), GP encounters for which Indigenous status was not reported have been included with encounters for non-Indigenous people under the 'other' category.

Data are presented for the five-year period 2000–01 to 2004–05, during which there were 7,296 GP encounters with Aboriginal and Torres Strait Islander patients recorded in the survey, representing 1.6% of total GP encounters.

## **Hospitalisations**

The National Hospital Morbidity Database is a compilation of episode-level records from admitted patient morbidity data collection systems in Australian hospitals in each state and territory. Information on the characteristics, diagnoses and care of admitted patients in public and private hospitals is provided annually to the AIHW by state and territory health departments.

Data are presented for the four jurisdictions which have been assessed as having adequate identification of Indigenous hospitalisations in 2003–04 – Queensland, Western Australia, South Australia and the Northern Territory (AIHW 2005a). These four jurisdictions represent approximately 60% of the Indigenous population of Australia. Data are presented by state/territory of usual residence of the patient.

Hospitalisations for which the Indigenous status of the patient was not reported have been included with hospitalisations data for non-Indigenous people under the 'other' category. This is to enable consistency across jurisdictions, as public hospitals in some states and territories do not have a category for the reporting of 'not stated' or inadequately recorded/reported Indigenous status.

Hospitalisation data are presented for the two-year period July 2002 to June 2004. An aggregate of two years of data has been used as the number of hospitalisations for some conditions is likely to be small for a single year.

The principal diagnosis is the diagnosis established to be the problem that was chiefly responsible for the patient's episode of care in hospital. The term 'hospitalisation' has been used to refer to a separation which is the episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a change in a type of care (for example, from acute to rehabilitation).

## **Mortality**

The National Mortality Database is a national collection of de-identified information for all deaths in Australia and is maintained by the AIHW. Information on the characteristics and causes of

death of the deceased is provided by the Registrars of Births, Deaths and Marriages and coded nationally by the ABS. Information on the cause of death is supplied by the medical practitioner certifying the death, or by a coroner. The data are updated each calendar year.

While the identification of Indigenous deaths is incomplete in all state and territory registration systems, four jurisdictions (Queensland, Western Australia, South Australia and the Northern Territory) have been assessed by the ABS and the AIHW as having adequate identification. These four jurisdictions represent approximately 60% of the Indigenous population of Australia. Data are presented by state/territory of usual residence rather than state/territory where death occurs.

Deaths for which the Indigenous status of the deceased was not reported have been excluded from the analysis.

Data have been combined for the five-year period 2000–2004 due to the small number of deaths from some conditions each year. Data have been analysed using the year of occurrence of death for the period 2000–2003 and year of registration of death for 2004. This is because mortality data by year of occurrence of death are a more accurate reflection of mortality during a particular year than year of registration data, however, year of occurrence data for 2004 are still incomplete owing to late registrations.

### **Community mental health care**

Information on the use of community mental health services by Aboriginal and Torres Strait Islander people is available from the AIHW National Community Mental Health Care Database. The information collected in the database is a nationally agreed set of common data elements collected by service providers based on the National Minimum Data Set for Community Mental Health Care.

The quality of Indigenous identification in this database varies by jurisdiction. In 2003–04, Western Australia, Tasmania and the Northern Territory reported that the quality of their data was suitable for analysis.

As with hospitalisation data, service contacts in which the Indigenous status of the client was not reported have been included with contacts for non-Indigenous clients under the 'other' category.

## **Analyses**

Age-standardised rates and ratios have been used for this indicator as a measure of the Indigenous population relative to other Australians. Ratios of this type illustrate differences between the rates among Indigenous people and those of other Australians, taking into account differences in age distributions.

### **Self-reported prevalence**

Self-reported data on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people are available from the 2004–05 NATSIHS and the 2002 NATSISS. Data from these two surveys are outlined below.

The social and emotional wellbeing module in the 2004–05 NATSIHS comprised selected questions from two established mental health surveys – the Kessler Psychological Distress Scale and the Medical Outcome Short Form (SF-36). The module also included some questions related to feelings of anger, the impact of psychological distress, cultural identification and stressors.

### **Feelings of positive wellbeing**

- In 2004–05, approximately 60% of Indigenous males and 53% of Indigenous females reported they felt calm and peaceful and around 73% of Indigenous males and 70% of Indigenous females reported they had been a happy person all or most of the time in the last four weeks. The proportion of Indigenous Australians who reported these positive feelings was similar across all age groups (Table 1.17.1).
- Around 58% of Indigenous males and 51% of Indigenous females reported they were full of life; and 54% of Indigenous males and 41% of Indigenous females reported they often had a lot of energy all or most of the time in the last four weeks. A higher proportion of Indigenous Australians aged 18–24 years reported these feelings of positive wellbeing than Indigenous Australians aged 55 years and over.

### **Feelings of anger**

- In 2004–05, approximately 13% of Indigenous males and 18% of Indigenous females reported they felt annoyed and irritated a lot in the last four weeks.
- Approximately 5% of Indigenous males and 4% of Indigenous females reported they had violent thoughts and 3% of Indigenous males and 4% of Indigenous females reported they wanted to break and smash things a lot in the last four weeks (Table 1.17.2).
- Around 4% of Indigenous males and 7% of Indigenous females reported they got into a lot of arguments and 3% of Indigenous males and 5% of Indigenous females reported they shouted or threw things a lot in the last four weeks.
- Indigenous Australians aged 18–24 years were generally more likely to report these feelings or anger than those in the older age groups.

**Table 1.17.1: Aboriginal and Torres Strait Islander persons aged 18 years or over: selected indicators of positive wellbeing, <sup>(a)</sup> by sex and age group, 2004–05**

Type of feeling felt <sup>(b)</sup>	18–24 years			25–34 years			35–44 years			45–54 years			55+ years			Total		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
(Per cent)																		
<b>How often felt calm and peaceful (in last 4 weeks)</b>																		
All/most	62	54	58	55	50	53	64	52	58	60	52	56	63	59	61	60	53	56
Some	25	28	27	31	30	30	19	25	22	21	25	23	21	23	22	24	27	26
A little	9 <sup>(c)</sup>	12	10	8	14	11	10	17	14	13	13	13	10 <sup>(c)</sup>	11	10	10	13	12
None	2 <sup>(c)</sup>	5 <sup>(c)</sup>	4	4 <sup>(c)</sup>	5	5	5 <sup>(c)</sup>	5	5	5 <sup>(c)</sup>	8	7	4 <sup>(c)</sup>	4 <sup>(c)</sup>	4	4	5	5
Total <sup>(d)</sup>	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
<b>How often been a happy person (in last 4 weeks)</b>																		
All/most	73	70	71	75	70	72	72	70	71	71	70	70	70	74	72	73	70	71
Some	18	23	21	19	20	20	18	19	18	20	19	19	13	16	15	18	19	19
A little	6 <sup>(c)</sup>	6	6	4	8	6	5	9	7	7	7	7	11 <sup>(c)</sup>	5 <sup>(c)</sup>	8	6	7	7
None	1 <sup>(c)</sup>	2 <sup>(c)</sup>	1 <sup>(c)</sup>	— <sup>(c)</sup>	2 <sup>(c)</sup>	1 <sup>(c)</sup>	2 <sup>(c)</sup>	2 <sup>(c)</sup>	2	2 <sup>(c)</sup>	3 <sup>(c)</sup>	3 <sup>(c)</sup>	4 <sup>(c)</sup>	2 <sup>(e)</sup>	2 <sup>(c)</sup>	2	2	2
Total <sup>(d)</sup>	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
<b>How often felt full of life (in last 4 weeks)</b>																		
All/most	62	49	55	62	54	58	59	53	56	55	50	52	47	47	47	58	51	55
Some	27	31	29	25	27	26	26	24	25	25	28	27	26	27	26	26	27	27
A little	7	13	11	8	14	11	7	14	11	11	11	11	11	14	13	9	13	11
None	3 <sup>(c)</sup>	5	4	3 <sup>(c)</sup>	4	4	6 <sup>(c)</sup>	8	7	8	9	8	14	8	11	6	7	6
Total <sup>(d)</sup>	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(continued)

**Table 1.17.1 (continued): Aboriginal and Torres Strait Islander persons aged 18 years or over: selected indicators of positive wellbeing, <sup>(a)</sup> by sex and age group, 2004–05**

Type of feeling felt <sup>(b)</sup>	18–24 years			25–34 years			35–44 years			45–54 years			55+ years			Total		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
	(Per cent)																	
<b>How often had a lot of energy (in last 4 weeks)</b>																		
All/most	61	40	50	62	45	53	52	40	45	46	41	43	38	38	38	54	41	47
Some	24	38	32	24	31	27	27	35	32	31	29	30	31	33	32	27	33	30
A little	12	16	14	9	18	14	12	17	15	15	17	16	14	13	14	12	17	14
None	2 <sup>(c)</sup>	5 <sup>(c)</sup>	3	4 <sup>(c)</sup>	5	5	7	7	7	8	11	9	15	12	13	6	7	7
Total <sup>(d)</sup>	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(a) Questions from SF-36 scale.

(b) Type of feeling over previous 4 weeks.

(c) Estimate has a relative standard error of between 25% and 50% and should be interpreted with caution.

(d) Includes don't know, not stated and refusal.

(e) Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

Source: ABS and AIHW analysis of 2004–05 National Aboriginal and Torres Strait Islander Health Survey.

Table 1.17.2: Social and emotional wellbeing items related to anger, <sup>(a)</sup> by sex and age group, 2004–05

Type of feeling felt <sup>(b)</sup>	18–24 years			25–34 years			35–44 years			45–54 years			55+ years			Total		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
(Per cent)																		
<b>Felt annoyed and irritated</b>																		
A lot	12	18	15	12	21	17	15	21	18	15	16	16	12	*12	12	13	18	16
Some	48	58	53	55	57	56	57	57	57	55	58	56	49	46	47	53	56	55
Not at all	39	24	31	32	21	26	26	22	24	29	25	27	37	38	38	32	25	28
Total <sup>(c)</sup>	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
<b>Had violent thoughts</b>																		
A lot	7	4	5	5 <sup>(d)</sup>	5	5	5	4	4	3 <sup>(d)</sup>	4 <sup>(d)</sup>	3 <sup>(d)</sup>	1 <sup>(e)</sup>	2 <sup>(d)</sup>	2 <sup>(d)</sup>	5	4	4
Some	23	21	22	18	22	20	19	18	18	21	20	20	11	9	10	19	19	19
Not at all	69	75	72	76	72	74	74	77	76	75	75	75	86	85	85	75	76	76
Total <sup>(c)</sup>	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
<b>Wanted to break and smash things</b>																		
A lot	4 <sup>(d)</sup>	6 <sup>(d)</sup>	5	4 <sup>(d)</sup>	5	4	3 <sup>(d)</sup>	4	3	1 <sup>(e)</sup>	2 <sup>(d)</sup>	2 <sup>(d)</sup>	— <sup>(e)</sup>	2 <sup>(d)</sup>	1 <sup>(d)</sup>	3	4	3
Some	23	18	20	15	22	19	14	15	15	15	14	15	6	10	8	15	17	16
Not at all	72	75	74	80	72	75	80	81	80	83	82	82	92	85	88	80	78	79
Total <sup>(c)</sup>	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
<b>Got into lots of arguments</b>																		
A lot	7	8	7	4 <sup>(d)</sup>	9	6	5	6	6	3 <sup>(d)</sup>	6 <sup>(d)</sup>	5	1 <sup>(d)</sup>	2 <sup>(d)</sup>	2 <sup>(d)</sup>	4	7	6
Some	32	37	35	31	31	31	31	32	31	26	29	28	14	16	15	28	30	29
Not at all	59	54	57	64	60	62	61	61	61	70	64	67	84	78	80	66	62	64
Total <sup>(c)</sup>	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(continued)

