

Appendix 1

Depression in Australia: indicator-based reporting

This appendix provides statistical information on depression using a set of indicators. The statistical information provided is limited to meet the data requirements for each indicator, although the interpretation offered is somewhat broader than the design of the indicator would suggest. This is in accordance with the basic tenet of indicator-based reporting.

What are indicators?

Indicators are conceptual conveniences, ways to extract information from available data for enhanced interpretation and utility. However, the quality and usefulness of indicator-based reporting is enhanced further by establishing a defined set of indicators across the continuum of care, an approach favoured in NHPA monitoring and reporting. The purpose in selecting a defined set is twofold: to organise the wide-ranging information into manageable size, and to ensure that the best information is always extracted and reported.

The format

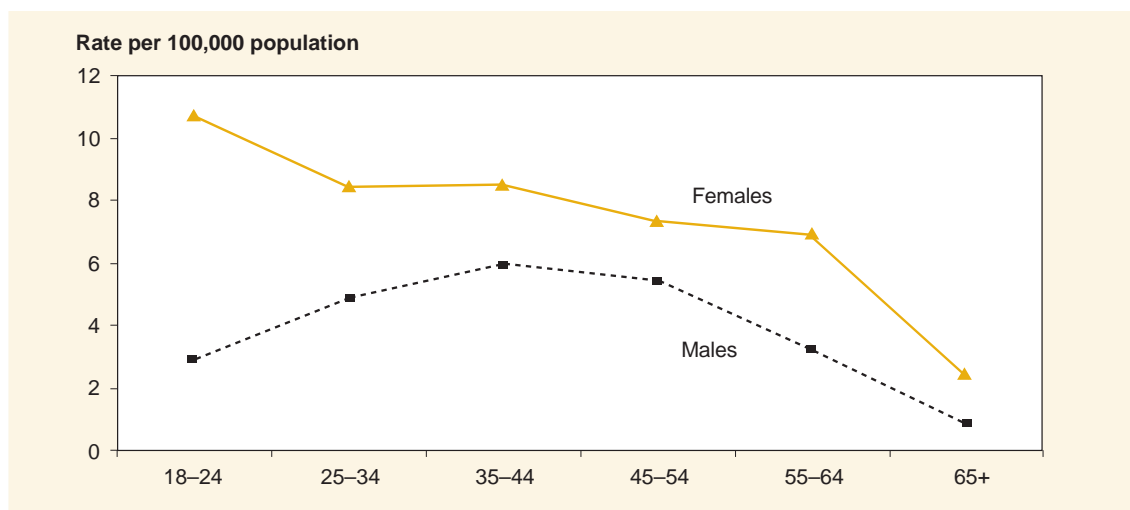
The dot point format used for indicator-based reporting here is simple and to the point, aimed at providing a clear interpretation of the results. Where possible, time series and collateral information is included to enhance the interpretability of the results. Data issues specific to each indicator have also been described.

No attempt has been made to discuss the health issues in a comprehensive manner. It is recommended that this appendix be read in conjunction with overviews of the epidemiology of mental health in general and depression in particular, given in Chapters 1 and 2, respectively. For detailed statistical and data issues, also see Appendix 2.

While considerable progress has been made in developing and reporting indicators for other NHPAs, this is the first time that information has been put together for depression in this format. The quality and comparability of much of the data presented here is variable. These problems, with appropriate caveats, are discussed throughout the appendix. The readers are nonetheless urged to build in these caveats in interpreting the results.

Appendix 1

Indicator 1.2: Prevalence rates for depressive disorders



Population group	Age group (years)						Total
	18-24	25-34	35-44	45-54	55-64	65 and over	
Males	2.9	4.9	6.0	5.4	3.2	0.8	4.2
Females	10.7	8.4	8.5	7.3	6.9	2.4	7.4
Persons	6.7	6.6	7.2	6.4	5.0	1.7	5.8

Notes: Includes all affective disorders.

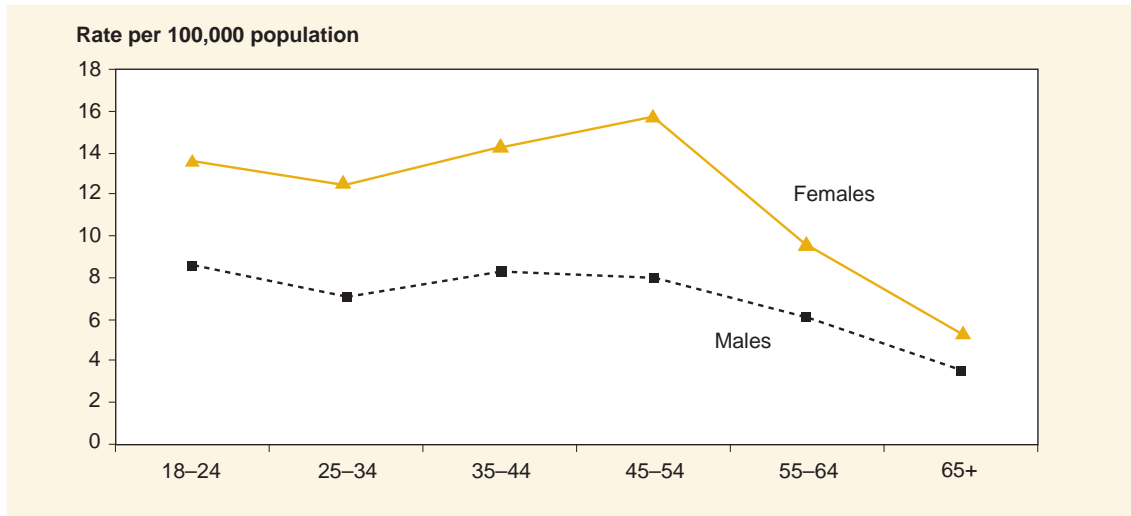
Based on data for persons aged 18 years and over only.

Source: 1997 National Survey of Mental Health and Wellbeing: Adult Component, Australian Bureau of Statistics (1998).

