National Comorbidity Initiative

A review of data collections relating to people with coexisting substance use and mental health disorders

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A review of data collections relating to people with coexisting substance use and mental health disorders

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Contents

List of tables

Appendix: Collection summaries

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Abbreviations

ABS	Australian Bureau of Statistics
ADHD	Attention Deficit Hyperactivity Disorder
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
ALSWH	Australian Longitudinal Study on Women's Health
AODTS–NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ARIA	Accessibility/Remoteness Index of Australia
ASCDC	Australian Standard Classification of Drugs of Concern
ASCL	Australian Standard Classification of Languages
ASCO	Australian Standard Classification of Occupations
ASGC	Australian Standard Geographic Classification
ASSADS	Australian Schools Students Alcohol and other Drug Survey
BEACH	Bettering the Evaluation and Care of Health survey of general practice activity
CAI	Computer-assisted interview
CATI	Computer-assisted telephone interview
CIDI	Composite International Diagnostic Interview
COAG IDDI	Council of Australian Governments Illicit Drug Diversion Initiative
COTSA	Clients of Treatment Services Agencies
CSHA–CAP	Commonwealth–State Housing Agreement Crisis Accommodation Program
CSHA–CH	Commonwealth–State Housing Agreement Community Housing
CSHA–HPA	Commonwealth–State Housing Agreement Home Purchase Assistance
CSHA–NMDS	Commonwealth–State Housing Agreement National Minimum Data Set
CSHA–PRA	Commonwealth–State Housing Agreement Private Rental Assistance
CSS	Crime and Safety Survey
CSTDA–NMDS	Commonwealth State/Territory Disability Agreement National Minimum Data Set
DASR	Drug and Alcohol Services Report—annual data collected from Australian Government funded Aboriginal and Torres Strait Islander substance use specific services
DEST	Australian Government Department of Education, Science and Training
DEWR	Australian Government Department of Employment and Workplace Relations
DoHA	Australian Government Department of Health and Ageing
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders Version IV
DUCO	Drug Use Careers of Offenders
DVA	Australian Government Department of Veterans' Affairs
DUMA	Drug Use Monitoring in Australia

FaCS	Australian Government Department of Family and Community Services
FTE	Full-time equivalent
GCS	General Customer Survey
GP	General practitioner
GSS	General Social Survey
HACC MDS	Home and Community Care Minimum Data Set
HILDA	Household, Income and Labour Dynamics in Australia
HoNOS	Health of the Nation Outcome Scales
ICD	International Classification of Diseases
ICD–10–AM	International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ICPC–2	International Classification of Primary Care, Version 2
ICPC–2 PLUS	International Classification of Primary Care, Version 2 Plus
ID	Identification
IDRS–IDU	Illicit Drugs Reporting System – Injecting Drug Users
IDRS–PDI	Illicit Drugs Reporting System – Party Drug Initiative
JJ NMDS	Juvenile Justice National Minimum Data Set
KHLS	Kids Help Line Statistics
KI	Key informant
LDS	Longitudinal Data Set
LGA	Local government area
MBS	Medicare Benefits Scheme
MHNOCC	Mental Health National Outcomes and Casemix Collection
NAC	National Alcohol Campaign tracking research
NACCHO	National Aboriginal Community Controlled Health Organisation
NAPEDCD	National Non-admitted Patient Emergency Department Care Database
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSIS	National Aboriginal and Torres Strait Islander Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NCMHCD	National Community Mental Health Care Database
NCIS	National Coroners Information System
NCPDC	National Child Protection Data Collection
NCSDD	National Community Services Data Dictionary
NDSHS	National Drug Strategy Household Survey
NHDD	*National Health Data Dictionary*
NHMD	National Hospital Morbidity Database
NHS	National Health Survey
NMD	National Mortality Database
NMDS	National Minimum Data Set
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data collection
NPC	National Prisoner Census
NPCS	National Police Custody Survey

NRMHCD	National Residential Mental Health Care Database
NSMHW (adult)	National Survey of Mental Health and Wellbeing (adults)
NSMHW (C & A)	National Survey of Mental Health and Wellbeing (children and adolescents)
NSMHW (psychotic)	National Survey of Mental Health and Wellbeing (low prevalence (psychotic) disorders)
NSP	National Needle and Syringe Program Survey
NSW–IHS	New South Wales Inmate Health Survey
NTCS	National Tobacco Campaign Survey
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OC NMDS	Outpatient Care National Minimum Data Set
PAPI	Pen and Paper Interviewing
PBS	Pharmaceutical Benefits Scheme
PDU	Party drug users
QLD–WPHS	Queensland Women Prisoners' Health Survey
RADAR	Register of Australian Drug and Alcohol Research
RRMA	Rural, Remote and Metropolitan Areas classification
SAAP NDC	Supported Accommodation Assistance Program National Data Collection
SACC	Standard Australian Classification of Countries
SAND	Supplementary Analysis of Nominal Data
SAR	Service Activity Reporting—annual data collection from Australian Government funded Aboriginal and Torres Strait Islander primary health care services
SDAC	Survey(s) of Disability, Ageing and Carers
SEIFA	Socio-Economic Indexes for Areas
SF	Short form
SLA	Statistical Local Area
SLK	Statistical linkage key
SOMIH	State Owned and Managed Indigenous Housing
Veterans' data	Survey of Entitled Veterans, War Widows and their Carers
WHO	World Health Organization

Summary

This project identifies, reviews and reports on the current state of data collections relating to people with coexisting substance use and mental health disorders ('comorbidity') in Australia.

Background *(see Chapter 1)*

The Australian Government, under the National Illicit Drug Strategy, allocated $9.7 million over five years to a National Comorbidity Initiative to improve service coordination and treatment outcomes for people with coexisting mental health and substance use disorders. One priority under this Initiative is to improve data systems and collection methods within the mental health and alcohol and other drug sectors to manage comorbidity more effectively. The Australian Government Department of Health and Ageing (DoHA) commissioned the Australian Institute of Health and Welfare (AIHW) to undertake this project to inform this priority area.

Process *(see Chapters 2–6)*

At the outset of the project, a project advisory group (comprising representatives from the AIHW, DoHA and the Australian Institute of Criminology) was established to provide expert advice to the project team throughout the duration of this work.

The first stage of the project focused on current literature within the field, previous work commissioned under the National Comorbidity Initiative, as well as the National Mental Health Plan (2003–2008) and the National Drug Strategy (2004–2009) to gain a more comprehensive understanding of what stakeholders want and need to know about people with comorbidity in Australia. From this, a list of key questions relating to comorbidity was identified.

During the second stage of the project, 56 data collections in the areas of mental health, alcohol and other drugs, general health and/or welfare, housing, income support, criminal justice and child protection, and education and training were explored, in the first instance to determine whether they were of relevance to the issue of comorbidity, and therefore this project. Of these, 38 data collections ('key data sources') were identified as being relevant and able to inform the understanding of comorbidity in Australia. A comparative analysis was then undertaken of the key data sources, comparing them in terms of their methodology, scope, coverage, timing, collection counts and data items. The key data collections were then related back to the key questions about comorbidity, to determine the extent to which the data collections could currently answer them.

Exploring the comparability of key data collections and attempting to answer the key questions about comorbidity revealed a number of gaps and areas for improvements in existing data collections. Options for improving the usefulness and availability of information about people with comorbidity in Australia are then discussed.

The current state of play *(see Chapter 5)*

The key data sources provide information which would enable analysts to address, to varying extents, the majority of the key questions relating to comorbidity. For example, with appropriate methodology, the key data sources provide information to describe comorbidity in the Australian population (in various demographic subgroups and settings) and the many types of services accessed by this group. However, current data sources are not able to fully address questions about service delivery models and outcomes for people with comorbidity.

The extent to which the data sources are capable of addressing these questions depends partly on their comparability in terms of factors such as methodology, definitions and classifications. Before attempting to use the data sources to address research questions, analysts would need to consider these and a number of other issues, including sample size and data quality.

Future possibilities *(see Chapter 6)*

Australia is currently in the relatively privileged position of having a rich set of data sources relating to the issue of comorbidity. While in most cases the reviewed data sources provide information that contributes towards an understanding of comorbidity, these collections were not designed to specifically address all questions about comorbidity. It may be possible in the future, and in cooperation with the stakeholders responsible for these data sources, to improve the usefulness of existing data. A number of suggestions for such improvements, together with options for future analysis, are highlighted.

1 Introduction

1.1 Purpose of project

In the 2003–04 Federal Budget, the Australian Government allocated funding for the development of the National Comorbidity Initiative to improve service coordination and treatment outcomes for people with coexisting mental health and substance use disorders.[1] One priority area for action under this initiative was 'to improve data systems and collection methods within the mental health and alcohol and other drugs sectors to manage comorbidity more effectively'. This report was commissioned by the Australian Government Department of Health and Ageing (DoHA) to inform this area.

This project identifies and reports on the current state of data collections relating to people with coexisting substance use and mental health disorders ('comorbidity') in Australia. The project achieves this by:

- identifying current national data collections relating to comorbidity, including population survey data collections (e.g. National Drug Strategy Household Survey (NDSHS)) and administrative data collections (e.g. Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) and National Community Mental Health Care Database (NCMHCD))
- reviewing the purpose, content, definitions, methodology and scope of relevant national data collections
- highlighting gaps within, and inconsistencies between, key existing data collections in terms of their capacity to describe the characteristics of people with comorbidity (e.g. mental health, substance use, sex, age, cultural and linguistic profile, and Indigenous status)
- outlining options for improving the availability and usefulness of data pertaining to this population group.

Links between substance use and health conditions, other than mental health, are beyond the scope of this report.

This report assesses a core, or key, set of data sources in terms of their capacity to address key questions relating to comorbidity. While the report does not involve analysing the data sources to answer these questions, it provides a sound basis on which to consider and conduct such analysis.

1 This follows previous work on the National Comorbidity Project, jointly funded under the National Mental Health Strategy and the National Drug Strategy, embodied in the Second National Mental Health Plan (1998–2003) and the National Drug Strategic Framework (1998–99 to 2002–03).

1.2 Scope of project

The project focuses on data sources relating to people with comorbidity and the services, particularly treatment services, they access. While most of these data sources come from the health and welfare areas, relevant data collections in the areas of housing, income, criminal justice, and education and training were also explored. These provide additional information to describe people with comorbidity and their access to treatment or other services. This report focuses predominately on national collections (both population survey based and administrative data) that are in the public domain (that is, available to the public either through published reports or access to the data for research).

1.3 Analytical framework for the assessment of data collections

An analytical framework was developed in order to organise the assessment of data collections. This framework is based on the identification of key features of selected data collections (based on early analysis) a literature review and discussions with the DoHA. Analytical frameworks such as that used in *A Guide to Australian Alcohol Data* (AIHW 2004a) and the 'Conceptual Framework for Australia's Health' (AIHW 2004b) also informed the development of the framework.

The framework or template for analysing data sources is designed to indicate their ability to address key questions about the Australian population with comorbidity. These questions, derived from the literature and agreed with DoHA, enable us to articulate the extent to which Australia's key data sources meet the identified information needs relating to comorbidity.

Data collections are analysed in two phases. Firstly, 56 *relevant* data collections are analysed individually in terms of their characteristics, as specified in the template in Table 3.1 (e.g. scope, coverage, counting rules, data items etc.) (see Section 3.2).

Secondly, further analysis is undertaken on a subset (38) of these data collections which are considered *key* data collections in terms of their ability to inform questions about comorbidity. Key data collections are:

- compared and contrasted in terms of their characteristics, as specified in the template in Table 3.1 (e.g. their comparability in terms of counting rules and frequency of collection, and the consistency with which they define key variables such as mental health status, substance use status, comorbidity, and Aboriginal and Torres Strait Islander status) (sections 4.1 and 4.2)
- analysed as a national set of data sources in terms of their ability to address key questions in the area of comorbidity as identified in the literature (Chapter 5).

2 What are the key questions and information needs in relation to comorbidity?

Chapter 2 comprises two parts: Section 2.1 briefly outlines the key information needs raised in the literature relating to comorbidity, and Section 2.2 distils the information presented in Section 2.1 and presents a summary set of questions about comorbidity that one might expect national data sources to be able to address.

2.1 Literature review

The purpose of this literature review is to provide the context for this report, particularly in terms of highlighting what stakeholders want and need to know about comorbidity. The literature review is based predominantly on work previously commissioned by DoHA under the National Comorbidity Initiative. It is not the purpose of this report to duplicate or comment on this body of work; what follows is a brief summary of it.

It has been suggested that 'comorbidity in mental health and substance use disorders is widespread and often associated with poor treatment outcomes, severe illness course and high service utilisation' (Kessler et al. 1994, Wu et al. 1999, cited in Teesson & Byrnes 2001). Comorbidity of this kind presents particular challenges in terms of identification, prevention and treatment. Teesson and Byrnes (2001) suggest that work to date sends a clear message that improved treatment and management of comorbidity requires improved coordination and collaboration between mental health and alcohol and other drug treatment services. One way of facilitating such improvements is to ensure that reliable and valid information is collected on the extent and nature of comorbidity in the treatment population. In particular, the need for relatable national minimum data sets in the areas of mental health and drug and alcohol treatment was highlighted in the first consultation report on the National Comorbidity Project (Teesson & Byrnes 2001).

The literature contains much discussion about what comorbidity is, with considerable debate on the use of terminology relating to the subject. Broadly, the term comorbidity has been defined as 'any distinct additional clinical entity, that has existed or that may occur during the clinical course of a patient who has the index disease under study' (Feinstein 1970 in Siggins Miller Consultants 2003). This includes the co-occurrence of two or more diseases or health conditions that are physical and/or psychological in nature. A distinction may be made between concurrent and successive comorbidity, with concurrent comorbidity existing when two or more disorders are present simultaneously, and successive comorbidity occurring when the disorders occur at different points in time. Alternatively, some researchers (e.g. Andrews 1996 in Siggins Miller Consultants 2003) distinguish between the terms 'comorbidity' and 'co-occurrence', where the term co-occurrence equates roughly with concurrent comorbidity and the term comorbidity with successive comorbidity. Others make a distinction between heterotypic comorbidity (comorbidity between different classes of mental disorders) and homotypic comorbidity (comorbidity between different members of a general class of disorder) (e.g. Angold, Costello & Erkanli 1999 in Siggins Miller Consultants 2003). Throughout this report, comorbidity is discussed using the National Comorbidity Initiative definition of 'coexistence of substance use and mental health disorders', and is generally taken to assume that an individual experiences these disorders concurrently.

There are various theories about the causes of coexisting substance use and mental health disorders. While there are numerous ways of categorising these theories, they fit broadly into three main explanations. Two disorders might co-occur because:

1. there is a direct causal relationship between the two disorders whereby the presence of one disorder makes the other more likely to develop
2. there is an indirect causal relationship between the two disorders whereby one disorder affects a third variable in a way that makes the second disorder more likely to develop, or
3. there are common factors that increase the risk of both disorders (Teesson & Proudfoot 2004).

Much remains unknown about the causes of comorbidity but there is increasing evidence to suggest that simple causal hypotheses are not sufficient to explain the association (Teesson & Proudfoot 2004).

Efforts to estimate the prevalence of comorbidity have been frustrated by the varied approaches to its definition, including different opinions about, for example, the inclusion of tobacco as a relevant substance or nonpsychotic mental health conditions as relevant mental health disorders. While much of the current research focuses on comorbidity between psychosis and substance abuse, particularly cannabis abuse, international and Australian epidemiological data suggest that a large part of the burden of comorbidity occurs elsewhere (Teesson & Proudfoot 2004). For example, substance use disorders are also likely to co-occur with anxiety, affective, personality and other substance use disorders, all of which are more prevalent in the population than psychotic disorders. Similarly, tobacco use is a common form of comorbid substance use in all mental disorders, particularly those with serious mental disorders (Teesson & Byrnes 2001). There is therefore extensive interest in improving our understanding of the various types of comorbidity, including those relating to the full range of mental health disorders and substances. Further, some researchers call for a broadening of the discussion to include people who present with symptoms of substance use and anxiety or affective problems that do not meet the criteria for disorder. They argue that limiting discussion to those people who meet the criteria for 'disorder' may conceal the extent of the problem (Teesson & Byrnes 2001).

Estimates of the prevalence of comorbidity are also affected by factors including the demographic subpopulation of study (e.g. the homeless or imprisoned); the diagnostic tools used; whether rates are based on admitted patient, outpatient or population studies; and whether the rates are for comorbidity experienced over a lifetime, in the past 12 months or currently (Siggins Miller Consultants 2003). Further, the way in which prevalence estimates are presented often causes problems when making comparisons. For example, prevalence estimates are often presented as a proportion of those with a mental disorder or as a proportion of those with a substance use disorder. For example, Kessler and colleagues reported that 36% of people with a substance use disorder had also experienced an anxiety disorder in the past 12 months, while 15% of people with an anxiety disorder in the past 12 months experienced a substance use disorder (Kessler et al. 1996 in Siggins Miller Consultants 2003). The Siggins Miller review reports on an even wider range of 'prevalence estimates' which, presumably, requires careful scrutiny of the methodology and the factors listed above to understand the differences.

The most common dual diagnoses are substance use disorders (especially alcohol and tobacco) in conjunction with anxiety and affective disorders, largely because of the relatively high prevalence of each of these disorders in their own right (Siggins Miller Consultants 2003). Australian population data from the National Survey of Mental Health and Wellbeing (NSMHW) estimate that 1.2% of the Australian adult population have an affective and/or anxiety disorder with concurrent substance use disorder (Teesson, Hall, Lynskey et al. 2000 in Siggins Miller Consultants 2003). This survey has also been used to indicate that, among people who are dependent on cannabis, 17% had an anxiety disorder and 14% an affective disorder. Starting from another perspective, of those with anxiety disorder or affective disorder, 4% and 3% respectively also reported cannabis dependence.

As well as much interest in the prevalence of comorbidity there is interest in which types of comorbidity are the most disabling. For example, it has been documented both in community and clinical settings that people with comorbidity experience higher levels of disability (Bijl et al. 1998, Kessler et al. 1994, in Teesson & Proudfoot 2004). Further, Australian population data indicate that 'respondents with more than one disorder reported significantly higher levels of disability, distress and service utilisation, with levels increasing in a linear trend as the number of disorders increased' (Andrews et al. 2002 in Teesson & Proudfoot 2004). The literature identifies a gap in current information about which combinations of comorbidity are the most prevalent and most disabling, and how this information can influence health service planning (Teesson & Proudfoot 2004).

It is reported that people with comorbidity are at increased risk of adverse health and social outcomes. For example, people with comorbidity are likely to: '(1) have worse psychiatric symptoms, treatment compliance and prognosis; (2) use more treatment and service resources; (3) have greater propensity for suicidal and self-harming behaviours and poorer physical health habits; (4) have fewer social supports or financial resources with which to seek treatment other than on an outpatient basis from public sector community providers; and (5) exhibit the highest rates of expensive public psychiatric hospital admissions and criminal justice involvement' (Johnson 2000 in Siggins Miller Consultants 2003).

The co-occurrence of mental health and substance use disorders and the reasons they co-occur have implications for the way in which they are prevented and treated (Teesson & Byrnes 2001). While Australia is perceived as having excellent treatment services for both mental health and substance use disorders, a lack of communication between the two sectors has consistently been identified as a barrier to providing effective support to people who experience comorbidity (Teesson & Byrnes 2001). In recognition of the challenges faced by particular service sectors, the National Comorbidity Initiative has provided funding for research into the treatment of comorbidity in general practice (McCabe & Holmwood 2003) and a brief guide for the primary care clinician (Holmwood 2003). These references provide excellent summaries of the literature relating to the detection, assessment, diagnosis and management of comorbidity in primary care settings.

The National Comorbidity Initiative has also directed funding towards research into the treatment of comorbidity in specialist tertiary service settings, assumed to be those provided by 'psychiatrists, drug and alcohol practitioners/workers, nurses, counsellors and client support staff across both public and private clinical sectors, including government and non-government organisations', where a particular program or approach had been developed for providing services to clients with comorbid mental health and substance use disorders (Siggins Miller Consultants 2003).

Specific research has also been undertaken to review the alcohol and other drug and psychiatric screening and diagnostic instruments used to assess comorbidity (Dawe et al. 2002). The resulting report reviews the instruments used across a broad range of service settings as well as providing recommendations about when they should be used, by whom and how results should be interpreted including their limitations (Dawe et al. 2002).

A lack of appropriate and coordinated services for Indigenous Australians with comorbidity has been highlighted in the literature, as has the need to develop and implement culturally appropriate and effective services and promotion strategies among communities of different cultural and linguistic backgrounds (Teesson & Byrnes 2001).

Overall there remains a lack of evidence about best practice in how to treat people with comorbidity. Study in this area is complicated by a number of factors, including the poor understanding of the aetiology of comorbidity and the high rates of attrition of people with comorbidity from studies (Siggins Miller Consultants 2003). The large number of potential combinations of comorbidity and the associated possible treatment options also mean that the evidence base for any one combination is likely to be small (Siggins Miller Consultants 2003).

Where specialist treatment services exist for mental health or alcohol or other drug disorders, these services are generally separated in a physical, administrative and philosophical sense (Holmwood 2003). 'Research on service delivery is scarce, turf wars are common, and people with comorbid mental disorders and substance use disorders often fall through the cracks in the separate service systems' (Teesson & Proudfoot 2004). A recent review noted that the current separate funding structures for mental health and alcohol and other drug services provide little incentive for each to assess and treat comorbid conditions. Comorbidity is often used as an excluding factor in research carried out in either area, meaning that this important group is not only poorly served but less likely to be studied (Teesson & Proudfoot 2004).

According to Teesson and Proudfoot (2004), people with comorbidity are over-represented in both primary and secondary treatment sectors (in both alcohol and other drug and mental health settings), and there is much interest in implementing appropriate assessment mechanisms and evidence-based interventions to deal with comorbid disorders effectively. Previous work on comorbidity has also highlighted the need for whole-of-government approaches to treatment, noting that comorbidity is an issue which may touch on health, welfare, housing, income, criminal justice, education and training programs and policies (Teesson & Byrnes 2001:xi). This profile of possible outcomes for people with comorbidity highlights the need to have information about the full range of services that people with comorbidity might access, the characteristics of people with comorbidity, and the social context in which they live.

Evidence suggests that 'it is feasible to prevent the onset of both psychiatric and substance use disorders if early intervention and prevention strategies are implemented during childhood and adolescence' (Teesson & Proudfoot 2004). This finding raises the possibility that large-scale screening and brief intervention among young people may alleviate some of the burden borne by these individuals and the service system (Teesson & Proudfoot 2004). Prevention is a theme of both the National Mental Health Plan (2003–2008) and National Drug Strategy (2004–2009).

The issue of comorbidity and its importance is reflected in the National Mental Health Plan (2003–2008) and National Drug Strategy (2004–2009).

2.2 Key questions highlighted in literature

The following key questions were derived predominantly from the literature review (Section 2.1) and discussions with DoHA. The extent to which the available data sources are able to address these questions is detailed in Section 5.1.

A Describing comorbidity in the population

A1 What is comorbidity, why does it occur and what causes it?

A2 How common is comorbidity in the Australian population?

A3 What types of comorbidity are there and which are most prevalent in the Australian population?

A4 What are the most disabling types of comorbidity?

A5 What do we know about the people with comorbidity (e.g. demographics such as age, sex, Aboriginal and Torres Strait Islander status, cultural and linguistic background, geographical location)?

B Service delivery models for prevention and treatment of comorbidity

B1 What service delivery models are being used to deal with comorbidity?

B2 What are the implications of comorbidity for service delivery? For example, how is comorbidity best detected, prevented and treated?

B3 How can people with comorbidity and their carers be more aware of services and more involved in service planning?

B4 How can we best highlight the importance of comorbidity?

C Need for, demand for and receipt of treatment services by people with comorbidity

C1 How many people with comorbidity need services? What do we know about them?

C2 How many people with comorbidity demand services? What do we know about them?

C3 How many people with comorbidity receive services? What do we know about them?

C4 What types of services are being received by people with comorbidity?

C5 What do we know about people with comorbidity who do not receive services?

C6 How many times do people demand services over their life course?

C7 What do we know about the appropriateness of services received by people with comorbidity?

D Outcomes for people with comorbidity

D1 What are the outcomes (of treatment and more broadly) for people with comorbidity who receive services and who do not receive services?

3 Data sources relating to comorbidity

3.1 Relevant data sources

The following list includes all data sources that were explored by the Australian Institute of Health and Welfare (AIHW) in the first instance to determine whether they were of relevance to the issue of comorbidity and therefore this project. Data sources were selected if they were nationally based and considered either to describe the prevalence or nature of comorbidity in the population or relate to services or benefits that one might expect people with comorbidity to access (including services specific to the treatment of drug and alcohol and/or mental health problems and generic services such as housing or income support). A small number of state/territory surveys were also selected as they were known to include information about comorbidity and relate to populations that are likely to experience comorbidity (e.g. people in contact with the correctional system).

The data sources are grouped according to major topic area. For an alphabetical list of all data sources see the Abbreviations section of this report.

Alcohol and drug related data sources

	Collection name	**Abbreviation**
1	Alcohol and Other Drug Treatment Services National Minimum Data Set	AODTS–NMDS
2	National Drug Strategy Household Survey	NDSHS
3	Australian Schools Students Alcohol and other Drugs Survey	ASSADS
4	Illicit Drugs Reporting System—Injecting Drug Users	IDRS–IDU
5	Illicit Drugs Reporting System—Party Drugs Initiative	IDRS–PDI
6	Drug and Alcohol Service Report	DASR
7	Service Activity Report	SAR
8	National Opioid Pharmacotherapy Statistics Annual Data collection	NOPSAD
9	Clients of Treatment Services Agencies survey	COTSA
10	Council of Australian Governments Illicit Drug Diversion Initiative data	COAG IDDI
11	National Needle and Syringe Program Survey	NSP
12	National Alcohol Campaign tracking research data	NAC
13	National Tobacco Campaign Survey	NTCS

Mental health related data sources

	Collection name	Abbreviation
14	National Community Mental Health Care Database	NCMHCD
15	National Residential Mental Health Care Database	NRMHCD
16	Mental Health National Outcomes and Casemix Collection	MHNOCC
17	Australian Bureau of Statistics (ABS) National Survey of Mental Health and Wellbeing (adults aged 18 years and over) 1997	NSMHW (adult)
18	National Survey of Mental Health and Wellbeing (children and adolescents aged 4–17 years) 1998	NSMHW (C & A)
19	National Survey of Mental Health and Wellbeing (psychotic or low-prevalence disorders for adults 18–64 years) 1997–98	NSMHW (psychotic)

General health or welfare related data sources

	Collection name	Abbreviation
20	ABS Survey(s) of Disability, Ageing and Carers	SDAC
21	National Hospital Morbidity Database	NHMD
22	Commonwealth State/Territory Disability Agreement National Minimum Data Set	CSTDA–NMDS
23	National Mortality Database	NMD
24	Bettering the Evaluation and Care of Health survey of general practice activity	BEACH
25	ABS National Health Survey	NHS
26	ABS National Aboriginal and Torres Strait Islander Health Survey	NATSIHS
27	ABS National Aboriginal and Torres Strait Islander Social Survey	NATSISS
28	ABS General Social Survey	GSS
29	Survey of Entitled Veterans, War Widows and their Carers	Veterans' data
30	Pharmaceutical Benefits Scheme data	PBS
31	Medicare Benefits Scheme data	MBS
32	National Coroners Information System	NCIS
33	Australian Longitudinal Study on Women's Health survey	ALSWH
34	Kids Help Line Statistics	KHLS
35	Lifeline Statistics	–
36	Outpatient Care National Minimum Data Set	OC NMDS
37	National Non-admitted Patient Emergency Department Care Database	NAPEDCD

Housing data sources

	Collection name	Abbreviation
38	Supported Accommodation Assistance Program National Data Collection	SAAP NDC
39	Commonwealth–State Housing Agreement National Minimum Data Set	CSHA–NMDS
40	Commonwealth–State Housing Agreement Community Housing	CSHA–CH
41	Commonwealth–State Housing Agreement Home Purchase Assistance	CSHA–HPA
42	Commonwealth–State Housing Agreement Crisis Accommodation Program	CSHA–CAP
43	Commonwealth–State Housing Agreement Private Rental Assistance	CSHA–PRA

Income support data sources

	Collection name	Abbreviation
44	Longitudinal Data Set	LDS
45	General Customer Survey	GCS
46	Household, Income and Labour Dynamics in Australia	HILDA

Criminal justice and child protection data sources

	Collection name	Abbreviation
47	Juvenile Justice national minimum Data Set	JJ NMDS
48	National Police Custody Survey	NPCS
49	National Prisoner Census	NPC
50	Drug Use Careers of Offenders survey	DUCO
51	Drug Use Monitoring in Australia survey	DUMA
52	2001 New South Wales Inmate Health Survey	NSW–IHS
53	2002 Queensland Women Prisoners' Health Survey	QLD–WPHS
54	ABS Crime and Safety Survey	CSS
55	National Child Protection Data Collection	NCPDC

Education and training data sources

56	Australian Government Department of Education, Science and Training (DEST) administrative collections relating to higher education, vocational education and schools.[a] (a) While some of these data collections (e.g. the Annual Census of Universities) include items which identify whether or not the student has a disability, they do not generally contain sufficient information of relevance to this project. Such education and training data sources were therefore excluded from all further analysis in this report. Some information about secondary school students is, however, available via the ASSADS, listed above as an alcohol and drug related data source.	

3.2 Descriptions of relevant data sources

All[2] of the relevant data sources listed in Section 3.1 have been described in terms of the following template (Table 3.1). The completed templates (collection summaries) are included at Appendix 1.

Table 3.1: Template for describing relevant data sources in the area of comorbidity

Data source (title)	*Full name of the survey or data collection.*
Brief description	*Brief outline of the data source.*
Purpose(s)	*Main stated purpose or purposes of the data source.*
Collection methodology	*Key features of the collection methodology such as whether it is an administrative data collection or survey, the method of data collection (e.g. computer-assisted telephone interview (CATI), self-completion, administrative by product data) and sampling methodology (e.g. multi-stage, stratified area design sample of households).*
Scope	*Theoretical or intended coverage of the relevant population.*
Coverage	*Actual coverage of the theoretical or intended population including, wherever possible, information about response rates.*
Geographic coverage	*The Australian state and territory or other jurisdictions covered by the data source.*
Frequency/timing	*The year(s) in which data have been collected for the data source and the period over which data were collected (e.g. 1999, 2001, 2003 or each financial year from 1997–98).*
Basic collection count	*The basic counting unit for the data source, e.g. treatment episode, separation, client etc.*
Does the collection include a unique client identifier or statistical linkage key?	*Whether or not the collection includes a unique client identifier or statistical linkage key and a description of this identifier or key. In relation to the statistical linkage key, this template item does not reflect whether it is possible, using items currently included in the data source, to generate a statistical key, but rather that a statistical linkage key per se is currently part of the collection.*
Data content	*List of all data items.*
Has there been variation over time in any of the above descriptors for this collection?	*This item highlights variations over time in any of the key descriptors (e.g. collection count, scope, data items) that may affect potential analysis of the data source.*
Are there any proposed developments relating to comorbidity in the near future for this collection?	*Whether there are plans to include information in the near future that would enable an estimate of comorbidity among the data source population to be established.*
Definitions—how are the following concepts addressed and/or defined?	
Substance use	*For example, information relating to 'problem drinking', drug use behaviours, whether an individual has accessed relevant service types (such as alcohol and other drug treatment services), information about diagnoses (e.g. alcohol dependence).*

(continued)

2 The Australian Government Department of Education, Science and Training administrative collections relating to higher education, vocational education and schools are excluded from this analysis. While some of these data collections (e.g. Annual Census of Universities) include items which identify whether or not a student has a disability, they do not generally contain sufficient information of relevance to this project. Such education and training data sources were therefore excluded from all further analysis in the report.

Table 3.1 (continued): Template for describing relevant data sources in the area of comorbidity

Mental health	*For example, information about an individual's mental wellbeing, whether an individual has accessed relevant service types (such as a psychiatric hospital), information about diagnoses (e.g. schizophrenia).*
Comorbidity	*Whether the information collected in relation to the 'substance use' and 'mental health' data items enables an estimate of comorbidity among the data source population to be established.*
Age	*Whether and how age details are recorded in the data source, e.g. date of birth, age or age groups.*
Sex	*Whether and how sex is recorded in the data source.*
Cultural and linguistic diversity	*Whether and how information about cultural and linguistic diversity is recorded in the data source, e.g. preferred spoken language, country of birth, English proficiency etc.*
Indigenous status	*Whether and how information about Indigenous status is recorded in the data source, e.g. Aboriginal, Torres Strait Islander, both Aboriginal and Torres Strait Islander, neither Aboriginal or Torres Strait Islander.*
Geographic location of respondent	*Whether and how information about a respondent's geographic location is recorded in the data source, e.g. postcode or Statistical Local Area (SLA) of an individual's usual residence.*
Geographic location of agency or other relevant unit	*Whether and how information about an agency's (or other relevant unit's) geographic location is recorded in the data source, e.g. postcode or SLA of an agency's central office or service delivery outlet.*
Treatment types	*Whether and how information about the type(s) of treatment provided are recorded in the data source, e.g. counselling, rehabilitation, respite care.*
Indicators of social context	*Whether and how information that provides indicators of an individual's social context is recorded in the data source, e.g. living arrangements, residential setting, marital status, household composition.*
Indicators of social participation	*Whether and how information that provides indicators of an individual's social participation is recorded in the data source, e.g. labour force status, education status.*
Treatment outcomes	*Whether the data source includes any information relating to outcomes of treatment provided.*
Collection management agency	
Title/name of contact	*Contact details for the agency that manages the data collection.*
Address	*Contact details for the agency that manages the data collection.*
Email	*Contact details for the agency that manages the data collection.*
Internet	*Contact details for the agency that manages the data collection.*
Phone/fax	*Contact details for the agency that manages the data collection.*
Data custodian/access	*Contact details for the person who should be contacted in relation to accessing information from the data source.*
Funding agency	*The agency or agencies responsible for funding the data collection.*
Output	*Links to or examples of recent publications or data products (e.g. data cubes) relating to the data source.*
References	*Publications or information sources used in preparing the template.*
When will data from this reference period/survey be available?	*Expected release date of the data for the most recent collection year (i.e. data relating to the definitions, scope, methodology etc. in the remainder of the template).*
Other comments	

3.3 Key data sources

Of the data sources identified as relevant to the understanding of comorbidity in Australia, a subset of data collections was selected as key data sources, namely those with the capacity (either currently or with minimal modification) to inform one or more of the key questions identified in Chapter 2.