**Table 1.17.2 (continued): Social and emotional wellbeing items related to anger, <sup>(a)</sup> by sex and age group, 2004–05**

Type of feeling felt <sup>(b)</sup>	18–24 years			25–34 years			35–44 years			45–54 years			55+ years			Total		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
(Per cent)																		
<b>Shouted or threw things</b>																		
A lot	4 <sup>(d)</sup>	5	4	4 <sup>(d)</sup>	6	5	3 <sup>(d)</sup>	6	5	2 <sup>(d)</sup>	6 <sup>(d)</sup>	4	1 <sup>(e)</sup>	2 <sup>(d)</sup>	1 <sup>(d)</sup>	3	5	4
Some	21	27	24	17	33	25	21	29	25	17	22	19	9	10	10	18	26	22
Not at all	73	67	70	78	60	68	73	65	69	81	71	76	88	84	86	77	68	72
Total <sup>(c)</sup>	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(a) Questions were adapted using a set developed for American Indian communities in the United States. The objective of these questions was not to provide a measure of anger, but to report on the manifestations of anger against other dimensions of the Social and Emotional Wellbeing module.

(b) Type of feeling over previous 4 weeks.

(c) Includes don't know, not stated and refusal.

(d) Estimate has a relative standard error of between 25% and 50% and should be interpreted with caution.

(e) Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

Source: ABS and AIHW analysis of 2004–05 National Aboriginal and Torres Strait Islander Health Survey.

The 2002 NATSISS collected information on a range of social issues relevant to the social and emotional wellbeing of Indigenous Australians including cultural, family and community attachments, financial stress and law and justice.

### **Cultural attachment**

- Approximately 38% of Indigenous people aged 15 years and over reported that they or a relative had been removed from their natural family, 54% reported they identified with a clan or tribal group, 22% currently lived in traditional lands, 68% had attended cultural events in the last 12 months and 14% did not speak English as a primary language.

### **Family and community attachments**

- Approximately 90% of Indigenous people aged 15 years and over reported that they had been involved in social activities in the last three months (such as religious activities, sporting activities, going out to a café, restaurant or bar, etc.) and 28% had undertaken voluntary work in the last 12 months. The large majority of Indigenous people (90%) reported that, in a time of crisis, they could get support from outside the household.
- Overall, approximately 82% of Indigenous people reported that they had experienced at least one stressor in the last 12 months. The most common stressors reported were the death of a family member or close friend (46%), serious illness or disability (31%) and inability to get a job (27%).
- Alcohol- and drug-related problems were reported as a stressor by one-quarter (25%) of all Indigenous people, and by 37% of Indigenous people living in remote areas of Australia.

### **Alcohol and other substance use**

The 2004–05 NATSIHS, the 2004 National Drug Strategy Household Survey and the 2002 NATSISS collected information on the alcohol consumption and substance use of Aboriginal and Torres Strait Islander people. These data are summarised below.

- The 2004–05 NATSIHS found that approximately 50% of Indigenous Australians aged 18 years and over reported having consumed alcohol in the week prior to the survey, of whom one-third (16%) reported drinking at long-term risky/high-risk levels. Approximately 55% of Indigenous adults drank at short-term risky/high-risk levels in the last 12 months and 19% drank at short-term risky/high-risk levels at least once a week in the last 12 months.
- In 2004–05, after adjusting for differences in age structure, Indigenous Australians were twice as likely as non-Indigenous Australians to drink at short-term risky/high-risk levels at least once a week in the last 12 months, but equally as likely to drink at long-term risky/high-risk levels in the week prior to survey (15% and 14% respectively). Indigenous adults were twice as likely as non-Indigenous Australians to have abstained from alcohol consumption in the last 12 months.
- In 2004–05, approximately 28% of Indigenous people aged 18 years and over reported rates of illicit substance use in the 12 months prior to the survey. In addition, around 50% of Indigenous Australians aged 18 years and over reported illicit substance use at least once in their lifetime. The substances most commonly used in the last 12 months were marijuana (23%), amphetamines (6%) and analgesics/sedatives (for non-medicinal use) (6%).

- The 2004 National Drug Strategy Household Survey found that illicit drug use among Aboriginal and Torres Strait Islander people was higher than for other Australians. For example, 27% of Aboriginal and Torres Strait Islander people aged 14 years and over had used drugs or other substances in the last 12 months compared with 15% of other Australians.
- The 2002 NATSISS reported that in non-remote areas of Australia approximately 4% of Indigenous Australians aged 15 years and over reported they had ever used heroin, 4% had ever used cocaine, 6% had ever used LSD or other synthetic hallucinogens, 5% had ever used ecstasy or designer drugs, 4% had sniffed petrol and 4% had used other inhalants.

Additional data and information on the consumption of alcohol and the use of illicit drugs can be found in Measures 2.19 and 2.20.

### **Financial stress**

- In 2002, over half (54%) of all Indigenous persons aged 15 years and over reported they were living in households in which they could not raise \$2,000 within a week in a time of crisis.

### **Law and justice**

- Approximately 20% of Indigenous people aged 15 years and over reported they had used legal services in the last 12 months, 16% had been arrested by the police, 7% had been incarcerated in the last five years, and 24% had been a victim of physical or threatened violence in the last 12 months. After adjusting for age differences between the Indigenous and non-Indigenous populations, Indigenous Australians aged 18 years and over experienced double the victimisation rate of non-Indigenous persons.
- The National Inquiry into the Human Rights of People with Mental Illness (HREOC 1993) found that anti-social and self-destructive behaviour, often the result of lack of acceptance, choice and opportunity, the history of dispossession, assimilation, cultural and community genocide and/or undiagnosed mental and social distress, brought Indigenous people into frequent contact with the criminal justice system. Mental illness and/or emotional distress may not only cause Indigenous and other Australians to come into contact with the criminal justice system, but incarceration may be a risk factor for mental illness (HREOC 1993). Incarceration separates Indigenous people and other nationalities from their communities and culture. However, removal from extended family or community tends to have a significant impact on Indigenous detainees. Indigenous prisoners frequently experience depressive symptoms associated with unresolved anger which can result in suicide attempts. The number of Indigenous deaths in custody is also relatively high. Of the 68 deaths in custody in Australia in 2003, 17 (25%) were Indigenous people (McCall 2004). Indigenous Australians are imprisoned at much higher rates than non-Indigenous Australians. In 2005, the incarceration rate for Indigenous people aged 18 years and over was 1,561 per 100,000 compared to 129 per 100,000 for non-Indigenous people.

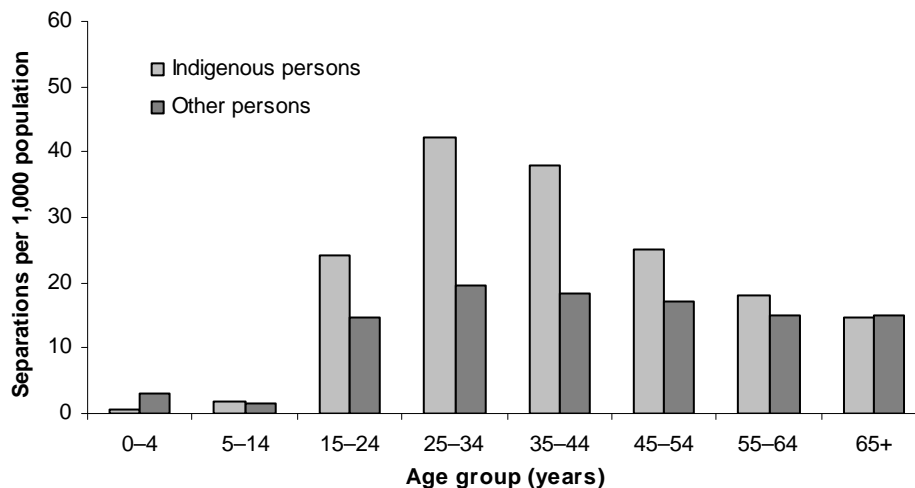
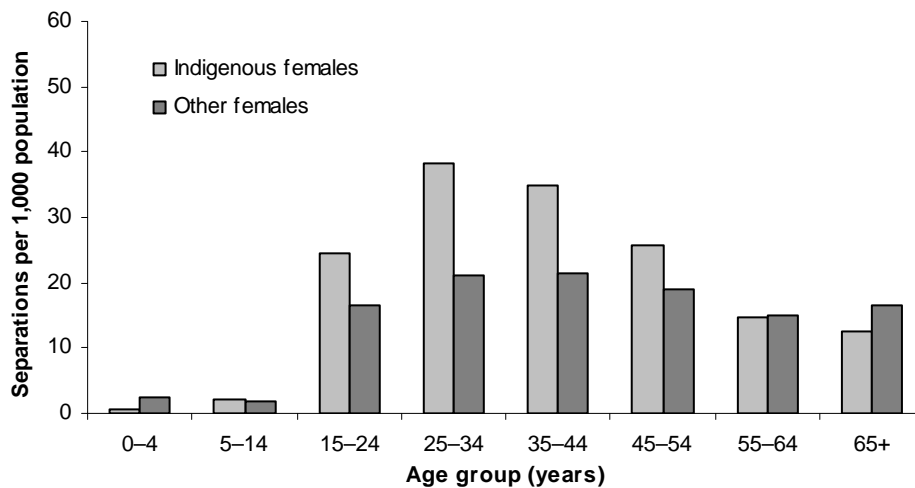
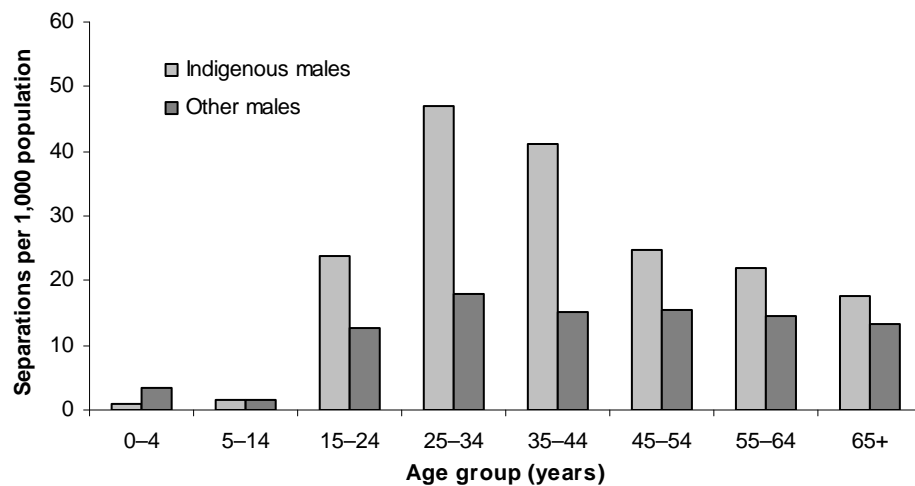
## Hospitalisations

Mental health related conditions include mental and behavioural disorders (such as schizophrenia and psychoactive substance use) and other mental health conditions (such as Alzheimer's disease and postnatal depression).