- This indicator has been designed to provide a comparative picture of the prevalence of depressive disorders in Australia.
- Overall males have a lower prevalence rate of depressive disorders compared to females. The age-standardised prevalence rate among females over the age of 18 years is 76 per cent higher than their male counterparts.
- While the prevalence rate ratio varies with age, the male rate remains consistently lower than the female rate across all age groups. In 1997, the female rate is almost four times higher than the male rate in the age group 18-24 years, but declined to less than 37 per cent higher in the age group 45-54 years.
- The prevalence rate for depressive disorders among females declines consistently over the life-time although the decline is much slower between the ages of 25 and 54 years. The male rate, on the other hand, increases to peak in the age group 35 to 44 years before declining.
- Strong associations exist between major depressive disorders, other affective disorders and substance use disorders (ABS 1998, Burvill 1995). According to the 1997 SMHWB, over half the people with an affective disorder or depressive disorder also have an anxiety disorder (ABS 1998).

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Indicator 1.3: Prevalence rates for anxiety disorders



Population group	Age group (years)						Total
	18-24	25-34	35-44	45-54	55-64	65 and over	
Males	8.6	7.1	8.3	8.0	6.1	3.5	7.1
Females	13.8	12.4	14.5	15.9	9.5	5.4	12.1
Persons	11.2	9.8	11.4	11.9	7.8	4.5	9.7

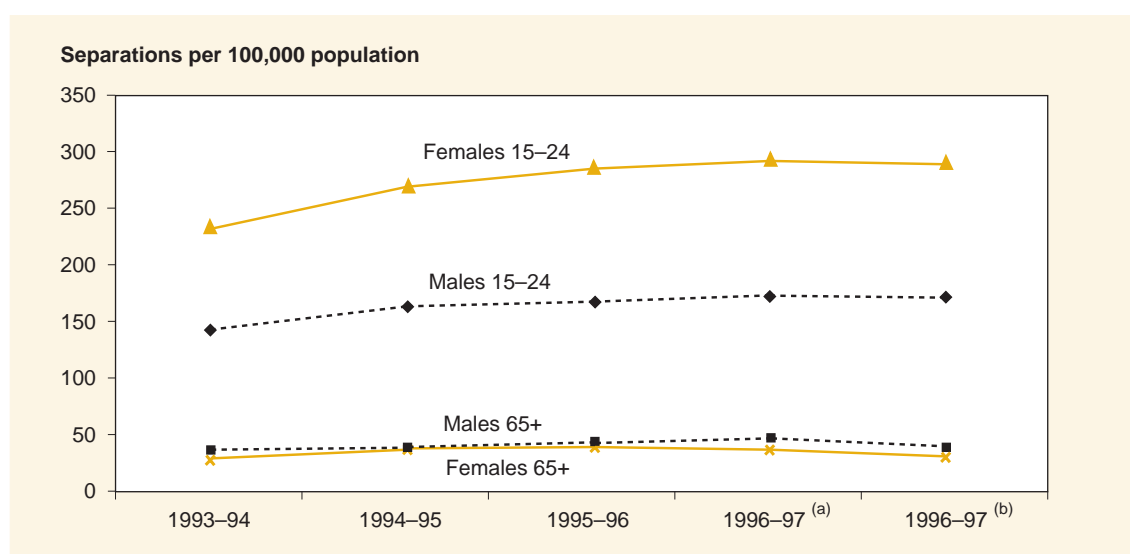
Note: Based on data for persons aged 18 years and over only.

Source: 1997 National Survey of Mental Health and Wellbeing: Adult Component, Australian Bureau of Statistics (1998).

- This indicator has been designed to provide a comparative picture of the prevalence of anxiety disorders in Australia.
- Overall, males have a lower prevalence rate for anxiety disorders compared to females. The age-standardised prevalence rate among females over the age of 18 years is 70 per cent higher than their male counterparts.
- While the overall patterns of age-specific distributions of the prevalence are similar in the two sexes, the female rate was found to be almost double the male rate in the age group 45-54 years in 1997.
- According to the 1997 SMHWB, over half the people with an affective disorder or depressive disorder also have an anxiety disorder (ABS 1998). However, the pattern of age-specific distribution for the two types of disorders is not the same among females.
- Over half the people with an affective or depressive disorder also have an anxiety disorder (ABS 1998).

Appendix 1

Indicator 2.1: Hospital separations for suicide and self-inflicted injury among young adults aged 15–24 years, and older people aged 65 years and over



Age group	Sex	Year				
		1993–94	1994–95	1995–96	1996–97 ^(a)	1996–97 ^(b)
Young adults (15–24 years)	Males	142.4	162.0	163.1	171.9	167.8
	Females	235.6	271.4	287.4	297.5	290.6
Older people (65 years and above)	Males	38.0	40.9	41.8	44.5	40.8
	Females	30.4	38.3	38.1	36.8	34.2

(a) In 1996–97 multiple diagnoses were recorded. These figures are only based on the principal external cause to make them comparable with the previous years in this table.

(b) Checking all diagnoses but only counting once for each separation, ie if a record was coded as poison and gunshot then the record would only be counted once.

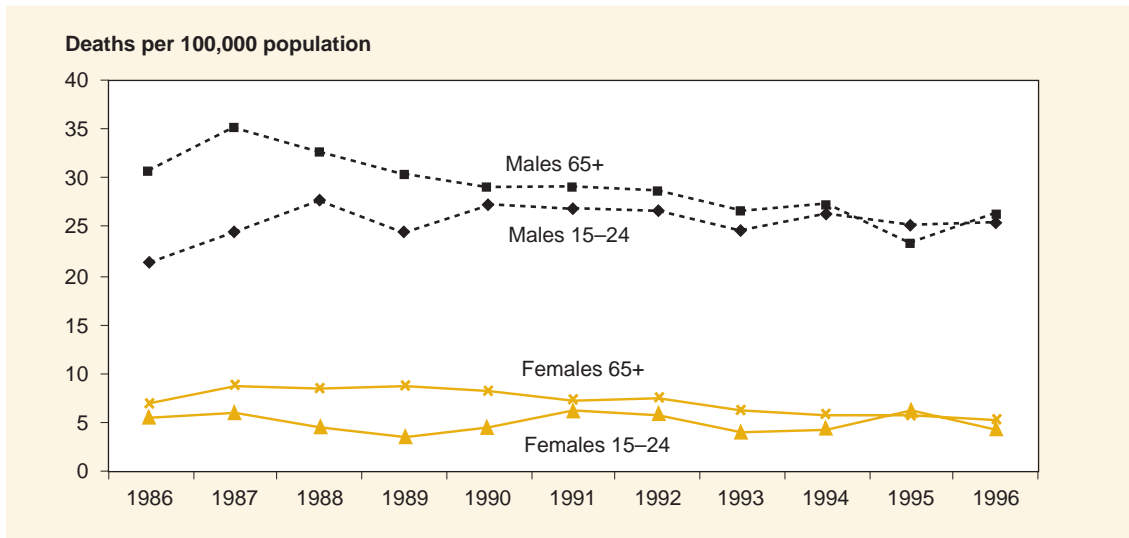
Note: Rates, given as separations per 100,000 persons, were standardised to the Australian population at 30 June 1991.