Based on analysis using the template in Table 3.1 and consideration of the questions identified in Chapter 2, the following data sources were excluded from further analysis:

- COTSA, because this collection was essentially replaced by the AODTS–NMDS after 2001.
- COAG IDDI, because the collection is incomplete and there is no information on mental health.
- The NSP, on the basis that it is a survey with the purpose of focusing on blood-borne infections due to injecting habits, there is no information on mental health and limited information about substance use (based on drug most recently injected).
- The GSS, on the basis that it provides very little relevant information about comorbidity, particularly compared to other ABS surveys selected for analysis.
- PBS) and MBS data sets, because, while they do capture some information about mental health, they do not enable comorbidity to be detected. For instance, while PBS data provide information about scripts that might relate to mental health (including substance use) disorders they do not readily enable an estimate of the number of people with mental health problems only, substance use problems only or a combination of the two. MBS data only enable estimates based on type of service received (for example, psychiatric attendances).
- The OC NMDS, on the basis that it is currently under development, and is unlikely to include relevant information as its scope specifically excludes mental health and alcohol and other drug treatment services (because they are already covered under existing national minimum data sets).
- Commonwealth–State Housing Agreement datasets, as they are based on households rather than people and they do not contain appropriately detailed information about the health of individuals receiving this form of support.
- The JJ NMDS, because it is in its early stages of implementation, and there are no plans to include information on either mental health or substance use.
- NPCS and NPC, because they do not contain any information about substance use or mental health. Further, there are other more appropriate data sources from the corrections area (e.g. NSW–IHS, DUMA and DUCO).
- ABS CSS, because it does not contain information about substance use or mental health and cannot inform any of the questions relating to comorbidity. Its objective is primarily to focus on the way that crime affects the Australian community.
- NCPDC statistics, because they do not include information that could be used to address any of the comorbidity questions raised.

Comparative analysis of the remaining 38 key data sources is included in Chapter 4.

4 Comparative analysis of key data sources

This chapter provides a comparative analysis of the 38 key data sources. Section 4.1 compares data sources in terms of their methodology, scope, coverage, timing and collection counts and Section 4.2 compares data sources in terms of relevant data items. Templates describing all data sources are included at Appendix 1.

4.1 Comparability of key data sources in terms of methodology, scope, coverage, timing and collection counts

Methodology

Of the 38 key data sources reviewed:

- 9 are population surveys, 5 of which are conducted by the ABS
- 13 are other surveys, for example one-off surveys or occasional surveys of particular populations such as people accessing a service sector such as corrections
- 16 are administrative collections, including national minimum data sets (Table 4.1).

Of the 16 administrative collections, 13 are considered unit record collections, on the basis that one record is recorded and stored for each unit of the collection count (whether this be client, closed treatment episode, episode of care, separation, phone call etc.). The remaining 3 administrative collections involve the collation and reporting of aggregate data, for example where state/territory departments forward a set of specified tables to a central agency for national collation.

Table 4.1: Collection methodology for relevant data sources

No.	Data source	Surveys (population)	Surveys (other)	Administrative collections
1	Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS–NMDS)			✓ (UR)
2	National Drug Strategy Household Survey (NDSHS)	✓		
3	Australian Schools Students Alcohol and other Drugs Survey (ASSADS)		✓	
4	Illicit Drugs Reporting System—Injecting Drug Users (IDRS–IDU)		✓	
5	Illicit Drugs Reporting System—Party Drugs Initiative (IDRS–PDI)		✓	
6	Drug and Alcohol Service Report (DASR)			✓ (A)
7	Service Activity Report (SAR)			✓ (A)
8	National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD)			✓ (A)
12	National Alcohol Campaign (NAC)		✓	
13	National Tobacco Campaign Survey (NTCS)		✓	
14	National Community Mental Health Care Database (NCMHCD)			✓ (UR)

Note: UR = unit record, A = aggregate data.

(continued)

Table 4.1 (continued): Collection methodology for relevant data sources

No.	Data source	Surveys (population)	Surveys (other)	Administrative collections
15	National Residential Mental Health Care Dataset (NRMHCD)			✓ (UR)
16	Mental Health National Outcomes and Casemix Collection (MHNOCC)			✓ (UR)
17	ABS National Survey of Mental Health and Wellbeing—adult (NSMHW adult)	✓		
18	National Survey of Mental Health and Wellbeing—children and adolescents (NSMHW C & A)	✓		
19	National Survey of Mental Health and Wellbeing—psychotic (NSMHW psychotic)	✓		
20	ABS Survey of Disability, Ageing and Carers (SDAC)	✓		
21	National Hospital Morbidity Database (NHMD)			✓ (UR)
22	Commonwealth–State/Territory Disability Agreement National Minimum Date Set (CSTDA NMDS)			✓ (UR)
23	National Mortality Database (NMD)			✓ (UR)
24	Bettering the Evaluation and Care of Health survey of general practice activity (BEACH)		✓	
25	ABS National Health Survey (NHS)	✓		
26	ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)	✓		
27	ABS National Aboriginal and Torres Strait Islander Social Survey (NATSISS)	✓		
29	Survey of Entitled Veterans, War Widows and their Carers (Veterans' data)		✓	
32	National Coroners Information System (NCIS)			✓ (UR)
33	Australian Longitudinal Study on Women's Health survey (ALSWH)		✓	
34	Kids Help Line Statistics (KHLS)			✓ (UR)
35	Lifeline Statistics			✓ (UR)
37	National Non-admitted Patient Emergency Department Care Database (NAPEDCD)			✓ (UR)
38	Supported Accommodation Assistance Program National Data Collection (SAAP NDC)			✓ (UR)
44	Longitudinal Data Set (LDS)			✓ (UR)
45	General Customer Survey (GCS)		✓	
46	Household, Income and Labour Dynamics in Australia (HILDA)	✓		
50	Drug Use Careers of Offenders survey (DUCO)		✓	
51	Drug Use Monitoring in Australia survey (DUMA)		✓	
52	New South Wales—Inmate Health Survey (NSW–IHS)		✓	
53	Queensland—Women Prisoners' Health Survey (QLD–WPHS)		✓	

Note: UR = unit record, A = aggregate data.

Scope, coverage and timing

The data sources reviewed have widely varied methodologies and purposes, which are reflected in their scope, coverage and timing (Table 4.2). For example, among population surveys, the scope varies mostly according to the age groups surveyed (e.g. all people, adults only, children). Among other surveys, the scope ranges from detainees, prisoners and remandees in correctional facilities to secondary school students, Indigenous Australians, women and income support customers. Administrative collections generally define their scope in terms of program boundaries and associated funding arrangements (e.g. the SAAP NDC collects information from all SAAP-funded agencies, the AODTS–NMDS collects information from publicly-funded alcohol and other drug treatment agencies). The IDRS collections (injecting drug users and party drug initiative) include samples of injecting drug users and ecstasy users as well as key informants, and triangulate this information with data from a range of other sources.

Most data sources include all states and territories in Australia in their geographic coverage. Exceptions are the NSMHW (psychotic) (metropolitan areas of the Australian Capital Territory, Queensland, Victoria and Western Australia only), DUCO (various jurisdictions over time), DUMA (Queensland, Western Australia, New South Wales and South Australia only), NSW–IHS and QLD–WPHS.

There are also widely differing timing arrangements for the reviewed data collections. Among the administrative data collections, most are conducted on a financial year basis, with the most recent data generally available for 2003–04. For data collections such as those relating to Lifeline, the Australian Government Department of Family and Community Services (FaCS), the Australian Government Department of Employment and Workplace Relations (DEWR) and the Australian Government Department of Education, Science and Training (DEST) income support customers, data are collected on an ongoing basis but can be collated on a financial year basis. Of the surveys reviewed, the most recent in the series had generally been conducted between 2001 and 2003. The most notable exception is the NSMHW, which was conducted only once (in 1997 for the adult component, 1998 for the child and adolescent component and 1997–98 for the psychotic component). The NATSIHS is the first in its series and is currently in the field.

Collection counts

One important characteristic to consider when comparing data sources is the collection count. The basic collection count varied widely across the reviewed collections, from population estimates of people or households (generated by surveys) to client counts or number of phone calls (generated by administrative data collections) (Table 4.2). Among administrative data collections, the basic counting unit varied substantially. For example:

- 'closed treatment episodes' in the AODTS–NMDS
- 'separations' in the NHMD
- 'service contacts' in the NCMHCD
- 'episodes of residential care' in the NRMHCD
- service level estimates of 'client numbers' and 'episodes of care' in the SAR and DASR
- 'clients', 'closed support periods' and 'ongoing support periods' in the SAAP NDC
- 'clients' in the NOPSAD
- 'service users' in the CSTDA–NMDS
- 'phone calls' in Lifeline and KHLS.

As variation also occurs in the way the above terms are defined, meaning that analysts should be cautious when comparing counts across collections. While definitions of 'clients' or 'service users' are generally broadly comparable, definitions relating to episodes of care have detailed definitions which relate mostly to the way commencement and cessation dates are specified and rules for when and why an episode should be closed. Thus, the broad concept of an episode of care is not generally directly comparable across collections using this count.

A number of the data sources also include a counting unit for the number of agencies or establishments that provide services or assistance to clients. For example:

- 'number of treatment agencies' in the AODTS–NMDS
- 'number of agencies' in the DASR and SAR
- 'number of establishments' in the NCMHCD
- 'number of CSTDA-funded service outlets' in the CSTDA–NMDS
- 'number of SAAP-funded agencies' in the SAAP NDC.

For more detail on the information presented in this section, see Table 4.2.

Table 4.2: Collection scope, coverage, frequency and count for key data collections

	Data source	Scope	Geographic coverage	Frequency	Count
1	Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS)	Publicly funded alcohol and other drug treatment services and their clients	All states and territories, Australia	Annually from 2000–01	Closed treatment episodes, number of agencies
2	National Drug Strategy Household Survey (NDSHS)	Population aged 12 years or more	All states and territories, Australia	Approximately triennial from 1985	Estimated number of people
3	Australian Schools Students Alcohol and other Drugs Survey (ASSADS)	Years 7 to 11 students aged 12–17 years	All states and territories, Australia	Triennial since 1984	Number of students
4	Illicit Drugs Reporting System – Injecting Drug Users (IDRS–IDU)	Sample of injecting drug users and key informants	All states and territories, Australia	Annually since 1996 (with staggered implementation across states and territories)	Number of people (users and informants)
5	Illicit Drugs Reporting System – Party Drugs Initiative (IDRS–PDI)	Sample of party drug users and key informants	All states and territories, Australia	Annually since 2003 (piloted in some states in 2002)	Number of people (users and informants)
6	Drug and Alcohol Service Report (DASR)	Australian Government funded Indigenous substance use services	All states and territories, Australia	Annually from 1999–2000	Service level estimates of total client numbers and episodes of care, number of agencies
7	Service Activity Report (SAR)	Australian Government funded primary health care services	All states and territories, Australia (with the exception of Tasmania and the Australian Capital Territory)	Annually from 1997–98 (with the exception of 2001–02)	Service level estimates of: total client numbers, episodes of care, client contacts and transport contacts, number of agencies
8	National Opioid Pharmacotherapy Statistics Annual Data collection (NOPSAD)	All opioid pharmacotherapy maintenance programs in Australia	All states and territories, Australia	Annually from 1998	Number of clients
12	National Alcohol Campaign tracking research data (NAC)	Sample of Australians aged 15–17 years of age	All states and territories, Australia	Annually from 2000	Number of individuals

(continued)

Table 4.2 (continued): Collection scope, coverage, frequency and count for key data collections

	Data source	Scope	Geographic coverage	Frequency	Count
13	National Tobacco Campaign Survey (NTCS)	Sample of Australians aged 18–69 years of age	All states and territories, Australia (ACT reported together with NSW, and NT reported together with SA)	Annually from 1997	Number of individuals
14	National Community Mental Health Care Database (NCMHCD)	All specialised public community mental health services	All states and territories, Australia	Annually from 2000–01	Service contacts, number of establishments
15	National Residential Mental Health Care Database (NRMHCD)	Publicly funded residential mental health services	All states and territories, Australia	Annually from 2004–05	Episode of residential care, number of establishments
16	Mental Health National Outcomes and Casemix Collection (MHNOCC)	All specialised mental health services managed or funded by state and territory health administrators	All states and territories, Australia	Some data collected from 2002–03 but limited data yet available.	Collection occasions: admission, review and discharge
17	National Survey of Mental Health and Wellbeing (adults) (NSMHW adult)	Population of Australians aged 18 years or more	All states and territories, Australia	1997	Estimated number of people
18	National Survey of Mental Health and Wellbeing (children and adolescents) (NSMHW C & A)	Population of Australians aged 4–17 years	All states and territories, Australia	1998	Estimated number of people
19	National Survey of Mental Health and Wellbeing (psychotic) (NSMHW psychotic)	People who attended a mental health service aged between 15–64 diagnosed with a psychotic disorder	Australian Capital Territory, Queensland, Victoria and Western Australia	1997–98	Estimated number of people
20	Survey(s) of Disability, Ageing and Carers (SDAC)	Population	All states and territories, Australia	1981, 1988, 1993, 1998, 2003	Estimated number of people
21	National Hospital Morbidity Database (NHMD)	All public and private acute and psychiatric hospitals	All states and territories, Australia	Annually from 1993–94	Number of separations

(continued)

Table 4.2 (continued): Collection scope, coverage, frequency and count for key data collections

	Data source	Scope	Geographic coverage	Frequency	Count
22	Commonwealth State/Territory Disability Agreement National Minimum Data Set (CSTDA–NMDS)	All CSTDA–funded services and their clients	All states and territories, Australia	Annually from 2002–03	Number of service users, number of outlets
23	National Mortality Database (NMD)	All people who die in Australia, including people from other countries	All states and territories, Australia	Annually from 1964	Number of deaths
24	Bettering the Evaluation and Care of Health survey of general practice activity (BEACH)	General practitioners (GPs)	All states and territories, Australia	Annually from 1998	Estimated number of GP encounters
25	National Health Survey (NHS)	Population	All states and territories, Australia	1989–90, 1995, 2001	Estimated number of people, estimated number of households
26	National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)	Population of Indigenous Australians in remote and non-remote areas	All states and territories, Australia	Every six years from 2004–05	Estimated number of people, estimated number of households
27	National Aboriginal and Torres Strait Islander Social Survey (NATSISS)	Population of Indigenous Australians aged 15 years and over	All states and territories, Australia	1994, 2002	Estimated number of people, estimated number of households
29	Survey of Entitled Veterans, War Widows and their Carers (Veterans' data)	Repatriation Health Care Card Holders living in Australia and their carers	All states and territories, Australia	1988–89, 1992, 1997–98, 2003	Number of people
32	National Coroners Information System (NCIS)	All deaths referred to a coroner (where case has been closed)	All states and territories, Australia (Queensland included from 2001)	Weekly since 2000	Number of deaths referred to a coroner
33	Australian Longitudinal Study on Women's Health survey (ALSWH)	Population of Australian women in 3 age cohorts	All states and territories, Australia	2002, 2003, 2004	Number of people
34	Kids Help Line Statistics (KHLS)	All callers who contact Kids Help Line phone/internet counselling service	All states and territories, Australia	Ongoing since May 1993	Number of phone calls, number of emails, number of web counselling sessions

(continued)

Table 4.2 (continued): Collection scope, coverage, frequency and count for key data collections

	Data source	Scope	Geographic coverage	Frequency	Count
35	Lifeline Statistics	All callers who contact Lifeline's counselling service	All states and territories, Australia	Ongoing since July 2001	Number of phone calls
37	National Non-admitted Patient Emergency Department Care Database (NAPEDCD)	Non-admitted patients registered for care in emergency departments in selected public hospitals	All states and territories, Australia	Annually from July 2003	Number of non-admitted patient emergency department service episodes
38	Supported Accommodation Assistance Program National Data Collection (SAAP NDC)	All SAAP-funded agencies and their clients	All states and territories, Australia	Annually from 1996–97	Number of clients, SAAP closed support periods, SAAP ongoing support periods, SAAP services requested, number of agencies
44	Longitudinal Data Set (LDS)	FaCS, DEWR and DEST income support customers	All states and territories, Australia	Ongoing from January 1995	Number of people
45	General Customer Survey (GCS)	Sample of FaCS customers	All states and territories, Australia	Three cohorts starting in 2000, 2001 and 2002	Number of people
46	Household, Income and Labour Dynamics in Australia (HILDA)	Population	All states and territories, Australia	Regular waves since July 2001	Number of people
50	Drug Use Careers of Offenders survey (DUCO)	Adult offenders sentenced to prison and sentenced and remanded juveniles	Four jurisdictions for males, six for females and all jurisdictions for juveniles	Male DUCO 2001, Female DUCO 2003 and Juvenile DUCO 2004 (each survey conducted once only, not repeated)	Number of people
51	Drug Use Monitoring in Australia survey (DUMA)	Detainees held in custody	Queensland, Western Australia, New South Wales, South Australia	Quarterly from 1999	Number of people
52	New South Wales Inmate Health Survey (NSW–IHS)	NSW male and female inmates in full custody	New South Wales	1996, 2001	Number of people
53	Queensland Women Prisoners' Health Survey (QLD–WPHS)	All females incarcerated in Queensland	Queensland	2002	Number of people

4.2 Comparability of key data sources in terms of data items

This section includes a series of tables and descriptive text describing the comparability of key data sources in terms of critical data items that inform the understanding of the comorbid population in Australia.

Defining comorbidity

A discussion of the various ways in which comorbidity can be conceptualised and defined is included in the literature review in Section 2.1. For example, some definitions distinguish between concurrent versus successive comorbidity, heterotypic (between different classes of mental disorders) versus homotypic (between different members of a general class of mental disorders such as coexisting anxiety disorder and phobia or coexisting alcohol and other drug use problems). Some researchers exclude tobacco as a relevant substance when discussing comorbidity while others argue it is one of the most critical substances of concern. Others narrowly define comorbidity as the co-occurrence of schizophrenia and substance use disorders while others include the full range of mental disorders. It should be recognised that the distinction between mental health disorders and substance use disorders is somewhat artificial, given that most classifications consider substance use disorders a subset of all mental health disorders.

In this section, as in the remainder of the report, discussion is based on the National Comorbidity Initiative's definition of comorbidity, namely 'coexisting mental health and substance use disorders'. We therefore highlight all data collections that include information relating to coexisting mental health and substance use *disorders.* We assume that a collection relates to the concept of *disorder* if there is evidence that an individual has obtained a diagnosis (at some stage) from a medical professional. However, we also highlight the key data sources that include information indicating coexisting mental health and substance use *problems*, which have not necessarily been diagnosed by a medical professional and/or for which there is no evidence of an actual diagnosis. We assume that a collection provides information about comorbidity problems if it includes information about, for example, level of substance use and a general mental health indicator.

Information type—problems or disorders?

Table 4.3 summarises the way in which mental health, substance use and comorbidity issues are addressed in each key data collection. It also indicates whether each collection enables an estimate to be developed of the prevalence of comorbidity and whether this definition would be based predominantly on the notion of *problems* or *disorders*.

Of the 38 key collections reviewed, 26 include information that can describe comorbidity in some way. Of these:

- 13 include information about both mental health and substance use *disorders*
- 13 include information about both mental health and substance use *problems*.

Information source—who provided the information?

Table 4.4 further delineates the information presented in Table 4.3 in terms of the source of the information used to define a comorbidity *problem* or *disorder,* specifying whether the information was obtained by self-report, from a medical practitioner/specialist or from 'other' source. Of the 13 collections that include information about mental health and substance use *disorders*, 8 are based on the individual's self-reported health conditions and 5

are based on medical diagnoses. Of the 13 collections that relate to mental health and substance use *problems,* 10 are based on self-reported information, 1 on a medical assessment of the individual's problems and 2 on other indirect measures. Of those self-reporting a mental health or substance use *problem,* it is not possible to indicate whether this information is reported as a result of information heard from their doctor.

Defining mental health and substance use disorders

The 26 data collections that include information about comorbidity (presented in Table 4.4) were further examined in terms of the classification used to describe mental health and substance use disorders. Of the 13 collections that include information sufficient to describe coexisting mental health and substance use *disorders:*

- 1 (NSMHW (adult)) uses the Composite International Diagnostic Interview, which enables diagnosis of mental disorders according to both the *International Classification of Diseases and Related Health Problems, 10th Revision* (ICD–10) and the *Diagnostic and Statistical Manual of Mental Disorders, Version IV* (DSM-IV)
- 4 (SDAC, NHS, NATSIHS and NSMHW (psychotic)) classify long-term health conditions according to the ICD–10
- 1 (NMD) classifies underlying cause of death and contributing diseases or conditions according to the ICD–10 (multiple causes of death are only available from 1997 onwards)
- 3 (NRMCHD, MHNOCC collection and NHMD) classify principal and additional diagnoses according to the *International Classification of Diseases and Related Health Problems, 10th Revision*, *Australian Modification* (ICD–10–AM)
- 4 use specially developed classifications, for example, the NDSHS and the Survey of Entitled Veterans, War Widows and their Carers each ask respondents to select from a specified short list, while the LDS and GCS collect information on multiple health conditions using Centrelink's 'disability' code (condition) classification.

A number of these collections also used other classifications in addition to the primary classifications described above. For example, the NDSHS also collects information about general mental wellbeing using the Kessler 10 and the NSMHW (psychotic) classifies health conditions according to the ICD–10 as well as a range of other classifications such as Farmer's schizophrenia subtypes. The NATSIHS, for the first time, includes a culturally appropriate measure of social and emotional wellbeing for Indigenous Australians.

Defining mental health and substance use problems

Among the 13 data collections assumed to describe mental health and substance use *problems*, there is great variation in the way these concepts could be defined. For example, substance use problems could be defined based on information about:

- the use and frequency of use of tobacco, alcohol and illicit drugs—for 5 of the collections (IDRS–IDU, NSMHW (C & A), ALSWH, NSW–IHS and QLD–WPHS)
- the use and frequency of use of alcohol and tobacco and use of illicit drugs (i.e. excluding frequency of use of illicit drugs)—for 2 of the collections (NSMHW (psychotic), NATSISS)
- use (ever, last 6 months, currently regular, frequency, age of onset/initiation) of illicit drugs (i.e. excluding tobacco and alcohol) and whether addicted to illegal drugs or alcohol (i.e. excluding tobacco) for 2 of the collections (DUCO and DUMA)

- issues raised by callers (Lifeline Statistics and KHLS), which may include, for example, drug misuse or problem drinking (but most likely excludes tobacco)
- 'reason for encounter', 'problems managed' and 'procedures, other treatments, counselling' for people seeing GPs, where these relate to substance use (BEACH survey)
- whether the 'presenting reason for seeking assistance', 'type of support provided' or 'type of housing/accommodation before/after support period' related to substance use issues (SAAP NDC).

For example, mental health problems could be defined based on information:

- from the Diagnostic Interview Schedule and Child Behaviour Checklist (NSMHWB (C & A))
- about current psychiatric treatment status; current, past year and lifetime experience of various mental health stressors and issues; medications used for mental health problems (the NSMHWB (psychotic), for which all respondents were aged between 18–64 years of age and had been previously diagnosed with a psychotic disorder)
- about the presence of long-term health conditions (that have lasted or were likely to last 6 months or more) coded according to the ICD–10 (NHS and NATSIHS) as well as information about type, length and duration of medications for mental health and wellbeing together with the Kessler 10 for the NHS, and a social and emotional wellbeing measure comprising a subset of the Kessler 10, impact questions from Kessler 10+, a subset of the SF–36 and anger questions for the NATSIHS
- ever been a patient in a psychiatric hospital for at least one overnight stay (DUMA)
- Beck Depression Inventory, Beck Hopelessness Scale, Kessler 10, previous psychiatric diagnosis and others in the NSW–IHS.

Proxy measures for coexisting mental health and substance use problems could therefore be derived using a combination of information about mental health problems and substance use problems. For example:

- a possible proxy measure for the NSMHW (C & A) would incorporate information about whether there is a substance use problem (defined in terms of frequency of consumption) in conjunction with a limited list of mental health disorders (the Diagnostic Interview Schedule identifies depressive disorder, attention deficit hyperactivity disorder (ADHD) and conduct disorder). The survey also captures a series of mental health problems (e.g. aggression, withdrawn behaviour etc.)
- a possible proxy measure for the ALSWH could be based on a combination of use of tobacco and alcohol (how often and quantity) and illicit drug use (use in last 12 months by type of drug) with, for example, types of condition a person has been diagnosed or treated for (e.g. depression), medications used (e.g. prescription medication for nerves, prescription medication for depression), mental health indicators on how a person is feeling (e.g. very nervous, so down in the dumps nothing can cheer you up) and information about stress.

Many of the data sources contained additional data items which could be used to support the information generated using such proxy measures (e.g. the NSMHW (psychotic) contained a range of other classifications such as Farmer's schizophrenia subtypes).

Table 4.3: Definitions of substance use, mental health and comorbidity in key data sources

No.	Data source	Substance use	Mental health	Comorbidity	Definition based on 'problem' or 'disorder'
1	AODTS–NMDS	Principal drug of concern (in relation to this treatment episode) (coded by drug type) Additional drug of concern	Source of referral (mental health care service)	No	—
2	NDSHS	Use and frequency of use of tobacco, alcohol and illicit drugs Whether the person has ever participated in a drug or alcohol treatment program to reduce or quit consumption	Kessler 10 scale of psychological distress SF–1 Information on diagnosis and/or treatment of health conditions in the last 12 months	Yes	Disorder
3	ASSADS	Use and frequency of use of tobacco, alcohol and illicit drugs	Not collected	No	—
4	IDRS–IDU	Use and frequency of tobacco, alcohol, and illicit drugs Injecting practices Brand and form of drug used	Presence of mental health problem (other than drug dependence) in last 6 months (specify)	Yes	Problem
5	IDRS–PDI	Use and frequency of tobacco, alcohol, and illicit drugs Injecting practices Brand and form of drug used	Not collected	No	—
6	DASR	Service level estimates of the substances for which treatment sought	Service level estimates of substance use clients that had emotional and/or social health issues.	No	—
7	SAR	Service level estimates of the substances for which treatment sought	Service level estimates of emotional and social wellbeing issues affecting clients and the services provided for these issues.	No	—
8	NOPSAD	Not collected	Not collected	No	—
12	NAC	Recency of alcohol consumption Type of alcohol consumed Prevalence of teenage drinking	Not collected	No	—
13	NTCS	Smoking status	Not collected	No	—

(continued)

Table 4.3 (continued): Definitions of substance use, mental health and comorbidity in key data sources

No.	Data source	Substance use	Mental health	Comorbidity	Definition based on 'problem' or 'disorder'
14	NCMHCD	Principal diagnosis (using ICD–10–AM codes)—mental and behavioural disorders due to psychoactive substance use (includes type of substance)	Principal diagnosis (using ICD–10–AM codes) Mental health legal status	Limited	—
15	NRMHCD	Principal diagnosis (using ICD–10–AM codes)—mental and behavioural disorders due to psychoactive substance use (includes type of substance) Additional diagnosis (using ICD–10–AM codes)	Principal diagnosis (using ICD–10–AM codes) Additional diagnosis (using ICD–10–AM codes) Mental health legal status	Yes	Disorder
16	MHNOCC	Principal and additional diagnosis (using ICD–10–AM codes) HoNOS (Health of the Nation Outcome Scales)	Principal and additional diagnosis (using ICD–10–AM codes) HoNOS Mental Health Inventory Behaviour and Symptoms Identification Scale Kessler 10 Mental health legal status	Yes	Disorder
17	ABS NSMHW (adult)	Mental disorders from the Composite International Diagnostic Interview (include substance use disorders) Health professionals accessed (includes drug and alcohol counsellor) Number of consultations (at a drug and alcohol service) Admissions to hospital (including admissions to psych hospital and drug and alcohol rehab centre) Smoking use Potential mental disorders (e.g. drug use, drinking)	Mental disorders from the Composite International Diagnostic Interview (i.e. anxiety or affective disorders) Mini-Mental State Examinations (e.g. presence of cognitive impairments) General health questionnaire 12-item scale (measure of health and wellbeing to detect psychological impairment) Eysenck personality questionnaire—neuroticism Kessler 10 Delighted–terrible scale SF–12 (measure of disability which addresses limitations due to physical and mental health issues) Suicidal thoughts and attempts Health professionals accessed (incl. psychiatrist, psychologist etc.) Admissions to hospital (e.g. to psychiatric hospital) Potential mental disorders (e.g. social fears, fear or panic)	Yes	Disorder

(continued)

Table 4.3 (continued): Definitions of substance use, mental health and comorbidity in key data sources

No.	Data source	Substance use	Mental health	Comorbidity	Definition based on 'problem' or 'disorder'
18	NSMHW (C & A)	Use and frequency of tobacco, alcohol, marijuana and other illicit drugs	Diagnostic interview schedule (modules on depressive disorder, ADHD and conduct disorder) Child Behaviour Checklist (provides info about a range of child and adolescent mental health problems)	Yes	Problem
19	NSMHW (psychotic)	Use and frequency of consumption of alcohol and tobacco Use of illicit drugs Lifetime diagnosis of dependence and dependence with psychopathology for alcohol, cannabis or other substance abuse Hospital type accessed (e.g. public drug and alcohol unit) Reason for attending emergency/casualty (e.g. drug overdose or drug and alcohol problem) Outpatient clinic attended (e.g. public drug and alcohol outpatient clinic) Health professionals seen (e.g. drug and alcohol counsellor)	Current psychiatric treatment status Main reason for absenteeism from work (e.g. mental health) Main reason for incapacity for housework (e.g. mental health) Current, past year and lifetime experience of various mental health stressors and issues (e.g. personality disorder, low energy, excessive sleep, bizarre delusions, hearing voices, thought withdrawal) Hospital type accessed (e.g. public psychiatric hospital) Reason for attending emergency/casualty (e.g. psychiatric problem) Profession of case manager (e.g. psychologist) Outpatient clinic attended (e.g. outpatient clinic in public psychiatric hospital) Health professional seen (e.g. psychiatrist, psychologist) Medications used for mental health problems (e.g. clozapine)	Yes	Disorder
20	ABS SDAC	Long-term health condition (could include substance use disorders)	For people with a disability, this survey collects long-term health conditions, coded using the ICD–10 (has lasted or are likely to last 6 months or more) and SF–12	Yes	Disorder
21	NHMD	Principal diagnosis using ICD–10–AM Additional diagnosis using ICD–10–AM	Principal diagnosis using ICD–10–AM Additional diagnosis using ICD–10–AM	Yes	Disorder
22	CSTDA NMDS	Not collected	Residential setting (e.g. psychiatric mental health community care facility) Primary and other significant disability group (i.e. psychiatric)	No	—

(continued)

Table 4.3 (continued): Definitions of substance use, mental health and comorbidity in key data sources

No.	Data source	Substance use	Mental health	Comorbidity	Definition based on 'problem' or 'disorder'
23	NMD	Cause of death (ICD–10 codes)	Cause of death (ICD–10 codes)	Yes	Problem
24	BEACH	Substance use-related codes in the International Classification of Primary Care, Version 2 with extended vocabulary of terms (ICPC–2 PLUS) can be used for each of the data items: 'reason for encounter', 'problems managed' and 'procedures, other treatments, counselling' (for example – Drug abuse (P19), Counselling; drug abuse (P58010)) Substance use-related codes in the Coding Atlas for Pharmaceutical Substances can also be used for the data item 'problems managed' For a limited number of people data on smoking status and alcohol consumption (WHO Alcohol Use Disorders Identification Test) were collected using the Supplementary Analysis of Nominated Data section of the survey	Mental health-related codes in the International Classification of Primary Care, Version 2 and ICPC–2 PLUS are used for the data items 'reason for encounter', 'problems managed' and 'procedures, other treatments, counselling'. For example – Depressive disorder (P76), Counselling; psychological (P58004). Mental health-related codes in Coding Atlas for Pharmaceutical Substances can also be used for the data item 'problems managed'. For a limited number of people data on depression, anxiety and perceived stress was collected using the Supplementary Analysis of Nominated Data section of the survey.	Yes	Problem
25	ABS NHS	Consumption and frequency of tobacco and alcohol Long-term conditions coded to ICD–10 Use of health services (e.g. alcohol and drug worker)	Kessler 10 Type, length and duration of medications for mental health and wellbeing Long term conditions coded to ICD–10	Yes	Disorder
26	ABS NATSIHS	Consumption and frequency of tobacco and alcohol Long-term conditions coded to ICD–10 Use of health services (e.g. alcohol and drug worker)	Social and emotional wellbeing measure based on: Kessler 10 (subset), impact questions from Kessler 10+, SF–36 (subset) and anger questions Long-term conditions coded to ICD–10	Yes	Disorder
27	ABS NATSISS	Consumption and frequency of tobacco and alcohol Stressors (e.g. alcohol or drug-related problems) Type of illicit drugs ever used Type of drug ever used for non-medical purposes Type of drug used in the last 12 months	Disability (conditions) (e.g. any mental illness for which help or supervision is required) Disability (restriction in everyday activities because of) (e.g. a nervous or emotional condition) Stressors (e.g. mental illness)	Yes	Problem

(continued)

Table 4.3 (continued): Definitions of substance use, mental health and comorbidity in key data sources