- For the two-year period July 2002 to June 2004, there were 210,420 hospitalisations from mental health related conditions in Queensland, Western Australia, South Australia and the Northern Territory combined, 11,264 (5.4%) of which were hospitalisations of Aboriginal and Torres Strait Islander peoples.
- Mental health related conditions were responsible for 3.6% of all hospitalisations of Aboriginal and Torres Strait Islander Australians.
- Mental and behavioural disorders were the seventh most common group of principal diagnosis for Aboriginal and Torres Strait Islander Australians admitted to hospital, behind care involving dialysis, injury and poisoning, complications of pregnancy and childbirth, diseases of the respiratory system, diseases of the digestive system, symptoms, signs and ill-defined conditions, and abnormal clinical and laboratory findings.

### Hospitalisations by age and sex

- For the two-year period July 2002 to June 2004, in Queensland, Western Australia, South Australia and the Northern Territory combined, Indigenous males and females had higher hospitalisation rates for mental health related conditions than other males and females across all age groups from 15–24 years and over (Figure 1.17.1).
- The greatest difference in rates occurred in the 25–34 years and 35–44 years age groups where Indigenous males were hospitalised for mental health related conditions at around three times the rate of other males and Indigenous females were hospitalised at twice the rate of other females in these age groups.
- For both Indigenous males and females and other Australian males and females, hospitalisation rates for mental health related conditions were highest among those aged 25–34 years.
- Approximately 51% of Indigenous Australians hospitalised for mental health related conditions were males (5,767) and 49% were females (5,496).



Source: AIHW analysis of AIHW National Hospital Morbidity Database.

**Figure 1.17.1: Age-specific hospitalisation rates for a principal diagnosis of mental health related conditions, by Indigenous status and sex, Qld, WA, SA and NT, July 2002-June 2004**

## **Hospitalisations by state/territory**

Table 1.17.3 presents hospitalisations for a principal diagnosis of mental health related conditions for the two-year period July 2002 to June 2004 in Queensland, Western Australia, South Australia and the Northern Territory.

- In Western Australia and South Australia, Indigenous Australians were hospitalised for mental health related conditions at around three times the rate of other Australians in these states and territories, and in the Northern Territory, Indigenous Australians were hospitalised at around twice the rate of other Australians.
- In Queensland, Western Australia, South Australia and the Northern Territory combined, Indigenous males were hospitalised from mental health related conditions at around twice the rate of other Australians in these states and territories. Indigenous females were hospitalised at a slightly higher rate than that of other females.

**Table 1.17.3: Hospitalisations for principal diagnosis of mental health related conditions, by Indigenous status and sex, Qld, WA, SA and NT, July 2002–June 2004<sup>(a)(b)(c)</sup>**

	Indigenous				Other <sup>(d)</sup>				Ratio <sup>(h)</sup>
	Number	Rate per 1,000 <sup>(e)</sup>	LCL 95% <sup>(f)</sup>	UCL 95% <sup>(g)</sup>	Number	Rate per 1,000 <sup>(e)</sup>	LCL 95% <sup>(f)</sup>	UCL 95% <sup>(g)</sup>	
<b>Qld</b>									
Males	2,422	23.0	22.0	24.1	48,912	13.3	13.2	13.4	1.7*
Females	1,941	17.3	16.4	18.2	59,752	16.1	16.0	16.2	1.1*
Persons	4,363	20.0	19.3	20.7	108,664	14.7	14.6	14.8	1.4*
<b>WA</b>									
Males	1,942	34.0	32.3	35.8	21,130	11.3	11.1	11.4	3.0*
Females	1,964	31.6	30.1	33.2	28,824	15.2	15.0	15.4	2.1*
Persons	3,906	32.7	31.6	33.9	49,954	13.2	13.1	13.3	2.5*
<b>SA</b>									
Males	834	36.9	33.9	39.9	17,799	12.0	11.8	12.2	3.1*
Females	1,135	45.2	42.3	48.1	21,361	13.6	13.5	13.8	3.3*
Persons	1,969	41.0	39.0	43.1	39,160	12.8	12.7	13.0	3.2*
<b>NT</b>									
Males	569	10.3	9.3	11.3	889	5.9	5.5	6.3	1.7*
Females	456	7.8	7.0	8.7	487	3.8	3.4	4.2	2.1*
Persons	1,026	9.0	8.4	9.7	1,378	5.0	4.7	5.3	1.8*
<b>Qld, WA, SA &amp; NT<sup>(i)</sup></b>									
<b>Males</b>	5,767	24.3	23.5	25.0	88,730	12.4	12.3	12.4	2.0*
<b>Females</b>	5,496	21.3	20.6	21.9	110,424	15.1	15.1	15.2	1.4*
<b>Persons</b>	11,264	22.7	22.2	23.2	199,156	13.8	13.7	13.8	1.6*

\* Represents results with statistically significant differences in the Indigenous/other comparisons at the p<.05 level.

(a) Data are from public and most private hospitals. Data exclude private hospitals in the Northern Territory.

(b) Categories are based on the ICD-10-AM (National Centre for Classification in Health 2004); ICD-10-AM codes F00–F99, G30, G47.0, G47.1, G47.2, G47.8, G47.9, 099.3, R44, R45.0, R45.1, R45.4, R48, Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z50.2, Z50.3, Z54.3, Z61.9, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5, Z76.0.

(c) Financial year reporting.

(d) Other includes hospitalisations for non-Indigenous people and those for whom Indigenous status was not stated.

(e) Directly age standardised using the Australian 2001 Standard population.

(f) LCL = lower confidence limit.

(g) UCL = upper confidence limit.

(h) Rate ratio Indigenous:other.

(i) Data are reported by state/territory of usual residence of the patient hospitalised and are for Western Australia, South Australia, the Northern Territory and Queensland only. These four jurisdictions are considered to have adequate levels of Indigenous identification, although the level of accuracy varies by jurisdiction and hospital. Data for these four jurisdictions over-represent Indigenous populations in less urbanised and more remote locations. Hospitalisation data for four jurisdictions should not be assumed to represent the hospitalisation experience in the other jurisdictions.

Note: Person numbers and rates include hospitalisations for which sex was not stated.

Source: AIHW analysis of AIHW National Hospital Morbidity Database.

## **Hospitalisations by principal diagnosis**

### **Mental health related conditions**

Table 1.17.4 presents hospitalisations for a principal diagnosis of mental health related conditions for the two-year period July 2002 to June 2004 for Queensland, Western Australia, South Australia and the Northern Territory combined.

- Mental and behavioural disorders due to psychoactive substance use was the most common mental health related condition for which Aboriginal and Torres Strait Islander people were hospitalised (34%), followed by schizophrenia, schizotypal and delusional disorders (18%).
- Based on the hospitalisation rates of other males and females, in the four jurisdictions, there were four–five times as many hospitalisations from mental and behavioural disorders due to psychoactive substance use among Indigenous males and females as would be expected.
- Indigenous males and females were hospitalised from schizophrenia, schizotypal and delusional disorders at around three times the rate of other males and females.

### **Self-harm and assault**

- While self-harm and assault are not included amongst the mental health related conditions presented in this indicator, hospitalisations for these conditions may be mental health related. In 2002–03 to 2003–04 in the four jurisdictions, Indigenous males and females were hospitalised for assault at nine and 37 times the rate, and for self-harm at three times and twice the rate of other males and females respectively for these causes of hospitalisation (Table 1.17.5).

For more information on assault and self-harm see Measures 1.03 (Hospitalisations for injury and poisoning) and 2.12 (Community safety).

**Table 1.17.4: Hospitalisations of Indigenous persons for principal diagnosis of mental health related conditions, by type of condition and sex, Qld, WA, SA and NT, July 2002–June 2004<sup>(a)(b)(c)(d)</sup>**

Principal diagnosis	Males						Females						Persons <sup>(e)</sup>					
	No.	% <sup>(f)</sup>	Rate per 1,000 <sup>(g)</sup>	LCL 95% <sup>(h)</sup>	UCL 95% <sup>(i)</sup>	Ratio <sup>(j)</sup>	No.	% <sup>(f)</sup>	Rate per 1,000 <sup>(g)</sup>	LCL 95% <sup>(h)</sup>	UCL 95% <sup>(i)</sup>	Ratio <sup>(j)</sup>	No.	% <sup>(f)</sup>	Rate per 1,000 <sup>(g)</sup>	LCL 95% <sup>(h)</sup>	UCL 95% <sup>(i)</sup>	Ratio <sup>(j)</sup>
Mental & behavioural disorders due to psychoactive substance use (F10–F19)	2,434	42.2	10.9	10.4	11.4	4.6*	1,365	24.8	5.3	5.0	5.6	3.6*	3,799	33.7	7.9	7.6	8.2	4.1*
Schizophrenia, schizotypal and delusional disorders (F20–F29)	1,804	31.3	6.7	6.3	7.0	2.4*	1,193	21.7	4.4	4.2	4.7	2.4*	2,998	26.6	5.5	5.3	5.7	2.4*
Mood disorders (F30–F39)	600	10.4	2.6	2.3	2.8	0.8*	1,297	23.6	5.0	4.7	5.3	0.8*	1,897	16.8	3.8	3.7	4.0	0.8*
Neurotic, stress-related disorders (F40–F49)	511	8.9	2.1	1.8	2.3	0.9*	986	17.9	3.7	3.5	4.0	1.1*	1,497	13.3	2.9	2.8	3.1	1.0
Disorders of adult personality and behaviour (F60–F69)	125	2.2	0.5	0.4	0.6	2.0*	166	3.0	0.6	0.5	0.7	1.0	291	2.6	0.5	0.5	0.6	1.3*
Organic, including symptomatic, mental disorders (F00–F09)	94	1.6	1.0	0.7	1.2	1.7*	83	1.5	0.9	0.7	1.1	2.0*	177	1.6	0.9	0.8	1.1	1.9*
Behavioural and emotional disorders (F90–F98)	62	1.1	0.2	0.1	0.2	1.4*	28	0.5	0.1	0.0	0.1	1.4*	90	0.8	0.1	0.1	0.2	1.4*

(continued)

**Table 1.17.4 (continued): Hospitalisations of Indigenous persons for principal diagnosis of mental health related conditions, by type of condition and sex, Qld, WA, SA and NT, July 2002–June 2004<sup>(a)(b)(c)(d)</sup>**