Source: AIHW National Hospital Morbidity Database.

- Suicides and self-inflicted injury are often expressions of breakdowns in social integration and cohesion. Trends in suicide attempts provide some indication of changes in the pattern of mental health status of the population.
- This indicator has been designed to provide a comparative picture of suicide and self-inflicted injury between the two sexes in the age groups 15–24 years and older people aged 65 years and over.
- The hospital separation rate for suicide and self-inflicted injury for females aged 15–24 years is consistently higher, from 1993–94 to 1996–97, compared to males in the same age group.
- In contrast, the separation rates in the older age group (65 years and above) indicate a marginally higher proportion of males compared to females.
- The younger age group shows higher hospital separation rate for suicide and self-inflicted injury compared to the older age group in both sexes.
- The age-standardised rates were more than four times higher among young males and more than eight higher among young females in 1996–97 in comparison with those aged 65 years and over.

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Indicator 2.2: Death rates for suicide among young adults (15–24 years) and older people (65 years and over)



Age group	Sex	Year										
		1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Young adults (15–24 years)	Males	21.3	24.7	28.2	24.1	27.3	26.8	26.8	24.5	26.7	25.0	25.5
	Females	5.4	6.0	4.5	3.5	4.4	6.3	5.7	4.0	4.2	6.3	4.3
Older people (65 years and over)	Males	30.7	35.5	32.7	30.1	29.1	29.0	28.8	26.4	26.9	23.4	26.1
	Females	7.0	8.7	8.4	8.6	8.1	7.2	7.5	6.2	5.6	5.7	5.2

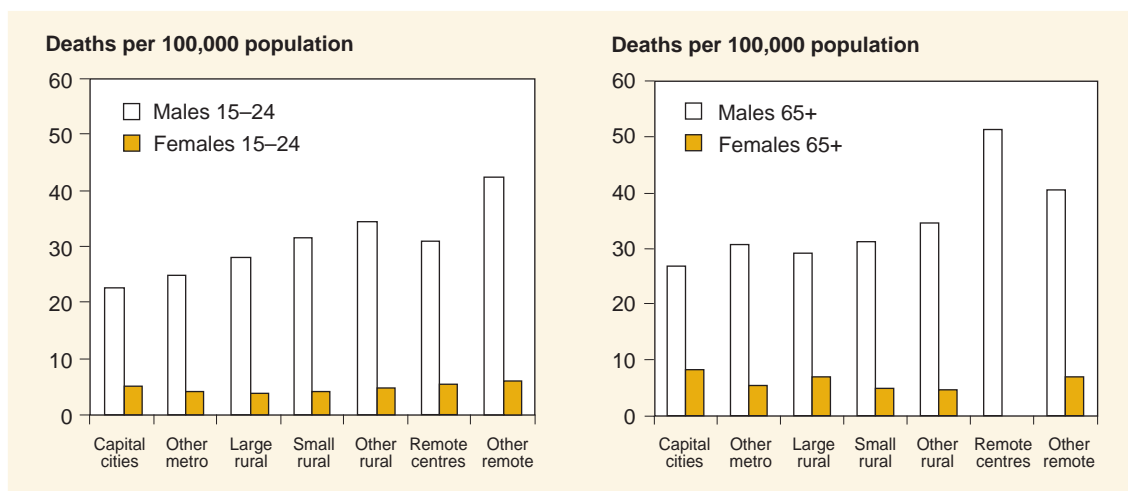
Note: Rates, given as deaths per 100,000 persons, were standardised to the Australian population at 30 June 1991.

Source: AIHW National Mortality Database.

- This indicator has been designed to provide a comparative picture of suicide rates in the two sexes in two different age groups.
- Suicide rates are known to be strongly associated with age. High-risk groups for suicide are young men between the ages of 15 and 24 years and older men aged 65 years and over.
- The suicide rates are higher among males than females in both the age groups. In 1996, the death rate ratio was almost six times higher in the age group 15–24 years, and more than five times higher among those aged 65 years and over when compared to females.
- Suicide rates are consistently higher for males in the two groups compared to females. However, females aged 65 years and over have a slightly greater risk of suicide than younger females aged 15–24 years.
- Consistent declines in suicide rates are apparent among both males and females among those aged 65 years and over, since 1987. However, no such trends are noted in the younger age group.
- More people attempt than complete suicide; mortality data may underestimate the incidence of self-harm. This information therefore should be interpreted in conjunction with the hospital separation data for suicide and self-inflicted injury.

Appendix 1

Indicator 2.3: Death rates for suicide in rural and remote areas among young adults (15–24 years) and older people (65 years and over)



Age group	Sex	Metropolitan zone		Rural zone			Remote zone	
		Capital cities	Other metro	Large centres	Small centres	Other rural	Remote centres	Other remote centres
Young adults (15–24 years)	Males	22.7	24.9	27.9	31.5	34.4	31.0	42.5
	Females	5.2	4.1	4.0	4.1	4.8	5.5	6.1
Older people (65 years and over)	Males	26.7	30.7	29.2	31.1	34.4	51.1	40.4
	Females	8.2	5.5	6.9	4.9	4.6	0.0	6.8

Note: Rates, given as deaths per 100,000 persons, were standardised to the Australian population at 30 June 1991.

Source: AIHW National Mortality Database.

- This indicator has been designed to understand the mortality of depression in rural and remote Australia in comparison to that in metropolitan areas, with particular emphasis on those in the age groups 15–24 years and 65 years and over. Suicide rate has been used as an indicator on the assumption that depression is a significant contributor to suicide. Mortality data for the period 1986–96 were pooled to generate the estimates.
- Suicide rates are higher among those living in remote areas, which in turn, are higher than the rates in metropolitan areas, in both age groups. Overall, a progressive increase in the rate is noted as one travels away from larger cities.
- While suicide rates are generally comparable among young adult and older males across various RRMA areas, the rates are much higher among older males living in remote areas.
- Younger females have an overall lower risk of suicide compared to older females except in other rural areas and remote centres.