No.	Data source	Substance use	Mental health	Comorbidity	Definition based on 'problem' or 'disorder'
29	Veterans' data	Medical condition (e.g. alcohol or drug problem) Alcohol as a health concern (doctor or someone has said alcohol is a problem to health) Better health (smoking or drinking habits)	Medical condition (e.g. panic disorder, depression, post-traumatic stress disorder) Feelings (e.g. ratings of loneliness and happiness in past 12 months)	Yes	Problem
32	NCIS	Drug-related death where there has been a positive toxicology reported; no or negative toxicology but a known history of drug/poison/alcohol abuse Drug type	Not collected	No	—
33	ALSWH	Use, frequency and age at initiation of tobacco, alcohol and illicit drugs Injecting drug use Poly drug use	Diagnosed or treated for (e.g. depression, anxiety disorder) Have had or seek treatment for and satisfaction with treatment for (e.g. depression, anxiety disorder) Medications used (e.g. prescription medication for depression) SF–36 (measure of health and wellbeing) Short form of the Centre for Epidemiological Studies–Depression Scale (CES–D) (depression) Current approach to life (e.g. mental health indicators such as 'if something can go wrong it will') Anxiety and depression scales Revised Life Orientation Test (detecting optimism from neuroticism and trait anxiety, self-mastery and self-esteem) Consultations for own health (e.g. counsellor/psychologist/social worker) Groups sought advice or help from (e.g. counsellor or other mental health services)	Yes	Problem
34	KHLS	Severity of alcohol and/or drug problem Main reason/problem client called about (alcohol use; drug use) Referral (to drug and alcohol counselling)	Severity of mental health and/or suicidality Main reason/problem client called about (mental health; suicide)	Yes	Problem

(continued)

Table 4.3 (continued): Definitions of substance use, mental health and comorbidity in key data sources

No.	Data source	Substance use	Mental health	Comorbidity	Definition based on 'problem' or 'disorder'
35	Lifeline	Issues raised by caller may include the following: Call issue (up to 2 call issues can be recorded, e.g. drug misuse, problem drinking) Referrals (e.g. drug and alcohol referral) Recent experiences (e.g. drinking or drug problem) Professional help the caller has received (e.g. substance misuse)	Call issue (up to 2 call issues can be recorded, e.g. war trauma, mental health issue, suicidality) Referral source (i.e. what made them call, e.g. psychiatrist) Referrals (e.g. mental health referral) Recent experiences (e.g. anxiety, eating problems, mood swings) Professional help the caller has received (i.e. for bipolar disorder, post-traumatic stress disorder etc.)	Yes	Problem
37	NAPEDCD	Presenting problem (relates to initial diagnosis) Diagnosis	Presenting problem (relates to initial diagnosis) Diagnosis	No, because only one presenting problem or diagnosis is expected to recorded	—
38	SAAP NDC	Presenting reason for seeking assistance (e.g. drug/alcoho/substance abuse) Main presenting reason (e.g. drug/alcohol/substance abuse) Type of housing/accommodation immediately before/after support period (e.g. detox unit, rehab centre) Support to clients (e.g. drug/alcohol support or intervention)	Source of referral (e.g. psychiatric unit) Presenting reason for seeking assistance (e.g. psychiatric illness) Main presenting reason (e.g. psychiatric illness) Type of housing/accommodation immediately before/after support period (e.g. hospital/psychiatric institution) Support to clients (e.g. psychiatric services)	Yes	Problem
44	LDS	Disability code (condition) (e.g. alcohol dependence, drug dependence)	Disability code (i.e. health conditions such as ADHD, bulimia, depression, post-traumatic stress disorder)	Yes	Disorder
45	GCS	Disability code (condition) (e.g. alcohol dependence, drug dependence)	Disability code (i.e. health conditions such as ADHD, bulimia, depression, post-traumatic stress disorder)	Yes	Disorder

(continued)

Table 4.3 (continued): Definitions of substance use, mental health and comorbidity in key data sources

No.	Data source	Substance use	Mental health	Comorbidity	Definition based on 'problem' or 'disorder'
46	HILDA	Use and frequency of tobacco and alcohol	Do you have a long-term health condition, impairment or disability (lasting or likely to last 6 months or more)? (e.g. nervous or emotional condition requiring treatment) Emotional/mental health and wellbeing questions (e.g. did you feel full of life in last 4 weeks)	Yes	Problem
50	DUCO	Illicit drugs used (coded to the Australian Standard Classification of Drugs of Concern (ASCDC)) (ever used, last 6 months, current regular user, frequency, age of onset/initiation, whether addicted to illegal drugs or alcohol in 6 months prior to arrest)	For females only: Mental health problems while growing up Sought help for mental health problems Received a diagnosis for mental health problem Had emotional problems that significantly interfered with their life	Yes	Problem
51	DUMA	Illicit drugs used (ever used, last 12 months, past 30 days, past 48 hours) Urine test results for alcohol, heroine, cocaine, methadone, cannabis, methamphetamines, benzodiazepines and MDMA	Ever been a patient in a psychiatric hospital for at least one overnight stay.	Yes	Problem
52	NSW–IHS	Consumption of alcohol Consumption, frequency and reduction strategies for tobacco Lifetime, regular use of illicit drug use, time since last injected, age when first injected Previous psychiatric diagnosis (e.g. drug dependence, alcohol dependence)	Beck Hopelessness Scale Beck Depression Inventory Referral Decision Scale Composite International Diagnostic Interview (includes the SF–12, BDQ (disability measure), International Personality Disorder Examination, GHQ-12 (measures general psychiatric morbidity), Kessler 10) SF–26 Previous psychiatric diagnosis (e.g. depression) Current psychiatric medication and treatment (e.g. antidepressants, lithium)	Yes	Problem
53	QLD–WPHS	Consumption, frequency and reduction strategies for tobacco Consumption, frequency and drinking behaviour for alcohol Use, frequency and type of illicit drug use Injecting drug use (type of drug injected, ever injected, age at first injection)	Psychiatric history (e.g. treatment or assessment from psychiatrist or doctor) Beck Depression Inventory	Yes	Problem

Note: See Abbreviations section for an alphabetical list of all data collections and their abbreviations or Section 3.1 for a list of all data collections and abbreviations (in the order presented throughout this report).

Table 4.4: Key data sources that describe substance use, mental health and comorbidity: type and source of information

Information type	Information source		
	Self-report	**Medical practitioner/specialist**	**Other (e.g. other service provider)**
Disorder	NDSHS (2) ABS NSMHW (adult) (17) ABS SDAC (20) ABS NHS (25) ABS NATSIHS (26) Veterans' data (29) LDS (44)[(a)] GCS (45)[(a)]	NRMHCD (15) MHNOCC (16) NSMHW (psychotic) (19) NHMD (21) NMD (23)	
Problem	IDRS–IDU (4) ABS NATSISS (27) ALSWH (33) KHLS (34) Lifeline Statistics (35) HILDA (46) DUCO (50) DUMA (51) [(d)] NSW–IHS (52) QLD–WPHS (53)	BEACH (24)[(b)]	NSMHW (C & A) (18)[(c)] SAAP NDC (38)

(a) Depending on the particular payment type, this information may be provided by a doctor or specialist rather than the individual.

(b) BEACH collects information on 'reason for encounter' (self-reported by patients) as well as 'problems managed' (specified by the doctor) and 'procedures' (which can include referrals).

(c) In relation to the adolescent component (15–17 year olds), it is possible to generate a proxy for comorbidity. In this subsample, parents complete the diagnostic interview schedule (includes modules for depressive disorder, ADHD and conduct disorder) and adolescents provide additional information themselves in relation to substance use and mental health issues.

(d) Information collected from DUMA is not purely self-reported, medical practitioners/specialists conduct urinalysis and provide this information to the collection.

The above analysis reveals little consistency across data collections in the classifications or assessment tools used. While this does not preclude comparative analysis across collections in terms of comorbidity disorders or problems, analysts would need to take into account the varied underlying definitions and tools used to generate the proposed estimates. For example, analysts would need to be aware that, depending on the collection, health conditions may be considered to be significant or 'long term' after either 6 months or 12 months or when the duration is not specified.

Demographic data items within the data sources

Table 4.5 outlines whether basic demographic data items are included within each of the key data sources.

Sex

The majority of data sources reviewed collect data on the sex of the respondent. How the data are collected varies, for example:

- in all of the population surveys and many of the administrative collections, individuals identify themselves as being male or female
- in the KHLS and the Lifeline collections the telephone counsellor makes an assumption on the sex of the caller based on their voice and conversation
- the target population of the QLD–WPHS is women prisoners, therefore sex of all participants is defaulted to female.

The SAR and DASR provide service-level estimates of service usage and therefore provide estimates of the number of episodes of care within the reporting period relating to male or female service users.

The NOPSAD collection does not collect any demographic data about the person receiving pharmacotherapy services.

Indicator of age

Almost all of the data sources reviewed collect data about the age of the respondent, NOPSAD and SAR being the only exceptions. The respondent's 'date of birth' is collected in 18 of the key data sources including the AODTS–NMDS, ASSADS, MHNOCC, LDS and HILDA. The ABS NHS collects date of birth information only on the children's form. The adult form of the NHS collects age information as 'current age (in years)'. Eight other data sources also collect 'current age'; however, 6 of these ask for age as 'age at time of collection' and the other 2 collect current age as 'age turned at last birthday'. The KHLS and Lifeline collect age information as 'age, estimated in years' based on the information provided during a telephone counselling session or estimated by the counsellor.

The remaining 7 data sources collect age information as 'age groups', where the respondent choses which age group they belong to. The age groups used within these data sources vary, for example the age groups in:

- DASR are 0–7, 8–13, 14–18, 19–25, 26–39, 40+
- NTCS are 18–24, 25–29, 30–34, 35–40, 41–45, 46–50, 51–55, 56–60, 61–65, 66–69
- NSMHW (adult) are 18–24, 25–34, 35–44, 45–54, 55–64, 65+
- NSMHW (psychotic) are 18–24, 25–34, 35–44, 45–54, 55–64
- Veterans' data are under 60, 60–69, 70–79, 80+
- NSW–IHS are under 25, 25–40, 40+
- QLD–WPHS are 17–24, 25–39, 40+

The NMD and the NCIS collect information about age at death.

Cultural and linguistic diversity

Within the key data sources reviewed, a variety of data items are used to obtain information about the cultural and linguistic diversity of respondents. Often, more than one data item relating to cultural and linguistic diversity is asked in each data source (Table 4.5). To summarise these data items:

- 'Country of birth' is collected in 20 data sources. Most data sources code country of birth using the ABS *Standard Australian Classification of Countries*
- 'Year of arrival in Australia' is collected in 4 data sources
- 'Main language spoken at home' is collected in 10 data sources and is often coded using the ABS *Australian Standard Classification of Languages*. The NDSHS also collects data on 'other' languages spoken at home
- 'Preferred language' is collected in 2 data sources. This data item refers to the language most preferred by the person for communication
- 'English proficiency' is collected in 3 data sources. Within the SAAP NDC, this is asked in terms of 'how well does the client speak English?', this data will no longer be collected in the SAAP NDC as of 1 July 2005
- 'Interpreter services required' is collected in the CSTDA–NMDS, as is 'communication method'
- 'Difficulty communicating in English' and 'Indigenous language spoken' are both collected in the NATSISS
- 'Birthplace of parents' is collected in the NAC
- 'Cultural identity', that is, the cultural background the client identifies with, is collected in the SAAP NDC; however, it will not be collected as of 1 July 2005
- 'English as a first language' is collected in HILDA
- 'English speaking status is collected in the NSW–IHS
- 'Non-English-speaking background' is collected in BEACH.

As indicated earlier, the NOPSAD collection does not collect demographic information and therefore does not include data items on cultural and linguistic diversity. Other collections that do not include data items relating to cultural and linguistic diversity include the DASR, SAR, MHNOCC, Veterans' data, ALSWH, Lifeline, DUCO and DUMA.

Indigenous status

The national standard for collecting data on the Indigenous status of a person is by asking 'Is the person of Aboriginal or Torres Strait Islander origin?' with the coding options then being:

- Aboriginal but not Torres Strait Islander origin
- Torres Strait Islander but not Aboriginal origin
- Both Aboriginal and Torres Strait Islander origin
- Neither Aboriginal origin nor Torres Strait Islander origin (NHDC 2003).

Indigenous status is therefore a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin. This is in accord with the first two of three components of the Commonwealth definition, which includes descent, self-identification and community acceptance (NHDC 2003).

Of the key data sources reviewed:

- 18 collect data about Indigenous status based on the national data standards. The LDS does not use the exact codes as in the standard, but the codes that are used can be mapped.
- 8 data sources—including the IDRS–IDU and PDI, NSMHW (C & A), NSMHW (psychotic) and BEACH—collect Indigenous status using the question 'Are you of Aboriginal and/or Torres Strait Islander origin?'. The coding options are limited to 'Yes' or 'No' for each of these. These codes limit the extent to which Indigenous status can be reported. The NSMHW (C & A) differs again from the national standards in that Indigenous status is asked from the parent's perspective on whether their child identifies as being Indigenous.
- The KHLS obtains data about the Indigenous status of a caller using a data item on 'ethnic background'. This item includes the following coding options: Anglo-Australian, Indigenous Australian-Aboriginal, Indigenous Australian-Torres Strait Islander, Non-English speaking background, and other. As with the collection of other demographic information, the KHLS code Indigenous status is based on the information provided during a telephone counselling session and is sometimes guessed.
- The DASR reports on the estimated proportion of episodes of care and client numbers that relate to Indigenous and non-Indigenous clients. Similarly, the SAR provides an estimate of the number of clients over the reporting period that are Aboriginal and/or Torres Strait Islander, non-Indigenous and unknown, as well as the proportion of clients who are Torres Strait Islanders.
- The NOPSAD, NTCS, MHNOCC, NSMHW(adult), SDAC, Veterans' data and Lifeline do not collect data on Indigenous status.

Location of the respondent

In many of the data sources, reviewed location of the respondent is often defined by the physical location of the respondent's residential setting. A number of different data items are used within the data sources to obtain this information, and often more than one data item is used within a data source to collect this information. Data items collected include:

- 'Postcode of residence', which is collected in 11 data sources. Importantly, postcode information also enables state or territory, Rural, Remote and Metropolitan Areas Classification (RRMA) and Accessibility/Remoteness Index of Australia (ARIA) to be identified
- 'Full residential address', which is collected in the NCIS, GCS and HILDA; however, data about full residential address are never reported, rather components of the address are used for reporting and analysis purposes, for example postcode
- 'State/territory of residence', which is collected in 9 data sources. The Lifeline data set collects data on the state or territory where the call originated
- 'Suburb or town of residence', which is collected in the ASSADS and IDRS–IDU
- 'Australian Standard Geographic Classification (ASGC) remoteness areas', which are collected in the NHS, NATSIHS and the NATSISS
- 'Area of usual residence' coded using the ASGC, which is collected in 5 data sources. This data item is a 5-digit code which is derived using a state/territory identifier and the SLA of the residence

- 'Suburb/town of residence', which is collected in ASSADS and IDRS–IDU
- 'City/town/state where the call was made', which is collected in the KHLS
- 'Regional area', which is collected in the NAC and the NSMHW(adult)
- 'Capital city or rest of state of residence', which is collected in the SDAC.

Nine data sources do not include information about the location of the respondent, including the AODTS–NMDS, DASR, SAR, NOPSAD, MHNOCC, SAAP NDC, DUCO, NSW–IHS and QLD–WPHS.

Location of agency (or other relevant unit)

Due to the nature of the majority of key data sources—being population or other surveys—information relating to the location of an agency or other relevant unit (such as prison or watch house) is not applicable and therefore not collected. In total, 21 data sources do not include information relating to location of agency for this reason, including the NDSHS, IDRS (IDU and PDI), SDAC, NHS, NATSIHS, NATSISS, LDS, GCS and HILDA.

Of the data sources that do include this information, as with data items about location of the respondent, location is often defined as the physical location of the agency (or other relevant unit) setting. A number of different data items are used within the data source to obtain this information, and often more than one data item is used within a data source to collect information about location. Data items collected include:

- 'Statistical Local Area' which is collected in the AODTS–NMDS, CSTDA–NMDS, SAAP NDC and NMD
- 'Local Government Area' which is collected in the SAAP NDC
- 'Postcode' which is collected in the ASSADS (relating to the location of the school), CSTDA–NMDS (relating to the location of the CSTDA-funded agency) and BEACH (relating to the location of the GP's practice). As mentioned earlier, postcode and SLA information also enables state or territory, RRMA and ARIA to be identified
- 'Full postal address' which is collected in the DASR and SAR, as well as DUMA (relating to the location of the prison), DUCO (relating to the location of the police station or watch house), NSW–IHS and QLD–WPHS (relating to the location of the prison)
- 'State/territory' which is collected in the MHNOCC, NMD (relating to the location of the registration) and AODTS–NMDS (relating to the location of the treatment agency)
- 'RRMA/ARIA' which is collected for the NHMD.

There are 3 data sources where, although it is applicable to collect information about an agency or other relevant unit, this information is not actually collected (NOPSAD, NCMHCD and NRMHCD).

Table 4.5: Status of demographic data items within the key data sources

No.	Data source	Sex	Indicator of age	Indicator of cultural and linguistic diversity	Indigenous status	Location of respondent	Location of agency or other relevant unit
1	AODTS–NMDS	Collected	Date of birth	Country of birth Preferred language spoken	Collected	—	SLA State/territory of service
2	NDSHS	Collected	Age turned at last birthday	Country of birth Main and other language(s) spoken at home Year of arrival to Australia	Collected	Postcode Metro/rural/remote classification State/territory	N/A
3	ASSADS	Collected	Date of birth	Main language spoken at home	Collected	Postcode of residence Suburb/town of residence	Postcode of school
4	IDRS–IDU	Collected	Age at time of collection	Main language spoken at home	Collected	State/territory of residence Suburb/town of residence	N/A
5	IDRS–PDI	Collected	Age at time of collection	Main language spoken at home	Collected	State/territory of residence Metropolitan region of residence	N/A
6	DASR	Collected	Age group	—	Collected	—	Postal address of service
7	SAR	Collected	—	—	Collected	—	Postal address of service
8	NOPSAD	—	—	—	—	—	—
12	NAC	Collected	Age at time of collection	Birthplace of mother and father Main language spoken at home	Collected	Regional area of residence	N/A
13	NTCS	Collected	Age group	Preferred language spoken at home	—	Postcode of residence	N/A
14	NCMHCD	Collected	Date of birth	Country of birth	Collected	State and Area of usual residence	State, region
15	NRMHCD	Collected	Date of birth	Country of birth	Collected	State and Area of usual residence	State, region
16	MHNOCC	Collected	Date of birth	—	—	—	State/territory of service Region of service
17	ABS NSMHW (adult)	Collected	Age group	Country of birth Language spoken at home	—	State/territory of residence Rural/remote/metro area of residence	—

(continued)

Table 4.5 (continued): Status of demographic data items within the key data sources

No.	Data source	Sex	Age	Cultural/ linguistic diversity	Indigenous status	Location of client	Location of agency or other relevant unit
18	NSMHW (C & A)	Collected	Date of birth	Country of birth	Collected	Postcode of residence	N/A
19	NSMHW (psychotic)	Collected	Age group	Country of birth	Collected	State/Territory of residence	N/A
20	ABS SDAC	Collected	Age at last birthday	Country of birth Year of arrival in Australia	—	Capital city or rest of state of residence	N/A
21	NHMD	Collected	Date of birth	Country of birth	Collected	State and SLA of residence Postcode of residence	Hospital RRMA & ARIA and state and SLA for public hospitals
22	CSTDA–NMDS	Collected	Date of birth	Country of birth Interpreter services required Communication method	Collected	Postcode of residence	Postcode and statistical local area of service
23	NMD	Collected	Date of birth Age at death	Country of birth	Collected	State and Area of usual residence, SLA of residence	State of registration Registration district
24	BEACH	Collected	Date of birth	Non-English-speaking background	Collected	Patient's postcode of residence	Postcode of GP's major practice address
25	ABS NHS	Collected	Date of birth (on children's form) Current age (on adults' form)	Country of birth Language spoken at home English proficiency	Collected	State/territory of residence ASGC remoteness area of residence	N/A
26	ABS NATSIHS	Collected	Age at time of collection	Language spoken at home	Collected	State/territory of residence ASGC remoteness area of residence	N/A
27	ABS NATSISS	Collected	Age at time of collection	Main language spoken at home Difficulty communicating in English Indigenous language spoken	Collected	State/territory of residence, ASGC remoteness area of residence	N/A
29	Veterans' data	Collected	Age group	—	—	State/territory of residence	N/A
32	NCIS	Collected	Date of birth Age at death	Country of birth Years in Australia	Collected	Residential address	N/A

(continued)

Table 4.5 (continued): Status of demographic data items within the key data sources

No.	Data source	Sex	Age	Cultural/ linguistic diversity	Indigenous status	Location of client	Location of agency or other relevant unit
33	ALSWH	Collected	Date of birth	—	Collected	Postcode of residence	N/A
34	KHLS	Collected	Age, estimated in years	Ethnic background	Ethnic background	City/town/state client is calling from	N/A
35	Lifeline	Collected	Age, estimated in years	—	—	State/territory where call was made	N/A
37	NAPEDCD	Collected	Date of birth	Country of birth	Collected	Area of usual residence	State/territory of service Region code of service
38	SAAP NDC	Collected	Date of birth	Country of birth Main language spoken* English proficiency* Cultural identity*	Collected	—	Region, SLA and local government area of service
44	LDS	Collected	Date of birth	Country of birth	Collected	Postcode of residence	N/A
45	GCS	Collected	Current age	Country of birth Year arrived in Australia	Collected	Full residential address	N/A
46	HILDA	Collected	Date of birth	Country of birth English as first language Year arrived in Australia	Collected	Full residential address	N/A
50	DUCO	Collected	Actual age at time of the interview	—	Collected	—	Postcode and State/territory of prison
51	DUMA	Collected	Date of birth	—	Collected	Postcode of residence	Location of police station/watch house
52	NSW–IHS	Collected	Age group	Country of birth English-speaking status	Collected	—	Location of prison
53	QLD–WPHS	Collected	Age group	Country of birth	Collected	—	Location of correctional facility

* The data items ‘main language spoken’, ‘English proficiency’ and ‘cultural identity’ will be excluded from the SAAP NDC as of 1 July 2005.

Note: See Abbreviations for an alphabetical list of all data collections and their abbreviations or Section 3.1 for a list of all data collections and abbreviations (in the order presented throughout this report).

Indicators of social context and social participation within the data source

Table 4.6 details whether indicators of social context and social participation data items are included within each key data source.

Indicators of social context

A host of different data items were used within the data sources to indicate the social context of a respondent. These data items are grouped into the following four headings and discussed below: accommodation, relationships, income, and other indicators. As detailed in Table 4.5, often more than one data item relating to social context is included in each of the data sources. However, of the key data sources reviewed 5 did not collect information on social context, including the AODTS–NMDS, NOPSAD, NAPEDCD, SAR and DASR.

Accommodation

- 'Accommodation type' is collected in 9 data sources and refers to the type of physical location the respondent resides in. The terminology used for this data item varies among the data sources. For example, accommodation type is referred to as 'residential setting' in the CSTDA–NMDS, ALSWH and SAAP NDC; 'type of dwelling' in HILDA; and 'type of housing' in the DUCO and DUMA collections. Further to this, the SAAP NDC asks for 'residential setting' immediately before and after the support period
- 'Tenure type' is collected in 4 data sources and refers to the nature of a person's legal right to occupy a dwelling, that is, whether they are the owner of the dwelling, or renter, homeless etc. This data item is referred to as '(home) ownership status' in the LDS and GCS. As of 1 July 2005 the SAAP NDC will also collect data on tenure type
- 'Number of bedrooms' is collected in 5 data sources, the NHS, NATSIHS, NATSISS, GCS and HILDA. Within the NATSISS this data item is referred to as 'housing characteristics'
- 'Number people in household' or 'household composition' is collected in 13 data sources
- 'Living arrangements' is collected in 9 data sources including SDAC, Veterans' data, KHLS and SAAP NDC. NSW–IHS refers to it as 'living situation'
- 'Length of time' is collected in 2 data sources. Within the KHLS this data item relates to the length of time in the current living arrangements, whereas within the GCS it relates to the length of time at the respondent's current address.

Relationships

- 'Marital status' is collected in 17 data sources. A further three data items relating to marriage are collected in the NMD including 'date of first marriage' and 'age at first marriage'
- 'Number of dependent children' is collected in the NDSHS and NSW–IHS and the 'number of children' is collected in the NMD, ALSWH and HILDA
- 'Number of siblings' is collected in the NSMHW (C & A)
- 'Relationship status' is collected in the KHLS, Lifeline data and HILDA
- 'Parental status' is collected in the NSMHW (psychotic)
- 'Carer information' is collected in the CSTDA–NMDS using the following four data items 'carer—existence of', 'carer—primary status of', 'carer—residency status' and 'carer—relationship to service user'. 'Carer information' is also included in HILDA.

Income

- 'Main source of income' is collected in 12 data sources and refers to the source by which the respondent derives most of their income
- 'Household income' is collected in the NATSIHS
- 'Disposable income in a normal week' is collected in ASSADS
- 'Source of retirement funding' is collected in the ALSWH.

Other indicators of social context

- 'Convicted of offences' is collected in the IDRS–IDU and IDRS–PDI
- 'Health care card type' is collected in the Veterans' data and 'Health care card holder' and 'Veterans' Affairs card holder' is collected in BEACH.

Indicators of social participation

As with the indicators of social context, a variety of data items are used to obtain information about the indicators of social participation. Again, most data sources use more than one data item to collect this information; these data items are discussed under the following headings: employment, education, and other indicators of social participation. Seven of the data sources reviewed did not collect information relating to indicators of social participation.

Employment

- 'Labour force status' or 'employment status' is collected in 20 data sources
- 'Working arrangements' is collected in 3 data sources and refers to the usual hours per week the respondent works
- '(current) Occupation' is collected in 12 data sources. In the NSW–IHS and QLD–WPHS collections the occupation of the respondent prior to imprisonment is collected. The data item for the NDSHS asks for the 'type of work undertaken'
- 'Duration of employment' is collected in the NSMHW (adult) and the GCS
- 'Industry last employed in' is collected in the NDSHS.

Education

- 'Highest year of school completed' or 'highest educational qualification' is collected in 10 data sources. Terminology in the NTCS refers to this item as 'highest educational level attained'. 'Number of school years completed' is collected in the IDRS–PDI
- 'Post-school qualifications' is collected in 6 data sources; this item includes completion of trade qualifications
- 'Current education status' or 'Year currently enrolled in at school' is collected in 10 data sources
- 'School expulsions' is collected in the NSW–IHS as is 'Type of school attended' which is also collected in HILDA
- 'Age finished school' is collected in the GCS, HILDA and QLD–WPHS.

Other indicators of social participation

- 'Support needs' is collected in the CSTDA–NMDS and relates to how often the respondent needs personal help or supervision with activities or participation in a range of life areas including self-care, mobility, education and community (civic) and economic life
- 'Activity participation' is collected in the Veterans' data and GCS
- 'Abbreviated life skills profile' and 'HoNOS' are collected in the MHNOCC.

Table 4.6: Indicators of social context and participation (data items) within the data sources

No.	Data source	Indicators of social context	Indicators of social participation
1	AODTS–NMDS	—	—
2	NDSHS	Marital status Number of people in household Dependent children in household Household type and composition Personal and household income	Current employment status Industry last employed in Type of work undertaken Highest year of primary/secondary school completed Completion of trade certificate or other educational qualification Highest qualification obtained
3	ASSADS	Disposable income in a normal week	Year of school currently enrolled
4	IDRS–IDU	Accommodation type Convicted of an offence Income source	Highest grade of school completed Post-school qualifications Employment status Engaged in sex work
5	IDRS–PDI	Accommodation type Convicted of an offence Income source	Number of years of school completed Post-school qualifications Employment status
6	DASR	—	—
7	SAR	—	—
8	NOPSAD	—	—
12	NAC	Household composition Family living arrangements	Current educational status Current employment status
13	NTCS	Number of people in household	Current occupation Employment status Highest educational level attained
14	NCMHCD	Marital status	—
15	NRMHCD	Marital status	—
16	MHNOCC	HoNOS (accommodation)	HoNOS (supportive relationships, activities of daily living, occupational and recreational activities) Abbreviated life skills profile Resource utilisation groups—activities of daily living Factors influencing health status

(continued)

Table 4.6 (continued): Indicators of social context and participation (data items) within the data sources

No.	Data source	Indicators of social context	Indicators of social participation
17	NSMHW (adult)	Marital status Household type Number of people in household Main source of income	Current educational status Secondary school completion Completed qualification since leaving school Highest educational qualification Labour force status Occupation (main job) Hours usually worked per week Duration of employment
18	NSMHW (C & A)	Household composition Number of siblings	Education status Labour force status
19	NSMHW (psychotic)	Marital status Parental status Residential setting Income source	Highest educational qualification Employment status Main occupation Nature of main job
20	SDAC	Housing tenure type Living arrangements Marital status	Assistance needed with transport Social and community participation Labour force status Occupation Educational attainment
21	NHMD	Marital status	Employment status
22	CSTDA–NMDS	Living arrangements Residential setting Carer–existence of Carer–primary status of Carer–residency status Carer–relationship to service user Receipt of Carer Allowance (child) Main source of income	Labour force status Support needs (self-care; mobility; communication; interpersonal interactions and relationships; learning, applying knowledge and general tasks and demands; education; community (civic) and economic life; domestic life; working)
23	NMD	Marital status Date of first marriage Age at first marriage Place at first marriage Number of children	Occupation of person
24	BEACH	Health care/card status	Veterans' Affairs card Social participation (unemployment problem; education problem; social handicap)
25	NHS	Household composition Number of bedrooms in dwelling Living arrangements Type of dwelling Marital status	Current educational status Highest educational qualification Labour force status Working/payment arrangements Occupation Shift work Usual hours of work
26	NATSIHS	Household composition Number of bedrooms in dwelling Dwelling location Marital status Household income	Current educational status Highest educational qualification Labour force status Occupation Shift work

(continued)

Table 4.6 (continued): Indicators of social context and participation (data items) within the data sources

No.	Data source	Indicators of social context	Indicators of social participation
27	NATSISS	Household composition Housing characteristics Level of income Source of income	Voluntary work Education attainment Current study Education experience Employment status Barriers to employment
29	Veterans' data	Marital status Health care card type Living arrangements Household composition	Frequency of driving Frequency of public transport use Organisation and club membership Activity participation
32	NCIS	Marital status	Employment status
33	ALSWH	Number of children Marital status Household composition Average gross income Source of retirement funding Residential setting	Type of paid work Highest educational qualification Current occupation Partner's current occupation Participation in selected activities
34	KHLS	Income source Living arrangements Length of time living in current living arrangements Marital/relationship status of clients parents	School status
35	Lifeline	Relationship status	—
37	NAPEDCD	—	—
38	SAAP NDC	Persons receiving assistance (with or without children) Main income source Living arrangements Residential setting	Labour force status Student status
44	LDS	Home ownership	Highest education level
45	GCS	Number of bedrooms in household Household ownership status Length at address Rating of standard accommodation Income, assets and expenditure (Centrelink payments, other sources of income, assets and liabilities)	Education (age left school, trade/other qualifications since leaving school, highest qualification) Employment (currently in paid work, why not currently in job, occupation, length of time in job, barriers to working, earnings per week/fortnight from work) Activities and participation (membership of clubs/associations, social/community/sporting activities participated in during last fortnight)
46	HILDA	Household composition and interrelationships Health/disability status Housing tenure Household income and spending Type of dwelling Number of bedrooms Family formation and partnering relationships Number of children Carer information	Employment status Highest year of school completed Age finished school Type of school attended Qualifications currently underway or completed

(continued)

Table 4.6 (continued): Indicators of social context and participation (data items) within the data sources

No.	Data source	Indicators of social context	Indicators of social participation
50	DUCO	Type of housing prior to prison Marital status Household composition Source of income	Education attainment Prior juvenile detention
51	DUMA	Type of housing in past month Marital status Household composition Source of income	Education attainment Work status
52	NSW–IHS	Marital status Living situation Number of dependents	Educational attainment Schools attended School expulsions Labour force status prior to imprisonment Occupation prior to imprisonment
53	QLD–WPHS	—	Educational attainment Age finished school Labour force status prior to imprisonment Occupation prior to imprisonment

5 Answering the key questions in relation to comorbidity

This section presents a discussion of the extent to which available data sources can currently answer the key questions about comorbidity.

The extent to which data collections are capable of addressing the key questions depends partly on their comparability in terms of factors such as methodology, definitions and classifications (discussed in Chapter 4). These issues are taken into account in the following assessment. However, the following discussion does not assess each collection in terms of the more detailed analytical issues that may confront analysts who choose to use the selected data sources. For example, analysts would need to consider sample size issues once the population with comorbidity is identified (e.g. it is possible that sampling issues may preclude the generation of reliable population estimates). Analysts would also need to consider whether the proposed proxies are sufficiently valid and reliable for their purposes. For example, the NHMD includes diagnosis information; however, it is likely that this relates predominantly to the reason the person is presenting to hospital and not necessarily to their broader health conditions. Finally, they may need to consider the likelihood that, in the case of many collections (e.g. SAAP NDC), respondents may have disincentives to identifying themselves as having substance use or mental health problems and there may therefore be an undercount of people with comorbidity in these collections.

Chapter 6 will expand on many of the issues raised below, for example, detailing future possibilities for analysis to close identified information gaps.

5.1 To what extent can the key questions be answered?

A Describing comorbidity in the population

A1 What is comorbidity, why does it occur and what causes it?

The research literature in the area of coexisting substance use and mental health disorders includes discussion and debate about the various possible definitions of this type of comorbidity and related causal factors or pathways to developing 'comorbidity'. This literature is referred to in Section 2.1.

While the types of data collections selected for this project are not generally designed to address the above questions, they are capable of informing them. For example, population data are useful in terms of highlighting population groups in which comorbidity appears to be over-represented (e.g. prisoners). Many administrative data sources are able to provide detailed demographic information about the characteristics of people with comorbidity who access the service sector for treatment and the types of treatment they receive. Such information is useful in terms of generating hypotheses and providing contextual information to support more targeted epidemiological studies.

A2 How common is comorbidity in the Australian population?

While there is no single survey or collection that can estimate the prevalence of comorbidity across the entire Australian population, various sources provide information about its prevalence in specific subpopulations.