Principal diagnosis	Males						Females						Persons <sup>(e)</sup>					
	No.	% <sup>(f)</sup>	Rate per 1,000 <sup>(g)</sup>	LCL 95% <sup>(h)</sup>	UCL 95% <sup>(i)</sup>	Ratio <sup>(j)</sup>	No.	% <sup>(f)</sup>	Rate per 1,000 <sup>(g)</sup>	LCL 95% <sup>(h)</sup>	UCL 95% <sup>(i)</sup>	Ratio <sup>(j)</sup>	No.	% <sup>(f)</sup>	Rate per 1,000 <sup>(g)</sup>	LCL 95% <sup>(h)</sup>	UCL 95% <sup>(i)</sup>	Ratio <sup>(j)</sup>
Behavioural syndromes assoc. with physiological disturbances (F50–F59)	6	0.1	0.0	0.0	0.1	1.0	41	0.7	0.1	0.1	0.2	0.3*	47	0.4	0.1	0.1	0.1	0.4
Disorders of psych. development (F80–F89)	14	0.2	0.0	0.0	0.0	0.5*	27	0.5	0.1	0.0	0.1	2.8*	41	0.4	0.0	0.0	0.1	1.2*
Unspecified mental disorder (F99)	18	0.3	0.1	0.0	0.1	5.9*	7	0.1	0.0	0.0	0.0	4.0*	25	0.2	0.0	0.0	0.1	5.2
Mental retardation (F70–F79)	14	0.2	0.1	0.0	0.2	3.0*	5	0.1	0.0	-0.1	0.2	0.8	19	0.2	0.0	-0.1	0.1	1.8*
Other <sup>(k)</sup>	85	1.5	0.3	0.2	0.4	0.7*	298	5.4	1.1	0.9	1.2	1.6*	383	3.4	0.7	0.6	0.8	1.3
<b>Total</b>	<b>5,767</b>	<b>100.0</b>	<b>24.3</b>	<b>23.5</b>	<b>25.0</b>	<b>2.0*</b>	<b>5,496</b>	<b>100.0</b>	<b>21.3</b>	<b>20.6</b>	<b>21.9</b>	<b>1.4*</b>	<b>11,264</b>	<b>100.0</b>	<b>22.7</b>	<b>22.2</b>	<b>23.2</b>	<b>1.6</b>

\* Represents results with statistically significant differences in the Indigenous/other comparisons at the p<.05 level.

(a) Data are from public and most private hospitals. Data exclude private hospitals in the Northern Territory.

(b) Categories are based on the ICD-10-AM (National Centre for Classification in Health 2004).

(c) Financial year reporting.

(d) Data are reported by state/territory of usual residence of the patient hospitalised and are for Western Australia, South Australia, the Northern Territory and Queensland only. These four jurisdictions are considered to have adequate levels of Indigenous identification, although the level of accuracy varies by jurisdiction and hospital.

(e) Includes hospitalisations for which sex was indeterminate or 'not stated'.

(f) Percentage of male, female and total hospitalisations of Indigenous people in the period 2002–03 to 2003–04.

(g) Directly age standardised using the Australian 2001 standard population.

(h) LCL = lower confidence limit.

(i) UCL = upper confidence limit.

(j) Rate ratio Indigenous:other.

(k) Other includes ICD-10-AM codes relating to mental health: G30, G47.0, G47.1, G47.2, G47.8, G47.9, O99.3, R44, R45.0, R45.1, R45.4, R48, Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z50.2, Z50.3, Z54.3, Z61.9, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5, Z76.0.

Source: AIHW analysis of AIHW National Hospital Morbidity Database.

**Table 1.17.5: Hospitalisations of Indigenous people for assault and self-harm, by sex, Qld, WA, SA and NT, July 2002–June 2004<sup>(a)(b)(c)(d)</sup>**

External cause	Males						Females						Persons <sup>(e)</sup>					
	No.	% <sup>(f)</sup>	Rate per 1,000 <sup>(g)</sup>	LCL 95% <sup>(h)</sup>	UCL 95% <sup>(i)</sup>	Ratio <sup>(j)</sup>	No.	% <sup>(f)</sup>	Rate per 1,000 <sup>(g)</sup>	LCL 95% <sup>(h)</sup>	UCL 95% <sup>(i)</sup>	Ratio <sup>(j)</sup>	No.	% <sup>(f)</sup>	Rate per 1,000 <sup>(g)</sup>	LCL 95% <sup>(h)</sup>	UCL 95% <sup>(i)</sup>	Ratio <sup>(j)</sup>
Assault (X85–Y09)	3,597	26.1	14.1	13.6	14.6	10.3*	4,259	37.1	14.8	14.3	15.2	47.2*	7,856	31.1	14.4	14.1	14.7	17.0*
Intentional self-harm (X60–X84)	642	4.7	2.3	2.1	2.5	2.4*	778	6.8	2.7	2.5	2.9	1.9*	1,420	5.6	2.5	2.4	2.7	2.1*

\* Represents results with statistically significant differences in the Indigenous/non-Indigenous comparisons at the p<.05 level.

- (a) Data are from public and most private hospitals. Data exclude private hospitals in the Northern Territory.
- (b) Categories are based on the ICD-10-AM (National Centre for Classification in Health 2004). Cause of injury is based on the first reported external causes where the principle diagnosis was 'injury, poisoning and certain other consequences of external causes'.
- (c) Financial year reporting.
- (d) Indigenous data are reported by state/territory of usual residence of the patient hospitalised and are for Western Australia, South Australia, the Northern Territory and Queensland only. These four jurisdictions are considered to have adequate levels of Indigenous identification, although the level of accuracy varies by jurisdiction and hospital. Data for these four jurisdictions over-represent Indigenous populations in less urbanised and more remote locations. Hospitalisation data for four jurisdictions should not be assumed to represent the hospitalisation experience in the other jurisdictions.
- (e) Includes hospitalisations for which sex was indeterminate or 'not stated'.
- (f) Percentage of male, female and total hospitalisations of Indigenous people in the period 2002–03 to 2003–04.
- (g) Directly age standardised using the Australian 2001 Standard population.
- (h) LCL = lower confidence limit.
- (i) UCL = upper confidence limit.
- (j) Rate ratio Indigenous:other.

Source: AIHW analysis of AIHW National Hospital Morbidity Database.

### **Average length of stay in hospital (days)**

- For the two-year period July 2002 to June 2004, the average length of stay in hospital due to mental health related conditions was eight days for Indigenous patients and six days for other patients (Table 1.17.6).
- On average, Indigenous males stayed in hospital for longer than Indigenous females for most types of mental and behavioural disorders.
- Mental retardation (disability characterised by significant limitations both in intellectual functioning and adaptive skills) was responsible for the highest number of bed days of all mental health related conditions (162 days for Indigenous patients and 142 days for other patients). Organic mental disorders (which include dementia, delirium and other mental disorders due to brain damage and dysfunction) and schizophrenia, schizotypal and delusional disorders were also responsible for a high number of days spent in hospital.
- Other mental health related conditions, including Alzheimer's disease and postnatal depression, were responsible for an average of four bed days for Indigenous patients and an average of seven bed days for other patients.

**Table 1.17.6: Average length of stay in hospital (days), mental health related conditions, by Indigenous status and sex, Qld, WA, SA and NT, July 2002–June 2004<sup>(a)(b)(c)(d)</sup>**

Mental health related condition	Indigenous			Other <sup>(e)</sup>		
	Males	Females	Persons	Males	Females	Persons
Mental retardation	217.9	5.0	161.8	183.6	94.6	141.7
Organic mental disorders	64.5	19.5	43.4	20.1	13.8	16.9
Schizophrenia, schizotypal and delusional disorders	17.8	15.1	16.7	15.3	14.9	15.1
Behavioural & emotional disorders with onset usually occurring in childhood & adolescence	10.8	12.4	11.3	5.8	3.7	5.1
Behavioural syndromes associated with psychological disturbances and physical factors	2.0	7.0	6.4	7.9	9.3	9.2
Mood disorders	7.4	5.6	6.2	4.1	3.4	3.7
Disorders of psychological development	8.5	1.9	4.1	8.2	4.7	7.2
Disorders of adult personality & behaviour	3.1	3.3	3.2	14.5	4.0	7.3
Mental disorders due to psychoactive substance use	3.0	2.4	2.8	2.6	2.2	2.5
Neurotic, stress-related and somatoform disorders	2.8	1.9	2.2	1.7	1.9	1.8
Unspecified mental disorder	1.1	0.4	0.9	2.0	5.5	3.3
<i>Total mental &amp; behavioural disorders</i>	<i>9.8</i>	<i>6.4</i>	<i>8.2</i>	<i>7.2</i>	<i>5.1</i>	<i>6.0</i>
Other mental health conditions	2.6	4.0	3.7	8.5	6.3	7.2
<b>Total</b>	<b>9.7</b>	<b>6.3</b>	<b>8.0</b>	<b>7.2</b>	<b>5.1</b>	<b>6.1</b>

(a) Data are from public and most private hospitals. Data exclude private hospitals in the Northern Territory.

(b) Categories are based on the ICD-10-AM (National Centre in Health Classification 2004); ICD-10-AM codes F00–F99, G30, G47.0, G47.1, G47.2, G47.8, G47.9, 099.3, R44, R45.0, R45.1, R45.4, R48, Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z50.2, Z50.3, Z54.3, Z61.9, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5, Z76.0.

(c) Financial year reporting.

(d) Data are reported by state/territory of usual residence of the patient hospitalised and are for Western Australia, South Australia, the Northern Territory and Queensland only. These four jurisdictions are considered to have adequate levels of Indigenous identification, although the level of accuracy varies by jurisdiction and hospital.

(e) Other includes hospitalisations of non-Indigenous people and those for whom Indigenous status was not stated.

Source: AIHW analysis of AIHW National Hospital Morbidity Database.

## Time series analysis

Hospitalisation rates, rate ratios and rate differences between Indigenous and other Australians for mental health related conditions over the five-year period 1998–99 to 2003–04 are presented in Table 1.17.7 and Figure 1.17.2.

- In Queensland, Western Australia, South Australia and the Northern Territory, there were significant increases in hospitalisation rates for mental health related conditions among Indigenous females during the period 1998–99 to 2003–04. The fitted trend implies an average yearly increase in the rate of around 0.7 per 1,000.
- There were significant declines in hospitalisation rates for mental health related conditions among other Australians over the same period with an average yearly decline in the rate of around 0.1 per 1,000. The declines in hospitalisation rates were significant for males but not for females.
- There were significant increases in both the hospitalisation rate ratios and rate differences between Indigenous and other Australians during the period 1998–99 to 2003–04. This reflects both a relative and absolute increase in the gap between hospitalisation rates of Indigenous and other Australians for mental health related conditions over the period 1998–99 to 2003–04.

It should be noted that changes in the level of accuracy of Indigenous identification in hospital records over this period will result in changes in the level of reported hospital separations for Indigenous Australians. Also, changes in access, hospital policies and practices all impact on the level of hospitalisation over time. Caution should be used in interpreting changes over time as it is not possible to ascertain whether a change in reported hospitalisation is due to changes in the accuracy of Indigenous identification or real changes in the rates at which Indigenous people are hospitalised. An increase in hospitalisation rates may reflect better hospital access rather than a worsening of health.