Appendix 2

Data and statistical issues

This appendix provides an overview of the gaps and deficiencies in national mental health-related data collections, as well as technical information to assist in the interpretation of demographic and statistical methods used in the report. Data and statistical issues about specific aspects of mental health have been discussed in relevant sections of the report. However, there are several common issues, relating mostly to the nature and quality of data, their comparability, availability, gaps and deficiencies, that are described more generally here. Notes on demographic and statistical procedures—age-standardisation, estimation of rates and ratios, etc.—have also been assembled here for easy reference.

NHPA's *goals and targets* approach has some definite requirements for the range of information collected, and its analysis. The adoption of a set of defined indicators not only necessitates the development of operational definitions, standardised data elements and establishment of baselines, but also appropriate time-series information for trend monitoring. In some cases, data collections may need to be tailored to meet the monitoring requirements, or new data collections instituted if required.

Information on NHPA indicators of depression has been presented in this report for the first time. Several data definition and collection issues however still need to be carefully resolved. This appendix briefly touches upon some of these issues. For a general discussion of sources, developments and deficiencies of Australian health statistics, see *Australia's Health 1998* (AIHW 1998a).

Data issues

Data sources

Sources of data for monitoring mental health are wide and varied. Many of the data collections that may be used for monitoring are by-products of administrative collections (for example, deaths and hospital separations). Other collections are specifically designed to monitor the prevalence of mental disorders and associated complications. However, most of the latter collections are not national in scope or coverage.

Statistical information for this report was extracted from several national and quasi-national data sources. These include the National Mortality and Morbidity databases, NHS, SMHWB, and the Western Australian Child Health Survey. Where no national or quasi-national data are available, relevant information from literature has been included to illustrate the point.

National Mortality Database

The AIHW maintains a national database of deaths registered in Australia, based on data provided to the ABS by the State and Territory Registrars of Births, Deaths and Marriages, currently for the years 1980–96. The Institute's database, also referred to as the National Mortality Database, has the cause of death coded according to the ninth revision of the International Classification of Diseases.

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Registration of deaths in Australia is the responsibility of the State and Territory Registrars of Births, Deaths and Marriages. Information on the cause of death is supplied by the medical practitioner certifying the death, or by a coroner. Other information about the deceased is supplied by a relative or a person acquainted with the deceased or by an official institution where the death occurred. Registration of death is a legal requirement in Australia, and compliance is virtually complete.

Mortality data remain the most comprehensively collected national data pertaining to health. The reliability of these data depends principally on the information listed on the death certificate, or that available in coroners' records, as well as on the reliability of the application of ICD codes to that information. In particular, deaths relating to mental problems such as dementia are substantially under-reported on the doctor's death certificate, as well as in the ABS coding which until 1996 was based on a single underlying cause of death. The latter issue has now been addressed following multiple cause of death coding by the ABS, that started in 1997.

A major difficulty encountered in using the mortality database is the poor identification of Aboriginal peoples and Torres Strait Islanders in New South Wales and Victoria, and absence of information on deaths of Aboriginal peoples and Torres Strait Islanders in Queensland until 1997. Analysis of the mortality of Aboriginal peoples and Torres Strait Islanders has therefore been limited to the Northern Territory, Western Australia and South Australia.

National Hospital Morbidity Database

This database, also maintained at the AIHW, is based on information collected by various State and Territory health authorities, and by the Department of Veterans' Affairs. The AIHW receives the data from these agencies, and maintains it in a national database.

Hospitals collect information about the patients they treat, both administrative and clinical data, including sociodemographic, diagnostic and duration of stay data, and the procedures performed. The information is event-based rather than individual-based.

Hospital separation data are limited in their utility as indicators of disease incidence and prevalence in that they do not identify multiple admissions for the same person. The feasibility of addressing this problem by linking records from different data collections is being investigated. The numbers and trends in hospital separations are also affected by differing admission practices, differing levels and patterns of service provision, and changes in coding practices over time.

The coverage of public and private hospitals in the database also varies. Information on separations from private hospitals in Victoria, Western Australia, the Australian Capital Territory and the Northern Territory, for example, is not included in the national collection for the years 1991–92 and 1992–93.

National Health Survey 1995

The 1995 NHS was the second in a series of five-yearly population surveys conducted by the Australian Bureau of Statistics to provide national benchmark information on a range of health-related issues. The Survey collected information on mental health status using the Short Form-36 (SF-36) instrument (Ware et al 1993).

The SF-36 questionnaire was included in the NHS for the first time in 1995, collecting self-reported information about general health and wellbeing from about 18,800 adult residents of private dwellings. SF-36 collects information across eight dimensions of health and wellbeing from which two summary measures can be calculated: the Physical Component Summary (PCS) and the Mental Component Summary (MCS). The procedure for calculating MCS is described later in the Appendix.

The MCS information is derived from a subset of items that ask respondents about their general mental health as well as any role limitations due to emotional problems. Questions inquiring about respondents' vitality and social functioning are also asked. Examples of questions include the amount of time spent feeling nervous or happy, the amount of time spent feeling 'full of pep', and the impact that emotional problems might have in limiting social activities.

National Survey of Mental Health Services

A national survey of all specialised public mental health services was first undertaken by consultants engaged by the former Commonwealth Department of Health and Family Services for the financial year 1993–94. The management and development of subsequent surveys for 1994–95 and 1995–96 have been the responsibility of the AIHW. Data are collected from central health departments in each State and Territory, from regional, area and district administrative units, and from organisations providing specialised mental health services. The 1995–96 survey included data provided by 187 mental health service organisations, which were all identified by the respective State and Territory central health administrators. The survey, which covers a range of inpatient and non-inpatient services, forms the main source of information for these services.

National Survey of Mental Health and Wellbeing (Adult Component) 1997

The survey, an initiative of and funded by the Commonwealth Department of Health and Family Services (now Health and Aged Care), as part of the National Mental Health Strategy (NMHS), was undertaken to collect broad-based epidemiological data on the mental health status of the population. The survey, conducted by the ABS in 1997, included 10,000 Australians aged 18 years and over who were selected from random households. Questions were designed to obtain information on the prevalence of a range of mental disorders. The survey also collected information on the level of disability associated with mental disorders, as well as on health services used and the help needed as a consequence of a mental health problem.

The Composite International Diagnostic Interview (CIDI) was used to diagnose mental disorders using criteria that enable coding to ICD-10 diagnostic categories. The CIDI allows a non-clinician interviewer to collect information about symptoms of mental disorders. A computer program was used to score the responses for diagnosis (WHO 1994).