Using the comorbidity definitions described in Section 4.2, the following data sources could be analysed to generate estimates of the prevalence of comorbidity among people living in private dwellings/households:

- The NDSHS 2004 provides an estimate of the prevalence of comorbidity among a representative sample of Australians aged 12 years or more. Previous surveys in this series did not collect information about mental health problems.
- The ABS NSMHW (adult) 1997 provides an estimate of the prevalence of comorbidity among a representative sample of Australian adults aged 18 years or more.
- The NSMHW (C & A) 1998 provides an estimate of the prevalence of comorbidity among a representative sample of Australian children and adolescents aged 4–17 years.
- The NHS provides an estimate of comorbidity among a representative sample of Australians of all ages.
- The NATSIHS will provide an estimate of comorbidity among a representative sample of Aboriginal and Torres Strait Islander people.
- The NATSISS provides an estimate of the prevalence of comorbidity among Aboriginal and Torres Strait Islander peoples aged 15 years and over.
- The HILDA survey provides information about comorbidity in relation to a representative sample of Australians aged 15 years and over.

The scope of the above collections explicitly means that they exclude people from various locations. For example, the NDSHS sample specifically excludes the homeless, institutions, correctional facilities, aged care facilities, military bases, schools or places of business. The number of people with comorbidity who live or are currently present in some of these locations may be estimated using the following data collections. However, it has to be remembered that the administrative collections are based on different counts—episode-based, separation-based etc.—and the population survey counts are different again:

- The NRMHCD provides an indication of comorbidity among residents of government-funded residential mental health care services.
- The MHNOCC provides information about comorbidity among users of specialised mental health services.
- The ABS SDAC provides population estimates of the number of people living in households as well as people living in cared accommodation such as hospitals, disability hostels and children's homes who have comorbidity and a disability. That is, only those respondents screened into the disability section of the survey are asked to provide details about their health conditions, from which comorbidity could be derived.
- The SAAP NDC enables an estimate to be developed of the number of people with comorbidity who receive support or assistance from SAAP-funded agencies.
- The DUCO survey can be used to indicate the presence of comorbidity among female offenders sentenced to prison in a selection of states and territories.
- The DUMA survey can be used to indicate the presence of comorbidity among people who have recently been apprehended by the police (i.e. detainees who have been arrested in the last 48 hours and are currently in custody) in a selection of locations within some states and territories.
- The NSW–IHS and the QLD–WPHS both describe comorbidity within prison populations (male and female in New South Wales and women only in Queensland).

Other data sources, while primarily useful in terms of describing access to services by people with comorbidity, are also useful in terms of providing an indication of the extent of comorbidity among people accessing specific services or among specific population groups. For example:

- The NHMD provides an indication of comorbidity within episodes of care of people accessing public acute hospitals, public psychiatric hospitals, private acute and psychiatric hospitals and private freestanding hospital facilities.
- The NSMHW (psychotic) 1997–98 provides estimates of the prevalence of comorbidity among a sample of people with psychotic disorders aged 18–64 years. The sample was generated by screening all people who accessed mental health services in certain locations over a specified period of time, identifying those with psychotic disorders and then selecting a random sample from within this group. This survey therefore fills in gaps in the NSMHW (adult component) in relation to low prevalence psychotic disorders.
- The BEACH survey can be used to estimate the number of GP encounters that related to comorbidity, using information about reasons for encounter, problems managed and procedures/other treatments/counselling.
- Within the veteran population (specifically Gold and White Repatriation Card holders), it is possible to estimate the prevalence of comorbidity using the Survey of Entitled Veterans, War Widows and their Carers 2003.
- The ALSWH includes a random sample of women selected from the Medicare database and recruited in three cohorts (based on their age). This study enables an estimate to be developed of the prevalence of comorbidity among Australian women of these age cohorts (25–30 years, 53–58 years and 76–81 years).
- The data collected by Lifeline and KHLS could be used to estimate the prevalence of comorbidity among callers. This information is limited, however, because it relates to calls, not people, and also because not all relevant fields are mandatory for completion.
- In relation to estimating the prevalence of comorbidity among income security recipients, FaCS, DEWR and DEST income support data holdings such as the LDS 1% sample and GCS could be used to estimate the prevalence of comorbidity.

Table 5.1 identifies the various populations within Australia in which it is possible to generate an estimate of comorbidity.

Table 5.1: Sources of information on comorbidity among subgroups of the Australian population

Data source	Data collection
Households/private dwellings	NDSHS NSMHW (adult) NSMHW (C & A) NHS NATSIHS NATSISS HILDA
General health services	NHMD BEACH
Mental health services	NRMHCD MHNOCC NSMHW (psychotic)
Cared accommodation	ABS SDAC
Homeless	SAAP NDC
Income support recipients	GCS LDS
Veterans	Veterans' and war widows' data
Corrections	DUCO DUMA NSW–IHS QLD–WPHS
Other	ALSWH Lifeline Statistics KHLS IDRS–IDU NMD

Note: The populations represented in each of the subgroups may overlap.

A3 What types of comorbidity are there and which are most prevalent in the Australian population?

Among the 26 data collections that can detect comorbidity generally in individuals, a sub-set are able to detect various types of comorbidity and their prevalence. Of the 13 collections that were judged to provide information about substance use and mental health *disorders*, 12 could be used to identify the prevalence of a potentially unlimited number of types of comorbidity among the study population. For 9 of these collections, the various types of comorbidity would be generated based on information about multiple health conditions or diagnoses (coded using the ICD–10 or ICD–10–AM) (see Section 4.2 for further detail)[3]. For the NDSHS, the estimates would be based on a selected short list of health conditions, with the possibility that respondents listed further conditions in the 'other major illness' response category. For the LDS and GCS, the estimates would be based on Centrelink's 'disability' code (condition) classification. The Veterans' data could be used to generate prevalence estimates among this population for a limited number of types of comorbidity. These types

3 It should be noted that some of these prevalence estimates would relate to counting units such as hospital separations (NHMD) or episodes (NRMHCD) and would therefore generate prevalence estimates of, for example, the number of episodes relating to an individual with a certain type of comorbidity.

of comorbidity would be based on the specially developed classification list developed for this collection.

In addition to the information available using health condition codes, many of the above collections include additional information that could be used to further refine estimates of comorbidity. For example, for the NHS a combination of information could be drawn from the long-term health conditions (classified to the ICD–10), Kessler 10 and data items specific to tobacco and alcohol consumption and medications used for mental wellbeing (e.g. antidepressants). Among Indigenous Australians, information from the social and emotional wellbeing measure could be used in combination with information on long-term health conditions (classified to ICD–10) and data items specific to tobacco and alcohol consumption and illicit substance use.

Among the 13 collections that provided information about substance use and mental health *problems,* the following 7 could be analysed to generate various kinds of estimates of the extent of some of these problems*:*

- The NATSISS enables a limited number of types of comorbidity to be estimated, through a combination of information about substance use problems (based on information about the use of tobacco, alcohol and illicit drugs) and information about disability (conditions which include 'any mental health condition for which health or supervision is required'). Further information about the nature of comorbidity could be derived from information on stressors (e.g. alcohol-or drug-related problems or mental illness).
- The ALSWH enables a limited number of types of comorbidity to be estimated based on a combination of information about substance use problems (based on use of tobacco and alcohol (how often and quantity) and illicit drug use (use in last 12 months by type of drug)) with, for example, types of condition a person has been diagnosed or treated for (e.g. depression), medications used (e.g. prescription medication for nerves, prescription medication for depression), mental health indicators on how person is feeling (e.g. very nervous, so down in the dumps nothing can cheer you up) and information about stress.
- The HILDA survey could provide estimates for limited types of comorbidity (based on long-term health conditions and frequency of use of alcohol and tobacco).
- The NSMHW (C & A) can detect whether there is a substance use problem (defined in terms of frequency of consumption) in conjunction with a limited list of mental health disorders (the Diagnostic Interview Schedule identifies depressive disorder, ADHD and conduct disorder). The survey also captures a series of mental health problems (e.g. aggression, withdrawn behaviour etc.).
- The BEACH program enables many forms of comorbidity to be defined. In this case, the types of comorbidity would not all relate to diagnosis but rather to mental health problems (which may in many cases be diagnoses) (including mental health problems related to substance use), recorded under reasons for encounter, problems managed and procedures/other treatment/counselling variables.
- The NSW–IHS and the QLD–WPHS both enable a description of various types of comorbidity within prison populations (male and female in New South Wales and women only in Queensland). In the case of the New South Wales survey, information could be drawn about substance use problems (based on information collected about the use of tobacco, alcohol and drugs) along with a large number of measures of mental health problems (e.g. previous psychiatric diagnosis by a doctor, Beck Hopelessness Scale, International Personality Disorder Examination, Kessler 10). Less detailed

information is collected in the Queensland study but this would still enable various forms of comorbidity to be delineated among this prison population.

The type of proxies used to estimate comorbidity in the remaining 6 collections (IDRS–IDU, Lifeline Statistics, KHLS and SAAP NDC, DUMA and DUCO) mean that, while they are useful in terms of detecting the presence of comorbidity, they do not provide details of the specific types of comorbidity.

A4 What are the most disabling types of comorbidity?

The International Classification of Functioning, Disability and Health defines disability as a multidimensional concept, relating to the body functions and structures of people, the activities they do, the life areas in which they participate, and the factors in their environment that affect these experiences (WHO 2001). Each of these components is defined in the context of a health condition.

When we talk of the most disabling types of comorbidity we are primarily asking which health conditions are associated with the greatest level of activity impairment or participation restriction. We are also asking about what is known about the environmental factors associated with these health conditions.

The collections reviewed for this project tend to include information in one or more of the following areas: health conditions, effects of health conditions on functioning, and mental wellbeing or distress. A small subset of data sources contain information about coexisting mental health and substance use disorders as well as such information (i.e. as well as some indication of the extent to which these conditions limit or restrict an individual in their life). For example, most ABS health-related surveys collect information using Short Forms (e.g. SF–12, SF–36), which contain information about health conditions, effects of health conditions on functioning and mental wellbeing. In the absence of other more detailed information, this information could be used to indicate level of functioning and therefore disability among people with comorbidity. For example, the NSMHW (adults), SDAC, NHS, NATSIHS and NATSISS may all be capable of indicating the level of disability among the respective populations with comorbidity. Similarly:

- the NSMHW (C & A) detects the degree of functioning using an adolescent version of the Child Health Questionnaire (for adolescents only)
- the HILDA survey includes information about restrictions associated with health conditions
- the NSW–IHS includes the Brief Disability Questionnaire,

all of which may enable analysts to develop proxy estimates for the extent of disability associated with various types of comorbidity.

The data sources reviewed for this project contain a wealth of information about the environmental factors experienced by people with comorbidity, including the characteristics of people with comorbidity and, in many cases, information about social context and social participation. For example, the NDSHS collects detailed demographic information as well as information about marital status and employment status, which could be used to inform discussion about the environmental context in which people with comorbidity experience life. Discussion of these data items is provided in Section 4.2 and in the following section.

A5 What do we know about the people with comorbidity (e.g. demographics such as age, sex, Aboriginal and Torres Strait Islander status, cultural and linguistic background, geographical location)?

Various collections have information about people with comorbidity, in a range of settings and population subgroups (e.g. corrections, mental health services, general health services, among people with psychotic illness) (see question A2). Most of these data collections are able to describe the characteristics of people with comorbidity, generally including their demographic characteristics and various indicators of social context and social participation. For more detail on the type of information contained in each data source see Section 4.2.

B Service delivery models for prevention and treatment of comorbidity

B1 What service delivery models are being used to deal with comorbidity?

The data sources reviewed do not provide information about the types of service delivery models that have been implemented or are under development to specifically target people with comorbidity. Such information is more likely to be found in relevant literature and policy documents from government and non-government service providers and funders. Further information on the services delivered to people with comorbidity is included in response to questions C3 and C4.

B2 What are the implications of comorbidity for service delivery? For example, how is comorbidity best detected, prevented and treated?

The literature review revealed great interest in questions about how service delivery can best be targeted to people with coexisting mental health and substance use issues. The areas of interest relate to a range of questions such as:

- How do we best assess, diagnose, prevent and provide early treatment for comorbidity?
- What are the most appropriate treatment modalities and combinations of treatment modalities?
- What are the most effective models of service delivery?
- What is best practice? How do we ensure that practice is evidence-based?
- What are the most effective referral practices?
- What evidence is there of systems/tools such as common assessments, points of entry and single patient files that facilitate coordination between relevant service sectors and professional modalities?
- What evidence is there that people with comorbidity are benefiting from a 'whole of government' approach to service delivery?

In general, the data collections reviewed do not provide information to answer such questions, although they may provide contextual information to support more detailed studies. For example, current administrative collections may yield important hypothesis-generating information about the characteristics of people with comorbidity who are likely to access services. Population data may provide further information about the characteristics of people with comorbidity who do and do not access services. It is also possible that some of the data sources could be used as sampling frames from which to conduct detailed epidemiological studies into these questions.

Some current administrative collections allow estimates to be generated of, for example, the numbers of treatment episodes in mental health care services relating to people with comorbidity, for instances NHMD and NRMHCD. However, it is not possible to determine whether these people also access other government-funded services (e.g. drug and alcohol treatment, crisis accommodation support, corrections) or whether they experience satisfactory continuity of care between these services. Similarly, as it is not generally possible to link client records over time (either within or across collections), the sources are not able to provide information about care patterns over the longer term. Few national collections include information about treatment outcomes and it is difficult to comment on the effectiveness of services in terms of client outcomes (see also the response to question D1).

All of the sources reviewed have been designed for specific and important purposes. Administrative data collections are generally designed to collect relatively broad brush but comparable information from agencies that use a range of assessment tools and provide varied treatment types, taking into consideration respondent burden. It is therefore understandable that, while such data sources provide useful information for planning and may assist in detecting emerging issues, they are not usually able to provide detailed information about the specific service delivery models employed (e.g. combined treatment for people with comorbidity) or outcomes for clients.

B3 How can people with comorbidity and their carers be more aware of services and more involved in service planning?

In the literature this question relates to what we know about community awareness of services as well as what we know about the involvement of consumers and carers in service planning (e.g. as indicated by the prevalence of care plans incorporating consumer and carer input?

In terms of the general awareness of services, only one population survey was noted to include such information. The ABS SDAC asks people with disabilities and their carers about their reasons for not accessing services, including a response option that the individual does not believe that appropriate services exist. The NDSHS also includes a question about individuals' awareness of the health effects of alcohol or other drugs and the source of this information (e.g. health centre, hospital, counselling or rehabilitation). This data source therefore provides some indication of the types of services which people with comorbidity are familiar with.

No information is available from the key data sources about consumer or carer involvement in service planning. However, some collections do include information about carers. For example, the SDAC includes details about carers (for people with disability and comorbidity) and questions that ask why formal services are not accessed (e.g. not aware of). While not able to detect comorbidity, the CSTDA–NMDS also includes carer information. Finally, the AODTS–NMDS, while not able to detect comorbidity, includes information about those who are receiving treatment for someone else's drug use (e.g. demographics, treatment type). Thus some general demographic information is available for this group of important support people.

B4 How can we best highlight the importance of comorbidity?

The reviewed data sources are not able to address this broad question, which relates to raising the prominence of comorbidity as an important issue. However, suggestions for improving the dissemination of information about comorbidity are likely to impact on general awareness of its importance (see Chapter 6).

C Need for, demand for and receipt of treatment services by people with comorbidity

The literature review reflected considerable interest in quantifying and describing the number of people with comorbidity who potentially need or who actually express need for (demand) treatment services related to their coexisting substance use and mental health conditions. There is also a great deal of interest into how such needs and demands relate to actual receipt of treatment services by people with comorbidity. For example, are those in greatest need receiving services?

Wherever possible, the following questions are addressed both in relation to services specifically targeted to people with mental health and/or substance use disorders and to the broader group of services and benefits that might be accessed by people with mental health and/or substance use issues more broadly (i.e. including housing, income support, justice etc.). That is, we extend discussion beyond services that would typically be termed 'treatment' services to the broader set of support services that may assist people with comorbidity. Where necessary, we have highlighted the collections that enable us to detect the presence of people with mental health problems or substance use problems but do not enable us to identify the presence of people with both (comorbidity).

C1 How many people with comorbidity need services? What do we know about them?

C2 How many people with comorbidity demand services? What do we know about them?

Questions C1 and C2 are addressed together.

There are limited options, using the reviewed data sources, to explore the complex issue of need and/or demand for services by people with comorbidity.

The SAAP NDC is the only reviewed administrative collection relating to service delivery that currently includes the capacity for monitoring unmet demand for services. The SAAP unmet demand for accommodation collection is run two times a year over a period of one week and collects information about the number of people who request support or accommodation at SAAP agencies but, for whatever reason, are not provided with the desired service. The SAAP client collection also includes information about referrals to other forms of support, providing a possible indicator of need for alternative services.

C3 How many people with comorbidity receive services? What do we know about them?

C4 What types of services are being received by people with comorbidity?

Questions C3 and C4 are addressed together.

The data sources reviewed for this project were selected in the hope that information would be available about people with comorbidity who receive health and welfare services generally, as well as specialist alcohol and drug treatment services, specialist mental health services, specialist disability services, hospitals, housing support, income support (including for veterans and war widows), assistance through the PBS and MBS, telephone help lines, the criminal justice and child protection systems, and the education and training systems. Data sources were also reviewed to establish whether it is possible to detect people with comorbidity in mortality and coronial data.

While it is possible that the full range of these services are being delivered to people with comorbidity, available data sources in their current format only enable people with comorbidity to be detected in 26 of the initial 56 in-scope data sources. While several of these data collections are episode-based, a number could provide information that could be used to generate estimates of the numbers of people with comorbidity who have received or are receiving the following types of services:

- mental health care provided to residential patients by government-funded residential mental health services (NRMHCD)
- specialised mental health services provided in public psychiatric hospitals and designated psychiatric units in general hospitals, community-based residential services and ambulatory care mental health services (MHNOCC)
- services provided in public acute hospitals, public psychiatric hospitals, private acute and psychiatric hospitals, and private free standing day hospital facilities (NHMD)
- specialist drug treatment (IDRS–IDU)
- health services generally (NHS), including whether the individual has accessed an alcohol or other drug worker
- health services including information, medication, counselling, social intervention to help sort out practical issues, skills training (NSMHW (adult))
- treatment by psychiatrists and hospitals to people with psychotic disorders (NSMHW (psychotic))
- health services (e.g. private psychiatrist, private psychiatrist or social worker, mental health clinic, drug or alcohol clinic), outpatient services (e.g. hospital based department of psychiatry) or overnight care services (NSMHW (C & A))
- formal and/or informal support services and specialist disability services (SDAC)
- general practice services (BEACH)
- income and other support to veterans and war widows (Veterans' data)
- income support (LDS, GCS)
- telephone support and counselling (Lifeline, KHLS)
- crisis accommodation support (SAAP NDC)
- corrections (DUCO, DUMA, NSW–IHS, QLD–WPHS).

The NDSHS also enables a population estimate to be generated of the number of people who have sought treatment from a drug and alcohol service to help reduce or quit their drug or alcohol consumption.

Any attempt to use these sources to generate estimates of the number of people with comorbidity would need to take into account the basis of the collection. Administrative collections which are service episode-based collections, unless they include unique patient identifiers or robust statistical linkage keys, can not generally provide prevalence information or estimates of the number of people using services.

There is also interest in more detailed questions about whether people with comorbidity receive only drug and alcohol services, only mental health services, both or other services, and information about the numbers of people being excluded from drug and alcohol services because of mental health issues and vice versa. In view of this interest, we outline below what the reviewed data sources can tell us about the types of services received by people

with substance use and by people with mental health problems. It is likely that a proportion of these people experience comorbidity, but the following data sources do not include this information.

For people with mental health problems only, the following reviewed data sources provide information about types of services received:

- The NCMHCD provides information about mental health care provided to non-admitted patients by public community mental health services. These people may have mental health disorders, including substance use disorders, but there is no way of knowing whether they have comorbidity as there is only one diagnosis item included in the collection (i.e. unlike the NRMCHD, no 'additional diagnosis' information is included here).
- The CSTDA–NMDS provides information about the number of people with psychiatric disability accessing CSTDA-funded services. Service types include accommodation support, community support (e.g. counselling and early intervention), community access (e.g. day programs), respite, employment.

For people with drug and alcohol problems only, the following reviewed data sources are able to generate estimates of certain types of services received:

- The AODTS–NMDS provides an estimate of the number of closed treatment episodes provided by government-funded AODTS in a given financial year for substance use problems in terms of service types including withdrawal management (detoxification), rehabilitation and counselling.
- The SAR collects information (at the service level) about referrals to other mainstream substance use services and Indigenous substance use services, and client contacts with substance misuse workers and emotional and social wellbeing staff.
- The DASR collects service-level estimates of, for example, client numbers and episodes of care for residential treatment/rehabilitation, sobering-up, and/or residential respite programs among people accessing dedicated Indigenous substance use programs. This collection also includes service-level estimates about treatment approaches used by the service (e.g. harm reduction, controlled drinking, controlled use of other substances and abstinence), how the care was provided (e.g. individual counselling/rehabilitation/education, crisis intervention), and program/activities provided (e.g. relapse prevention, relationship/social skills counselling, traditional healing). The DASR also collects information about before and after discharge/referral (eg. accommodation assistance), medical services provided to clients (e.g. medicated detoxification), and the types of agencies the service has working relationships with (e.g. SAAP services and mainstream drug and alcohol services).
- All of the clients included in the NOPSAD collection are receiving opioid maintenance pharmacotherapy treatment in Australia. Data provide an indication of the number of clients according to the dosing site (e.g. pharmacies, public clinics, private clinics, correctional facilities) and the prescriber type (e.g. public prescriber, private prescriber, correctional facilities).

Most of the above data collections are able to describe, to various extents, the demographic characteristics of people with comorbidity receiving services, including basic demographic information and indicators of social context and social participation. For more detail on the type of information contained in each data source see Section 4.2.

C5 What do we know about people with comorbidity who do not receive services?

This question relates to information about:

- people with comorbidity who seek services but who do not receive them (i.e. are turned away from services)
- people who do not seek services at all and therefore do not receive them
- the likely barriers to accessing services.

The SAAP NDC is the only data source reviewed that includes information about people who seek services but are not provided with support. The SAAP NDC includes a question asking service providers to indicate the types of support required by individuals and an indication of whether it is not provided (and no referral made). This question may be used to examine characteristics of people who are judged as needing support but did not receive the specified support from the SAAP agency and were not referred on. The SAAP NDC also conducts a biannual unmet demand for accommodation survey which identifies the number of people who are turned away from SAAP services and details some of their characteristics. Such information is used in targeted research (see for example, NSW Ombudsman 2004, also referred to in relation to question D1).

A number of other data sources provide some information about people with comorbidity who do not seek or receive services or support generally. These are:

- The NDSHS is capable of describing the characteristics of the comorbid population who had sought treatment for drug and alcohol issues compared to those who had not (e.g. age at initiation of drug problem, geographic location, sex).
- Both the adult and child and adolescent components of the NSMHW enable an estimate of the number of people in the Australian population with comorbidity who do not utilise health services. Further to this, the adult component of this survey can detect those with comorbidity who do not perceive that they have a need for such services.
- The SDAC could enable a comparison (among people with disability and comorbidity) of those who do and do not seek or receive support generally. However, it would not be clear whether this support related to treatment and whether the treatment was for comorbidity, and there would likely be issues around sample size.
- The NHS enables us to describe the characteristics of people who are estimated to have comorbidity and not receive services (e.g. their type of comorbidity, age, sex etc.).

In terms of barriers to services, none of the administrative data sources reviewed contain information on waiting lists (which would facilitate the collection of information on expressed demand for services and identify possible barriers such as a low priority rating of the client, maximum service capacity etc.). Some population surveys include information on comorbidity (e.g. NDSHS) and use of services, thus potentially providing rough proxy indicators of 'need' for services versus receipt of services and therefore 'unmet need' for services. However, these surveys did not generally collect information about what the perceived barriers are to accessing services. One exception is the SDAC, which contains some information on barriers to formal support services and provides potential questions that could be adopted elsewhere.

C6 How many times do people demand services over their life course?

Reviewed data sources, in their current format, are not readily able to address this question in relation to people with comorbidity. See Chapter 6 for suggestions of possible analysis that may shed light on this question in the future.

C7 What do we know about the appropriateness of services received by people with comorbidity?

While question C6 relates to continuity of care over the life course, this question relates to the broader issues of:

- continuity of care across service types (e.g. whether whole-of-government policy approaches are in practice on the ground)
- the appropriateness of care (e.g. whether people are accessing the service type(s) they really need or simply selecting what is on offer).

As it is not possible, using the data sources reviewed, to track clients across services, it is not possible to establish whether clients are flowing (seamlessly or otherwise) between services. The inconsistency between national data sources relating to these varied services suggests that the information structures on the ground are not likely to support seamless movement.

In order to adequately address questions about the appropriateness of services for people with comorbidity, more information would be required about, for example, the detailed models of service delivery currently on the ground, individual and/or service-level outcomes and client satisfaction with services. These types of information are not available from the reviewed data sources and, in some cases, could not feasibly be collected through such collections.

While not directly able to address the types of questions raised in relation to appropriateness of care, the reviewed data sources provide valuable information to support efforts to address such questions. For example, by using administrative collections to provide information about the characteristics of people with comorbidity who appear in various service sectors and population data to examine the characteristics of the comorbid population more generally, it may be possible to generate hypotheses about the characteristics of people who may be appearing in multiple service settings.

D Outcomes for people with comorbidity

D1 What are the outcomes (of treatment and more broadly) for people with comorbidity who receive services and who do not receive services?

Two types of outcomes are often described:

- Individual outcomes—which relate to the individual and may be narrow (e.g. getting a job) or broad (e.g. improved quality of life)
- Service-level outcomes, which are based on aggregations of individual outcomes and therefore reflect how well a service is achieving outcomes for its clients (AIHW 2000).

In terms of individual outcomes, information about the outcomes for people with comorbidity who do not receive services is not available from the data sources reviewed. Among data collections relating to people with comorbidity who do receive services, the MHNOCC contains some information about individual outcomes. The MHNOCC includes a range of outcome measures that are recorded at time of admission, review and discharge. This collection is relatively new and still under development, and the pool of usable data is

small. The linkage component is still under development, making it difficult to link outcome Person ID's with initial assessments. However, it is likely to provide useful information in the future about outcomes for clients of specific mental health services.

Some other collections, with modification, may provide information about both individual and service-level outcomes in the future. For example, while currently unable to detect comorbidity, there is interest in incorporating individual outcome measures into the AODTS–NMDS. A number of jurisdictions have already implemented such measures into their state collection (e.g. the Brief Treatment Outcome Module in New South Wales and the Significant Treatment Goal Achievements tool in Victoria).

6 Improving information about comorbidity

Exploring the comparability of reviewed data sources (Chapter 4) and attempting to answer the key questions about comorbidity (Chapter 5) illustrated a number of gaps and areas for improvement in existing data collections. This chapter presents possible options for improving the usefulness and availability of information about people with comorbidity in Australia. Section 6.1 outlines possible options for improving the usefulness of existing data, Section 6.2 focuses on data linkage as a possible option for improving the analytical power of existing data, and Section 6.3 finishes with a discussion of future possibilities for analysis and improving information dissemination.

Australia is currently in the relatively privileged position of having a rich set of data sources relating to the issue of comorbidity. Different methodological approaches, from individual case studies through to population surveys, targeted surveys of particular service sectors and ongoing administrative data collections within specific service sectors, are all capable of providing information which may inform comorbidity. For example, different sources are capable of working to generate hypotheses for further study, provide contextual background to research projects, act as sampling frames from which to draw appropriate research populations or directly answer research questions.

While in most cases the reviewed data sources provide information that contributes towards a better understanding of comorbidity, these collections were not specifically designed to support research into questions about comorbidity. Progressing and actioning any of the proposed changes to data collections (sections 6.1 and 6.2) would involve negotiation with the groups responsible for each of the reviewed collections. The proposed changes may not be consistent with existing collections' goals or other stakeholder needs, and may therefore not always be possible.

In relation to future possibilities for analysis, potential analysts would need to assess each collection in terms of, for example, sample size issues once the population with comorbidity is identified (e.g. it is possible that sampling issues may preclude the generation of reliable population estimates). Analysts would also need to consider whether the proposed proxies of mental health and substance use problems suggested in Chapter 4 are sufficiently valid and reliable for their purposes. Before embarking on detailed analysis, researchers may wish to assess each selected data collection in terms of their quality. For example, the National Statistical Service suggests that data collections be assessed in terms of their relevance, accuracy, timeliness, accessibility, interpretability and coherence (NSS 2004). While such a detailed audit of data collections was not within the scope of this project, much of the work to inform these areas is summarised in the templates for each collection (Appendix 1).

This chapter does not make recommendations but rather presents a series of possible options for improving information about comorbidity in Australia.

6.1 Improving usefulness of existing data

This section outlines options for improving the usefulness of existing data sources. The adoption of any proposed changes below would need to take into account a range of factors such as:

- the need for data to inform and monitor comorbidity-related initiatives
- the need for data to inform mental health and drug and alcohol initiatives and strategies (most notably The National Drug Strategy: Australia's integrated framework 2004–09 and the National Mental Health Plan 2003–2008)
- the need for proposed changes to align with the current goals of, and, stakeholder needs, in relation to existing data collections;
- the need for proposed changes to reflect broader needs such as interest in a range of possible types of comorbidity (e.g. outside the scope of mental health and substance use comorbidity)
- the need for proposed changes to inform varying interpretations of what mental health and substance use comorbidity means (e.g. definitions which include tobacco as a substance, concurrent versus successive comorbidity, heterotypic versus homotypic comorbidity)
- the varying needs and administrative structures of numerous service and policy sectors such as health, community services and corrections.

Keeping these general considerations in mind, possible avenues for improving the usefulness of existing data sources have been identified. These options are listed below in terms of increasing consistency in the following areas:

- adherence to national data standards
- definition and measurement of comorbidity
- describing the characteristics of people with comorbidity
- collection counts
- frequency of collections
- scope and coverage of collections.

Adherence to national data standards

To improve the usefulness of existing data, the value of consistency in data definitions and classifications cannot be overstated. As the data collections reviewed for this project were designed to meet the needs of various sectors (e.g. community services, health, corrections, income support etc.) and various purposes, it is understandable that definitions and classifications vary to meet the specific needs of various stakeholders. However, it is preferable that all collections are consistent with (e.g. can map to) the national data standards. The *National Community Services Data Dictionary* (NCSDC 2004) and the *National Health Data Dictionary* (NHDC 2003) provide nationally consistent and endorsed definitions and response options for a wide range of data items relevant to the community services and health sectors in Australia. Drawing on national data standards not only reduces respondent burden but increases the chances that resulting data are useful for comparative analysis.

Defining and measuring comorbidity

In general, there is a lack of consistency in the way in which comorbidity can be defined and therefore estimated using current data sources (see Section 4.2). It is possible to detect coexisting mental health and substance use *disorders* in a small number of collections but most data sources relate to coexisting mental health and substance use *problems*. A wide variety of tools and data items may be used to indicate such problems, and different classifications are used to classify them; many of these do not relate to the indicators used in other data sources.

These definitions clearly have an impact on the comparability of information relating to the prevalence of comorbidity. They also mean that comparisons of the prevalence of different types of comorbidity are difficult. With the exception of data sources where multiple diagnoses were obtained from medical professionals, it is generally not possible to directly compare information about types of comorbidity.

Options for improving information about the prevalence of comorbidity generally and about types of comorbidity more specifically include:

- increasing the number of collections containing information about:
  - multiple diagnoses
  - indicators of substance use problems (particularly to collections already containing information about mental health problems)
  - indicators of mental health problems (particularly to collections already containing information about substance use problems)
- ensuring that diagnosis information is recorded and collated using common classification tools, e.g. the ICD–10–AM
- ensuring that diagnosis information relates to a consistent interpretation of what constitutes a relevant health condition (e.g. 'long-term health conditions' that have lasted or are likely to last 6 months or more)
- improving consistency in the way information is collected about substance use disorders (e.g. align questions with the NDSHS on use, and frequency of use, of various types of substances)
- improving consistency in the way information is collected about mental health problems.

Any option for implementing information about diagnosis needs to consider the feasibility of introducing this data item (e.g. in administrative collections the person completing forms may not be able to make a diagnosis, in surveys the diagnostic information is self-reported).

In terms of specific collections, this would mean, for example:

- AODTS–NMDS—include information to enable substance use and mental health disorders to be estimated or add information to enable mental health problems to be estimated (and combined with existing information on substance use problems). This could involve, for example, adding diagnostic information on both mental health and substance use disorders, which would enable the prevalence of various types of comorbidity to be detected. Experiences in attempting to implement information about diagnosis into related collections such as the CSTDA suggest that such an approach is unlikely to be feasible (see AIHW 2002b:78). Logistical barriers include the difficulties in asking non-medical staff to provide or request medical diagnostic information from clients and the selection of a suitable classification. Alternatively, the AODTS–NMDS

might add indicators for mental health problems (e.g. the Kessler 10), which would enable comorbidity overall to be detected but no details of specific types of comorbidity.

- NDSHS—include information about mental health and substance use disorders, rather than indicators of mental health and substance use problems, as currently collected.
- ASSADS—add information about mental health problems (e.g. adolescent questions from the NSMHW (C & A)). This would enable an estimate of the overall prevalence of comorbidity among secondary school students, and possibly provide an important early warning system of increased prevalence among this age group. Further detail about types of comorbidity would be possible by including information about multiple diagnoses, but this may have limited feasibility given the methodology.
- NOPSAD—add information about mental health problems and/or include information about mental health and substance use disorders.
- NCMHCD—include 'additional diagnosis' data element (as well as existing 'principal diagnosis' data element) to enable coexisting mental health and substance use disorders to be reported.
- CSTDA–NMDS—which currently includes multiple diagnostic codes that enable detection of mental health disorders (including those associated with substance use), could add general information on substance use (to provide information about the prevalence of substance use problems among this population). However, this information is unlikely to be relevant to the vast majority of CSTDA service users and its introduction is therefore unlikely to be considered worthwhile.
- BEACH—map or relate information collected in BEACH via the ICPC–2 classification for 'reason for encounter' and 'problems managed' with multiple diagnosis codes (e.g. using the ICD–10–AM). In the near future it will be possible to classify the ICPC–2 PLUS terms (the more specific terms classified according to ICPC–2) according to the ICD–10–AM (due for release in mid-2005). This will allow analysis of the BEACH data, in the future, to be done in terms of either classification. However, classifying general practice terms in ICD–10–AM leads to a loss of specificity, as about 40% of the problems managed by general practitioners do not have a diagnostic label at the end of the consultation, but remain described in terms of symptoms and complaints or processes such as 'check-up' in a well patient.
- The SAAP NDC—introduce questions based on diagnosis (which is unlikely to be feasible) or introduce more generic questions on mental health and substance use problems (e.g. as per the NDSHS) to increase comparability with other collections describing mental health and substance use problems.
- HILDA—include illicit drugs in the questions on substance use to increase the comparability with other collections describing mental health and substance use problems.
- DUCO and DUMA—expand the questions on substance use to include reference to tobacco (currently only focus on alcohol and illicit drugs) to make them more comparable with others relating to mental health and substance use problems. DUCO would also need to be expanded to collect mental health information in any future surveys of males and DUMA would need a broader indicator of mental health problems than is currently included.