**Table 1.17.7: Age-standardised hospitalisation rates, rate ratios and rate differences from mental health related conditions, Qld, WA, SA and NT, 1998–99–2003–04**

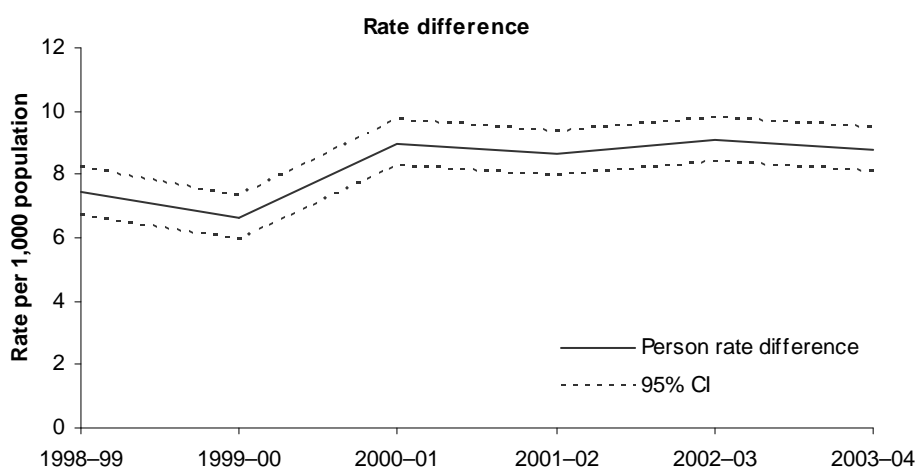
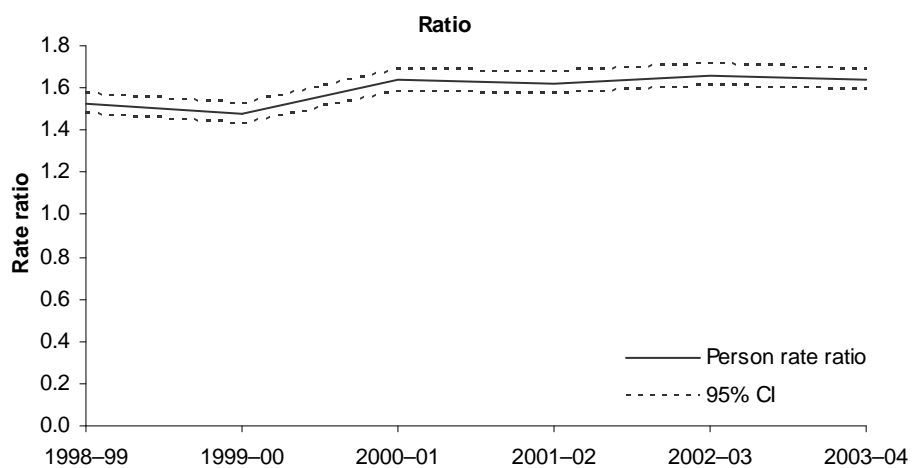
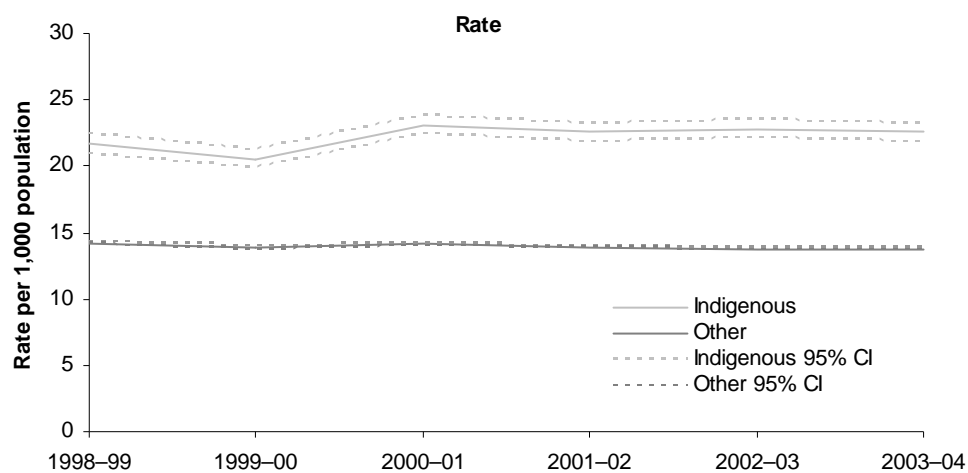
	1998–99	1999–00	2000–01	2001–02	2002–03	2003–04	Annual change <sup>(a)</sup>
<b>Indigenous rate per 1,000</b>							
Males	24.4	24.4	26.1	24.9	24.5	24.1	-0.1
Females	19.2	17.0	20.5	20.4	21.3	21.2	0.7*
Persons	21.7	20.5	23.1	22.5	22.8	22.6	0.3
<b>Other Australian<sup>(b)</sup> rate per 1,000</b>							
Males	13.6	12.9	13.2	13.1	12.4	12.3	-0.2*
Females	14.9	14.8	15.0	14.7	15.1	15.2	0.1
Persons	14.2	13.9	14.1	13.9	13.8	13.8	-0.1*
<b>Rate ratio<sup>(c)</sup></b>							
Males	1.8	1.9	2.0	1.9	2.0	1.9	0.03*
Females	1.3	1.1	1.4	1.4	1.4	1.4	0.04*
Persons	1.5	1.5	1.6	1.6	1.7	1.6	0.03*
<b>Rate difference<sup>(d)</sup></b>							
Males	10.8	11.5	12.8	11.8	12.1	11.7	0.2
Females	4.3	2.1	5.5	5.7	6.2	6.0	0.6*
Persons	7.5	6.6	9.0	8.7	9.1	8.8	0.4*

\* Represents results with statistically significant increases or decreases at the p<.05 level over the period 1998–99 to 2003–04.

- (a) Average annual change in rates, rate ratios and rate differences determined using linear regression analysis.
- (b) Includes hospitalisations for non-Indigenous Australians and those for whom Indigenous status was not stated.
- (c) Hospitalisation rates for Indigenous Australians divided by hospitalisation rates for other Australians.
- (d) Hospitalisation rates for Indigenous Australians minus hospitalisation rates for other Australians.

Note: Rates have been directly age standardised using the 2001 Australian standard population.

Source: AIHW analysis of AIHW National Hospital Morbidity Database.



Source: AIHW analysis of AIHW National Hospital Morbidity Database.

**Figure 1.17.2: Hospitalisation rates, rate ratios and rate differences between Indigenous and other Australians for mental health related conditions, Qld, WA, SA and NT, 1998-99 to 2003-04**

## Community mental health care services

Community mental health care is defined as care which is provided by specialised public mental health services dedicated to the assessment, treatment, rehabilitation and care of non-admitted clients. This excludes specialised mental health care services for admitted patients, support services that are not provided by specialised mental health care organisations, services provided by non-government organisations, and residential care services.

The number and rate of service contacts per 1,000 population for Aboriginal and Torres Strait Islander peoples varies among the states and territories. This may reflect variations in completeness of Indigenous identification among patients, varying coverage of service contacts for Aboriginal and Torres Strait Islander peoples or for the total population, or different patterns of service use by Indigenous and non-Indigenous persons.

- In 2003–04, there were 181,706 service contacts (3.7%) for clients of community mental health services who identified themselves as being of Aboriginal and/or Torres Strait Islander origin. This ranged from 1.3% for Victoria to 26.4% for the Northern Territory (AIHW 2005b).
- There were more service contacts per 1,000 population for Aboriginal and Torres Strait Islander peoples than for other Australians (413.9 per 1,000 and 243.6 per 1,000 respectively). This was true in all jurisdictions with the exception of the Northern Territory. These rates should be interpreted with caution as there is likely to be an underestimate of the actual number of service contacts for Indigenous clients.
- In 2003–04, Aboriginal and Torres Strait Islander people had higher proportions of mental health service contacts for the younger age groups than did other Australians, but lower proportions in the older age groups, reflecting the differences in age distribution in these populations (the mean age of Indigenous Australians is around 21 years compared to 36 years for non-Indigenous Australians). For example, 24% and 22% of service contacts for Indigenous Australian males and females were for clients aged between 15 and 24 years compared with 16% and 17% of service contacts for other Australian males and females (AIHW 2005b).
- In the older age groups, there were lower proportions of service contacts for Indigenous Australian males and females aged 65 years or more (1% and 3% respectively) than for other Australian males (7%) and females (15%).
- In 2003–04, Indigenous males and females had higher rates of community mental health care service contacts across all age groups except those aged less than 15 years. Differences were most marked in the 25–34 year and 35–44 year age groups where Indigenous males and females were twice as likely to be clients of community mental health care services than other Australians in these age groups.

For more information on community mental health services see Measure 3.08 (Access to mental health services).

## Mortality

- During the period 2000–2004, there were 8,143 deaths from mental health related conditions in Queensland, Western Australia, South Australia and the Northern Territory combined, 184 deaths (2.3%) of which were deaths of Aboriginal and Torres Strait Islander peoples; for 1.9% of deaths Indigenous status was ‘not stated’.
- Mental health related conditions (such as mental and behavioural disorders due to psychoactive substance use and organic mental disorders) were responsible for approximately 2.5% of all deaths of Aboriginal and Torres Strait Islander people.
- Mental and behavioural disorders are the twelfth most common cause of death among Aboriginal and Torres Strait Islander people, behind diseases of the circulatory system, external causes, cancer, endocrine, metabolic and nutritional disorders, diseases of the respiratory system, diseases of the digestive system, diseases of the genitourinary system, symptoms, signs and ill-defined conditions, certain conditions originating in the perinatal period, diseases of the nervous system and infectious and parasitic diseases.

## Mortality by age and sex

Table 1.17.8 presents age-specific mortality rates for mental health related conditions for the period 2000–2004 for Queensland, Western Australia, South Australia and the Northern Territory combined.

- Between 2000 and 2004, Indigenous Australians had twice the mortality rates as non-Indigenous Australians for mental health related conditions. Mortality rates for Indigenous males and females were higher across most age groups. Mortality rates were higher for males than for females across most age groups in both the Indigenous and non-Indigenous population.
- Differences were most marked in the 35–44 and 45–54 year age groups where Indigenous males died at between 10 and 14 times the rates of non-Indigenous males and Indigenous females died at between six and 11 times the rates of non-Indigenous females in these age groups. These differences in mortality rates are mainly the result of the high number of deaths due to mental and behavioural disorders due to psychoactive substance use among the Indigenous population in these age groups.
- Approximately 63% of Indigenous Australians who died from mental health related conditions were males (115 deaths) and 37% (69 deaths) were females.

**Table 1.17.8: Mental health related mortality rates per 100,000, by Indigenous status, age group and sex, Qld, WA, SA and NT, 2000–2004<sup>(a)(b)(c)(d)(e)(f)</sup>**

Age group (years)	Males			Females		
	Indigenous rate <sup>(g)</sup>	Non-Indigenous rate <sup>(g)</sup>	Rate ratio <sup>(h)</sup>	Indigenous rate <sup>(g)</sup>	Non-Indigenous rate <sup>(g)</sup>	Rate ratio <sup>(h)</sup>
Less than 1	—	3.1	—	—	3.3	—
1–4	4.1	0.8	5.4*	1.4	0.7	2.1*
5–14	0.5	—	—	1.2	—	—
15–24	6.0	1.2	5.2*	1.5	0.7	2.2*
25–34	15.8	2.0	7.9*	5.1	0.9	5.7*
35–44	23.1	2.4	9.6*	8.9	0.8	10.6*
45–54	46.3	3.3	14.1*	10.6	1.3	7.3*
55–64	51.2	6.8	7.5*	20.3	4.5	5.0*
65–74	102.5	31.5	3.3*	75.6	21.4	3.5*
75 and over	376.3	249.1	1.5	363.3	384.6	0.9
<b>Total<sup>(i)</sup></b>	<b>46.6</b>	<b>18.4</b>	<b>2.5*</b>	<b>32.2</b>	<b>24.5</b>	<b>1.3</b>

\* Represents results with statistically significant differences in the Indigenous/non-Indigenous comparisons at the p<.05 level.