The BDQ was used to measure general levels of disability. Respondents were asked whether they were limited in some activities (such as running, sports, carrying groceries, bathing, climbing stairs) because of health problems. They were also asked whether they have had to stop certain activities, had decreased motivation, or experienced deterioration in their social relations. All items referred to the four weeks prior to the interview.

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The Medical Outcomes Study (MOS) method of scoring (scale of 0–16) was used, with a high score indicating that the respondent has been limited in performing activities by health problems (ABS 1998).

Data development

Between 1993 and 1998, initiatives by the Commonwealth, States and Territories under the NMHS have led to improvements in the development and collection of data on a range of mental health issues. These include:

- the development of data collections to monitor reforms in mental health service delivery introduced under the NMHS;
- the establishment of ongoing national data collections based on records kept by hospitals and mental health services in the community; and
- a population survey conducted in 1997 to establish the prevalence of a range of major mental disorders for Australian adults (SMHWB), described above.

Several other initiatives are now in progress under the NMHS to improve data standards for the collection of information on patients and care provided in institutions and in the community for severe illness.

Some of the activities that should contribute to the improvement of national mental health information are described below.

National Survey of Mental Health and Wellbeing (Child and Adolescent Component)

The Child and Adolescent Component of the SMHWB was conducted in 1998. Information was collected on young people aged 4 to 17 years on the prevalence of mental disorders, measures of mental health, functional impairment, service utilisation, and exposure to risks (including social factors, physical health, mental health of parents and self-harm behaviours). The results from the survey are expected to become available in 1999.

National Survey of Low Prevalence Mental Disorders

A study of low prevalence, severe mental illness was conducted in 1998 to complement the results of the 1997 SMHWB. A separate study was needed as severe illnesses such as bipolar disorder, schizophrenia and other psychoses have too low a prevalence to cost-effectively generate reliable estimates through random sampling of the general population.

Estimates of one-month and one-year prevalence of severe mental illness in the community are expected to become available in 1999. Information on the extent to which services are being used currently, or have been used in the past (including government-funded specialised psychiatric services, NGOs, and services in the private sector such as general practice), will also become available. The study will also provide an assessment of the personal and social circumstances of people who have a low-prevalence severe mental illness.

National minimum data set for mental health care

A national minimum data set for mental health care has been developed for collecting information on a continuous basis on people who receive health care services for any mental disorder in both hospital and community settings. This will enable data to be collected on the demographic characteristics of patients, clinical diagnoses and how treatment is managed. Data on patients admitted to specialised psychiatric services in hospital will become available over the next two to three years.

Primary mental health care data

Information is needed on primary health care provided by a range of health professionals. In particular, information is required from general practitioners because of the central role they play in the provision of primary health care for mental health problems and disorders.

Few data have been collected on the activities of general practitioners in general, with limited Medicare data being the only source of national routinely collected information. No national data have been available on the 'casemix' of the general practitioners (ie on the characteristics of their patients, the problems or diagnoses managed, and the nature of the management) (AIHW 1998).

In response to this need, the AIHW and the University of Sydney are collaborating on a national, continuous survey of general practitioner activity, entitled 'Bettering the Evaluation and Health Care of Health'. The survey, for which the data collection began in April 1998, will sample about 1,000 general practitioners nationally on a rolling basis. The general practitioners are being asked to provide information on 100 consecutive patients, including home visits and consultations in nursing homes and hospitals.

Record linkage

Record linkage can be a powerful tool in mental health research and monitoring, particularly because of the frequent comorbidity of mental disorders. Linkages with the National Death Index, Medicare Benefits Schedule Database, the Pharmaceuticals Benefits Scheme Database and the National Hospital Morbidity Database will help provide more complete a profile of mental health problems. The Privacy Commissioner has endorsed guidelines developed by the NHMRC to protect privacy that allow, following ethical approval, health records to be linked for statistical and research purposes (Section 95 of the Privacy Act).

Data for Aboriginal peoples and Torres Strait Islanders

The need to improve the quality of health information for Aboriginal peoples and Torres Strait Islanders, including deaths data, has been identified as a national health information priority, and a plan was presented to the October 1997 AHMAC meeting. The Plan's major recommendations include:

- development of specific protocols for the sensitive handling of data concerning Aboriginal peoples and Torres Strait Islanders, with the active involvement of communities;
- establishment of permanent and long-term positions for personnel of Aboriginal and Torres Strait Islander descent, to facilitate substantial improvements in the quality of information;

Appendix 2

- ensuring all major health and related collections in all jurisdictions have the capacity to differentiate between Aboriginal peoples and Torres Strait Islanders and other Australians; and
- use of common identification classifications and collection protocols in all major collections.

Representatives from the National Health Information Management Group (NHIMG) and relevant health organisations representing Aboriginal peoples and Torres Strait Islanders are working together to help implement the plan. The ABS and AIHW have accepted leading roles in working with organisations to implement identification of Aboriginal peoples and Torres Strait Islanders in priority information systems. The ABS has this role for vital statistics and the AIHW for hospital separations, perinatal data and cancer registrations.

Data gaps and deficiencies

Although the range of data on mental health status has improved in recent years, gaps still exist. Key areas requiring action are:

- the development and collection of relevant and culturally appropriate data on service delivery and emotional and social wellbeing (mental health) status of Aboriginal peoples and Torres Strait Islanders;
- the establishment of a national collection strategy that targets the treatment needs and management of the care of older Australians with mental health disorders;
- the coordination of a national collection of data from State and Territory mental health case registers; and
- finalisation of a national collection and reporting process for suicide data from the National Coronial Information System (AIHW 1998b).

Further data requirements

There are currently no national data on several of the NHPA indicators for monitoring depression. This makes it difficult to assess the effect of public health measures on the preventing of depression, or the effect of health services and interventions on managing the problem.

Information on some of the depression indicators is presented in Appendix 1. However, there is inadequate information for a number of NHPA indicators. Availability of relevant information was not considered a constraint in designing NHPA indicators. No clear strategies with which to link depression outcomes were developed either. However, the indicators were designed and developed within a *goals and targets* framework. Since the data available for several of the depression indicators are at best a first cut, no attempt has been made to establish baselines at this stage. No targets have been set, either.

A plan is required urgently to develop the information systematically if regular reporting against all the indicators is to occur. Any such information development plan should also consider generating appropriate time series for long-term monitoring.