Further to this, the NCIS could improve its usefulness in terms of addressing comorbidity questions by coding more of the information about circumstances of death. Such information is currently included as text which limits its usefulness for some types of analysis.

Describing the characteristics of respondents

In Chapter 4 the various ways in which information is collected about the characteristics of respondents were outlined. Examples of data items for which improvements could be made include the use of consistent age groups (where date of birth is not collected) or moving towards collecting age, if not date of birth. However, it is appreciated that national data standards do not exist which specify suitable age groups, and these are often developed to suit specific program eligibility requirements or other needs.

Where national data standards exist (e.g. Indigenous status, cultural and linguistic diversity data items), improvements could be made in numerous data sources to adhere to these.

Collection counts

As highlighted in Section 4.1, the key data sources were based on various collection counts. These counts are generally selected for valid reasons relating, for example, to the purpose and scope of the collection (e.g. 'closed treatment episodes' in the AODTS–NMDS, 'episodes of residential care' in the NRMHCD and 'hospital separations' in the NHMD). However, the selection of varied collection counts makes comparison across collections complicated. It may be possible to account for such variation through a series of assumptions and careful analysis. However, if feasible, the inclusion of information which enables the number of clients or people to be estimated would add to the value of many of the reviewed data collections.

For example:

- The addition of client count information (possibly through the inclusion of a statistical linkage key or other form of client identifier) to the AODTS–NMDS, NCMHCD and NRMHCD (in conjunction with other changes around the definition of comorbidity) and a move to unit record data for the NOPSAD collection (on pharmacotherapy services) would improve estimates of the number of people accessing specialist treatment services in the drug and alcohol and mental health sectors.
- Moving the SAR and DASR collections to client-based rather than service-level collections would increase their analytical usefulness. For example, the current methodology means it is only possible to estimate the percentage of clients accessing DASR services for substance use problems who also have emotional and/or social health issues. However, such a significant change of methodology would have major resource implications.
- Similarly, attempting to collect client-based information in relation to Lifeline and KHLS would improve their capacity to provide information about comorbidity. However, this is almost certainly not feasible and the collections would still have other issues (e.g. not all questions are asked of all callers, as counsellors enter different prompt screens depending on the issues raised by callers) in terms of addressing questions about comorbidity.

Frequency of collections

In Chapter 4 we referred to the fact that there are widely differing timing arrangements for the reviewed data collections, with most being run on a financial year basis, some on a calendar year basis, and, in the case of surveys, generally every 3 to 5 years. The ability to compare collections is clearly affected by such timing factors. This is particularly problematic in relation to surveys which are run infrequently. For example, all components of the NSMHW are rich and useful data sources relating to comorbidity. However, these collections are now quite dated (conducted in 1997 and 1998) and updates would provide valuable current information about comorbidity.

Scope and coverage of collections

While the majority of data collections are conducted nationally, a small number are based on samples from specific states and territories (e.g. DUCO (excluding DUCO Juveniles) and DUMA). The NSW–IHS and QLD–WPHS are valuable data sources but results must be generalised based on these particular client groups and locations. Other data sources, such as the AODTS–NMDS, would benefit from fully expanding their coverage to include all clients in-scope; for instance, currently not all jurisdictions can provide data for both the government and non-government sectors.

6.2 Improving the analytical power of existing data

There are a number of possible ways to improve the analytical power of existing data sources. For example, it is possible that more complex data analyses, such as the construction and analysis of synthetic age cohorts over successive surveys or administrative data collections, could provide useful information about changes over time in the characteristics of people with comorbidity or the types of services they are accessing. Similarly, a number of data collections may be used in conjunction to explore the prevalence of certain types of comorbidity in the population compared to its prevalence in various service settings. A range of such options for future analysis is outlined in Section 6.3. This section focuses on one particular option for improving the analytical power of existing data, namely data linkage.

What is data linkage?

Data linkage refers to 'the bringing together of data from different sources in order to obtain a greater understanding of a situation or individual from the combined (or linked) data set' (NCSIMG 2004). Data linkage is usually undertaken for two main purposes:

- linkage for client management purposes, or
- linkage for statistical, research and policy purposes.

The two types of linkage are conceptually different.

Linkage for client management purposes relates to the linkage of an *individual's* data records across collections and must be as specific and accurate as possible to ensure that each linked record belongs to the same individual (NCSIMG 2004). An example of a variable that could be used for such forms of linkage is an individual's tax file number.

Linkage for statistical, research and policy purposes is designed to gain a better understanding of the patterns of service use by *groups* of individuals. The use of data for

such 'statistical linkage' purposes allows existing data sources to be used to gain new information about, for example, the access and use of services by client groups (NCSIMG 2004). In statistical linkage, the variables used to combine separate data collections for analysis may include date of birth, sex and other demographics such as postcode. Once combined, these variables are generally referred to as a 'statistical linkage key'. Since the individual's identity is not needed nor sought in this form of linkage, a certain amount of inaccuracy is both expected and acceptable. It is important to note that 'data that are statistically linked for research and policy purposes should not be used subsequently for individual client management purposes, especially where this might deprive an individual of a service or benefit' (NCSIMG 2004).

In this report, 'linkage' refers only to linkage for statistical, research or planning purposes.

What are the benefits of data linkage arrangements within and across data collections?

A number of data sources reviewed currently include data linkage arrangements, either using a statistical linkage key or some form of unique client identifier. For example, the CSTDA–NMDS, SAAP NDC and JJ NMDS use statistical linkage keys (SLKs), each of which is constructed from a limited number of elements of an individual's name, date of birth and sex (see below for details); and the PBS and MBS data sets use an individual's Medicare number as a unique identifier. The AODTS-NMDS, MHNOCC, NCMHCD, NRMHCD and NHMD collections all use a person identifier, which is a unique client identifier within an agency and may therefore be used for data-cleaning purposes, but is not unique across a jurisdiction or the country. Such 'local' unique client identifiers, such as the agency-specific person identifiers, do not allow for linkage to be undertaken across a whole program or with other programs.

Linkage processes can provide numerous benefits when analysing data within and across programs. Examples of benefits of linkage within programs are:

- the ability to reduce double-counting of clients who use multiple services in a reporting period and thereby provide a more accurate estimate or count of clients, their characteristics and patterns of service usage
- the ability to link across years and thereby identify client service usage patterns over time.

Across-program linkage may also be beneficial in terms of:

- the identification of gaps in service provision between programs or across agencies (NCSIMG 2004)
- the ability to explore the range of government programs offered by different agencies or sectors from the client's point of view (NCSIMG 2004), for example by identifying program pathways travelled by clients across various community and health service areas
- assistance in assessing the extent of integration and collaboration among community and health services
- the ability to assess the effects of one program on another (NCSIMG 2004).

The benefits of statistical linkage processes are therefore to provide both 'flow' data about how services are used, as well as more accurate point-in-time or 'stock' data.

The feasibility of SLK arrangements is discussed following the next section.

Examples of linkage arrangements in place

A number of the data sources reviewed for this project ask agencies to provide SLKs as part of a minimum data set. For example, the CSTDA–NMDS and the SAAP NDC use different SLKs, each of which is constructed from a limited number of elements of an individual's name, date of birth and sex.

The CSTDA–NMDS SLK is a 14-character key made up of the following components:

- second, third and fifth letters of the service user's last name
- second and third letters of the service user's given name
- service user's date of birth (8 digits)
- sex of service user (1–male, 2–female).

The CSTDA–NMDS SLK[4] is used in analysis to reduce the incidence of multiple-counting of service users across CSTDA-funded service types, and to enable an estimate of the actual number of service users at a point in time to be obtained. The SLK was initially developed for the Home and Community Care Minimum Data Set (HACC MDS) and is still used in that collection.

The SAAP NDC uses an SLK known as the 'alpha code'. This six-letter code is used, in conjunction with year of birth, to provide estimates of the number of people assisted by SAAP across the country, and how many occasions of support are required, on average, by SAAP clients. The alpha code is made up of:

- the second and third letters of the client's first name
- the first and second letters of the client's last name
- the last letter of the client's last name
- M if the client is male or F if the client is female
- the year of birth is then added to the end of the alpha code.

The SAAP NDC recently piloted and now has approval for implementing the same SLK as used in the CSTDA–NMDS from 1 July 2005.

The JJ NMDS is also planning to include the SLK once the collection is fully implemented.

A number of other data sources reviewed develop various codes, predominantly for the purpose of tracking the same individual over time, within the program or survey. For example:

- the ALSWH provides each participant with a unique identification number at the time of the first survey to link data across surveys
- the NSP includes a name code (the first two letters of a person's first name, and the first two letters of the last name, e.g. JOSM) to track drug use changes over time
- there is an ABS or registrar-generated unique identifier that is used to enable linkage between records in the NMD and the National Death Index.

Finally, some of the data collections reviewed include unique client identifiers for program administration purposes. For example:

- unique identifiers are included in both the PBS (Medicare number or Health Care card number) and MBS collections (Medicare number)
- a unique identifier that enables clients to be tracked over time, known as the Customer Identifier, is included in the LDS and GCS.

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4 A more generic name for this SLK is to be decided.

Feasibility of introducing linkage arrangements within relevant data sources

Data linkage appears to be an attractive option in terms of gaining a greater understanding of the patterns of service use by people with comorbidity, both at a point in time and over time. For example, if we wish to have a better indication of the overall service response to people with comorbidity, then it would be beneficial to implement data linkage arrangements within and across the AODTS–NMDS, NCMHCD, NHMD and NRMHCD.

Based on the experiences of implementing SLKs into community services data collections (for instance the CSTDA–NMDS and SAAP NDC), a number of points can be made about the feasibility of introducing SLKs or other linkage arrangements into other relevant collections.

The following factors influence the extent to which the implementation of an SLK would be acceptable:

- appropriate consultation and communication with stakeholders, especially data providers and clients
- appropriate data custodian arrangements and collection protocols at the national, state/territory and local levels
- the ways in which the SLK affects client confidentiality and privacy, conforms with privacy legislation and gains appropriate ethics committee clearance. For example, in relation to the AIHW Ethics Committee clearance for including an SLK in the CSTDA–NMDS, all jurisdictions agreed that consumers would be informed about the information being recorded and its purpose, as well as their right to access the information and update or correct it. The following paragraph was approved for this purpose:

  > Please note that <agency name> is required to release information about service users (without identifying you by full name, or address) to <CSTDA funding department name>, and to the Australian Institute of Health and Welfare, to enable statistics about disability services and their clients to be compiled. The information will be kept confidential. This information is used for statistical purposes only and will not be used to affect your entitlements or your access to services. As a user of CSTDA-funded services you have the right to access your own files and to update or correct information included in the CSTDA NMDS collection' (AIHW 2002b:58).

- Dissemination of information about how the SLK relates to client confidentiality and privacy and conforms with privacy legislation. For example, all agencies participating in the CSTDA–NMDS are provided with the collection's privacy and data principles, which outline the responsibilities of clients, agencies, jurisdiction departments and the AIHW and which are consistent with the relevant legislation such as the *Privacy Act 1988*, *Privacy (Private Sector) Amendment Act 2000*; see AIHW 2002b)
- development and dissemination of training and/or training materials. As part of the CSTDA–NMDS redevelopment, training materials were developed in 2002 to assist service providers collect the NMDS data requirements. These materials included a focus on collecting the SLK components, explaining how they are turned into the SLK, and the privacy considerations around collecting and transmitting these components. The SAAP NDC includes an ongoing round of direct training to agencies, which incorporates information about the alpha code and its relationship to privacy and confidentiality.

The Statistical Information Management Committee has been charged by the Australian Health Ministers' Advisory Council to progress linkage generally in the health sector. It is possible that the issue of comorbidity could be a beneficiary of this work in the long term.

Implementing SLKs within program areas or data collections involves a great deal of effort and consideration of a range of ethical issues. The additional challenges of extending such SLKs across program boundaries, including between community services and health sectors, may make alternative linkage approaches more attractive. In addition to considering the technical possibilities of such work (e.g. whether a key constructed out of the available data items would yield a sufficiently low number of duplicate records), the construction and use of such a key would require appropriate ethical clearance.

6.3 Future possibilities

Section 6.3 identifies a number of possible new policy-relevant analyses of data sources as they currently exist and as they would be with modifications as discussed in sections 6.1 and 6.2. The analysis options are framed in relation to the four key question headings that are used throughout this report.

This section draws on possibilities relating to all data sources that were reviewed throughout the course of this report, not just those that were identified as 'key'.

A number of positive developments—both policy and data related—are underway in the field of comorbidity and related areas. Just a few examples include:

- a range of projects commissioned under the National Comorbidity Initiative, including an analysis of general practice patient encounter databases, a mental health screening tool trial, and the development of a comorbidity information brochure
- work being undertaken by the National Data Development Unit at the AIHW to align data reporting requirements across selected community service and health collections (administered by Mission Australia) and reduce the reporting burden of service providers
- the National Deaths in Custody monitoring program (being undertaken by the Australian Institute of Criminology), which draws upon information from media reports, police and hospital reports, and data from the NCIS
- a project being undertaken by the Homelessness and Housing Taskforce of the National Mental Health Working Group to conduct a stocktake of accommodation options available to people with mental illness
- an extensive research agenda funded by FaCS using existing data sources such as the SAAP NDC (e.g. the Reconnect Program, which is designed to address the problem of youth homelessness) and various Australian Institute of Criminology sources (e.g. a study exploring drug use and mental health as barriers to the re-integration of prisoners into the community).

These examples suggest that there is great interest and considerable momentum in terms of a desire to work on policies on comorbidity and on better using existing data sources.

A Describing comorbidity in the population

As discussed earlier in the report, it is possible to identify a population with comorbidity in 26 data sources. With this in mind it may be possible to:

- conduct a comparative analysis of national surveys, calculating prevalence estimates of comorbidity (based on suggested proxy measures of comorbidity disorders and/or problems) in each of the different data source populations
- calculate prevalence estimates for different comorbidity types (based on suggested proxy measures of comorbidity disorders and/or problems) and compare these across various collections
- describe the populations with comorbidity in each of the data sources in terms of their demographic and other characteristics and conduct a comparative analysis in relation to the characteristics of this group across data sources
- describe the population with comorbidity in a data source and compare the characteristics to those in the data source who do not have comorbidity (e.g. using the SAAP NDC data, the SAAP 'substance abuse/mental health' client population could be identified and analysed in comparison to all SAAP clients, looking specifically at demographic differences, main reasons for seeking assistance, support services requested, support services provided and meeting the needs of clients).

For those data sources that are currently unable to identify comorbidity it may be possible over time to include extra data items to enable it to be detected. For example, it is possible that the AODTS–NMDS could introduce new questions or an ad hoc collection of information about the mental health status either for the entire client population or a sample of clients. Similarly, data sources such as the JJ NMDS, ASSADS and NCPDC, may be encouraged to include data items relating to comorbidity. These data sources are targeted to children and youth and could be used as an early detection for mental health and/or substance use problems among potentially 'at risk' groups within these populations.

The NCMHCD currently includes information about health condition; however, because only one diagnosis is recorded, it is currently not possible to detect comorbidity. If this collection incorporated additional diagnosis information, the comorbid service user population could be better understood.

B Service delivery models for prevention and treatment of comorbidity

Current data sources provide useful indications of the numbers of people with comorbidity in various settings, as well as describing their characteristics. This type of information could possibly support further research into preventative or treatment models. However, it is difficult to see how the reviewed data sources can inform these questions without fairly substantial and complex changes. For example, adding extra questions to administrative data sources about service delivery models in conjunction with information about client outcomes may yield interesting information about the effectiveness of various treatment models. However, administrative data sources are not generally designed to support such analysis and it is more likely that these types of questions would be addressed using more targeted research approaches.

C Need for, demand for and receipt of treatment services by people with comorbidity

Several options exist for analysing data or using the collection frameworks to examine need for, demand for and receipt of treatment services by people with comorbidity. For example:

- Surveys such as the NDSHS could be used in conjunction with other data sources (e.g. AODTS–NMDS, mental health data sets) to estimate the need and/or demand for services by people with comorbidity and compare it with estimated supply. Such analysis could draw on the methodology developed for studies of unmet need in the disability services sector (AIHW 2002a).
- The NSMHW (adult), which collected information from respondents about their perceived need for health services, could help inform what services people with comorbidity need. Likewise, the SDAC, which collects information on whether people with disabilities (a subset of whom are likely to have comorbidity) and their carers require formal and/or informal services, including whether they need more than they are currently receiving, and could inform questions about demand for and receipt of support.
- Estimates of the number of people with comorbidity receiving treatment could be generated and compared across treatment or service types.
- Selected data sources could be used to map the prevalence of comorbidity and treatment use over the life course. This could be done either by looking at different age groups at one point in time (i.e. cross-sectionally), via data linkage, or through the development and analysis of synthetic age cohorts over successive surveys or administrative data collections.
- Some collections, such as the AODTS–NMDS, could be expanded to collect information about unmet demand, such as that obtained via waiting lists or ad hoc surveys of 'turnaways' (as per the SAAP NDC unmet demand for accommodation collection). Both methods require complex analysis for estimating the numbers of clients, in the absence of client identification or linkage arrangements.

A number of possible options for national analysis could be developed based on recent work using the SAAP NDC:

- The framework for the SAAP NDC recently enabled the NSW Ombudsman to conduct an inquiry into the exclusion policies and practices of SAAP agencies in New South Wales, and the implications these policies may have for people with high or complex needs. This report expressed concern that a significant number of people, including those with mental health or substance use issues, are denied access to some SAAP agencies because of their exclusion policies and practices (NSW Ombudsman 2004). This type of work could be mirrored at a national level for SAAP agencies or expanded to other data collections (e.g. AODTS–NMDS, mental health settings). In the latter case, more information would also need to be collected to indicate comorbidity.
- SAAP NDC data are also being used at local levels to examine issues pertinent to comorbidity. For example, the OASIS Youth Support Service in New South Wales is undertaking an analysis investigating youth homelessness, drug use and young people's mental health status. Similarly, the Merri Outreach Service in Victoria is determining the factors that affect on people's capacity to maintain long-term tenancies, which include access to mental health and alcohol and drug services.

Introducing additional data items to some data sources would strengthen information about the services needed and received by people with comorbidity. For example, it may be possible to introduce a data item into the NDSHS, similar to the current alcohol and drug treatment question, focusing on mental health treatment. Similarly, it may be possible to include supplementary surveys or modules to the SAAP NDC to further explore comorbidity within the SAAP population (i.e. using definitions more closely aligned with other key data sources).

If linkage was introduced into some of the data sources the possibilities for analysis could include, for example, using alcohol and other drug treatment data (from the AODTS–NDMS) and community mental health data (from NCMHCD) to estimate the proportion of clients who access specialist drug and alcohol services and who also access public community mental health services. Similarly, SAAP NDC and AODTS–NMDS data could be used to examine whether clients who have been assisted under a specialist drug and alcohol service have a lower/higher entry/re-entry into SAAP. Finally, inclusion of a linkage key such as the SLK in future NDSHSs may enable exploration of the types of services accessed across a number of sectors by the population with comorbidity.

D Outcomes for people with comorbidity

A number of potential avenues for improving data in the area of outcomes were referred to in Section 5.1. These include:

- exploring the potential of the MHNOCC methodology, of measuring a range of outcome measures at time of admission, review and discharge, for inclusion in other data collections, while acknowledging the time, resources and stakeholder negotiations that might be needed to achieve this
- exploring the possibility of increasing the level of information in key data sources such as the AODTS–NMDS so that comorbidity and client outcomes can be recorded.

Developments in these areas would greatly enhance the possibilities for enhancing analysis.

Using data collections as they currently exist, it is already possible to explore, for example, general access by people with comorbidity to a range of services, or their prevalence in certain populations. For example, the presence (and possible over-representation) of people with comorbidity in correctional settings could be viewed as an outcome indicator for this sector. The DUCO survey allows an estimate of the number of sentenced females with comorbidity and the DUMA survey allows an estimate of the number of people with comorbidity among those who have recently been apprehended by the police. Similarly, the presence (and possible over-representation) of people with comorbidity in death statistics (e.g. NMD and NCIS) provides an indication of one possible negative outcome for people with comorbidity.

The SAAP NDC has already been used to inform a range of specific research projects relating to client and service-level outcomes in New South Wales, including a recent inquiry by the New South Wales Ombudsman into access to, and exiting from, the SAAP (NSW Ombudsman 2004). This inquiry found that people with high and complex needs, including people with coexisting mental health and substance use problems, were more likely to be turned away (i.e. denied services) than others. It is possible that such methodology could be extended either to a national level or to other administrative data collections.

6.4 Dissemination

As part of this project, we undertook to identify options for improving the dissemination of information from data collections relevant to the National Comorbidity Initiative to identified data collection managers. As part of the process of reviewing and finalising this report, data custodians for all reviewed data sources were asked to provide comment on this report and confirm that the details included for their respective data sources (in Appendix 1) were current and accurate. Thus, the level of awareness of this broad set of data sources and their potential usefulness in relation to comorbidity has already increased among these data managers. The publication of this report will provide an ongoing reference for people interested in using the reviewed data sources to address issues relating to comorbidity and more broadly.

The NDSHS currently includes a list of information sources from which respondents can select the sources of information that informed their opinion about which drugs caused the most deaths in Australia and which are of the most concern. The responses to this item may give an indication of the most useful information dissemination avenues for people with comorbidity.

The Alcohol and other Drugs Council of Australia's Resource Centre has also developed a Register of Australian Drug and Alcohol Research (RADAR), which is funded and endorsed by DoHA. RADAR aims to promote awareness of alcohol, tobacco and other drug research in Australia. This is achieved by having an online register which contains up-to-date records of current and recently completed research projects relating to substance use. The inclusion of, or reference to, this report and other relevant comorbidity information on this register could significantly enhance dissemination in this area.

There are clear benefits, relating to data improvements, of increasing communication between and within sectors relevant to comorbidity (including mental health, alcohol and other drugs, corrections, education and training, and housing). This may be achieved by, for example, establishing a mailing list which relates to key comorbidity data sources and research, encouraging relevant peak bodies in the mental health and drug and alcohol sectors to include links toeach other on their websites; and encouraging dialogue on information issues between key committees with responsibilities in the areas of mental health (e.g. National Mental Health Working Group) and alcohol and other drugs (e.g. the Intergovernmental Committee on Drugs, which includes experts in the alcohol, drugs and corrections sectors).

6.5 Conclusion

This report identifies and describes current data collections relating to comorbidity in Australia and assesses them in terms of their ability to inform key questions about comorbidity. There is a rich supply of data sources in Australia, including a range of relevant population surveys and administrative collections which detail activity in a broad array of service settings. Inconsistencies between, and gaps within, these data sources are highlighted, along with possible ways to improve the synergy among collections. The report also identifies a range of possibilities for future analysis using data in their existing formats, or with minimal or more substantial changes.

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Appendix: Collection summaries

1 Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS)

Data source (title)	Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS)
Brief description	The AODTS–NMDS aims to monitor and evaluate key objectives of the National Drug Strategy and assist in the planning, management and quality improvement of alcohol and other drug treatment services.
Purpose(s)	To provide information on publicly funded government and non-government alcohol and drug treatment services at a national level. To monitor broad patterns of service utilisation and access to services for specific population groups. To inform planning and development of service delivery strategies and support the development of strategies for benchmarking.
Collection methodology	Administrative by-product data collected at the treatment agency level, forwarded to health departments in each jurisdiction and then to the AIHW.
Scope (theoretical coverage of relevant population)	All publicly funded government and non-government alcohol and/or drug treatment services, excluding correctional institutions, halfway houses, sobering-up shelters and agencies whose sole function is to provide opioid maintenance pharmacotherapy treatment or whose main function is health promotion (e.g. needle and syringe programs), or alcohol and drug treatment centres that report to the Admitted Patient Care National Minimum Data Set and do not provide treatment to non-admitted patients. Acute care hospitals or psychiatric hospitals are included if they have specialist alcohol and drug units that provide treatment to non-admitted patients (e.g. outpatient services). Aboriginal or Mental Health Services may be included in the AODTS–NMDS if they provide specialist alcohol and other drug treatment. However, for example, the vast majority of dedicated Indigenous services funded by DoHA are not included in this collection.
Coverage (actual)	In 2002–03, a total of 587 alcohol and other drug treatment agencies contributed data to the collection. This represents 94% of agencies from which data were requested.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Annually, from 2000–01.
Basic collection count (i.e. treatment episodes, separations etc.)	Closed treatment episode and number of agencies. A closed treatment episode refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. A closed treatment episode may be for a specific treatment, such as information and education only, that may not be part of a larger treatment plan, or for a specific treatment, such as withdrawal management (detoxification), that may be part of a long-term treatment plan.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Agency-related data items: establishment identifier, establishment type, geographical location of establishment. Treatment episode-related data items: client type (whether seeking treatment for own or other's drug issue), country of birth, date of birth, date of cessation of treatment episode for alcohol and other drugs, date of commencement of treatment episode for alcohol and other drugs, Indigenous status, injecting drug use, main treatment type for alcohol and other drugs, method of use for principal drug of concern, other drugs of concern, other treatment type for alcohol and

(continued)

Data content (continued)	other drugs, person identifier, preferred language, principal drug of concern, reason for cessation of treatment episode for alcohol and other drugs, sex, source of referral to alcohol and other drug treatment services, treatment delivery setting for alcohol and other drugs.
Has there been variation over time in any of the above descriptors for this collection?	In the first year of the collection (2000–01), there was a mix of client registration and treatment episode data and one jurisdiction (Queensland) was unable to supply data. For the 2001–02 collection period, Queensland supplied data for police diversion clients only and South Australia supplied client registration data rather than treatment episode data. All other jurisdictions supplied treatment episode data. In 2002–03, data were also provided from Queensland government AODTS agencies and/or police diversion clients but not for other non-government-funded agencies. It is anticipated that Queensland will be able to report on most Queensland-funded treatment agencies for the 2004–05 annual report. As at 2002–03, data relating to police and court diversion programs were included for all jurisdictions except Tasmania, which expects to be able to provide these data from 2003–04. The data item *Number of service contacts within a treatment episode for alcohol and other drugs* and data concept *Service contact* were included in the 2001–02 data collection but subsequently excluded. Minor clarifications to data items and data domains (i.e. response categories) are made each collection year, as required.
Are there any proposed developments relating to comorbidity in the near future for this collection?	There has been discussion about the possible inclusion of a data item on concurrent conditions (which would include mental health conditions) but there are no plans to implement such a question in the near future.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Principal drug of concern, other drugs of concern, injecting drug use (*National Health Data Dictionary* (NHDD) definition with four-digit codes as per the *Australian Standard Classification of Drugs of Concern (ASCDC)* ABS Cat. No. 1248.0 (2000)).
Mental health	Source of referral—coding option includes: mental health care service.
Comorbidity	Very-low level proxy for comorbidity can be determined using the above two data items.
Age	Date of birth (NHDD) is collected and 10-year age groups are reported in all publications (i.e. 10–19, 20–29, 30–39, 40–49, 50–59, 60+ years).
Sex	Sex (NHDD).
Cultural and linguistic diversity	Country of birth (NHDD definition with four-digit codes as per the *Standard Australian Classification of Countries* (SACC) ABS Cat. No.1269.0 (1998). Preferred language (NHDD definition with two-digit codes as per the *Australian Standard Classification of Languages* (ASCL) ABS Cat. No. 1267.0 (1997).
Indigenous status	Indigenous status (NHDD).
Geographic location of respondent	Not collected.
Geographic location of agency or other relevant unit	Geographical location of establishment (NHDD definition with five-digit code to indicate the SLA within as defined in the *Australian Standard Geographical Classification* (ASGC) ABS Cat. No. 1216.0, presented in terms of remoteness areas). State/territory of agency.
Treatment types	Main treatment type for alcohol and other drugs and Other treatment type for alcohol and other drugs (NHDD). The data domain is: withdrawal management (detoxification), counselling, rehabilitation, pharmacotherapy, support and case management only, assessment only, other.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Not collected.

(continued)

Indicators of social participation (e.g. labour force status, education status)	Not collected.
Treatment outcomes	Not collected.
Collection management agency	AIHW.
Title/name of contact	Head, Functioning and Disability Unit / Ms Ros Madden
Address	GPO Box 570, Canberra, ACT 2601
Email	ros.madden@aihw.gov.au
Internet	www.aihw.gov.au
Phone/fax	(02) 6244 1189 / (02) 6244 1199
Data custodian/access	AIHW
Funding agency	DoHA
Output	AIHW 2004a. Alcohol and other drug treatment services in Australia 2002–03: Report on the national minimum data set. AIHW Cat. No. HSE 33. Canberra: AIHW.
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When will data from this reference period/survey be available?	Data from the 2004–05 collection period are scheduled to be published in August 2006.
Other comments	**NSW** Additional data items included within the NSW collection which address mental health are: *Referral to another service*—coding options include: psychiatric hospital; residential community mental health care unit; non-residential community mental health care. [This data item could be used as a proxy for mental health issues/problems.] *Usual accommodation*—coding option includes: psychiatric hospital. **Tasmania** Tasmania are introducing a system known as the 'Statewide Client Registration System'; this will include a unique client identifier and will enable matching across services/agencies. **Victoria** Extra data items included within the Victorian collection which address mental health: *Program type*—coding option includes: Dual Diagnosis Initiative *Source of referral*—coding options include: ABI agency; community mental health unit–residential; psychiatric service-non-residential; psychiatric service–residential.
	Accommodation status—coding option includes: psychiatric home/hospital. *Substance related disorders*—coding options include: substance dependence; substance abuse; substance intoxication; substance withdrawal. *Concurrent conditions*—coding options include: psychiatric; ABI diagnosed. *Referral destination*—coding options include: private psychiatrist; psychiatric services. **Outcomes** While no national data are collected on treatment outcomes, the Brief Treatment Outcomes Measure (NSW) and Significant Treatment Goal Achievements (Victoria) are examples of such measures currently collected in state-based AODTS–NMDS collections.

2 National Drug Strategy Household Survey (NDSHS)

Data source (title)	National Drug Strategy Household Survey (NDSHS)
Brief description	A household survey of drug use, exposure, knowledge, attitudes and awareness.
Purpose(s)	To contribute to the development of drug-related policies. To monitor and measure the public's experience with drug use patterns, attitudes and behaviours. To provide data for monitoring and evaluating the National Drug Strategy.
Collection methodology	Households selected by a multi-stage, stratified area sample design, drop and collect (self-complete) interview, and Computer Assisted Telephone Interview (CATI). Comprehensive logic and edit checks.
Scope (theoretical coverage of relevant population)	Australian population aged 12 years or more.
Coverage (actual)	Stratified random sample of households across Australia. Not in scope are the homeless, institutions, correctional facilities, aged care facilities, military bases, schools or places of business.
Geographic coverage	All states and territories, Australia
Frequency/timing	Approximately triennial (since 1985)—1985, 1988, 1991, 1993, 1994 (Indigenous supplement), 1995, 1998, 2001, 2004 (active).
Basic collection count (i.e. treatment episodes, separations etc.)	Individuals within households.
Does the collection include a unique client identifier or statistical linkage key?	The questionnaire number is in practice a unique identifier but it is not identifiable. No statistical linkage key exists.
Data content (list of all data items)	Age, sex, marital status, education, country of birth, languages spoken, income, employment status, alcohol and drug-related knowledge, attitudes, awareness, behaviours, age first used, place of use, where drug was obtained, prevalence of use among friends, days lost from work or education, health problems due to drugs or alcohol, people's perception of problems with drug use, and attitudes towards changes in regulations and treatments.
Has there been variation over time in any of the above descriptors for this collection?	Yes. There have been a large number of changes to the detail of questions included in the survey since its inception in 1985. For example, there were no questions asked about mental health status in 2001 and none to inform comorbidity issues.
Are there any proposed developments relating to comorbidity in the near future for this collection?	—
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Tobacco—'Daily', 'Weekly', 'Less than weekly', 'Ex-smoker' & 'Never smoked'. Alcohol—'Daily', 'Weekly', 'Less than weekly', 'Ex-drinker' & 'Never a full glass of alcohol'. Alcohol risk—'Abstainer', 'Low risk', 'Risky' & 'High risk'. Alcohol-related harm—'Short-term' & 'Long-term'. Illicit Drugs—'Ever used', 'Use in the last 12 months', '…last month' & '…last week'.
Mental health	The 2004 survey introduced questions seeking information on diagnoses and/or treatment of health conditions in the last 12 months. Conditions included 'depression', 'anxiety disorder', 'schizophrenia', 'bipolar disorder', 'other form of psychosis' and 'eating disorder'. The 2004 survey also includes the Kessler 10 scale of psychological distress and SF1.
Comorbidity	Yes, a proxy can be dervied using a combination of information about substance use and mental health status.
Age	'Date of birth' is not collected. 'Age' is collected (age as turned at last birthday).