(a) ICD-10 codes: F00–F99, G30, G47.0, G47.1, G47.2, G47.8, G47.9, O99.3, R44, R45.0, R45.1, R45.4, R48.

(b) Data are reported for Queensland, Western Australia, South Australia and the Northern Territory only. These four states and territories are considered to have adequate levels of Indigenous identification in mortality data. Data for these four jurisdictions over-represent Indigenous populations in less urbanised and more remote locations. Mortality data for four jurisdictions should not be assumed to represent the experience in the other jurisdictions.

(c) Data are presented in five-year groupings due to small numbers each year.

(d) There data exclude 155 registered deaths where the Indigenous status is not stated.

(e) While most deaths of Indigenous Australians are registered, it is likely that some are not accurately identified as Indigenous. Therefore, these statistics are likely to underestimate the Indigenous all causes mortality rate. It is also difficult to exactly identify the difference between the Indigenous and non-Indigenous mortality rates due to these data quality issues.

(f) Deaths are by year of occurrence except the latest year which is based on year of registration.

(g) Age-specific death rates per 100,000 using the average December populations for the relevant years.

(h) Rate ratio—rate for Indigenous divided by rate for non-Indigenous.

(i) Total includes age not stated. Total rates have been directly age standardised using the Australian 2001 Standard population.

Note: The completeness of identification of Indigenous deaths can vary by age.

Source: AIHW analysis of AIHW National Mortality Database.

## **Mortality by cause of death**

### **Mental health related conditions**

Deaths for the period 2000–2004 among Aboriginal and Torres Strait Islander people in Queensland, Western Australia, South Australia and the Northern Territory combined are presented in Table 1.17.9 by type of mental health related condition.

- For Indigenous males, the most common cause of death was from mental and behavioural disorders due to psychoactive substance (89 deaths or 48%). For Indigenous females it was organic mental disorders, which include dementia, delirium and other mental disorders due to brain damage and dysfunction (32 deaths or 17%).
- In the four jurisdictions combined, Indigenous males died from mental health related conditions at around three times the rate of other males. Indigenous females died from mental health related conditions at a slightly higher rate than other females.
- Indigenous males and females died from mental and behavioural disorders due to psychoactive substance use at 10 and seven times the rate of other males and females respectively.
- Indigenous Australians died from organic mental disorders, which include dementia, delirium and other mental disorders due to brain damage and dysfunction, at twice the rate of non-Indigenous Australians.

### **Assault and self-harm**

- In addition to the mental health related conditions presented here, there were 355 deaths of Aboriginal and Torres Strait Islander peoples due to self-harm (suicide) (4.7%) and 147 deaths of Aboriginal and Torres Strait Islander peoples due to assault (2.0%) in Queensland, Western Australia, South Australia and the Northern Territory between 2000 and 2004.
- Indigenous Australians died from self-harm and assault at two and 10 times the rate of non-Indigenous Australians for these causes of death respectively.
- Mental health related conditions, assault and self-harm together were responsible for 9.2% of all deaths of Indigenous Australians.

**Table 1.17.9: Deaths from mental health related conditions for Indigenous Australians, by sex, Qld, WA, SA and NT, 2000–2004<sup>(a)(b)(c)(d)(e)</sup>**

Cause of death	Males					Females					Persons				
	No.	Rate per 100,000 <sup>(f)</sup>	LCL 95% <sup>(g)</sup>	UCL 95% <sup>(h)</sup>	Ratio <sup>(i)</sup>	No.	Rate per 100,000 <sup>(f)</sup>	LCL 95% <sup>(g)</sup>	UCL 95% <sup>(h)</sup>	Ratio <sup>(i)</sup>	No.	Rate per 100,000 <sup>(f)</sup>	LCL 95% <sup>(g)</sup>	UCL 95% <sup>(h)</sup>	Ratio <sup>(i)</sup>
Mental and behavioural disorders due to psychoactive substances use (F10–F19)	89	27.7	20.4	35.0	9.7*	27	5.9	3.2	8.6	7.3*	116	15.8	12.2	19.3	8.8*
Organic, including symptomatic mental disorders (F00–F09)	17	15.2	7.6	22.8	1.7	32	20.4	13.1	27.7	1.6*	49	18.2	12.9	23.5	1.6*
Other <sup>(j)</sup>	9	3.7	0.3	7.0	0.6	10	5.9	2.0	9.8	0.6	19	5.0	2.3	7.7	0.6
<b>Total</b>	<b>115</b>	<b>46.6</b>	<b>35.5</b>	<b>57.7</b>	<b>2.5*</b>	<b>69</b>	<b>32.2</b>	<b>23.5</b>	<b>40.9</b>	<b>1.3</b>	<b>184</b>	<b>39.0</b>	<b>32.1</b>	<b>45.9</b>	<b>1.8*</b>

\* Represents results with statistically significant differences in the Indigenous/non-Indigenous comparisons at the p<.05 level.

- (a) Data are reported for Queensland, Western Australia, South Australia and the Northern Territory only. These four states and territories are considered to have adequate levels of Indigenous identification in mortality data. Data for these four jurisdictions over-represent Indigenous populations in less urbanised and more remote locations. Mortality data for four jurisdictions should not be assumed to represent the experience in the other jurisdictions.
- (b) Data are presented in five-year groupings due to small numbers each year.
- (c) These data exclude 314 registered deaths where the Indigenous status is not stated.
- (d) While most deaths of Indigenous Australians are registered, it is likely that some are not accurately identified as Indigenous. Therefore, these statistics are likely to underestimate the Indigenous all causes mortality rate. It is also difficult to exactly identify the difference between the Indigenous and non-Indigenous mortality rates due to these data quality issues.
- (e) Deaths are by year of occurrence except the latest year which is based on year of registration.
- (f) Directly age standardised using the Australian 2001 Standard population.
- (g) LCL = lower confidence limit.
- (h) UCL = upper confidence limit.
- (i) Rate ratio Indigenous:non-Indigenous.
- (j) Includes ICD-10 codes: F20–F99, G30, G47.0, G47.1, G47.2, G47.8, G47.9, O99.3, R44, R45.0, R45.1, R45.4, R48.

*Note:* It should be noted that different causes of death may have different levels of completeness of identification of Indigenous deaths that differ from the 'all cause' under-identification (coverage) estimates.

*Source:* AIHW analysis of AIHW National Mortality Database

## General practitioner encounters

Information about general practitioner encounters is available from the BEACH survey. Data for the five-year period 2000–01 to 2004–05 are presented below. Mental health related problems are among the top five most common types of problems managed at GP encounters with Aboriginal and Torres Strait Islander patients. The other four most common types of problems managed at GP encounters with Indigenous patients are respiratory conditions, skin problems, musculoskeletal conditions and circulatory conditions.

- In the period 2000–01 to 2004–05 there were 7,296 GP encounters with Aboriginal and Torres Strait Islander patients recorded in the survey, at which 10,955 problems were managed. Of these, 8.8% (971) were mental health related problems (Table 1.17.10).
- Depression was the most common mental health-related problem managed at GP encounters with Indigenous patients, followed by drug misuse (licit or illicit), anxiety and sleep disturbance.
- Mental health related problems were managed at a rate of 13.3 per 100 GP encounters with Indigenous patients.
- After adjusting for differences in age distribution, mental health-related problems were managed at GP encounters with Indigenous patients at a similar rate to encounters among other patients.
- Alcohol misuse was managed at GP encounters with Indigenous patients at around three times the rate of encounters with other patients. Drug misuse and tobacco misuse were managed at twice the rate of encounters with other patients.
- Schizophrenia was also more commonly managed at GP encounters with Indigenous patients than with other patients (at around twice the rate).

**Table 1.17.10: Most frequently reported mental health related problems managed by general practitioners, by Indigenous status of patient, 2000-01 to 2004-05<sup>(a)(b)(c)</sup>**

Problem managed	Number		% of total problems		Crude rate per 100 encounters						Age-standardised rate per 100 encounters <sup>(d)</sup>		
	Indigenous	Other <sup>(e)</sup>	Indigenous	Other <sup>(e)</sup>	Indigenous	95% LCL <sup>(f)</sup>	95% UCL <sup>(g)</sup>	Other <sup>(e)</sup>	95% LCL <sup>(f)</sup>	95% UCL <sup>(g)</sup>	Indigenous	Other <sup>(e)</sup>	Ratio <sup>(h)</sup>
Depression <sup>(i)</sup> (P03, P07)	241	19,166	2.2	2.7	3.3	2.7	3.9	4.1	4.0	4.2	3.2	4.1	0.8*
Drug abuse (P19)	112	2,527	1.0	0.3	1.5	1.0	2.1	0.5	0.5	0.6	1.2	0.5	2.2*
Anxiety <sup>(i)</sup> (P01, P74)	109	8,487	1.0	1.2	1.5	1.0	2.0	1.8	1.8	1.9	1.5	1.8	0.8*
Sleep disturbance (P06)	108	7,910	1.0	1.1	1.5	1.1	1.9	1.7	1.6	1.8	1.5	1.7	0.9
Alcohol misuse <sup>(i)</sup> (P15, P16)	84	1,750	0.8	0.2	1.2	0.8	1.5	0.4	0.3	0.4	1.0	0.4	2.6*
Schizophrenia (P72)	62	2,223	0.6	0.3	0.8	0.6	1.1	0.5	0.4	0.5	0.8	0.5	1.6*
Tobacco misuse (P17)	56	1,755	0.5	0.2	0.8	0.4	1.1	0.4	0.4	0.4	0.7	0.4	1.9*
Acute stress reaction (P02)	49	2,891	0.4	0.4	0.7	0.4	0.9	0.6	0.6	0.7	0.7	0.6	1.0
Affective psychosis (P73)	13	779	0.1	0.1	0.2	0.1	0.3	0.2	0.2	0.2	0.1	0.2	0.9
Dementia (P70)	10	2,234	0.1	0.3	0.1	0.1	0.2	0.5	0.4	0.5	0.4	0.5	0.9
Other <sup>(i)</sup>	127	6,777	1.2	0.9	1.7	1.3	2.2	1.5	1.4	1.5	1.5	1.5	1.0
<b>Total mental health</b>	<b>971</b>	<b>56,499</b>	<b>8.8</b>	<b>7.8</b>	<b>13.3</b>	<b>11.0</b>	<b>15.6</b>	<b>12.1</b>	<b>11.8</b>	<b>12.4</b>	<b>12.6</b>	<b>12.1</b>	<b>1.0</b>

\* Represents results with statistically significant differences in the Indigenous/other Australian comparisons at the p<.05 level.