Statistical issues

Age-standardisation

To control for any effects of differing age structures of populations, direct age-standardisation was applied to death rates, incidence rates, prevalence rates and hospital separation rates. The total estimated resident population of Australia at 30 June 1991 was used as the standard (Table A2.1).

Table A2.1: Age composition of the Australian population by sex, 30 June 1991

Age group	Males	Females	Total
0–4	652,302	619,401	1,271,703
5–9	652,418	619,790	1,272,208
10–14	638,311	603,308	1,241,619
15–19	698,773	665,301	1,364,074
20–24	707,124	689,640	1,396,764
25–29	702,728	696,935	1,399,663
30–34	713,784	711,951	1,425,735
35–39	664,228	664,159	1,328,387
40–44	655,138	639,133	1,294,271
45–49	526,498	502,647	1,029,145
50–54	433,762	413,172	846,934
55–59	367,302	358,648	725,950
60–64	366,779	370,089	736,868
65–69	320,142	351,248	671,390
70–74	228,494	282,261	510,755
75–79	158,993	225,502	384,495
80–84	84,413	145,415	229,828
85 and over	44,220	110,027	154,247
Total	8,615,409	8,668,627	17,284,036

Source: Australian Bureau of Statistics.

The usual convention of using age-specific rates for five-year age groups, as shown in Table A2.1, was followed using the following formula:

$$SR = \frac{\sum \{R_i \times P_i\}}{\sum P_i}$$

where SR = the age-standardised rate

R_i = the age-specific rate for age group i , and

P_i = the standard population in age group i .

It should be noted that trends in age-standardised rates estimated using this standard population might differ from those obtained using another standard population.

Appendix 2

Short Form-36 (SF-36) scoring

Indicators for eight dimensions of health were derived from responses given to the questions in SF-36. The eight dimensions of health included physical functioning, role limitation due to physical problems, bodily pain, general health, vitality, social functioning, role limitation due to emotional problems, and mental health.

Scoring of health dimensions

Items and scales for the eight dimensions of health were scored in three stages:

- *item recoding*, for those eight items in the scale for which the response categories were listed in reverse order. This stage of scoring also incorporated imputation of missing values where possible. The SF-36 scoring rules allowed for values of missing items to be imputed if at least 50% of the items for a scale were present. The algorithm used in the imputation process substitutes a person-specific estimate for the missing item: the estimate is the average score across completed items in the same scale for that respondent.
- *computing raw scores for each dimension*, by summing across component items; and
- *transforming the raw dimension scores to a 0–100 scale*. The formula used converted the lowest and highest possible score to zero and 100 respectively; scores between these values represented the percentage of the total possible score which had been achieved.

Rural, remote and metropolitan areas classification

The rural, remote and metropolitan areas (RRMA) classification has been developed by the DPIE, and DSHS, based primarily on population numbers and an index of remoteness (DPIE & DSHS 1994). The RRMA categories show a natural hierarchy, providing a model for incremental health disadvantage with rurality and remoteness as risk factors. Based on population density, the following three zones and seven area categories are recognised:

Box A2.1: Structure of the rural, remote and metropolitan areas (RRMA) classification

Zone	Category
Metropolitan zone	Capital cities Other metropolitan centres (urban centres pop'n $\geq 100,000$)
Rural zone (index of remoteness <10.5)	Large rural centres (urban centres pop'n 25,000–99,000) Small rural centres (urban centres pop'n 10,000–24,999) Other rural areas (urban centres pop'n $< 10,000$)
Remote zone (index of remoteness >10.5)	Remote centres (urban centres pop'n $\geq 5,000$) Other remote areas (urban centres pop'n $< 5,000$)

Appendix 3

Framework for a three-year plan developed at the National Workshop on Depression, November 1997

Promotion and prevention

- Goal One: Promote the understanding of, and need for, an evidence base in preventive mental health strategies.
- Goal Two: Develop and implement a data strategy that provides adequate monitoring and surveillance of population mental health.
- Goal Three: Improve child-bearing processes and outcomes as they relate to mental health.
- Goal Four: Enhance early maternal–infant attachment, maternal/paternal/infant relationships and family wellbeing.
- Goal Five: Enhance parenting capacities and family harmony/mental health in the pre-school period.
- Goal Six: Within school settings, enhance wellbeing and resilience in children and youth in developmentally appropriate ways.
- Goal Seven: Enhance mental health outcomes for adults in settings of increased risk including life transitions and crises. Implement programs in the workplace, in institutional settings and with the unemployed.

Early interventions

- Goal One: Reduce the duration of untreated disorder.
- Goal Two: Extend the capacity of the service system to respond to identified need.
- Goal Three: Extend the evidence base for early intervention.
- Goal Four: Assess and disseminate information on successful interventions.

Management of depression

- Goal One: Develop and implement best practice guidelines for: detection and identification of depression; and the management of depression.
- Goal Two: Improve access to services.
- Goal Three: Coordinate, integrate and network service delivery and research on depression at the national, state and local level.

Appendix 3

Community education

- Goal One: Improve public recognition of depressive symptoms (as distinct from normal life problems) and general knowledge of services and access.
- Goal Two: Reduce systemic discrimination against those suffering depression.
- Goal Three: Accurate and informed media reporting on depression and mental health issues.

Data needs

- Goal One: Develop a minimum set of depression indicators across the health continuum for reporting at a national level.
- Goal Two: Standardised definitions for: data elements; indicators; and evaluation.
- Goal Three: Produce a depression-related information development plan for the next three years incorporating: new evidence (new or collated); evaluation of existing evidence; and improvement of the quality of data collection and collation.
- Goal Four: Identify indicators for reporting: in 1998 and 2000.