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Sex	'Sex' is collected and defined as 'Male' or 'Female'.
Cultural and linguistic diversity	2001 questions: 'In which country were you born?' 'In what year did you first arrive in Australia to live here for one year or more?' 'What is the main language spoken at home?' 'What other languages are spoken at home?'.
Indigenous status	2001 question: 'Are you of Aboriginal or Torres Strait Islander origin?' • No • Yes, Aboriginal • Yes, Torres Strait Islander • Yes, both Aboriginal and Torres Strait Islander.
Geographic location of respondent	For respondent: Postcode, census collection district, and state/territory are all available on the master data file. The public use data file has only state/territory and metro/rural/remote classifications.
Geographic location of agency or other relevant unit or other relevant unit	—
Treatment types	*Have you ever participated in an alcohol or other drug treatment program to help you reduce or to quit your consumption*—coding options include: smoking (e.g. Quit); alcohol (e.g. Alcoholics Anonymous); detoxification centre; methadone maintenance; prescription drugs (e.g. GP supervised); counselling; therapeutic community; Naltrexone; other. [This question is also asked in relation to whether the person has used such programs in the last 12 months.]
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	2001 questions: • marital status • number of people aged 14 years and over living in household • number of dependent children in household • age categories of dependent children • household description • household type and composition • personal and household income.
Indicators of social participation (e.g. labour force status, education status)	2001 questions: • current employment status • history of paid work • industry of last employer (coded using Australian and New Zealand Standard Industry Classification) • type of work (coded using Australian Standard Classification of Occupations) • highest year of school completed • completion of a trade certificate or other educational qualification • highest qualification obtained.
Treatment outcomes	—
Collection management agency	AIHW
Title/name of contact	Mr Mark Cooper-Stanbury
Address	MDP 14, GPO Box 9848, Canberra, ACT 2601
Email	mark.cooper-stanbury@health.gov.au
Internet	www.aihw.gov.au
Phone/fax	(02) 6289 7027 / (02) 6289 8483

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Data custodian/access	AIHW and DoHA.
Funding agency	DoHA
Output	AIHW 2002. 2001 National Drug Strategy Household Survey: first results. AIHW Cat. No. PHE 35. Canberra: AIHW. AIHW 2002. 2001 National Drug Strategy Household Survey: detailed findings. AIHW Cat. No. PHE 41. Canberra: AIHW. AIHW 2002. National Drug Strategy Household Survey: state and territory findings. .AIHW Cat. No. PHE 37. Canberra: AIHW. AIHW 2003. Statistics on drug use in Australia 2002. AIHW Cat. No. PHE 43. Canberra: AIHW. Public use data file managed by the Australian Social Science Data Archive.
References (for preparing this template)	See publications listed in output and the 2004 NDSHS questionnaire.
When will data from this reference period/survey be available?	2001: Results from this collection became publicly available in May 2002. 2004: Results from this collection will become available in April/May 2005.
Other comments	This survey is a good candidate for collection or general information on drug use and mental health status (from the general population).

3 Australian Schools Students Alcohol and other Drugs Survey (ASSADS)

Data source (title)	Australian Schools Students Alcohol and other Drugs Survey (ASSADS)
Brief description	A national survey of school student's behaviours regarding drug use.
Purpose(s)	To provide data on school students behaviours regarding drug use. To develop drug-related trend data. To identify needs, strategies and policies to address drug problems.
Collection methodology	Secondary schools randomly selected, stratified by state and type of school, self-enumeration of surveys.
Scope (theoretical coverage of relevant population)	Year 7 to 11 school students aged between 12 to 17 years (with variations in year levels in different states and territories)
Coverage (actual)	The sample size in 2002 was 24,403 in 363 schools across Australia.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Triennial since 1984 (illicit drug questions introduced in 1996).
Basic collection count (i.e. treatment episodes, separations etc.)	Individuals (students).
Does the collection include a unique client identifier or statistical linkage key?	A unique identifier is constructed for each student in the study. The identifier is made from a state id, a school id and a student id within each school. A year identifier is added to this unique identifier to construct a unique id for each student in each year of the ASSADS study. In addition, postcode of school and student residence is collected.
Data content (list of all data items)	Age, sex, language spoken at home, year at school, level of spending money, incidence and prevalence of tobacco smoking and alcohol use (since 1984), over-the-counter and illicit drug use (since 1996) and sun exposure.
Has there been variation over time in any of the above descriptors for this collection?	Yes. There have been minor changes to questions.
Are there any proposed developments relating to comorbidity in the near future for this collection?	There are no proposed developments to collect this information at a national level at this stage. Some states participating in the study may collect information about injury, depressed mood, anxiety, study problems and being in trouble out of school.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Tobacco use: • Never: Those who had not had even a puff of a cigarette. • Ever: Those who indicated they had had at least a puff of a cigarette in their lifetime (ever use) • Year: Those who had smoked cigarettes within the past year. • Month: Those who had smoked cigarettes within the four weeks prior to completing the survey. • Current smokers: Those who had smoked cigarettes within the seven days prior to completing the survey. • Committed smokers: Those who had smoked cigarettes on at least three days of the preceding seven days. • Daily smokers: Those who had smoked on each of the seven days prior to the survey day. Alcohol use: • Never: Those who had not had even a sip of an alcoholic drink. • Ever: Those who indicated they had had at least a sip of an alcoholic drink in their lifetime (ever use). • Year: Those who had had an alcoholic drink within the past year. • Month: Those who had had an alcoholic drink within the four weeks prior to completing the survey. • Current drinkers: Those who had an alcoholic drink on any of the seven days prior to completing the survey. • Drinking at risk of short-term harm: Those males who consumed seven or more drinks on at least one day of the preceding seven days and those females who consumed at least five drinks on at least one day of the preceding seven days (harmful drinking).

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Substance use (continued)	Illicit drug use: • Never: Those who had never used the substance. • Ever: Those who indicated any use of the substance, either in their lifetime, the past month, or past week (ever use). • Year: Those who had used the substance within the past year. • Month: Those who had used the substance within the four weeks prior to completing the survey. • Week: Those who had used the substance within the seven days prior to completing the survey. • Regular use: Students who used a substance 10 or more times within the past year were defined as regular users.
Mental health	No information collected in 2002.
Comorbidity	No information collected in 2002.
Age	'Age' (in years) is collected and so is 'date of birth' (DD/MM/YYYY).
Sex	'Sex' is collected and defined as 'Male' or 'Female'.
Cultural and linguistic diversity	2002 question: 'What is the main language spoken at home?'.
Indigenous status	2002 question: 'Are you of Aboriginal or Torres Strait Islander descent?' • No • Yes – Aboriginal descent • Yes – Torres Strait Islander descent • Yes – both Aboriginal and Torres Strait Islander descent.
Geographic location of respondent	Suburb/town of residence, postcode of residence.
Geographic location of school	Postcode of the school is collected.
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Disposable income 'During a normal week, how much money do you have available to spend on yourself (e.g. from pocket money, part time job)?'.
Indicators of social participation (e.g. labour force status, education status)	Year of school currently enrolled.
Treatment outcomes	—
Collection management agency	The Cancer Council Victoria (Centre for Behavioural Research In Cancer)
Title/name of contact	Dr Vicki White
Address	Centre for Behavioural Research in Cancer, The Cancer Council Victoria, 1 Rathdowne Street, Carlton VIC 3053.
Email	vicki.white@cancervic.org.au
Internet	http://www.accv.org.au/index.htm
Phone/fax	(03) 9635 5197 / (03) 9635 5380
Data custodian/access	The Cancer Council Victoria (Centre for Behavioural Research In Cancer) and DoHA.
Funding agency	Funding is from a range of sources including state cancer councils, state health departments and DoHA.
Output	White V and Hayman J 2004. Smoking behaviours of Australian secondary school students in 2002. National Drug Strategy Monograph 54. Canberra: DoHA. White V and Hayman J 2004. Australian secondary school students' use of over-the-counter and illicit substances in 2002. National Drug Strategy Monograph 56. Canberra: DoHA. White V and Hayman 2004. Australian secondary school students' use of alcohol in 2002. National Drug Strategy Monograph 55. Canberra: DoHA.

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References (for preparing this template)	Australian secondary students' use of alcohol in 1999. National Drug Strategy Monograph 45. Canberra: DoHA. White V 2001 Australian secondary students' use of over-the-counter and illicit substances in 1999. National Drug Strategy Monograph 46. Canberra: DoHA. White V and Hayman J 2004. Smoking behaviours of Australian secondary school students in 2002. National Drug Strategy Monograph 54. Canberra: DoHA.
When will data from this reference period/survey be available?	2002 survey: data from some individual jurisdictions is already available. National data will be available in late 2004. 2005 survey: Data will be available in 2006/2007.
Other comments	The questionnaire for the 2005 study is currently being developed. It is expected that the survey used in the 2002 study will be repeated with the possibility of adding a small number of new items. States participating in the study have the option to ask state-specific questions of students. States are currently reviewing surveys used in 2002 to determine content of this questionnaire.

4 Illicit Drug Reporting System (IDRS) – Injecting Drug Users (IDU)

Data source (title)	Illicit Drug Reporting System (IDRS) – Injecting Drug Users (IDU)
Brief description	The IDRS monitors the price, purity, availability and patterns of use of heroin, methamphetamine, cocaine and cannabis. The IDRS is designed to be sensitive to trends, providing data in a timely manner rather than describing issues in detail.
Purpose(s)	The IDRS is a national illicit drug monitoring system intended to serve as a strategic early warning system, identifying emerging trends of local and international concern in illicit drug markets. The primary aims of the 2003 IDRS were: • to document the price, purity, availability and patterns of use of the four main illicit drug classes in Australia, namely heroin, methamphetamine, cocaine and cannabis • to detect and document emerging drug trends of national significance that require further and more detailed investigation.
Collection methodology	The IDRS consists of three components: • a quantitative survey of injecting drug users (IDU), who act as a sentinel group for the detection of emerging trends in illicit drug use • a qualitative survey of key informants (KIs), or experts who work in the field of illicit drugs • a synthesis of extant indicator data sources such as Customs data, seizure purity data, arrest data and so on.
Scope (theoretical coverage of relevant population)	All Australian states and territories. IDU survey: drug users. KI survey: professional informants.
Coverage (actual)	All Australian capital cities. 970 IDU were surveyed in 2003.
Geographic coverage	All Australian capital cities.
Frequency/timing	Annual. First 1996 (New South Wales only), additional jurisdictions included in 1997 (Victoria and South Australia). All states and territories were included in 1999, but all three components were only performed for New South Wales, Victoria and South Australia. The complete IDRS has been conducted since 2000 (including all jurisdictions and all three components).
Basic collection count (i.e. treatment episodes, separations etc.)	IDU survey: individuals; KI survey: individuals; Indicator data: various.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	IDU survey: age, sex, language spoken at home, suburb/town of residence, accommodation type, Indigenous status, education, employment status, source of income, sex worker status, current and previous drug treatment, prison history, age first used, frequency of use, method of use, form of drug used, knowledge of price, purity and availability, criminal activity, risk-taking behaviour (including unsafe injecting practices), place of use, injection-related health problems, mental health problem other than drug dependence, trends in illicit drug use. KI survey: demographic characteristics of users, drug use patterns, price, purity and availability of drugs, criminal activity, health, drug importation, manufacture and/or dealing. Indicator data: drug purity, consumer and provider arrests, awareness, attitudes, and behaviours of individuals, morbidity, treatment services, drug injection prevalence, pharmacotherapy, overdose fatalities, customs seizures.
Has there been variation over time in any of the above descriptors for this collection?	Yes, but IDU survey data is directly comparable over time since 2000.

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Are there any proposed developments relating to comorbidity in the near future for this collection?	Yes, the 2004 questionnaire includes two additional questions (see mental health section below).
Definitions—how are the following concepts addressed and/or defined?	The following concepts are all in reference to the IDU survey:
Substance use	Tobacco—'Ever used', 'Use in the last 6 months'. Alcohol—'Ever used', 'Use in the last 6 months'. Illicit drugs—'Ever used', 'Use in the last 6 months', injection practices, form of drug used, brand used.
Mental health	2003: Attendance of mental health professional in last 6 months for a mental health problem other than drug dependence. Type of professional and nature of problem. 2004: Increased precision of questions and included 'Have you had any mental health problems other than drug dependence in the last 6 months?'. If yes, 'What type?'.
Comorbidity	Yes, a low-level proxy can be determined using information about substance use and mental health.
Age	Single year age.
Sex	'Male' or 'Female'.
Cultural and linguistic diversity	Main language spoken at home.
Indigenous status	2003 question: Do you identify as Aboriginal and/or Torres Strait Islander?
Geographic location of respondent	State, suburb/town.
Geographic location of agency or other relevant unit	Not applicable.
Treatment types	2003 questions: What is the main type of drug treatment you are currently in? What forms of treatment have you been in over the last six months?
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Accommodation type (includes homelessness), convicted of an offence, income source.
Indicators of social participation (e.g. labour force status, education status)	Highest grade of school completed, post-school qualifications, employment status, engaged in sex work.
Treatment outcomes	—
Collection management agency	National Drug and Alcohol Research Centre (NDARC)
Title/name of contact	Dr Louisa Degenhardt
Address	National Drug and Alcohol Research Centre, University of New South Wales Sydney, NSW 2052
Email	l.degenhardt@unsw.edu.au
Internet	NDARC Illicit Drug Reporting System website http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS
Phone/fax	(02) 9385 0333 / (02) 9385 0222
Data custodian/access	National Drug and Alcohol Research Centre (NDARC)
Funding agency	DoHA and the National Drug Law Enforcement Research Fund (NDLERF).
Output	Breen C, Degenhardt L, Roxburgh A, Bruno R, Fetherston J, Jenkinson R, Kinner S, Moon C, Proudfoot P, Ward J & Weekley J 2004. Australian drug trends 2003: findings from the illicit drugs reporting system. National Drug and Alcohol Research Centre Monograph 51. Sydney: NDARC.

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References (for preparing this template)	Breen C, Degenhardt L, Roxburgh A, Bruno R, Fetherston J, Jenkinson R, Kinner S, Moon C, Proudfoot P, Ward J & Weekley J 2004. Australian drug trends 2003: findings from the illicit drugs reporting system. National Drug and Alcohol Research Centre Monograph 51. Sydney: NDARC. IDRS Drug Trends Bulletin. June 2004. Sydney: NDARC. IDRS Drug Trends Bulletin. April 2004. Sydney: NDARC. IDRS Drug Trends Bulletin. December 2003. Sydney: NDARC. NDARC Illicit Drug Reporting System website http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS
When will data from this reference period/survey be available?	Data from the 2003 collection is currently available. Data from the 2004 collection will be released in mid-2005.
Other comments	It is important to note that the information from the IDU survey is not representative of illicit drug use in the general population nor is the information representative of all illicit drug users, but is indicative of emerging trends that warrant further monitoring.

5 Illicit Drug Reporting System (IDRS) – Party Drugs Initiative (PDI)

Data source (title)	Illicit Drug Reporting System (IDRS) – Party Drugs Initiative (PDI)
Brief description	The PDI is a national study designed to investigate trends in the markets for ecstasy and other party drugs.
Purpose(s)	A national monitoring system of ecstasy and other party drugs that is intended to serve as a strategic early warning system, identifying emerging trends of local and national interest in party drug markets. In 2003, the specific aims of the PDI were: • to describe the characteristics of a sample of current ecstasy users interviewed in each capital city of Australia • to examine the patterns of ecstasy and other drug use of these samples • to document the current price, purity and availability of ecstasy and other party drugs across Australia • to examine participant's perceptions of the incidence and nature of ecstasy-related harm, including physical, psychological, financial, occupational, social and legal harms • to identify emerging trends in the party drug market that may require further investigation.
Collection methodology	The PDI is based on the IDRS–IDU methodology and consists of three components: interviews with party drug users (PDU); interviews with key KIs, professionals who have regular contact with PDUs through their work; and analysis and examination of indicator data sources related to party drugs (price, purity, availability and patterns of use of ecstasy, methamphetamine, cocaine, ketamine, GHB and other party drugs).
Scope (theoretical coverage of relevant population)	All Australian states and territories.
Coverage (actual)	All Australian capital cities. 809 regular ecstasy users recruited.
Geographic coverage	All Australian capital cities.
Frequency/timing	Annual (first full coverage in 2003), piloted in 2002 in New South Wales, Queensland and South Australia.
Basic collection count (i.e. treatment episodes, separations etc.)	Individuals.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Sex, age, postcode, accommodation, main language spoken, Indigenous status, schooling, treatment, employment, sexual identity, convicted of an offence, use of methamphetamine, ecstasy, cocaine, ketamine, GHB and other party drugs, use, price, purity, ease of obtaining, side effects, risk perception, commission of crimes, help-seeking behaviour (2004).
Has there been variation over time in any of the above descriptors for this collection?	Yes, minor changes in questions included. States and territories ask additional non-comparable questions in addition to the standardised questionnaire.
Are there any proposed developments relating to comorbidity in the near future for this collection?	Minor. Severity of Dependence scales have been included in the 2004 questionnaire. PDU will also be asked about help-seeking behaviour and other problems.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Tobacco—'Ever used', 'Use in the last 6 months'. Alcohol—'Ever used', 'Use in the last 6 months'. Illicit drugs—'Ever used', 'Use in the last 6 months', injection practices, form of drug used.
Mental health	—
Comorbidity	—

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Age	'Age' is classified as 'Age in years'.
Sex	Sex is 'Male' or 'Female'.
Cultural and linguistic diversity	Main language spoken at home.
Indigenous status	2003 question: Do you identify as Aboriginal and/or Torres Strait Islander?
Geographic location of respondent	State, metropolitan region (e.g. West, Inner West, Inner City, no fixed address), non-metropolitan.
Geographic location of agency or other relevant unit	Not applicable.
Treatment types	'Are you currently in any form of drug treatment' coded as 'yes', 'no' & 'specify'.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Accommodation type (includes homelessness), convicted of an offence, income source.
Indicators of social participation (e.g. labour force status, education status)	Number of years of school completed, post-school qualifications, employment status.
Treatment outcomes	—
Collection management agency	National Drug and Alcohol Research Centre (NDARC)
Title/name of contact	Dr Louisa Degenhardt
Address	National Drug and Alcohol Research Centre, University of New South Wales, Sydney, NSW 2052
Email	l.degenhardt@unsw.edu.au
Internet	NDARC Party Drugs Initiative website http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.partydrugs
Phone/fax	(02) 9385 0333 / (02) 9385 0222
Data custodian/access	National Drug and Alcohol Research Centre (NDARC)
Funding agency	National Drug Law Enforcement Research Fund (NDLERF)
Output	Breen C, Degenhardt L, White B, Bruno R, Chanteloup F, Fischer J, Johnston J, Kinner S, Moon C, Proudfoot P, & Weekley J 2004. Australian party drug trends 2003: findings of the party drugs initiative. National Drug and Alcohol Research Centre Monograph 52. Sydney: NDARC.
References (for preparing this template)	Breen C, Degenhardt L, White B, Bruno R, Chanteloup F, Fischer J, Johnston J, Kinner S, Moon C, Proudfoot P, & Weekley J 2004. Australian party drug trends 2003: findings of the party drugs initiative. National Drug and Alcohol Research Centre Monograph 52. NDARC. IDRS Party Drug Trends Bulletin. June 2004. Sydney: NDARC. IDRS Party Drug Trends Bulletin. April 2004. Sydney: NDARC. IDRS Party Drug Trends Bulletin. December 2003. Sydney: NDARC. NDARC Party Drugs Initiative website http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.partydrugs
When will data from this reference period/survey be available?	Data from the 2003 collection is currently available. Data from the 2004 collection will be released in mid-2005.
Other comments	Results from the PDI surveys are not representative of party drug use in the general population. The PDI is a sentinel group of regular ecstasy users who provide information on patterns of drug use and market trends.

6 Drug and Alcohol Service Report (DASR)

Data source (title)	Drug and Alcohol Service Report (DASR)
Brief description	The DASR collects information about the activities of Indigenous substance use services over a 12-month period. This includes detailed service-level information about client numbers, episodes of care provided, service resources, staffing profiles and the broad range of activities undertaken by services to help prevent and treat substance use.
Purpose(s)	The DASR aims to collect comparable service data across all services funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) services to satisfy government accountability requirements relating to quality and activity of Australian government funded Aboriginal and Torres Strait Islander substance misuse services. The DASR provides information that the sector and OATSIH can use in formulating policy, in planning and to profile the work of Indigenous substance use services.
Collection methodology	Annual survey (by paper-based questionnaire).
Scope (theoretical coverage of relevant population)	Stand-alone Indigenous substance use services funded by the Australian Government through OATSIH. A separate process is undertaken to gather information from Aboriginal and Torres Strait Islander primary health care services funded by OATSIH, some of which also deliver substance use services (see the SAR collection).
Coverage (actual)	The final response rate from services was 95% in 1999–2000. In 2000–01 it was 100%, in 2002–03 it was 98%.
Geographic coverage	All states and territories except Tasmania and the Australian Capital Territory (where there are no services in scope for DASR).
Frequency/timing	Annually from 1999–2000, except for 2001–02.
Basic collection count (i.e. treatment episodes, separations etc.)	Service-level estimates of: total client numbers seen by the service in the reporting period; and episodes of care.
Does the collection include a unique client identifier or statistical linkage key?	No. The DASR does not collect client–level data.
Data content (list of all data items)	Program information: what substance use programs were offered by the service in the reporting period, times and days of the week the service is available, total number of beds/residential places at the service, whether there is travel outside the local service area. Numbers of clients/episodes of care: • total client numbers (includes all clients seen individually by the service with their own file/record) • residential treatment/rehabilitation clients and episodes of care (includes all clients that stay in residential care and receive formal treatment/rehabilitation) • sobering-up/residential respite clients and episodes of care (includes all clients that stay in short-term residential care (1 to 7 days) and do not receive formal treatment/rehabilitation) • total number of clients receiving 'other care' and total number of 'other episodes of care' (includes non-residential counselling/rehabilitation, follow-up from residential services, Mobile Assistance Patrol/Night Patrol)(this enables the service to record the number episodes that take place with clients not in residential care who contact the service for substance use counselling, assessment, treatment etc.) • group episodes of care (includes all groups that are run by the service to help prevent and/or treat substance use, or to support communities and families affected by substance use). Specific additional questions are asked in relation to each of the above client/episode data areas (e.g. length of stay in residential treatment/rehabilitation, readmissions to residential treatment/rehabilitation).

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Data content (continued)	Staffing details: for each staff member as at 30 June of the reporting period, services are asked to report occupation/job title, hours paid per week, gender, Indigenous status, qualifications, staff development/training, funding source, length of employment. Services also report as at 30 June about visiting/volunteers/community development employment projects staff not employed/paid by the service, staff vacancies, length of vacancies. Service level: summary information is requested about referral sources for the program's clients, achievements and success stories. Substance specific service level information is requested about: • substances treated • emotional and social health issues of substance use clients (e.g. anxiety/stress, depression/hopelessness/despair etc.) • approaches to treating substance use in the reporting period; which treatment approach was used most often in the reporting period; types of care provided to clients in the reporting period • programs/activities provided; what did the service do for clients with needs beyond the capacity of the service in the reporting period (e.g. no support and/or not referral provided, client referred to another service) • support before and after discharge/referral • access to medical staff during the reporting period (where they were located (e.g. Aboriginal Medical Service) and what medical services were provided to clients (e.g. medicated detoxification) • working relationships: types of agencies the service has working relationships with. • management of service; governance arrangements, computers/information technology, funding sources (including client charges and service's income).
Has there been variation over time in any of the above descriptors for this collection?	Yes, minor variations to questions and counting rules.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Service-level estimates of the substances/drugs the service provided treatment or assistance for during the reporting period (using tick box list including alcohol, tobacco/nicotine, cannabis, petrol, multiple drug use etc.). Service-level estimates of which one substance/drug affected the largest number of their clients in the reporting period. Service-level estimates of which one substance/drug required the most staff time and resources overall in the reporting period. Service's opinion about whether changes have been noticed in the patterns of substance use in their community.
Mental health	Service-level estimates of the number of substance use clients that had emotional and/or social health issues in the reporting period (tick box responses are anxiety/stress, depression/hopelessness/despair, self-harm/suicide/ schizophrenia or other psychotic disorder, grief and loss issues, survivor of childhood sexual assault, sexual assault, issues with sexuality, family/relationship issues, family and community violence, removal from homelands/traditional country, stolen generation issues, loss of cultural identity, other (please specify)).
Comorbidity	Not directly, although both substance use and mental health issues are addressed at the service level.

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Age	The service is asked to allocate an age group to all episodes of care (age groups are 0–7, 8–13, 14–18, 19–25, 26–39, 40 years or more). That is, service-level estimates are available for the number of clients in each of these age groups.
Sex	The service is asked to allocate a sex to the client numbers and episodes of care.
Cultural and linguistic diversity	—
Indigenous status	The service is asked to allocate Indigenous status to the client numbers and episodes of care (Indigenous, non-Indigenous). Services are asked whether staff are of Aboriginal and/or Torres Strait Islander origin (i.e. standard NHDD question).
Geographic location of respondent	Out of scope of DASR (no client level data are reported)
Geographic location of agency or other relevant unit	The postal address, physical location of service as well as other geographical information such as x,y coordinate of the service, ARIA, ASGC remoteness index, SLA etc. are known by the collection managers.
Treatment types	During the reporting period, services are asked to provide estimates for: • client numbers and episodes of care for residential treatment/rehabilitation, sobering-up and/or residential respite programs, other care • group episodes of care • treatment approaches used by the service (tick box response options are harm reduction, controlled drinking, controlled use of other substances, abstinence, cultural support/involvement, family/community support/involvement, religious/spiritual support, other (please specify); treatment approaches used most often) • how the service provided care for clients (tick box response options are individual counselling/rehabilitation/education, group counselling/rehabilitation/education, telephone counselling/follow-up, crisis intervention, referral services, welfare assistance and/or emergency relief, case management, transport, other (please specify)) • programs/activities provided (e.g. counselling approaches include options for education provided, relapse prevention, relationships/social skills counselling; cultural activities include options for traditional healing, bush tucker, bush outings; social health programs include helping clients to access methadone management) • support before and after discharge/referral (tick box options include no support provided, support and practical assistance in resuming independent living, help clients to access training/education, accommodation assistance, telephone counselling/follow-up) • medical services provided to clients (tick box options include clients medically assessed on admission/when starting with service, management of client medications, medicated detoxification, first aid) • types of agencies the service has working relationships with (e.g. other Aboriginal and Torres Strait Islander substance use services, mainstream drug and alcohol services, homeless support shelters/SAAP etc.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	—
Indicators of social participation (e.g. labour force status, education status)	—
Treatment outcomes	—
Collection management agency	OATSIH
Title/name of contact	Assistance Director, Research and Data / Ms Rachel Meyer

(continued)

Address	GPO Box 9848, Canberra, ACT 2601
Email	rachel.meyer@health.gov.au or oatsih.enquiries@health.gov.au
Internet	www.health.gov.au
Phone/fax	(02) 6289 5011 / (02) 62891412
Data custodian/access	OATSIH and DoHA
Funding agency	OATSIH and DoHA
Output	OATSIH & Australian Government Department of Health and Ageing 2001. Drug and Alcohol Service report (formerly the Substance Misuse Service Report) key results 1999–2000. <http://www.health.gov.au/oatsih/pubs/dasr.htm>.
References (for preparing this template)	Drug and Alcohol Service Report (DASR) 2003–04 questionnaire <http://www.health.gov.au/oatsih/pubs/dasrq.htm>.
When will data from this reference period/survey be available?	Data from the 2000–01 and 2002–03 DASR collections are expected to be released in mid 2005. Data from the 2003–04 DASR collections are expected to be released in late 2005.
Other comments	Data are provided back to service providers for confirmation and use prior to publication of national reports. DASR and SAR data definitions are comparable for episodes, contacts clients and staffing.

7 Service Activity Reporting (SAR)

Data source (title)	Service Activity Reporting (SAR)
Brief description	The SAR collects service-level data on health care and health-related activities over a 12-month period from Australian Government funded Aboriginal and Torres Strait Islander primary health care services. The SAR is a joint data collection project of the National Aboriginal Community Controlled Health Organisation (NACCHO) and OATSIH.
Purpose(s)	The SAR aims to collect comparable service data across all OATSIH-funded services to satisfy government accountability requirements relating to quality and activity of Australian government funded health services. The SAR data collection provides information that NACCHO, OATSIH and the sector use in formulating policy, in planning and to profile the work of Australian Government funded Aboriginal and Torres Strait Islander primary health care services.
Collection methodology	Annual survey (by paper-based questionnaire).
Scope (theoretical coverage of relevant population)	Aboriginal and Torres Strait Islander primary health care services funded by the Australian Government. A separate process is undertaken to gather information from stand-alone Indigenous substance use services funded by the Australian Government (see the DASR collection).
Coverage (actual)	The final response rate from services was 96% in 2000–01, 96% in 2001–02 and 99% in 2002–03.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Annually from 1997–98.
Basic collection count (i.e. treatment episodes, separations etc.)	Service-level estimates of: total client numbers seen by the service in the reporting period; episodes of care; client contacts; and transport contacts.
Does the collection include a unique client identifier or statistical linkage key?	No. The SAR does not collect client-level data.
Data content (list of all data items)	Episodes of care and client contacts during the reporting period: • episodes of health care provided by Indigenous status and gender (defined as contact between an individual client and a service by one or more staff to provide health care, does not include residential care or groups) • individual client contacts made by each type of worker from the service (defined as when someone receives health care from a health professional at the service, health professionals include Aboriginal and Torres Strait Islander Health Workers (AHWs), doctors, nurses, substance misuse workers etc.). Does not include residential care or groups • number of influenza and pneumococcal vaccinations provided; how information was collected (e.g. appointment book/client contact register, computer records) • percentage of episodes for people who normally live outside the health service area. • percentage of episodes provided for Torres Strait Islanders • percentage of episodes provided outside the usual opening hours of the service (from 2001–02 on). Clients during the reporting period: • total client numbers by Indigenous status (includes all clients seen individually by the service with their own file/record, excluding those who only attended groups and did not receive individual care); the number of clients who are Aboriginal and Torres Strait Islander people-and non-Indigenous people (from 2001–02 on).

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Data content (continued)	Staffing and visiting health professionals: • includes information as at 30 June of the reporting period about full-time equivalent positions the service paid the wages/salaries/fees for, according to type of worker, vacant staff positions, information over the full year about other people (full-time equivalent positions) working in the service who were not paid by the service, and number of staff (according to worker type) who received training (as well as the type of training) and AHW qualifications. Service details: • details about the times and days of the week the service is available, care provided outside usual opening hours, service sites, health-related activities undertaken/facilitated during the reporting period, contact between the service and nearby hospital(s), contact between the service and local Division of General Practice, contact between services and GPs, contact with other health-related organisations; achievements and success stories; computing facilities, resource issues; governance arrangements and general comments. Substance use (see below on definitions for substance use). Emotional and social wellbeing (see below on definitions for mental health).
Has there been variation over time in any of the above descriptors for this collection?	Yes, variations to questions and counting rules (e.g. inclusion of information about number of clients from 2001–02).
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions – how are the following concepts addressed and/or defined?	
Substance use	Service-level estimates of which substance use issues the service provided treatment/assistance for in the reporting period (tick box options include alcohol, tobacco/nicotine, cannabis/marijuana, petrol etc.). The number of full-time equivalent (FTE) substance use workers employed by the service. The number of male and female client contacts with substance use workers. How many times the service ran specifically targeted programs over the reporting period for each substance (tick box options include 0, 1–4, 5–12, 13+ times). Service's description of the nature and extent of the impact of substance use on the service during the reporting period. What substance use services are provided by the service (tick box options include case management, management of hepatitis C, information/education about substance use) etc.
Mental health	Which emotional and social wellbeing issues were dealt with by the service over the reporting period (tick box options are grief and loss issues, serious mental illness (e.g. schizophrenia, depression), anxiety/stress, self-harm/suicide prevention, stolen generation issues, family/relationship issues, family violence, youth issues, comorbidities with substance use, other (please specify)). The service is asked whether each of these is an issue: in their community, covered on an individual client basis as they arise, and whether this service runs ongoing care/program in relation to these issues. What mental health/emotional and wellbeing activities were provided by the service in relation to the above issues (i.e. schizophrenia, depression, anxiety/stress) (tick box options include short-term counselling, ongoing counselling programs, visiting psychologist, psychiatrist and/or social worker, this service regularly participates in case management with other agencies in the care of patients with mental illness, clients with mental health problems are referred to this service from other services, workers visit clients at home for emotional and social wellbeing, family support and education, outreach services

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Mental health (continued)	to public/private psychiatric institutions, mental health promotion activities (e.g. youth camps, drop-in centres), referral (please specify), other (please specify)). The number of FTE social and emotional wellbeing staff employed by the service, and the number of FTE social and emotional wellbeing staff who visit the service to provide health care. The number of male and female client contacts with emotional and social wellbeing staff.
Comorbidity	Service-level estimates of whether there are 'comorbidities with substance use' that are an issue in the community, an issue covered on an individual client basis as they arise, and whether the service runs ongoing care/programs in relation to comorbidities with substance use.
Age	—
Sex	Provided at service-level for contacts, episodes and AHW staff data.
Cultural and linguistic diversity	—
Indigenous status	Collected as service level estimates in relation to client numbers (i.e. services are asked to report the number of clients over the reporting period that are Aboriginal and Torres Strait Islander clients, non-Indigenous clients, unknown as well as a separate question about the proportion of total clients who are Torres Strait Islanders).
Geographic location of respondent	Out of scope of SAR collection.
Geographic location of agency or other relevant unit	The postal and physical addresses of the services as well as other geographical information such as x,y coordinate, ARIA, SLA, ASGC remoteness index, etc. are known by the collection managers.
Treatment types	Services are asked to provide estimates over the reporting period for: • client contacts according to worker type (e.g. AHW, doctors, nurses, substance misuse workers, emotional and social wellbeing staff etc.) • health-related activities undertaken/facilitated by the service (tick box options for health-related and community support services; options include transport, school-based activities, medical evacuation services; clinical health care includes diagnosis and treatment of illness/disease, management of chronic disease, dialysis services on site; traditional health care includes traditional healing, bush tucker nutrition programs; preventive care programs include health promotion/education, infectious disease programs/education; screening programs include renal screening, diabetic screening; pharmaceutical services; medical records and health information) • contact with other health-related organisations (includes tick box options for other community-controlled health service(s), mainstream substance use service(s), Indigenous substance use service(s)).
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Not collected. Out of scope of SAR collection.
Indicators of social participation (e.g. labour force status, education status)	Not collected. Out of scope of SAR collection.
Treatment outcomes	—
Collection management agency	OATSIH
Title/name of contact	Assistant Director, OATSIH Research and Data / Ms Rachel Meyer
Address	MDP 17, Department of Health and Ageing, GPO Box 9848, Canberra, ACT 2601
Email	rachel.meyer@health.gov.au or oatsih.enquiries@health.gov.au
Internet	www.health.gov.au/oatsih
Phone/fax	(02) 6289 5011 / (02) 62891412

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Data custodian/access	OATSIH/DoHA NACCHO may provide data on services that have also agreed to provide their data to NACCHO.
Funding agency	OATSIH and DoHA
Output	Commonwealth of Australia 2003. Service Activity Reporting 2000–2001 key results: a national profile of Australian Government funded Aboriginal and Torres Strait Islander primary health care services. Results of a joint Office of Aboriginal and Torres Strait Islander Health (OATSIH) & National Aboriginal Community Controlled Health Organisation (NACCHO) Initiative. Canberra: OATSIH (at http://www.health.gov.au/oatsih/pubs/sar.htm).
References (for preparing this template)	Service Activity Reporting 2003–04 questionnaire (see http://www.health.gov.au/oatsih/pubs/sar1.htm). Commonwealth of Australia 2003 (above).
When will data from this reference period/survey be available?	Data from the 2001–02 and 2002–03 SAR collections are expected to be published in mid-2005. Data from the 2003–04 SAR collections is expected to be published in late 2005.
Other comments	Data are provided back to service providers for confirmation and use prior to publication of national reports.