(a) These survey results are likely to undercount the number of Indigenous Australians visiting doctors.

(b) Combined financial year data for five years.

(c) Data for Indigenous and Other Australians have not been weighted.

(d) Directly age-standardised rate per 100 encounters. Figures do not add to 100 as more than one problem can be managed at each encounter.

(e) Includes non-Indigenous patients and patients for whom Indigenous status was 'not stated'.

(f) LCL = lower confidence interval.

(g) UCL = upper confidence interval.

(h) Rate ratio Indigenous:other.

(i) Includes multiple ICPC-2 or ICPC-2 PLUS codes.

(j) ICPC-2 codes: P02, P04-P05, P08-P13, P18-P20, P22-P25, P27-P29, P71, P75-P82, P85-P86, P98-P99.

Source: AIHW analysis of BEACH data.

## **Additional information**

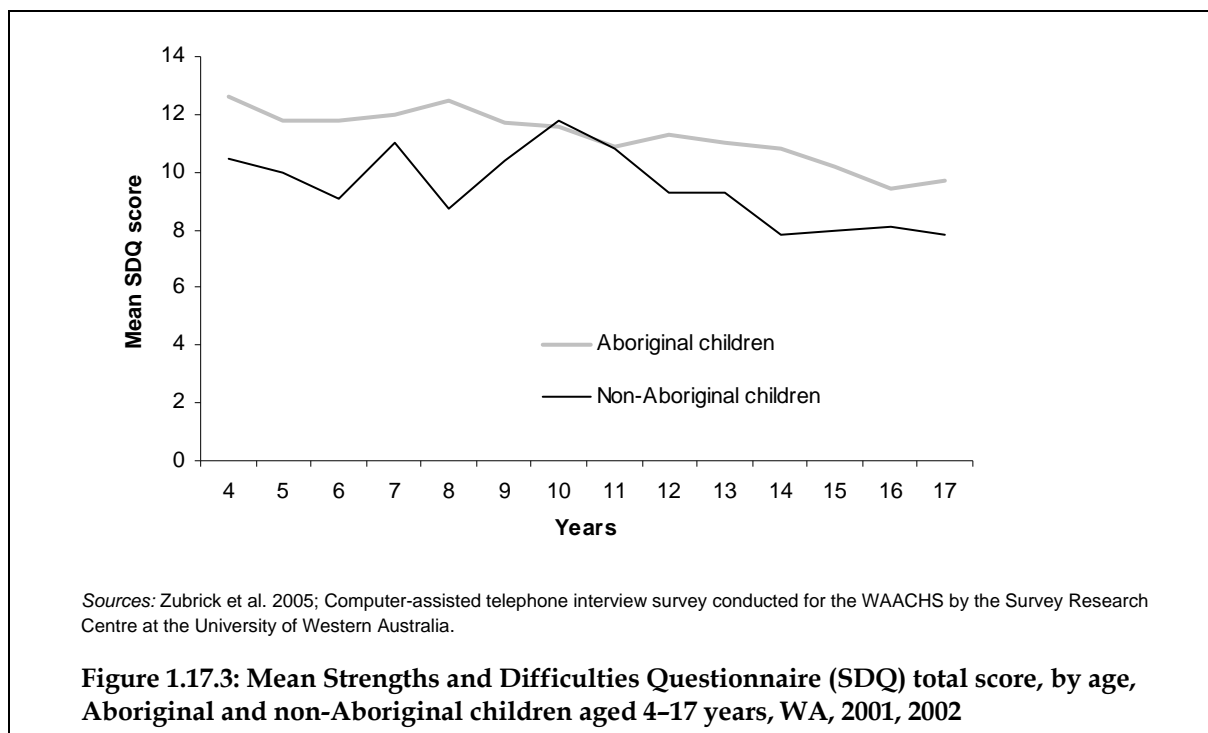
### **Social and emotional wellbeing of Aboriginal children**

The Western Australian Aboriginal Child Health Survey collected information on the social and emotional wellbeing of Aboriginal and a small number of Torres Strait Islander children over 2001 and 2002. It found that a variety of health conditions, social circumstances and behaviours experienced by individuals, their carers and families can have an impact on the social and emotional wellbeing of Indigenous children (Zubrick et al. 2005). Some of the findings from the survey are presented below. It should be noted that the term 'Aboriginal' is used here and in the survey but refers to both Aboriginal and Torres Strait Islander children.

### **Emotional and behavioural difficulties**

The Strengths and Difficulties Questionnaire (SDQ), used throughout the world to measure emotional and behavioural difficulties in children, was modified for Aboriginal children in the WAACHS. The SDQ comprises questions looking into emotional symptoms, conduct problems, hyperactivity, peer problems and pro-social behaviour.

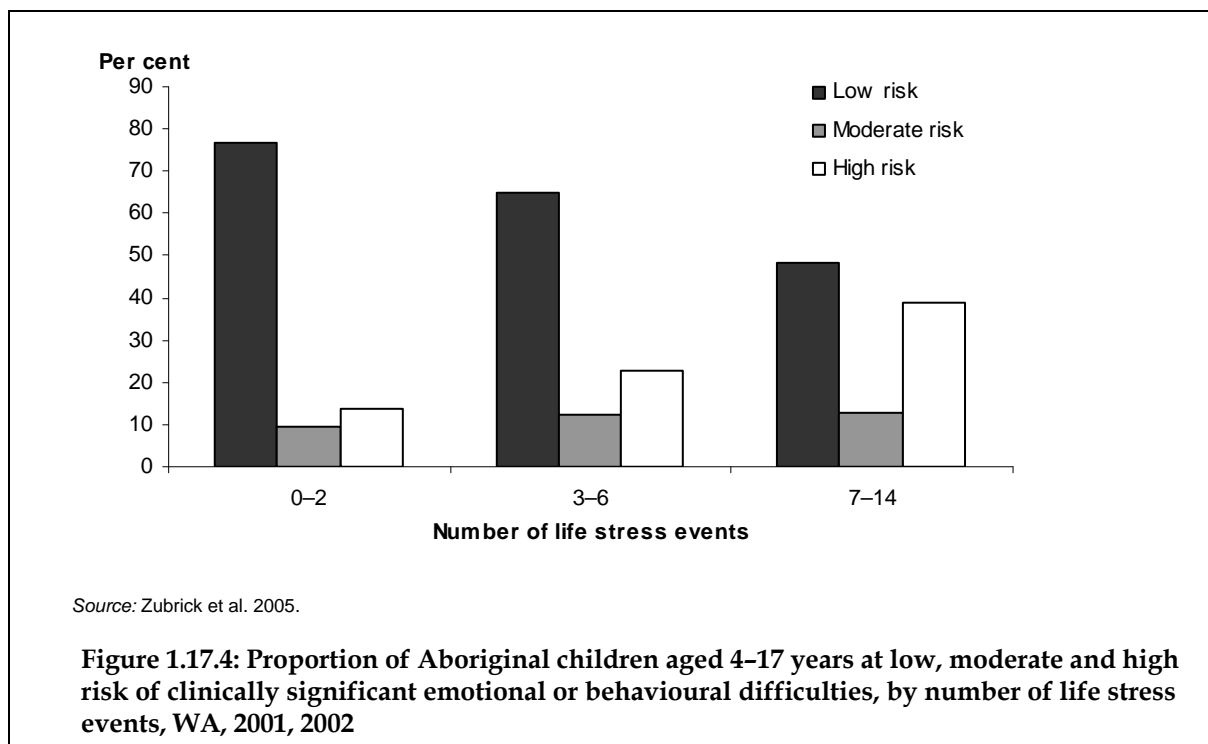
- Approximately 24% of Aboriginal children aged 4-17 years surveyed were assessed from the SDQ completed by their carers as being at high risk of clinically significant emotional or behavioural difficulties compared with 15% of other children (Zubrick et al. 2005).
- Aboriginal children had higher mean SDQ scores at all ages between 4 and 17 years except for ages 10 and 11 where mean scores were similar (Figure 1.17.3).
- Male Aboriginal children were twice as likely as female Aboriginal children to be at high risk of clinically significant emotional or behavioural difficulties.
- Those children living in areas of extreme isolation were less at risk than those living in urban areas.



### Family and household factors

The WAACHS looked at a range of family and household factors which could impact on the social and emotional wellbeing of children. Factors which were found to be associated with high risk of clinically significant emotional or behavioural difficulties in Aboriginal children included the number of stress events experienced by the family in the 12 months before the survey (such as illness, hospitalisation, death of a close family member, family break-up, arrests, job loss, financial difficulties), quality of parenting, family functioning and family care arrangements. Residential mobility, the physical health of the child (speech, hearing and vision problems), the physical health of the carer and the carer's use of mental health services were also associated with an increased risk of clinically significant emotional or behavioural difficulties in children.

- For example, around 22% of children aged 4–17 years in Western Australia were living in families where seven or more life stress events had occurred over the preceding 12 months. Of these children, 39% were at high risk of clinically significant emotional or behavioural difficulties compared to 14% of children in families where two or fewer life stress events had occurred (Figure 1.17.4).



- Around one-quarter of Aboriginal children were living in families with poor quality of parenting (measured by how often carers praised their children, hit or smacked their children and laughed together with their children) and one-fifth of children were living in families that functioned poorly (families with poor communication and decision making, poor emotional support, limited time spent together and poor family cooperation). These children were over twice as likely to be at high risk of emotional and behavioural difficulties as children living in families with very good quality of parenting or very good family functioning (Zubrick et al. 2005).

## Health risk factors

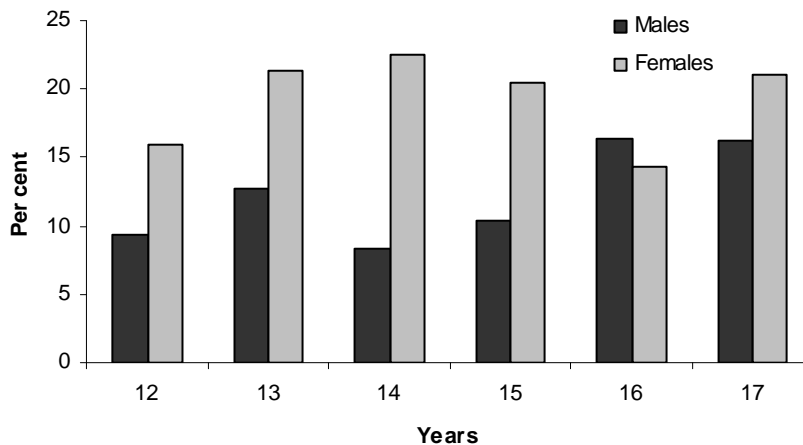
A number of health risk factors were also found to be associated with a high risk of clinically significant emotional and behavioural difficulties.

- An estimated 18% of Western Australian Aboriginal young people aged 12–17 years who smoked regularly were at high risk of emotional and behavioural difficulties compared with 7% of non-smokers.
- Approximately 29% of young people aged 12–17 years who used marijuana/cannabis daily were at risk of clinically significant emotional or behavioural difficulties compared with 9% of young people who had never used marijuana/cannabis. While Indigenous males were more likely to use marijuana than Indigenous females, particularly at aged 17 years (45% compared to 21%), Indigenous females who used marijuana/cannabis were more likely to be at risk of clinically significant emotional or behavioural difficulties than Indigenous males.
- Young people who did not participate in organised sport were twice as likely to be at high risk of emotional and behaviour difficulties compared with young people who did participate in sport (16% and 8% respectively).
- Those who had been subject to racism in the past six months were more than twice as likely to be at high risk of emotional and behavioural difficulties than those who had not experienced racism.