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
ACCHSs	Aboriginal Community Controlled Health Services
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
ANAMH	Australian National Association for Mental Health
ANZCMHN	Australian and New Zealand College of Mental Health Nurses
APA	American Psychiatric Association
APS	Australian Psychological Society
ARAFM	Association for Relatives and Friends of the Mentally Ill
ARC	Australian Research Council
BDQ	Brief Disability Questionnaire
CADET	Community Aged Depression Education Therapy
CBT	Cognitive behaviour therapy
CIDI	Composite International Diagnostic Interview
CSDA	Commonwealth/State Disability Agreement
DHFS	Commonwealth Department of Health and Family Services
DHHS	Department of Health and Human Services, United States
DPIE	Commonwealth Department of Primary Industries and Energy
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, fourth edition
DSS	Commonwealth Department of Social Security
DVA	Commonwealth Department of Veterans' Affairs
ECT	Electroconvulsive therapy
FEPP	Focused Educational and Psychological Therapy Program
HRT	Hormone replacement therapy
ICD-9	International Classification of Diseases, ninth revision
ICD-10	International Classification of Diseases, tenth revision
ICIDH	International Classification of Impairments, Disabilities and Handicaps
LSIA	Longitudinal Survey of Immigrants to Australia
MAOIs	Monoamine oxidase inhibitors
MBS	Medicare Benefits Schedule

Acronyms and abbreviations

MCS	Mental Component Summary
MH-CASC	Mental Health Classification and Service Costs
MIEA	Mental Illness Education Australia
MOS	Medical Outcomes Study
NACCHO	National Aboriginal Community Controlled Health Organisation
NDAP	National Depression Action Plan
NGO	Non-government organisation
NHIMG	National Health Information Management Group
NHMRC	National Health and Medical Research Council
NHPAs	National Health Priority Areas
NHPC	National Health Priority Committee
NHS	National Health Survey
NMHS	National Mental Health Strategy
NNAAMI	National Network of Adult and Adolescent children who have Mentally Ill parents
PaNDa	Post and AnteNatal Depression Association
PCS	Physical Component Summary
PPAP	Promotion and Prevention Action Plan
PTSD	post-traumatic stress disorder
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RAP-A	Resourceful adolescent project for adolescents
RAP-P	Resourceful adolescent project for parents
RFPS	Risk Factor Prevalence Survey
RRMA	Rural, remote and metropolitan areas
SERUs	Support and Evaluation Resource Units
SF-12	Short Form-12
SF-36	Short Form-36
SMHWB	Survey of Mental Health and Wellbeing
SMR	Standardised Mortality Ratio
SSRIs	Selective serotonin reuptake inhibitors
TCAs	Tricyclic antidepressants

Acronyms and abbreviations

TMS Transcranial Magnetic Stimulation

WHO World Health Organization

Glossary of terms

Aetiology (etiology)

All the factors that contribute to the development of an illness or disorder.

Affective disorders (mood disorders)

This is a term that can be used to describe all those disorders that are characterised by mood disturbance. Disturbances can be in the direction of elevated expansive emotional state or in the opposite direction, a depressed emotional state.

Alcoholism

A behavioural disorder in which consumption of alcoholic beverages is excessive and impairs health and social and occupational functioning; a physiological dependence on alcohol.

Antidepressant

A drug that alleviates depression, usually by energising the person and thus elevating mood.

Anxiety

An unpleasant feeling of fear or apprehension accompanied by increased physiological arousal.

Antixiolytics

Tranquillizers; drugs that reduce anxiety.

Assessment

Ongoing process beginning with first client contact and continuing throughout the intervention and maintenance phases to termination of contact. The major goals of assessment are: (a) identification of vulnerable or likely cases; (b) diagnosis; (c) choice of optimal treatment; and (d) evaluation of the effectiveness of the treatment.

Attempted suicide

The deliberate or ambivalent act of self-destruction, or other life-threatening behaviour, not resulting in death.

Best practice guidelines

Best practice is the benchmark against which programs can be evaluated. Best practice guidelines are statements based on the careful identification and synthesis of the best available evidence in a particular field. They are intended to assist people in that field, including both practitioners and consumers, to make the best use of the available evidence.

Bipolar disorder

A mood disorder characterised by the presence of history of manic (or hypomanic) episodes usually alternated with depressive episodes. (A history of depressive episodes is not required for all categories of bipolar disorder.)

Biopsychosocial approach

An holistic approach that considers all the interacting biological, psychological and social factors that contribute to disorder.

Carer

A person whose life is affected by virtue of a close relationship and a caring role with a consumer.

Glossary of terms

Chronic

Of lengthy duration or recurring frequently, often with progressive seriousness.

Cognitive behaviour therapy

A short-term goal-oriented psychological treatment. The two guiding principles are: how we behave (including how we feel) is learned through experience, and therefore may often be changed or unlearned; and thought processes directly impact on the person. The person is encouraged to examine negative perceptions and interpretations of their experiences. They are also taught problem-solving techniques.

Comorbidity

The co-occurrence of two or more disorders such as depressive disorder with anxiety disorder or depressive disorder with anorexia.

Community education

An organised campaign designed to increase awareness of an issue.

Conduct disorder

Condition characterised by aggressive, destructive, deceitful and rule-breaking behaviours. Defined according to standard psychiatric criteria.

Consumer

A person utilising, or who has utilised, a mental health service.

Counsellor

At present, anyone in Australia can call himself or herself a counsellor, therapist or psychotherapist. There are, however, credentialling bodies for counsellors, such as the Australian Body of Certified Counsellors and a range of professional organisations that offer standards, codes of practice, ethical guidelines and continuing education such as the Australian Psychological Society, the Psychotherapy and Counselling Federation of Australia and the Australian National Network of Counsellors.

Cyclothymia

A mood disorder of at least two years' duration (one year in adolescents) characterised by numerous periods of mild depressive symptoms not sufficient in duration or severity to meet criteria for major depressive episodes, interspersed with periods of hypomania.

Dementia

Deterioration of mental faculties—of memory, judgment, abstract thought, control of impulses, intellectual ability—that impairs social and occupational functioning and may eventually alter the personality.

Depressed mood

A sad or unhappy mood. May be assessed by self-report questionnaire.

Depression workforce

The depression workforce primarily comprises psychiatrists, psychologists, mental health nurses, general practitioners, some primary care workers, and some occupational therapists.

Depressive disorder

A constellation of disturbances in emotional, behavioural, somatic and cognitive functioning defined according to clinically derived standard psychiatric diagnostic criteria.

Diagnosis

A decision based on the recognition of clinically relevant symptomatology, the consideration of causes that may exclude a diagnosis of another condition, and the application of clinical judgment.

Dysthymia

A mood disorder characterised by depressed mood and loss of interest or pleasure in customary activities, with some additional signs and symptoms of depression, that is present most of the time for at least two years (one year in adolescents).

Effectiveness

The extent to which an intervention does more good than harm for the patient when used under 'normal' circumstances.

Efficacy

The extent to which an intervention does more good than harm for the patient when applied under 'ideal' conditions.

Epidemiology

The study of statistics and trends in health as applied to the whole community.

Evaluation

The process of measuring the value or worth of a program or service.