8 National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection

Data source (title)	National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection
Brief description	The NOPSAD collection is a collation of information routinely collected by state and territory health departments about clients, prescribers and dispensers participating in opioid pharmacotherapy maintenance programs for the treatment of opioid dependence, and prescribers participating in the delivery of pharmacotherapy treatment.
Purpose(s)	To provide national information about opioid pharmacotherapy treatment programs in Australia.
Collection methodology	State and territory health departments forward specified aggregate tables to DoHA for collation.
Scope (theoretical coverage of relevant population)	All opioid pharmacotherapy maintenance programs in Australia.
Coverage (actual)	Unknown.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Annually, since 1998.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of pharmacotherapy clients at 30 June each year, although interpretation/collection practices are variable across jurisdictions.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Client information is requested according to the following variables: state/territory; prescriber sector (public, private, correctional facility); dosing site (pharmacy, public clinic, private clinic, correctional facility, other); pharmacotherapy maintenance drug (methadone, buprenorphine, total). States and territories are also asked to provide information about the number of doctors registered to prescribe methadone/buprenorphine, total; the number of clients who have switched from methadone to buprenorphine treatment.
Has there been variation over time in any of the above descriptors for this collection?	Yes, in addition to minor variations in table specifications, the question asking about pharmacotherapy maintenance drug (i.e. differentiating between methadone and buprenorphine) was introduced in 2001 and the question asking about switches between methadone and buprenorphine was introduced in 2003. Data were requested about GP prescribers for the first time in 2002–03.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	—
Mental health	—
Comorbidity	—
Age	—
Sex	—
Cultural and linguistic diversity	—
Indigenous status	—
Geographic location of respondent	—
Geographic location of agency or other relevant unit	—
Treatment types	All clients are receiving opioid pharmacotherapy treatment.

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Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	—
Indicators of social participation (e.g. labour force status, education status)	—
Treatment outcomes	—
Collection management agency	DoHA
Title/name of contact	Director, Illicit Drugs Section / Klaus Klaucke
Address	Drug Strategy Branch, Population Health Division, Australian Government Department of Health and Ageing, GPO Box 9848, Canberra, 2601
Email	klaus.klaucke@health.gov.au
Internet	www.health.gov.au
Phone/fax	(02) 6289 8562 / (02) 6289 7837
Data custodian/access	DoHA
Funding agency	DoHA
Output	Excerpts from the data are reported each year in the reports on the AODTS–NMDS (see for example: AIHW 2004). Alcohol and other drug treatment services in Australia 2002–03: report on the National Minimum Data Set. Drug Treatment Series 3. AIHW Cat. No. HSE 33. Canberra: AIHW. Data are provided to researchers on an ad hoc basis and to the Intergovernmental Committee on Drugs.
References (for preparing this template)	Unpublished tables provided by DoHA for 2002–03.
When will data from this reference period/survey be available?	It is anticipated that data for 2004 will be published by the AIHW in its report on the 2003–04 AODTS–NMDS (in September 2005).
Other comments	DoHA have commissioned the AIHW (February 2005) to take over the collection management and reporting role of NOPSAD for the 2004 collection period.

9 Clients of Treatment Service Agencies (COTSA) Census

Data source (title)	Clients of Treatment Service Agencies (COTSA) Census
Brief description	A one-day snapshot census (usually conducted in May) of all clients who use drug and alcohol treatment services across all of Australia.
Purpose(s)	To monitor the changing characteristics of people using drug and alcohol treatment services.
Collection methodology	Survey of treatment service agencies.
Scope (theoretical coverage of relevant population)	All drug and alcohol treatment services.
Coverage (actual)	90.3% of agencies contacted participated in the survey.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Irregular 1990, 1992, 1995, 2001.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of clients.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Type, age, sex, country of birth, language spoken at home, employment status, usual residence postcode, service provided, principal drug problem, drugs injected during the past 12 months.
Has there been variation over time in any of the above descriptors for this collection?	No.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No. This collection is not expected to be repeated due to the development of the AODTS–NMDS.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	'Type' classifies the client as either 'Substance user' or 'Relative/friend of user'. 'User's main problem (Agency opinion)' is classified as: alcohol, opiates (e.g. heroin), tobacco, benzodiazepines (e.g. Valium), cocaine, amphetamines (e.g. speed, crystal), amphetamine-related substances (e.g. ecstasy, PMA), barbiturates (e.g. Nembutal), other tranquillisers, cannabis (e.g. marijuana), hallucinogens (e.g. LSD), steroids, volatile substances (inhalants), poly-drugs including opiates, poly-drugs excluding opiates, other drug (please specify).
Mental health	Not collected.
Comorbidity	Not collected.
Age	Age is collected in years, though not specifically defined.
Sex	Sex is collected as M or F though not specifically defined.
Cultural and linguistic diversity	*Country of birth* is classified as: Australia (non-Aboriginal); Australia (Aboriginal); Torres Strait Islander; Other (please specify); Not known. *Main language spoken at home* is classified as: English; Aboriginal languages; Italian; Greek; Vietnamese; Spanish; Other (please specify); not known.
Indigenous status	See above.
Geographic location of respondent	Postcode
Geographic location of agency or other relevant unit	Address and name of agency collected but conditions of use regarding access to protect anonymity.

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Treatment types	*Main service provided to client today* is classified as: NON-RESIDENTIAL: assessment or referral; counselling; methadone and counselling; outpatient detoxification; other (please specify) RESIDENTIAL: rapid detoxification; other inpatient detoxification; inpatient rehabilitation; therapeutic community; other (please specify). [More than one service may recorded for each client].
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	See above for residential setting.
Indicators of social participation (e.g. labour force status, education status)	*Employment status* is classified as: employed full-time; employed part-time; unemployed; home duties; retired; pensioner; student; prisoner; other (please specify); not known.
Treatment outcomes	—
Collection management agency	National Drug and Alcohol Research Centre
Title/name of contact	Fiona Shand
Address	National Drug and Alcohol Research Centre, University of New South Wales Sydney, NSW 2052
Email	fionas@unsw.edu.au
Internet	www.med.unsw.edu.au/ndarc
Phone/fax	(02) 9385 0333 / (02) 9385 0222
Data custodian/access	National Drug ans Alcohol Research Centre / DoHA / Australian Social Science Data Archive.
Funding agency	DoHA
Output	Shand FL & Mattick RP 2002. Clients of treatment service agencies: May 2001 census findings report. National Drug Strategy Monograph 47. Canberra: DoHA.
References (for preparing this template)	Shand FL & Mattick RP 2002. Clients of treatment service agencies: May 2001 census findings report. National Drug Strategy Monograph 47. Canberra: DoHA.
When will data from this reference period/survey be available?	Results from the 2001 COTSA were released in 2002. Datasets from all four collection years are available via application to the Australian Social Science Data Archive.
Other comments	This collection has been superseded by the AODTS–NMDS.

10 Council of Australian Governments Illicit Drug Diversion Initiative (COAG IDDI)

Data source (title)	Council of Australian Governments Illicit Drug Diversion Initiative (COAG IDDI) National Minimum Data Set.
Brief description	Data collection related to Illicit Drug Diversion Initiative funded programs.
Purpose(s)	Monitoring and evaluation of Illicit Drug Diversion Initiative programs.
Collection methodology	Relevant state/territory governments are required to report in relation to all Illicit Drug Diversion Initiative funded programs.
Scope (theoretical coverage of relevant population)	Information not provided.
Coverage (actual)	All participants in police and court diversion programs.
Geographic coverage	National.
Frequency/timing	Ongoing.
Basic collection count (i.e. treatment episodes, separations etc.)	Diversion episodes.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Assessment provider: Refer to AODTS–NMDS data items; unique identifier; postcode of usual address; treatment/education options recommended; compliance or non-compliance. Education provider: Refer to AODTS–NMDS data items; unique identifier; postcode of usual address; date of session/s; compliance or non-compliance. Treatment provider: Refer to AODTS–NMDS data items; unique identifiers; postcode of usual address; compliance or non-compliance.
Has there been variation over time in any of the above descriptors for this collection?	No.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Information not provided.
Mental health status	Information not provided.
Comorbidity	Information not provided.
Age	Information not provided.
Sex	Information not provided.
Cultural and linguistic diversity	Information not provided.
Indigenous status	Information not provided.
Geographic location of respondent	Information not provided.
Geographic location of agency or other relevant unit	Information not provided.
Treatment types	Information not provided.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Information not provided.
Indicators of social participation (e.g. labour force status, education status)	Information not provided.
Treatment outcomes	Information not provided.

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Collection management agency	DoHA
Title/name of contact	Assistant Director, Alcohol and Harm Reduction Initiatives / Bruce Lowes
Address	DoHA, GPO Box 9848, Canberra, 2601
Email	Bruce.Lowes@health.gov.au
Internet	www.health.gov.au
Phone/fax	(02) 6289 7230 / (02) 6289 7837
Data custodian/access	DoHA
Funding agency	DoHA
Output	Information not provided.
References (for preparing this template)	Information not provided.
When will data from this reference period/survey be available?	Information not provided.
Other comments	Information not provided.

11 National Needle and Syringe Program (NSP) Survey

Data source (title)	National Needle and Syringe Program Survey, 1999–2003
Brief description	A cross-sectional survey conducted at selected NSP sites during a specified week of the year.
Purpose(s)	HIV and hepatitis C surveillance among IDUs in Australia. Monitoring behavioural indices of risk and prevalence of HIV/hepatitis C among IDUs. Provision of information for planning prevention, treatment and harm reduction policies and services.
Collection methodology	A brief, self-administered (anonymous) questionnaire and provision of a capillary blood sample for HIV and hepatitis C antibody testing.
Scope (theoretical coverage of relevant population)	Injecting drug users from a sample of NSP sites across Australia.
Coverage (actual)	Sites were originally selected based on: • volume of syringes distributed • coverage of all states and territories • willingness of sites to participate. The list of participating sites was expanded based on size, geographic coverage and subpopulations targeted. The response rate for participants in the survey ranged between 42–50% in 1999–2003. In 2003, 48 sites participated in the survey, and responses were received from 2,495 participants (response rate of 45%). Sites were located in: Adelaide, Alice Springs, Brisbane, Cairns, Canberra, Darwin, Gold Coast, Hobart, Melbourne, Nimbin, Perth, Sydney, Sunshine Coast and Toowoomba.
Geographic coverage	All states and territories of Australia.
Frequency/timing	Annual survey carried out in a specified week of the year (September/October) since 1999.
Basic collection count (i.e. treatment episodes, separations etc.)	Persons (number of respondents).
Does the collection include a unique client identifier or statistical linkage key?	Yes—a name code is used to track drug use changes over time. The first two letters of a person's first name, and the first two letters of the last name are collected (e.g. JOSM).
Data content (list of all data items)	Demographic and personal information: Sex; sexual identity (heterosexual, bisexual, homosexual); age; age when first drug injected; last drug injected; imprisonment (ever); imprisonment in last year; injected drugs in prison last year; condom use at last sex; sex work last month; condom use at last sex work last month; sexual activity last month; condom use for: new sex partner(s), casual sex partner(s), regular sex partner(s); duration of regular sexual relationship; history of methadone treatment; history of other pharmacotherapy treatment; other therapies for drug use (ever); tattoos; tattoos in last 12 months (if so, where was it done); body/ear piercings; body/ear piercings in last 12 months (if so, where done); previous use of needle by others for piercings; living in this city/town for at least 6 months; main language spoken at home; country of birth; Indigenous status; syringe acquisition frequency last month (chemist and NSP); been in survey before; name code. Data items related to injections over the last month: frequency of injection; places injected; use of new sterile needle and syringe; equipment used after someone else; injected by someone after that person injected themselves or others; frequency of reuse of another's needle or syringe; number of people needle and syringe was re-used after; relationship to people needle and syringe was used after.

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Data content (continued)	Previous test information: ever had hep B infection; ever had hep B vaccination; ever tested for HIV; result of last HIV test; ever tested for hep C; result of last hep C test—if positive hep C—antibody and/or virus; year of positive result; treatment (ever); treatment (current).
Has there been variation over time in any of the above descriptors for this collection?	There was a slight variation in the 2003 survey from previous years e.g., exclusion of the descriptor 'living in this city/town for at least 6 months' and inclusion of 'if positive hep C—antibody and/or virus'.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Last drug injected (heroin; heroin + cocaine; cocaine; speed; methadone; morphine; anabolic steroids; other—specify). Frequency of injection over last month (more than 3 times most days; 2–3 times most days; once a day; more than weekly, not daily; less than weekly—on 1 to 6 days; not in last month). Places injected last month—tick all (own home; friend's home; dealer's home; street, park or bench; car; public toilet; commercial 'shooting' room; MSIC (KX injecting centre added in 2003); squat; other—specify). Information also collected about last month's injections—use of new sterile needle & syringe; use of others' needle & syringe; equipment used after others; injections by someone else (see full list of data items for details).
Mental health status	—
Comorbidity	—
Age	Age in years; month and year of birth.
Sex	Sex (male; female; transgender).
Cultural and linguistic diversity	Country of birth (Australia; other—please specify). Main language spoken at home by parents (open-ended question).
Indigenous status	Aboriginal or Torres Strait Islander origin (yes; no).
Geographic location of respondent	Not collected.
Geographic location of agency or other relevant unit	Reported at state/territory level only.
Treatment types	Ever been on methadone program (current; past; never). Ever been on other pharmacotherapy treatment (eg. Natrexone, buprenorphine or LAAM) (current; past; never). Ever had any other therapies for drug use (e.g. detox, counselling, N/A) (yes; no). Treatment for hepatitis C: ever and current (none; interferon; interferon & ribavirin; other—specify).
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	N/A
Indicators of social participation (e.g. labour force status, education status)	N/A
Treatment outcomes	N/A
Collection management agency	National Centre in HIV Epidemiology and Clinical Research
Title/name of contact	A/Professor / Lisa Maher
Address	Level 2, 376 Victoria Street, Sydney, NSW 2010

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Email	LMaher@nchecr.nsw.edu.au
Internet	www.med.unsw.edu.au/nchecr/
Phone/fax	(02) 9385 0900 / (02) 9385 0920
Data custodian/access	National Centre in HIV Epidemiology and Clinical Research
Funding agency	DoHA
Output	Australian NSP Survey National Data Report 1999–2003.
References (for preparing this template)	Australian NSP Survey National Data Report 1999–2003 (from methodological section and survey form, pp.163–168, see also data tables for variable names) MacDonald MA, Wodak AD, Dolan KA et al. 2000. Hepatitis C virus antibody prevalence among injecting drug users at selected needle and syringe programs in Australia, 1995–1997. Medical Journal of Australia 172 (2):57–61.
When will data from this reference period/survey be available?	Reports covering the preceding 5-year period are published annually.
Other comments	All questions on the survey are voluntary. Name codes cannot be checked because the survey is anonymous.

12 National Alcohol Campaign (NAC) tracking research

Data source (title)	National Alcohol Campaign (NAC) tracking research – Youth survey
Brief description	The NACis one of many initiatives under the National Drug Strategic Framework 1998–99 to 2002–03 and the National Alcohol Action Plan. The National Alcohol Campaign consists of a mass-media component targeting teenagers and parents of teenagers, is supported by other communication strategies, and has been designed to provide a framework within which a range of initiatives at the national, state/territory or community level can be undertaken.
Purpose(s)	The main focus of the campaign is to reduce alcohol-related harm among Australian teenagers. The campaign communication strategy for teenagers has sought to increase consideration of the potential negative consequences of drinking decisions, to increase motivation to avoid these negative alcohol-related consequences, and to model and promote ways of avoiding this harm. The campaign strategy has also sought to promote greater engagement among parents towards reducing harmful drinking.
Collection methodology	Face-to-face survey with 800 respondents. Self-report, random sample through electronic white pages. Respondent selected based on next birthday, some clustering.
Scope (theoretical coverage of relevant population)	Teenagers aged 15–17 years of age.
Coverage (actual)	Metropolitan and non-metropolitan represented.
Geographic coverage	All states and territories, Australia.
Frequency/timing	The evaluation research has preceded and followed on from campaign periods, such as the launch phase in February 2000, the second phase in November 2000–January 2001 and the third phase in August 2002. Research has also been conducted in February over the past four years to monitor any shifts in alcohol consumption trends.
Basic collection count (i.e. treatment episodes, separations etc.)	Individuals.
Does the collection include a unique client identifier or statistical linkage key?	No. The questionnaire does contain an ID number but it is not transferred to the datafile.
Data content (list of all data items)	The data covers process measures (relating to the target group's response to the campaign) and outcome measures (relating to young people's attitudes and behaviour towards alcohol).
Has there been variation over time in any of the above descriptors for this collection?	Yes, some minor changes have been made to the questionnaire over time.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Prevalence of teenage drinking: the proportion of teenagers who had consumed more than ten alcoholic drinks in their life. Recency of consumption: those respondents who had ever consumed an alcoholic drink or part thereof (not including a few sips) were asked how long it had been since they had their last alcoholic drink. These figures are reported as a proportion of the total sample. Type of alcohol consumed: teenagers who reported having consumed alcohol within the last three months were asked to describe the type of alcoholic drinks they consumed on their last drinking occasion.
Mental health status	—
Comorbidity	—
Age	Age is collected (either 15, 16 or 17 years of age).

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Sex	Sex is recorded by the interviewer as 'male' or 'female'.
Cultural and linguistic diversity	Birthplace of mother and father. Main language spoken at home.
Indigenous status	Aboriginal and Torres Strait Islander status is collected as part of the survey.
Geographic location of respondent	The respondent's location is captured by the interviewer. The following areas are in scope: CITY & MAJOR REGIONAL: Sydney; Melbourne; Brisbane; Adelaide; Perth; Hobart; Launceston; ACT; Wollongong; Newcastle; Geelong; Ballarat; Bendigo; Gold Coast; Mount Gambier; Rockhampton RURAL: Wagga Wagga; Dubbo; Lismore; Warrnambool; Moe; Bunbury; Bundaberg; Maryborough; Sunshine Coast; Toowoomba; Whyalla; Geraldton.
Geographic location of agency or other relevant unit	Not applicable.
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Household composition: Q27l. How many people live in your home, including yourself? Aged 0–5, Aged 6–10, Aged 11–17, Aged 18+, In total. Family living arrangements: Q27m. Which of the following would best describe your household? Both parents with children mainly 7–12; Both parents with children mainly 13+; Single parent–children mainly 7–12; Single parent–children mainly 13+; Other household type.
Indicators of social participation (e.g. labour force status, education status)	Education: Thinking about this year will you be studying at school, college or elsewhere? Which line best describes where you will be studying this year—coding options include: secondary school; at technical school; commercial college or TAFE; at university or institute of technology; other. Employment: Are you now in paid employment? Are you now looking for a paid job? How many weeks, months or years have you been looking for a job?
Treatment outcomes	—
Collection management agency	DoHA
Title/name of contact	Liz King
Address	Research Manager, Research and Marketing Group, Communications Branch, Level 7, 1 Oxford Street, Darlinghurst, Sydney, NSW 2010.
Email	liz.king@health.gov.au
Internet	www.nationalalcoholcampaign.health.gov.au
Phone/fax	(02) 9263 3545 / (02) 9263 3549
Data custodian/access	DoHA
Funding agency	DoHA
Output	2002: SPSS data files, data tables printouts, based on predetermined table specifications. King E, Barbir N, Ball J, Carroll T, Sutton G 2003. Summary report: evaluation of the Third Phase of the National Alcohol Campaign: June – September 2002. Sydney: DoHA. King E, Ball J, Carroll T 2003. Alcohol consumption patterns among Australian 15–17 year olds from February 2000 to February 2002 Sydney: DoHA.
References (for preparing this template)	2004 NYAC Questionnaire AIHW 2004. A Guide to Australian Alcohol Data. AIHW Cat. No. PHE 52. Canberra: AIHW. http://www.aihw.gov.au/publications/index.cfm/title/10002
When will data from this reference period/survey be available?	The 2004 alcohol consumption report is finalised and is anticipated to be released with the NAC evaluation report in November 2004.

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Other comments	NCS Pearson was the preferred supplier from February 2000 to the end of 2002. Now Roy Morgan Research is the preferred supplier for the data. The campaign encourages teenagers to consider the negative consequences associated with excessive alcohol consumption, thus challenging the positive expectancies that they often associate with drinking alcohol. The campaign evaluations have consistently shown that most teenagers who are aware of the campaign, report that the campaign made them think about the negative things that can happen when they drink too much, and consider the choices they make about drinking.

13 National Tobacco Campaign Survey (NTCS)

Data source (title)	National Tobacco Campaign Survey (NTCS)
Brief description	The National Tobacco Campaign (NTC) was launched by the now Australian Department of Health and Ageing in 1997, and primarily targets 18–40 year old smokers with a cessation-focused strategy promoting the message 'Every cigarette is doing you damage'. The NTC is designed to elevate quitting on the personal agendas of smokers by demonstrating new insights on the health effects of smoking and moving people through the stages-of change to contribute to an overall reduction in smoking prevalence. Nine national evaluation surveys have been conducted to date, including a benchmark survey conducted in May 1997. Subsequent annual evaluation surveys have taken place in November to ensure consistency with the timing of these cross-sectional surveys. The annual surveys track the progress of the NTC, and provide evidence of the effectiveness of the NTC as well as informing tobacco control policy development.
Purpose(s)	These data are collected to inform the evaluation of the NTC.
Collection methodology	CATI – cross-sectional survey, quota-based.
Scope (theoretical coverage of relevant population)	Nationally sourced sample of 18–69 year old Australians from electronic white pages. Sample comprises 75% smokers.
Coverage (actual)	Two parts to the survey – each year the household component conducted with approx. 30,000 informants aged 18+, the evaluation component conducted with approx. 2,800 respondents aged 18–69.
Geographic coverage	Sample selected from each of six states and the Australian Capital Territory included with New South Wales, and the Northern Territory included with South Australia
Frequency/timing	Annually – November since 1997 and a benchmark in May 1997.
Basic collection count (i.e. treatment episodes, separations etc.)	Individuals.
Does the collection include a unique client identifier or statistical linkage key?	The collection does contain a unique id but it is not linked to anything.
Data content (list of all data items)	Awareness of NTC advertising, age group, sex, household composition, occupation of main income earner, tobacco consumption, preferred language, postcode, smoking cessation behaviour, brand, strength and packet size of cigarette smoked, feelings about being smoker, awareness of harms caused by smoking, use of Zyban, nicotine replacement therapy, awareness of health impacts of smoking, type of tobacco smoked, workplace restrictions.
Has there been variation over time in any of the above descriptors for this collection?	Yes – the Tobacco Drug Prevention & Youth Policy Section sometimes adds questions to assist them with policy development (e.g. nicotine replacement therapy, workplace smoking, illicit tobacco).
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	See appendix in http://www.quitnow.info.au/hotspot/2003report.pdf
Substance use	Regular smokers: Currently smoke daily and at least weekly. Not regular smokers: Currently don't smoke at all or smoke less often than weekly or can't say. Smokes at all: Currently smokes daily, at least weekly or less often than weekly Recent quitters: Quit less than one year ago. Long-term quitters: Quit one year ago or longer. Smoking status (a computed variable): • 'smokers / recent quitters': if is a regular smoker or a recent quitter • 'non-smokers': if is not a 'smoker/recent quitter' as defined above and is a current 'non-smoker' or quit 1 year ago or longer or cannot say when quit • Irregular smokers: if smokes less frequently than weekly or can't say.

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Mental health status	—
Comorbidity	—
Age	Date of birth is not collected. Age recorded in age groups. Age of the next oldest person in household is also collected (if more than one person in the household).
Sex	Sex is collected and recorded by the interviewer as either male or female.
Cultural and linguistic diversity	Preferred language spoken at home is collected.
Indigenous status	—
Geographic location of respondent	Postcode of residence (where call is received) is collected.
Geographic location of agency or other relevant unit	Not applicable.
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Total number of people living in the household is collected. Age of the next oldest person in household is also collected (if more than one person in the household).
Indicators of social participation (e.g. labour force status, education status)	Occupation – (What is (the main income earner's / your) occupation) coding options include: professional, owners or executives, owners of small businesses, sales, semi-professional, other white collar, skilled, semi-skilled, unskilled, farm owners, farm workers, no occupation, other, refused. Employment (Which of the following best describes your employment status) coding options include: working full-time, working part-time, retired/pensioner, student, non-worker, home duties, unemployed/looking for work Education – (Can you please tell me what is the highest educational level you have attained) coding options include: some primary school, finished primary school, some secondary school, finished secondary school, some tertiary education (university, TAFE or college), finished tertiary education, higher degree or higher diploma (e.g. PhD, masters, grad. dip.), can't say, refused.
Treatment outcomes	—
Collection management agency	Research and Marketing Group, DoHA.
Title/name of contact	Trinette Kinsman
Address	Research Manager, Research & Marketing Group, Business Group, DoHA, Level 7, 1 Oxford Street, Darlinghurst, Sydney, NSW 2010.
Email	trinette.kinsman@health.gov.au
Internet	www.quitnow.info.au
Phone/fax	(02) 9263 3546 / (02) 9263 3549
Data custodian/access	DoHA
Funding agency	DoHA
Output	http://www.quitnow.info.au/hotspot/2003report.pdf http://www.quitnow.info.au/hotspot/prevalence.pdf
References (for preparing this template)	http://www.quitnow.info.au/hotspot/2003report.pdf
When will data from this reference period/survey be available?	March/April 2005
Other comments	—

14 National Community Mental Health Care Database (NCMHCD)

Data source (title)	National Community Mental Health Care National Database—based on the National Minimum Data Set
Brief description	The NCMHCD provides information on mental health care provided to non-admitted patients by public community mental health services.
Purpose(s)	To present information on mental health care provided to non-admitted patients by public community mental health services. To monitor patterns of service use and access to services for specific population groups.
Collection methodology	Administrative by-product data collected at the treatment agency level, forwarded to health departments in each jurisdiction, and then to the AIHW.
Scope (theoretical coverage of relevant population)	The scope is service contacts classified as 'ambulatory' that are provided by community mental health establishments. These include all specialised public mental health services. Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function. A specialised mental health service is not dependent on the inclusion of the service within the state or territory mental health budget. A service is not defined as a specialised mental health service solely because its clients include people affected by a mental disorder or psychiatric disability. These services can be a subunit of a hospital even where the hospital is not a specialised mental health establishment itself (e.g. designated psychiatric units and wards, outpatient clinics etc.). Excluded are specialist drug and alcohol services and services for people with intellectual disabilities, except where they are established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability. Also excluded are any specialised psychiatric care provided for admitted patients (including same day admissions) or residential care, and any non-specialised mental health support services (e.g. accommodation support) and services provided by non-government organisations. The data set includes both community-based and hospital-based ambulatory care services such as community mental health care services, outpatient clinics and day clinics. Examples of these services are: adult mental health services, child and adolescent mental health services, crisis assessment and treatment services, mobile assertive case management services, outpatient clinic services, whether provided from a hospital or community health centre, child and adolescent outpatient treatment teams, social and living skills programs, and psychogeriatric assessment and day programs.
Coverage (actual)	In 2002–03, there were 151 establishments that contributed data to the NCMHCD. This represented 92% of mental health care establishments that provided ambulatory care services.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Annually, from 1 July 2000.
Basic collection count (i.e. treatment episodes, separations etc.)	The statistical unit for data in the CMHC–NMDS is the service contact: 'The provision of a clinically significant service by a specialised mental health service provider(s) for patients/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24-hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.' A service contact must involve at least two persons, one of whom must be a specialised mental health service provider. Mobile and outreach services and consultation and liaison services are included as service contacts. Service contacts are not restricted to 'in person' communication but can include telephone, video link or other forms of direct communication.

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Basic collection count (continued)	Service contacts can either be with a patient/client, or with a third party such as a carer or family member, other professional or mental health worker or other service provider. Services involving only a service provider and a third party(ies) are included as service contacts, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question. There may be multiple service contacts on any one day for a patient/client or a third party(ies) and each service contact should be recorded separately. A service contact should be recorded for each patient/client for which the service is provided, whether by phone or other electronic means or in person, regardless of the number of patients/clients or third parties participating or the number of service providers providing the service. Service provision is only regarded as a service contact if it is relevant to the clinical condition of the patient/client. This means that it does not include services of an administrative nature (e.g. telephone contact to schedule an appointment) except where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question. There may however be instances where notes are made in the patient/client clinical record that have not been prompted by a service provision for a patient/client (e.g. noting receipt of test results that require no further action). These instances would not be regarded as service contacts.
Does the collection include a unique client identifier or statistical linkage key? (Describe its nature)	No.
Data content (list of all data items)	Agency-related data items: Establishment identifier, version 4 (NHDD V12) comprising: Australian state/territory identifier, version 4 (NHDD V12 Supplement) Establishment number, version 4 (NHDD V12) Establishment sector, version 4 (NHDD V12 Supplement) Region code, version 2 (NHDD V12) Service contact related data items: Area of usual residence, version 3 (NHDD V12) Country of birth, version 4 (NHDD V12 Supplement) Date of birth, version 5 (NHDD V12 Supplement) Indigenous status, version 5 (NHDD V12 Supplement) Marital status, version 4 (NHDD V12 Supplement) Mental health legal status, version 5 (NHDD V12 Supplement) Mental health service contact duration, version 1 (NHDD V13) Mental health service contact—Session type, version 1 (NHDD V13) Mental health service contact—Patient/client participation indicator, version 1 (NHDD V13) Person identifier, version 2 (NHDD V12 Supplement) Principal diagnosis, version 4 (NHDD V12 Supplement) Service contact date, version 1 (NHDD V12) Sex, version 4 (NHDD V12 Supplement) Data element concepts: Diagnosis, version 2 (NHDD V12 Supplement) Mental health service contact, version 1 (NHDD V13).
Has there been variation over time in any of the above descriptors for this collection?	This is a relatively new data collection and, as a result, there have been gaps in reporting. The level of reporting has been improving and is set to improve further, particularly from 2005–06. Of particular note is the variation in reporting of ‘Principal diagnosis’. In 2001–02 and 2002–03, Principal diagnosis was not reported by Queensland, New South Wales used a combination of ICD–10–AM and ICD–10–PC codes, and the Australian Capital Territory and Northern Territory used only the chapter ‘Mental and behavioural disorders’ from the ICD–10–AM classification. For these years, ‘Mental health legal status’ was not reported by Western Australia. But this data element will be reported by Western Australia from 2003–04.