## Suicidal behaviour

An additional survey was administered by the Telethon Institute to Aboriginal young people aged 12–17 years to measure rates of suicidal thoughts and suicide attempts.

- Suicidal thoughts were reported by around one in six (16%) Western Australian Aboriginal people aged 12–17 years in the 12 months prior to the survey.
- Overall, a higher proportion of Aboriginal females reported they had seriously thought about ending their own life than Aboriginal males (20% compared to 12%). This was true for all ages from 12–17 years except for those aged 16 years where Indigenous males were more likely than females to report having thought about ending their own life (Figure 1.17.5).
- Of those who had suicidal thoughts in the 12 months prior to the survey, 39% reported they had attempted suicide in the same period. This finding is similar to the proportion of the general young population aged 12–16 years who reported suicide attempts in the 1993 Western Australian Child Health Survey (Zubrick et al 2005).
- Aboriginal young people who had been exposed to family violence were more than twice as likely to have thought about ending their own life (22%) as Aboriginal young people who had not been exposed to family violence (9%).
- A higher proportion of Aboriginal males reported they had thought about ending their own life if they had low self-esteem (21%) than if they had high self-esteem (5%).
- Suicidal thoughts were associated with a number of health risk behaviours. The proportion of Aboriginal children who reported suicidal thoughts was significantly higher among those who smoked regularly, used marijuana, drank to excess in the six months prior to survey, were exposed to some form of family violence and who had a friend who had attempted suicide.



Source: Zubrick et al. 2005.

**Figure 1.17.5: Proportion of Aboriginal young people who had seriously thought about ending own life, by sex and age, WA, 2001, 2002**

### Effects of forced separation

- Children of Aboriginal carers who had been forcibly separated from their natural family by past removal policies and practices or removed from country to a welfare institution or a mission were twice as likely to be at high risk of clinically significant emotional or behavioural difficulties as children whose primary carer had not been forcibly separated from their natural family. These children also had higher rates of conduct and hyperactivity problems.
- Children whose primary carers had been forcibly separated from their natural families were over one and a half times as likely to be at high risk of clinically significant conduct problems and two and a half times as likely to be at high risk of clinically significant hyperactivity problems (Zubrick et al. 2005).

## **Data quality issues**

### **National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and National Aboriginal and Torres Strait Islander Social Survey (NATSISS)**

*The NATSIHS and NATSISS both use the standard Indigenous status question. The survey samples were specifically designed to select a representative sample of Aboriginal and Torres Strait Islander Australians and thus overcome the problem inherent in most national surveys with small and unrepresentative Indigenous samples. As with other surveys, the NATSIHS and NATSISS are subject to sampling and non-sampling errors. Calculations of standard errors and significance testing help to identify the accuracy of the estimates and differences.*

*Information recorded in these surveys are essentially 'as reported' by respondents. The ABS makes every effort to collect accurate information from respondents, particularly through careful questionnaire design, pre-testing of questionnaires, use of trained interviewers and assistance from Indigenous facilitators. Nevertheless, some responses may be affected by imperfect recall or individual interpretation of survey questions.*

*Non-Indigenous comparisons are available through the National Health Survey (NHS) and the 2002 General Social Survey. The NHS was conducted in major cities, regional and remote areas, but very remote areas were excluded from the sample. Time series comparisons are available through the 1995 and 2001 National Health Surveys and the 1994 National Aboriginal and Torres Strait Islander Survey.*

*In remote communities there were some modifications to the NATSIHS and NATSISS content in order to address language and cultural appropriateness in traditional communities, as well as to assist respondents in understanding the concepts. Some questions were excluded and some reworded. Also, paper forms were used in communities in remote areas and computer-assisted interview (CAI) instruments were used in non-remote areas. The CAI process included built in edit checks and sequencing.*

*Further information on NATSIHS and NATSISS data quality issues can be found in the national publications (ABS 2004a, 2006a).*

### **Western Australian Aboriginal Child Health Survey (WAACHS)**

*Survey data are subject to sampling and non-sampling errors. Confidence intervals are published with the data to provide a guide to the reliability of the estimates. Non-sampling errors can occur in surveys due to questionnaire design problems, respondent difficulty recalling information/lack of appropriate records, and errors made in the recording and processing of the data. Every effort was made to minimise non-sample errors in this survey.*

### **General practitioner data (BEACH)**

*Information about general practitioner encounters is available from the BEACH survey. The BEACH data on Indigenous Australians should be treated with care. First, the sample frame has not been designed to produce statistically significant results for population subgroups such as Indigenous Australians. Second, the identification of Indigenous Australians is not complete. In the BEACH survey 'not stated' responses to the Indigenous identification question are often higher than the 'yes' responses. It can be assumed, therefore, that the survey consistently undercounts the number of Indigenous Australians visiting general practitioners, but the extent of this undercount is not measurable.*

*(continued)*

## **Data quality issues (continued)**

### **Hospital separation data**

#### ***Separations***

*The number and pattern of hospitalisations can be affected by differing admission practices among the jurisdictions and from year to year, and differing levels and patterns of service delivery. In terms of mental health service delivery, there are a number of different service delivery models ranging from ambulatory care in community mental health services and hospitals and non-ambulatory care in hospitals and residential services.*

#### ***Indigenous status question***

*Some jurisdictions have slightly different approaches to the collection and storage of the standard Indigenous status question and categories in their hospital collections. The not stated category is missing from several collections. It is recommended that the standard wording and categories be used in all jurisdictions (AIHW 2005).*

#### ***Under-identification***

*The incompleteness of Indigenous identification means the number of hospital separations recorded as Indigenous is an underestimate of hospitalisations of Aboriginal and Torres Strait Islander people. While the identification of Indigenous people in hospitalisations is incomplete in all states and territories, four jurisdictions (Queensland, Western Australia, South Australia and the Northern Territory) have been assessed as having adequate identification in 2003–04 (AIHW 2005a). It has therefore been recommended that reporting of Indigenous hospital separations be limited to aggregated information from Queensland, Western Australia, South Australia, and the Northern Territory. The proportion of the Indigenous population covered by these four jurisdictions is 60%. The following caveats have also been recommended:*

- *Interpretation of results should take into account the relative quality of the data from the jurisdictions included (currently a degree of Indigenous under-identification in Western Australia and relatively marked Indigenous under-identification in Queensland data).*
- *Data for these four jurisdictions over-represent Indigenous populations in less urbanised and more remote locations.*
- *Hospitalisation data for four jurisdictions should not be assumed to represent the hospitalisation experience in other jurisdictions (ABS & AIHW 2005).*

#### ***Numerator and denominator***

*Rate and ratio calculations rely on good numerator and denominator data. The changes in the completeness of identification of Indigenous people in hospital records may take place at different rates than changes in the identification of Indigenous people in other administrative collections and population Censuses. Denominators used here are sourced from ABS's Experimental estimates and projections: Aboriginal and Torres Strait Islander Australians 1991 to 2009 (ABS 2004b).*

### **Community Mental Health Care Database**

*The quality of the Indigenous identification in this database varies by jurisdiction.*

*The number and rate of service contacts per 1,000 population for Aboriginal and Torres Strait Islander peoples vary among the states and territories. This may reflect variations in completeness of Indigenous identification among patients or different patterns of service use by Indigenous and non-Indigenous persons.*

*(continued)*

## **Data Quality issues (continued)**

*All states and territories use the standard ABS question of Indigenous status. For a number of jurisdictions, the National Community Mental Health Care Database (NCMHCD) data reported for the 'Both Aboriginal and Torres Strait Islander' category are suspected to be affected by misinterpretation of the category to include non-Aboriginal and Torres Strait Islander peoples (for example, Maoris and South Sea Islanders) and use of the category as 'Indigenous, not further specified'.*

*All state and territory health authorities provided information on the quality of the data for the NCMHCD 2003–04. Only Western Australia, Tasmania and the Northern Territory reported that the quality of their data was acceptable.*

## **Mortality data**

### **Deaths**

*The mortality rate for Indigenous Australians can be influenced by identification of Indigenous deaths, late registration of deaths, and changes to death forms and/or processing systems. Due to the small size of the Indigenous population these factors can significantly impact on trends over time and between jurisdictions.*

### **Indigenous status question**

*All jurisdictions comply with the standard wording for the Indigenous status question and categories for their death registration forms. However, New South Wales, Victoria, South Australia, the Northern Territory and the Australian Capital Territory all have slightly different wording to the national standard for the instruction on those with both Aboriginal and Torres Strait Islander origin (ABS & AIHW 2005). While the wording is only slightly different, it would be ideal to have all jurisdictions asking the question in exactly the same way.*

### **Under-identification**

*Almost all deaths in Australia are registered. However the Indigenous status of the deceased is not always recorded, or recorded correctly. The incompleteness of Indigenous identification means the number of deaths registered as Indigenous is an underestimate of deaths occurring in the Aboriginal and Torres Strait Islander population (ABS 1997). As a result, the observed differences between Indigenous and non-Indigenous mortality are under-estimates of the true differences.*

*While the identification of Indigenous deaths is incomplete in all state and territory registration systems, four jurisdictions (Queensland, Western Australia, South Australia and the Northern Territory) have been assessed by the ABS and the AIHW as having adequate identification. Longer term mortality trend data are limited to three jurisdictions (Western Australia, South Australia and the Northern Territory) with 10 years of adequate identification of Indigenous deaths in their recording systems. The quality of the time series data is also influenced by the late inclusion of a not stated category for Indigenous status in 1998. Prior to this time, the not stated responses were probably included with the non-Indigenous. The ABS calculated the implied coverage (identification) of Indigenous deaths for the period 2000–2004 using population estimates: New South Wales – 46%, Victoria – 35%, Queensland – 53%, South Australia – 66%, Western Australia – 72%, the Northern Territory – 94%, Tasmania and the Australian Capital Territory were not calculated due to small numbers, Australia – 57% (ABS 2005).*

*It should be noted that different causes may have different levels of under-identification that differ from the 'all cause' coverage estimates. It should also be noted that the quality of the cause of death data depends on every step of the process of recording and registering deaths (including the documentation available at each step of the process) from certification to coding of cause of death.*

*(continued)*

### **Data Quality issues (continued)**

*There are also current concerns about data quality for causes of death especially relating to external causes of death to all Australians (not just Indigenous) (ABS 2006b).*

#### ***Numerator and denominator***

*Rate and ratio calculations rely on good numerator and denominator data. The changes in the completeness of identification of Indigenous people in death records may take place at different rates than changes in the identification of Indigenous people in other administrative collections and population censuses. Denominators used here are sourced from the ABS's Experimental estimates and projections: Aboriginal and Torres Strait Islander Australians 1991 to 2009 (ABS 2004b).*

#### ***Cause of death coding***

*Causes of death based on the tenth revision of the ICD-10. Mortality coding using ICD-10 was introduced into Australia from 1 January 1997.*

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