Evidence-based practice

A process through which professionals use the best available evidence integrated with professional expertise to make decisions regarding the care of an individual. It is a concept which is now widely promoted in the medical and allied health fields and requires practitioners to seek the best evidence from a variety of sources; critically appraise that evidence; decide what outcome is to be achieved; apply that evidence in professional practice; and evaluate the outcome. Consultation with the client is implicit in the process.

Follow-up study

A research procedure whereby individuals observed in an earlier investigation are contacted at a later time for further study.

Hypomania

An episode of illness that resembles mania, but is less intense and less disabling. The state is characterised by an euphoric mood, unrealistic optimism, increased speech and activity, and a decreased need for sleep. For some, there is increased creativity, while others evidence poor judgment and impaired function.

Interpersonal psychotherapy

A time-limited psychotherapy approach that aims at clarification and resolution of one or more of the following interpersonal difficulties: role disputes, social isolation, role transition.

Indigenous

Includes people of Aboriginal and Torres Strait Islander descent and other native islander communities within Australia.

Maintenance treatment

Treatment designed to prevent a new mood episode.

Glossary of terms

Management

Ongoing process beginning with initial client contact and encompassing all practitioner actions in relation to a particular client. Includes assessment/evaluation, education of the person and family or carer(s), diagnosis, treatment, addressing problems of adherence to treatment, and liaison with or referral to other agencies.

Mania

Illness characterised by hyperexcitability, euphoria, and hyperactivity. Rapid thinking and speaking, agitation, a decreased need for sleep, and a marked increase in energy are nearly always present. During manic episodes, some patients also experience hallucinations or delusions.

Mental disorder

A recognised, medically diagnosable disorder, which results in a significant impairment of an individual's cognitive, social or emotional abilities and may require intervention.

Mental health

The capacity of individuals and groups to interact with one another and the environment, in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational). The achievement of individual and collective goals consistent with justice is central to a positive state of mental health.

Mental health problem

A disruption in the interactions between the individual, the group and the environment, producing a diminished state of mental health.

Mental health literacy

The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments and of professional help available, and attitudes that promote recognition and appropriate help-seeking.

Mental health problems

Diminished cognitive, emotional or social abilities but not to the extent that the criteria for a mental disorder are met.

Mental health professionals

Professionally trained people working specifically in mental health, such as social workers, occupational therapists, psychiatrists, psychologists and psychiatric nurses.

Mental health promotion

Action to maximise mental health and wellbeing among populations and individuals.

Meta-analysis

A systematic review that employs statistical methods to combine and summarise the results of several studies.

Outcome

A measurable change in the health of an individual, or group of people or population, which is attributable to an intervention or series of interventions.

Perinatal

Relating to the period shortly prior to and shortly after the birth of a baby.

Peer education

The use of identified and trained peers to provide information aimed at increasing awareness of influencing behaviour change.

Placebo

An inactive therapy or chemical agent, or any attribute or component of such a therapy or chemical, that may affect a person's behaviour for reasons related to their expectation of change.

Population-based interventions

Population-based interventions are targeted to populations, rather than high risk individuals or high-risk groups. These interventions include whole population activities as well as those activities deliberately targeted to population subgroups such as rural or Indigenous peoples.

Prevalence

The proportion of the population with the disease/disorder.

Preventive interventions

Programs designed to decrease the incidence, prevalence and negative outcomes of depression.

- Universal—preventive programs applied to the entire population.
- Selective—preventive programs applied to groups or individuals at increased risk of developing the disorder.
- Indicated—preventive programs targeted at high risk individuals on the basis of the individual's minimal, but detectable, behaviours or symptoms that could later develop into a full blown disorder.

Public health framework

Public health describes those activities that aim to benefit a population rather than individuals. Prevention, protection and promotion are emphasised, as distinct from treatment tailored to the needs of individuals with symptoms. A public health approach is structured around the continuum of primary, secondary and tertiary prevention.

Primary care

In the health sector generally, 'primary care' services are provided in the community by generalist providers who are not specialists in a particular area of health intervention. For example, general practitioners, Aboriginal health workers, pharmacists and community health workers provide primary health care. Specialist care, or tertiary services, may be provided by accident and emergency services, hospital wards, youth health or mental health services.

Psychologist

While there are various governing laws throughout the States and Territories of Australia, a practitioner is not allowed to call himself or herself a 'psychologist' unless the required training has been undertaken and they are registered with the relevant state registration body.

Psychiatrist

Medical practitioner with specialist training in psychiatry.

Randomised controlled trial

Research study where participants are allocated at random to receive one of two or more alternative forms of care with the aim of creating unbiased treatment groups for comparison.

Reliability

The extent to which a test, measurement or classification system produces the same scientific observation each time it is applied.

Glossary of terms

Risk factors

Those characteristics, variables, or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder.

Risk-taking behaviours

Behaviours in which there is some risk of immediate or later self-harm. Risk-taking behaviours might include activities such as dangerous driving, graffiti, train surfing, and self-harming substance use. Some authors see risk-taking behaviours as coping strategies for psychological pain, and others refer to the role of risk-taking in the transition from childhood to adulthood, especially for males.

Self-harm

This includes the various methods by which people may harm themselves, such as self-laceration, self-battering, taking overdoses, or deliberate recklessness. Recent research suggests that self-harm is more common than attempted suicide, and is a serious youth health problem.

Socioeconomic status

A relative position in the community as determined by occupation, income and amount of education.

Stakeholders

The different groups that are affected by decisions, consultations and policies.

Stressor

An event that occasions a stress response in a person.

Substance misuse

The use of a drug to an extent that the person is often intoxicated throughout the day and fails in important obligations and in attempts to abstain, but where there is not necessarily physical dependence.

Substance dependence

The misuse of a drug accompanied by a physiological dependence on it, made evident by tolerance and withdrawal symptoms.

Substance use disorders

Disorders in which drugs are used to such an extent that behaviour becomes maladaptive; social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug may be psychological, as in substance misuse, or physiological, as in substance dependence.

Suicide

Suicide is a conscious act to end one's life. By conscious act, it is meant that the act undertaken was done in order to end the person's life.

Suicidal behaviour

Suicidal behaviour includes the spectrum of activities related to suicide and self harm including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts. Some writers also include deliberate recklessness and risk-taking behaviours as suicidal behaviours.

Symptom

An observable physiological or psychological manifestation of a disorder or disease, often occurring in a group to constitute a syndrome.

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