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Are there any proposed developments relating to comorbidity in the near future for this collection?	The addition of the data element 'Additional diagnosis' would make identification of comorbidity possible. This proposal is scheduled for discussion and possible action in 2005.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Collected through 'Principal diagnosis' data element which is coded using ICD–10–AM codes (note caveats above in Variations over time section). Includes the following relevant codes: Mental and behavioural disorders due to psychoactive substance use (F10-F19 ICD–10–AM) comprising alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine, other stimulants including caffeine, hallucinogens, tobacco, volatile solvents, multiple drug use and use of other psychoactive substances. Relevant subcategories for these codes include: harmful use, dependence syndrome and withdrawal state. It can be assumed that all clients have a mental disorder. However, only one diagnosis is recorded, so substance use will not necessarily be reported.
Mental health	It can be assumed that all clients have a mental disorder. Principal diagnosis is collected using ICD–10–AM codes. In 2002–03, the majority of codes that were specified (64.7% of all service contacts) were in the chapter 'Mental and behavioural disorders' (98.1%). 'Mental disorder not otherwise specified' codes comprised 9.9% of service contacts and there were 25.4% of service contacts with 'Not reported' for principal diagnosis. 'Mental health legal status' is also collected.
Comorbidity	Not collected specifically, except for the information relating to 'Mental and behavioural disorders due to psychoactive substance use' (F10-F19 ICD–10–AM) where both a substance use problem and a mental or behavioural disorder can co-occur. These codes comprised 2.7% of service contacts with a specified principal diagnosis in 2002–03. See section on Substance use. It can be assumed, however, that all clients have a mental disorder.
Age	Date of birth, version 5 (NHDD V12 Supplement)
Sex	Sex, version 4 (NHDD V12 Supplement)
Cultural and linguistic diversity	Country of birth, version 4 (NHDD V12 Supplement) definitions with four-digit codes as per the Standard Australian Classification of Countries (SACC) (ABS Cat. No.1269.0 (1998)).
Indigenous status	Indigenous status, version 5 (NHDD V12 Supplement).
Geographic location of respondent	Area of usual residence, version 3 (NHDD V12).
Geographic location of agency or other relevant unit	Australian state/territory identifier, version 4 (NHDD V12 Supplement). Region code, version 2 (NHDD V12). Name and location of the agency are provided separately to AIHW.
Treatment types	Not collected.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Marital status, version 4 (NHDD V12 Supplement) provides information on both social and registered marital status.
Indicators of social participation (e.g. labour force status, education status)	Not collected.
Treatment outcomes	Not collected.
Collection management agency	AIHW
Title/name of contact	Head, Hospital and Mental Health Services Unit /Ms Jenny Hargreaves
Address	GPO Box 570, Canberra, ACT 2601.
Email	jenny.hargreaves@aihw.gov.au

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Internet	www.aihw.gov.au
Phone/fax	(02) 6244 1121 / (02) 6244 1299
Data custodian/access	AIHW
Funding agency	DoHA
Output	AIHW 2005. Mental health services in Australia 2002–03. AIHW Cat. No. HSE 35. Canberra: AIHW (Mental Health Series No.6).
References (for preparing this template)	AIHW: National Health Data Dictionary Version 12 and Version 12 Supplement. AIHW 2005. Mental health services in Australia 2002–03. AIHW Cat. No. HSE 35. Canberra: AIHW (Mental Health Series No.6). AIHW 2004. Community mental health care *2000–01*. AIHW Cat. No. HWI 66. Canberra: AIHW (Resources Division Working Paper No.2).
When will data from this reference period/survey be available?	Data from the 2002–03 collection period were published in the *Mental Health Services in Australia 2002–03* report in February 2005.
Other comments	—

15 National Residential Mental Health Care Database (NRMHCD)

Data source (title)	National Residential Mental Health Care Database
Brief description	The NRMHCD provides information on mental health care provided to residential patients by government-funded residential mental health services. It is based on the Residential Mental Health Care National Minimum Data Set.
Purpose(s)	To present information on mental health care provided to residential patients by government-funded residential mental health services. To monitor patterns of service use and access to services for specific population groups.
Collection methodology	Administrative by-product data collected at the treatment agency level, forwarded to health departments in each jurisdiction and then to the AIHW.
Scope (theoretical coverage of relevant population)	The scope of the Residential Mental Health Care National Minimum Data Set is episodes of residential care for residents in all government-funded mental health services. The scope of the NMDS excludes: residential care services that are in receipt of funding under the Aged Care Act and subject to Commonwealth reporting requirements (i.e. report to the System for the Payment of Aged Residential Care (SPARC) collection). A residential mental health service is a specialised mental health service (see definition in NCMHCD template) that: employs mental health-trained staff on-site; provides rehabilitation, treatment or extended care to residents provided with care intended to be on an overnight basis in a domestic-like environment; and encourages the resident to take responsibility for their daily living activities. From 1 July 2004, Government-operated services that employ mental health-trained staff on-site 24 hours per day are included for collection. Government-funded, non-government operated services and non-24-hour staffed services may be included from 1 July 2004, *optionally*. Non-24-hour staffed services may only be included if they employ mental health-trained staff on-site at least 50 hours per week, with at least 6 hours staffing on any single day.
Coverage (actual)	Unknown. Data not provided until 31 December 2005.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Annually, from 1 July 2004.
Basic collection count (i.e. treatment episodes, separations etc.)	The data collected for this database is for each episode and not each client. An episode for the purposes of this collection is defined in the data element concept 'Episode of residential care' as the period of care between the start of residential care (either through the formal start of the residential stay or the start of a new reference period) and the end of residential care (either through the formal end of residential care, commencement of leave intended to be greater than seven days or the end of the reference period). Reference period is 1 July to 30 June each year.
Does the collection include a unique client identifier or statistical linkage key? (Describe its nature)	No.
Data content (list of all data items)	Agency-related data items: Establishment identifier, version 4 (NHDD V12) comprising: Australian state/territory identifier, version 4 (NHDD V12 Supplement) Establishment number, version 4 (NHDD V12) Establishment sector, version 4 (NHDD V12 Supplement) Region code, version 2 (NHDD V12) Episode of residential care-related data items: Additional diagnosis, version 4 (NHDD V12 Supplement) Area of usual residence, version 3 (NHDD V12) Country of birth, version 4 (NHDD V12 Supplement) Date of birth, version 5 (NHDD V12 Supplement)

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Data content (continued)	Episode of residential care end date, version 1 (NHDD V12 Supplement) Episode of residential care end mode, version 1 (NHDD V12 Supplement) Episode of residential care start date, version 1 (NHDD V12 Supplement) Episode of residential care start mode, version 1 (NHDD V12 Supplement) Indigenous status, version 5 (NHDD V12 Supplement) Leave days from residential care, version 1 (NHDD V12 Supplement) Marital status, version 4 (NHDD V12 Supplement) Mental health legal status, version 5 (NHDD V12 Supplement) Person identifier, version 2 (NHDD V12 Supplement) Principal diagnosis, version 3 (NHDD V12 Supplement) Referral from specialised mental health residential care, version 1 (NHDD V12 Supplement) Residential stay start date, version 1 (NHDD V12 Supplement) Sex, version 4 (NHDD V12 Supplement) Data element concepts: Diagnosis, version 1 (NHDD V12 Supplement) Episode of residential care, version 1 (NHDD V12 Supplement) Episode of residential care end, version 1 (NHDD V12 Supplement) Episode of residential care start, version 1 (NHDD V12 Supplement) Resident, version 1 (NHDD V12 Supplement) Residential mental health service, version 1 (NHDD V12 Supplement) Residential stay, version 1 (NHDD V12 Supplement) Specialised mental health service, version 1 (NHDD V12 Supplement).
Has there been variation over time in any of the above descriptors for this collection?	No, current year is first year of collection.
Are there any proposed developments relating to comorbidity in the near future for this collection?	—
Definitions – how are the following concepts addressed and/or defined?	
Substance use	Collected through ‘Principal and additional diagnosis’ data element which is coded using ICD–10–AM codes. Includes the following relevant codes: Mental and behavioural disorders due to psychoactive substance use (F10-F19 ICD–10–AM) comprising alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine, other stimulants including caffeine, hallucinogens, tobacco, volatile solvents, multiple drug use and use of other psychoactive substances. Relevant subcategories for these codes include: harmful use, dependence syndrome and withdrawal state. It can be assumed that all clients have a mental disorder.
Mental health	‘Principal diagnosis’ and ‘Additional diagnosis’ are collected using ICD–10–AM codes. It can be assumed that all clients have a mental disorder. ‘Mental health legal status’ is also collected.
Comorbidity	The inclusion of the ‘Additional diagnosis’ data element together with the ‘Principal diagnosis’ data element enables information on comorbidity to be provided. It can be assumed that all clients have a mental disorder. Records containing the following ICD–10–AM codes: Mental and behavioural disorders due to psychoactive substance use (F10-F19 ICD–10–AM) comprising alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine, other stimulants including caffeine, hallucinogens, tobacco, volatile solvents, multiple drug use and use of other psychoactive substances and subcategories for these codes of: harmful use, dependence syndrome and withdrawal state would indicate substance use.
Age	Date of birth, version 5 (NHDD V12 Supplement).
Sex	Sex, version 4 (NHDD V12 Supplement).

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Cultural and linguistic diversity	Country of birth, version 4 (NHDD V12 Supplement) with four-digit codes as per SACC (ABS Cat. No.1269.0 (1998)).
Indigenous status	Indigenous status, version 5 (NHDD V12 Supplement).
Geographic location of respondent	Area of usual residence, version 3 (NHDD V12).
Geographic location of agency or other relevant unit	Australian state/territory identifier, version 4 (NHDD V12 Supplement). Region code, version 2 (NHDD V12).
Treatment types	Not collected.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Marital status, version 4 (NHDD V12 Supplement) provides information on both social and registered marital status.
Indicators of social participation (e.g. labour force status, education status)	Not collected.
Treatment outcomes	Not collected.
Collection management agency	AIHW
Title/name of contact	Head, Hospital and Mental Health Services Unit / Ms Jenny Hargreaves
Address	GPO Box 570, Canberra, ACT 2601.
Email	jenny.hargreaves@aihw.gov.au
Internet	www.aihw.gov.au
Phone/fax	(02) 6244 1121 / (02) 6244 1299
Data custodian/access	AIHW
Funding agency	DoHA
Output	None yet.
References (for preparing this template)	National Health Data Dictionary, Version 12 and Version 12 Supplement.
When will data from this reference period/survey be available?	Data from the 2004–05 collection period are likely to be published in early 2007 in the Mental Health Services in Australia 2004–05 report.
Other comments	—

16 Mental Health National Outcomes and Casemix Collection (MHNOCC)

Data source (title)	Mental Health National Outcomes and Casemix Collection (MHNOCC)
Brief description	A dataset containing de-identified, patient-level unit record data on outcomes and casemix information obtained from specialised public sector mental health services and supplied by state and territory health departments.
Purpose(s)	• to serve as a means of routine consumer outcomes assessments using standard clinical assessment scales and consumer self-report instruments • to further develop a casemix classification for mental health as a clinical and management information tool • to allow national analysis of data for development of 'service quality' benchmarks.
Collection methodology	De-identified, patient-level unit record data is used. A variety of standard measures (some rated by consumers and some by clinicians) are recorded for three defined collection occasions (Admission, Review, Discharge).
Scope (theoretical coverage of relevant population)	All managed or funded by the state and territory health administrations. In general, the scope of the MHNOCC initiative is equivalent to the coverage of the annual National Survey of Mental Health Services. Specialised mental health services include: • public psychiatric hospitals and designated psychiatric units in general hospitals • community-based residential services • ambulatory care mental health services.
Coverage (actual)	Recognising the variable development of an information infrastructure in specialised mental health services, the timetable for implementation of the outcome measures and the MHNOCC specifications was negotiated separately by the Australian Government with each jurisdiction. At 30 June 2003, 57% of services across seven jurisdictions have the capacity to collect the MHNOCC, either in part or full. All but one jurisdiction has submitted data up to 30 June 2003. It is important to note, however, that completion rates for the period 2002–03 are low and vary significantly by jurisdiction. While most jurisdictions have completed the implementation of outcome measurement, reporting in most jurisdictions for this period is known to be partial given the current status of information systems to capture and report MHNOCC data. It is expected that more complete data will be available for the period 2003–04.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Files are to be sent to DoHA by 31 December each year (or closest working day). Each annual file will include data for the preceding financial year, e.g. December 2003 file should include data for the 2002–03 financial year. Jurisdictions have been encouraged to report more frequently, on a quarterly basis, in order to expedite any actions required to improve data quality.
Basic collection count (i.e. treatment episodes, separations etc.)	Collection occasion. A specific data set is to be reported for three defined collection occasions (Admission, Review, Discharge).
Does the collection include a unique client identifier or statistical linkage key?	Person identifier (AIHW Knowledgebase ID 000127) Within the MHNOCC dataset, this identifier enables the linking of collection occasions and building of 'episodes of mental health care' for analysis purposes. The feasibility of linkage of the MHNOCC data set with the Admitted and Community National Mental Health Minimum Data Set will be explored in 2004–05.
Data content (list of all data items)	Admission date, age group, collection occasion date, collection occasion identifier, date of birth, discharge date, mental health service setting, mental health service organisation number, mental health provider entity identifier, MHNOCC reporting specification version, person identifier, reason for collection,

(continued)

Data content (continued)	record type, record count, region code, report period end date, report period start date, service unit identifier, sex, state identifier. **Clinical data specific to adults and older people** Health of the Nation Outcome Scales (HoNOS & HoNOS65+) – a 12-item clinician-rated measure used for assessment of consumer outcomes in mental health services. HoNOS65+ is a variant of HoNOS designed for use with adults aged over 65. Abbreviated Life Skills Profile (LSP-16) – an abbreviated form of the original 39-item LSP instrument used to assess a consumer's abilities with respect to basic life skills. Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) – used for the measurement of nursing dependency. Measures ability with respect to 'late loss' activities – those activities that are likely to be lost last in life (eating, bed mobility, transferring and toileting). Focus of care – a single-item developed by MH-CASC that requires the clinician to make a judgment about each consumer's primary goal of care (acute, functional gain, intensive extended, and maintenance). Consumer reported outcome measures – • Mental Health Inventory (MHI-38) – 38-item instrument. Each item with a brief description of a particular symptom or state of mind. Designed to estimate the effects of different health care financing arrangements on the demand for services as well as on the health status of the patients in the study. • Behaviour and Symptoms Identification Scale (BASIS-32) – this consists of 32 questions that assess the extent to which the person has been experiencing difficulties on a range of dimensions. It was developed for use in outcome assessment. • Kessler 10 Plus (K10+) – a 10-item self-report questionnaire designed to yield a global measure of 'non-specific psychological distress' based on questions about the level of nervousness, agitation, psychological fatigue and depression. It also contains questions to assess functioning and related factors. Overall it is an extremely brief symptoms and functioning measure, validated against diagnosis, which is intended to be supplemented with additional measures of domains relevant to consumers. **Clinical data specific to children and adolescents** Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) – a 15-item clinician rated measure modelled on the HoNOS and designed specifically to measure child and adolescent consumer outcomes in mental health services. Children's Global Assessment Scale (CGAS) – the CGAS was developed to provide a global measure of severity of disturbance in children and adolescents, it is designed to reflect the lowest level of functioning for a child or adolescent during a specified period. Factors Influencing Health Status (FIHS) – a simple checklist used to measure seven 'psychosocial complications' (based on ICD–10 factors influencing health status). Parent and Consumer self-report measure – the Strengths and Difficulties Questionnaire (SDQ) – a brief behavioural screening questionnaire for 4–17 year olds. **Other clinical data common to all consumer groups** Principal and additional diagnoses – a principal diagnosis and up to two additional diagnoses may be recorded (ICD–10–AM codes). Mental health legal status – used to indicate whether the person was treated on an involuntary basis under the relevant state or territory legislation.

(continued)

Has there been variation over time in any of the above descriptors for this collection?	Not yet, but different jurisdictions use different consumer-reported outcome measures. BASIS-32 is used by Victoria, Tasmania and the Australian Capital Territory; K10+ is used by New South Wales, the Northern Territory and South Australia; MHI-38 is used by Western Australia and Queensland.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No. But see sections for substance use and comorbidity.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Health of the Nation Outcome Scales (HoNOS, HoNOS65+, HoNOSCA) – Scale 3 (HoNOS and HoNOS65+) is about problem drinking or drug-taking. Scale 4 (HoNOSCA) is about Alcohol, substance or solvent misuse.
Mental health	Health of the Nation Outcome Scales (HoNOS & HoNOS65+, HoNOSCA) Mental Health Inventory (MHI-38) Behaviour and Symptoms Identification Scale (BASIS-32) Kessler 10 Plus (K10+) Principal and additional diagnoses Mental health legal status
Comorbidity	The inclusion of the 'Additional diagnosis' data element together with the 'Principal diagnosis' data element will enable information on comorbidity as a diagnosis to be provided. Records containing the following ICD–10–AM codes: Mental and behavioural disorders due to psychoactive substance use (F10-F19 ICD–10-AM) comprising alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine, other stimulants including caffeine, hallucinogens, tobacco, volatile solvents, multiple drug use and use of other psychoactive substances and subcategories for these codes of: harmful use, dependence syndrome and withdrawal state could be used with other codes from the ICD–10–AM relating to the chapter on Mental and behavioural disorders. In addition, the HoNOS will enable information on comorbidity as an outcome in relation to both mental health and substance use.
Age	Date of birth. Clinical measures are designed around three age groups – child and adolescents, adults and older persons. These groups reflect the nature of public sector mental health services rather than formally follow the consumer's age at time of service.
Sex	Sex.
Cultural and linguistic diversity	Not currently collected. Work is being undertaken to determine types of cultural issues and therefore the most relevant data element(s) to use.
Indigenous status	Not collected since it is available in the National Minimum Data Set.
Geographic location of respondent	Not collected.
Geographic location of agency or other relevant unit	State identifier. Region code (AIHW Knowledgebase ID 000378). Mental health service organisation number. Service Unit identifier.
Treatment types	Not collected.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Not collected.
Indicators of social participation (e.g. labour force status, education status)	Health of the Nation Outcome Scales (HoNOS & HoNOS65+, HoNOSCA) – Scales 9, 10 and 12 (HoNOS, HoNOS65+) are about supportive social relationships; activities of daily living; and occupational and recreational activities, respectively. Scales 11, 12 and 13 (HoNOSCA) are about problems

(continued)

Indicators of social participation (continued)	with self care and independence; problems with family life and relationships; and poor school attendance, respectively. Abbreviated Life Skills Profile (LSP-16) Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) Factors Influencing Health Status (FIHS)
Treatment outcomes	Health of the Nation Outcome Scales (HoNOS & HoNOS65+, HoNOSCA) – a 12-item clinician-rated measure used for assessment of consumer outcomes in mental health services. Focus of care Mental Health Inventory (MHI-38) Behaviour and Symptoms Identification Scale (BASIS-32) Kessler 10 Plus (K10+)
Collection management agency	Australian Mental Health Outcomes and Classification Network
Title/name of contact	Secretariat
Address	Australian Mental Health Outcomes and Classification Network, NSW Institute of Psychiatry, Locked Bag 7118, Parramatta BC, NSW 2150.
Email	amhocn@mhnocc.org
Internet	http://www.mhnocc.org/
Phone/fax	(02) 9840 3833 / (02) 9840 3838
Data custodian/access	Ms Suzy Saw, Acting Director, Quality and Effectiveness Section, Health Priorities & Suicide Prevention Branch, DoHA.
Funding agency	DoHA
Output	None as yet.
References (for preparing this template)	Department of Health and Ageing 2003. National Outcomes and Casemix Collection: overview of clinical measures and data items. Canberra: DoHA. Department of Health and Ageing 2003. Mental Health National Outcomes and Casemix Collection: technical specification of state and territory reporting requirements for the outcomes and casemix components of 'Agreed Data', Version 1.50. Canberra: DoHA. These materials are available at: http://www.mhnocc.org/resources/
When will data from this reference period/survey be available?	Early 2005.
Other comments	This collection is relatively new and is still under development. The volume of data has been increasing over time; however, the pool of usable data is relatively small as the linkage component is still under development, making it difficult to link outcome Person ID's with initial assessments. It is expected that the capacity to link outcomes with initial assessments will be possible as more work is undertaken. Initial investigations suggest that data integrity across sequences of records (admission, review, discharge) will require significant attention by jurisdictions.

17 National Survey of Mental Health and Wellbeing of Adults (NSMHW (adult))

Data source (title)	Australian Bureau of Statistics 1997 National Survey of Mental Health and Wellbeing of Adults
Brief description	The survey collected information on the prevalence of selected mental disorders, the level of disability associated with each and the use of health services and level of help needed as a result of a mental health problem for Australians aged 18 years or more.
Purpose(s)	To provide information on the prevalence of selected major mental disorders and the level of disability associated with these disorders. To provide information on the health services used and the help needed as a consequence of a mental health problem.
Collection methodology	Computer-assisted personal interview (CAI): The CAI was a modified version of the Composite International Diagnostic Interview (CIDI) which covered topics such as: mental disorders and physical conditions; disability measures; health service utilisation and perceived health needs; other scales and measures (e.g. Kessler 10, general health questionnaire); and demographic and socioeconomic characteristics.
Scope (theoretical coverage of relevant population)	Urban and rural areas across all states and territories, Australia. Survey was restricted to people 18 years or over who were usual residents in private dwellings. Non-Australians working in Australia, or in Australia as students or settlers, and their dependents, were considered within scope of the survey. The survey focused on the following major mental disorders: • Anxiety disorders: panic disorder, agoraphobia, social phobia, generalised anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder • Affective disorders: depression, dysthymia, mania, hypomania, bipolar affective disorder. • Alcohol use disorders: harmful use, dependence. • Drug use disorders: harmful use, dependence.
Coverage (actual)	Sampled 15,531 private dwellings, of which 10,641 participants fully responded (78% response rate).
Geographic coverage	The survey covered urban and rural areas across all states and territories of Australia.
Frequency/timing	The 1997 survey was in the field from May to August 1997. This survey has only been conducted once.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of people, prevalence.
Does the collection include a unique client identifier or statistical linkage key? (Describe its nature)	No.
Data content (list of all data items)	Sex; age; country of birth; year of arrival; number of times married/de facto; marital status; number of children; age when only child born; age when oldest child born; age when youngest child born; language; education (e.g. whether attending, currently studying, highest qualification); employment (e.g. labour force status, occupation); main income source; tenure type; household details (e.g. household type, number of persons in household); geography (e.g. state, part of state, Socio-Economic Index for Areas (SEIFA)); physical conditions; ICD–10 classification of mental and behavioural disorders; DSM-IV classification of mental disorders; personality disorder screener; psychosis screener; other measures (such as the Kessler Psychological Distress Scale 10); disability; service utilisation and days out of role; suicide ideation/self-harm; smoking; potential mental disorders; health service utilisation and perceived health needs.

(continued)

Has there been variation over time in any of the above descriptors for this collection?	—
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Mental disorders (from the CIDI)— including: substance use disorders–alcohol harmful use, substance use disorders–alcohol dependence, substance use disorders–drug use disorders. Health professionals seen—coding option includes: drug and alcohol counsellor. Number of consultations—coding option includes: at a drug and alcohol service. Admissions to hospital—coding category includes: number of admissions to psychiatric hospitals and drug and alcohol rehabilitation centres. Smoking—data items include: smoking: currently, smoking: regularly smoking, smoking: ever smoked regularly. Potential mental disorders—coding options include: drug use, drinking.
Mental health	Mental disorders (from the CIDI)—including: anxiety disorders (these can be broken down into a number of sub-categories), affective disorders (can be broken down). Mini-mental state examination: screens for the presence of cognitive impairment, but does not identify any particular organic mental disorders (includes all persons aged 65+). General health questionnaire-12 item scale: measure of health and wellbeing designed to detect psychological impairment among respondents in community settings. Eysenck personality questionnaire–neuroticism: measures the extent to which respondents view themselves as being sensitive or emotional. Kessler psychological distress scale-10: scale of current psychological distress. Delighted–terrible scale: overall rating from a respondent regarding their life as a whole. Short form-12: measure of disability which addresses limitations due to physical and mental health issues. Suicidal thoughts and attempts Health professionals—coding options include: psychiatrist, psychologist, mental health team. Admissions to hospital—coding category includes: number of admissions to psychiatric hospitals and drug and alcohol rehabilitation centres. Potential mental disorders—coding options include: tiredness, social fears, fear of travelling, fear of panic, months of worry, sad 2+ years, sad 2+ weeks, happy/irritable, unusual ideas, memory failure, recurrent thoughts, traumatic event, nature/personality.
Comorbidity	Mental disorders—comorbidity can be derived and analysis can/have been done looking at multiple responses to the type of mental disorders data items. Other proxies for comorbidity can also be derived using information collected about substance use and mental health as listed above.
Age	Age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65+.
Sex	Males, females.
Cultural and linguistic diversity	Country of birth: reported as Australia, main English-speaking (NZ, UK, Ireland, Canada, USA and South Africa) or other. Language spoken at home: English, other languages.
Indigenous status	—

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Geographic location of respondent/respondent	State. Rural, remote and metropolitan areas: capital city and other metropolitan centre; large/small rural centre; other rural areas. Part of state: capital city; rest of state. SEIFA.
Geographic location of agency or other relevant unit	—
Treatment types	Perceived need for health services (for respondents who used services for mental health problems): • Types of services: information; medication; counselling; social intervention to help sort out practical issues; skills training. • For each type of service received, respondents were asked if they received as much as they needed and if not, they were asked to choose the main reason from the following: I preferred to manage myself; I didn't think anything more could help; I didn't know how or where to get help; I was afraid to ask for more help, or of what others would think of me if I did; I couldn't afford the money; I asked but didn't get help; I got help from another source. • For each type of help, respondents who used services for mental health problems were classified into one of the following: no (perceived) need—those who were not receiving help and felt that they had no need of it; need fully met—those who were receiving help and felt that it was adequate; need partially met—those who were receiving help but not as much as they felt they needed; need not met—those who were not receiving help but felt that they needed it. Health service utilisation—coding options under hospital admissions include (for example): admission to psychiatric hospital, nights in drug and alcohol unit in a hospital, times in general hospital for mental problem.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Marital status (mappable to NHDD data item). Household type (mappable to National Community Services Data Dictionary (NCSDD) data item 'living arrangements'). Number of people in household. Main source of income.
Indicators of social participation (e.g. labour force status, education status)	Education: data items include: whether attending school, whether completed secondary school, whether completed qualification since leaving school, whether currently studying, highest qualification. Employment: data items include: labour force status, occupation (main job), hours usually worked per week, duration of employment.
Treatment outcomes	—
Collection management agency	Australian Bureau of Statistics
Title/name of contact	National Information and Referral Service
Address	Health Section, Australian Bureau of Statistics, Locked Bag 10 Belconnen, ACT 2616.
Email	client.services@abs.gov.au
Internet	www.abs.gov.au
Phone/fax	1300 135 070
Data custodian/access	Australian Bureau of Statistics
Funding agency	Commonwealth Department of Health and Family Services (now DoHA) through the National Mental Health Strategy.

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Output	ABS 1998. Mental health and Wellbeing: profile of adults, 1997.ABS Cat. No. 4326.0. Canberra: ABS.
References (for preparing this template)	ABS 1998. Mental health and Wellbeing: profile of adults, 1997.ABS Cat. No. 4326.0. Canberra: ABS. ABS 1997. National Survey of Mental Health and Wellbeing of adults: users' guide. ABS Cat. No. 4327.0. Canberra: ABS.
When will data from this reference period/survey be available?	Data currently available.
Other comments	A child and adolescent component of the survey was conducted in 1998 (see template 18) as well as a third component looking at low prevalence (psychotic) disorders (template 19).

18 Child and Adolescent component of the National Survey of Mental Health and Wellbeing (NSMHW (C & A))

Data source (title)	Child and Adolescent Component of the National Survey of Mental Health and Wellbeing, 1998 (NSMHW (C & A))
Brief description	The survey collected information on the prevalence of mental health problems, the level of disability associated with each and the use of health services as a result of a mental health problem for Australian children and adolescents.
Purpose(s)	To provide information on the number of children and adolescents in Australia who have mental health problems and the nature of these problems. To examine/determine the degree of disability associated with the reported mental health problems. To provide information on the health services used by children and adolescents with mental health problems.
Collection methodology	Multistage random sampling scheme was used to obtain a sample of 4,500 children aged 4 to 17 years. Information was collected for the survey using the following methods: • behaviour checklists to identify mental health problems • diagnostic interview schedule for children (parents version for children 6 to 17 years) to identify mental disorders • information obtained from parents (interview and questionnaire) • information obtained from adolescents. Information was obtained from the parents of all participants and also from adolescents aged 13–17 years.
Scope (theoretical coverage of relevant population)	Metropolitan and non-metropolitan areas across all states and territories in Australia except the Northern Territory where only children living in metropolitan areas were recruited. Survey was restricted to people aged 4 to 17 years who were usual residents in private dwellings.
Coverage (actual)	Participation rate 86%.
Geographic coverage	All states and territories, Australia.
Frequency/timing	The 1998 survey was in the field from February to April 1998. This survey has only been conducted once.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of people, prevalence.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	**Parent interview/questionnaire** Sex; relationship to participant; date of birth; family composition; country of birth; state of birth; Indigenous status; educational status; employment status; significant life events; child behaviour checklist; child health questionnaire; diagnostic interview schedule (includes modules for depressive disorder, ADHD and conduct disorder); service utilisation; primary/secondary caregiver demographics and information (e.g. country of birth, age, Indigenous status, educational attainment, payments/allowances, labour force status). **Adolescent questionnaire** Youth risk behaviour questionnaire (e.g. tobacco use, alcohol use, drug use, suicidal behaviour); youth self-report (e.g. physical activities, everyday activities, pain, getting along, general wellbeing, self-esteem, your health, you and your family); degree of disability (using adolescent version of the Child health questionnaire); service utilisation (e.g. need for professional services, receipt of services, attended GP/family doctor/school counsellor for help).
Has there been variation over time in any of the above descriptors for this collection?	No

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Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions–how are the following concepts addressed and/or defined?	
Substance use	Tobacco use (includes questions about): • ever tried • age when smoked whole cigarette • quantity over specified period (30 days/day) • usual obtainment of cigarettes. Alcohol use (includes questions about): • age at first full drink • consumption frequency and quantity. Marijuana use (includes questions about): • age when first tried • frequency of use. Other drug use (includes questions about): • frequency of drug use for the following—hallucinogens, amphetamines, inhalants, over-the-counter pain killers, prescription drugs, designer drugs, cocaine, heroin • frequency of injecting illegal drugs.
Mental health	Diagnostic interview schedule which includes modules to assess: • depressive disorder • ADHD • conduct disorder. Child behaviour checklist—provides information about a range of child and adolescent mental health problems.
Comorbidity	A proxy can be derived using the information collected under substance use and mental health.
Age	Date of birth, age group reported (4–12, 13–17 years).
Sex	Male, female.
Cultural and linguistic diversity	Country of birth.
Indigenous status	Yes, no (coded from parents' perspective on whether their child considers themselves to be of Aboriginal or Torres Strait Islander descent). Indigenous status of primary and secondary caregiver is also collected (coded as NHDD item).
Geographic location of respondent	Postcode of residence.
Geographic location of agency or other relevant unit	—
Treatment types/service utilisation	Health service utilisation—coding options include: private psychiatrist, private psychiatrist or social worker, mental health clinic, drug or alcohol clinic. Outpatient services—coding option includes hospital-based department of psychiatry. Overnight care services—coding option includes: drug or alcohol treatment unit.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Household composition. Number of siblings.
Indicators of social participation (e.g. labour force status, education status)	Education status—series of questions. Labour force status—have a job, yes/no.
Treatment outcomes	—

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Collection management agency	Department of Psychiatry at the University of Adelaide were responsible for conducting the survey.
Title/name of contact	Information not provided.
Address	Information not provided.
Email	Information not provided.
Internet	—
Phone/fax	Information not provided.
Data custodian/access	De-identified data is available to bona fide researchers within Australia and internationally, subject to conditions.
Funding agency	The then Commonwealth Department of Health and Aged Care (now DoHA) through the National Mental Health Strategy.
Output	Sawyer et al. 2000. Mental health of young people in Australia. Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care. Canberra: DoHA.
References (for preparing this template)	Sawyer MG, Arney FM, Baghurst PA, Clark JJ, Graetz BW, Kosky RJ, Nurcombe B, Patton GC, Prior MR, Raphael B, Rey J, Whaites LC and Zubrick SR 2000. Mental health of young people in Australia. Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care. Canberra: DHAC. Parent interview. Parent questionnaire. Adolescent questionnaire.
When will data from this reference period/survey be available?	Data currently available.
Other comments	An adult component of the survey was conducted in 1997 by the ABS (see template) as well as a third component looking at low prevalence (psychotic) disorders conducted in 1997–98 by the University of Western Australia.

19 National Survey of Mental Health and Wellbeing—Low prevalence (psychotic) disorders (NSMHW (psychotic))

Data source (title)	National Survey of Mental Health and Wellbeing—Low Prevalence (Psychotic) Disorders 1997–98 (NSMHW (psychotic))
Brief description	The census collected information on the prevalence, demographics, service utilisation and rates of disablement of adults (aged 18–64 years) with a psychotic disorder in Australia.
Purpose(s)	To establish reliable one-month and one-year prevalence estimates of psychotic disorders among adults aged 18–64 years in Australia. To determine treated prevalence and give an estimate of those individuals with psychotic disorders no longer in contact with mental health services. To establish the demographic profile of individuals with psychotic disorders, as well as quantify the rates of disablement and determine service utilisation by individuals with psychotic disorders. To provide an estimate of unmet need for individuals with psychotic disorders.
Collection methodology	Two-phase study: • Phase 1: all individuals who made contact with a mental health service within the catchment areas within a one-month period were screened for a psychotic disorder. • Phase 2: a random sample of screen-positive persons were approached with a request for an interview. Those who agreed were interviewed with the Diagnostic Interview for Psychosis and were included within the collection.
Scope (theoretical coverage of relevant population)	Four catchment areas with a total population of 1,084,978 were delineated in the Australian Capital Territory, Queensland, Victoria and Western Australia. From this population group, people who attended mental health services, aged between 18–64 years of age diagnosed with a psychotic disorder were considered in scope. Census group was screened for a psychotic disorder.
Coverage (actual)	Following a one-month census 3,800 Australians aged 18–64 years were identified and screened as having a psychotic disorder. Of these, a random sample of 980 persons participated in the study.
Geographic coverage	Australian Capital Territory, Queensland, Victoria and Western Australia—metropolitan areas only.
Frequency/timing	A one-month census and subsequent interviews were undertaken in each of the four catchment areas across 1997–98. This census has only been conducted once.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of people (estimated).
Does the collection include a unique client identifier or statistical linkage key?	No. Within the data set there is a dummy ID and the data are at the level of the individual with one record per person.
Data content (list of all data items)	**Diagnostic interview for psychosis – Part 1** Sex; current psychiatric treatment status; length of current hospital stay; country of birth; age at immigration to Australia; Indigenous status; language spoken at home; marital status; household composition; main carer for dependent children; quality of child care; age at leaving school; secondary school completion; highest qualification; residential setting; homeless/hospitalised status; violence victim; size of household; frequency of undertaking house activities; participation in household; company and contact with; employment status; main occupation; nature of main job; main reason for absenteeism; income source; main reason for incapacity for housework/study; income benefit type; participation in activities of daily living.

(continued)

Data content (continued)	**Diagnostic interview for psychosis – Part 2** Source of Operational Criteria Checklist for Psychotic Illness (OPCRIT); sex; lifetime marital status; age at onset of psychiatric symptoms; mode of onset; series of questions relating to experience of (psychosocial stressors; premorbid personality disorder; dysphoria; loss of pleasure; suicidal ideation; diurnal variation; poor concentration; slow activity; loss of energy; diminished libido; poor appetite; increased appetite; weight loss; weight gain; initial insomnia; middle insomnia; early morning waking; excessive sleep; excessive self-reproach; delusions of guilt; delusions of poverty; nihilistic delusions; elevated mood; irritable mood; thoughts racing; distractibility; excessive activity; reduced need for sleep; reckless activity; increased sociability; increased self-esteem; non-affective hallucinations in any modality; any kind of auditory hallucinations; accusatory voices; running commentary; third-person auditory hallucinations; thought insertion; thought broadcast; thought withdrawal; thought echo; other primary delusions; delusions of passivity; persecutory delusions; delusions of influence; grandiose delusions; bizarre delusions; primary delusional perception; lack of insight); alcohol use and consumption; drug use/frequency (cannabis; amphetamines; tranquilisers; heroin; cocaine; LSD; PCP; inhalants/solvents; other drugs); tobacco use; substance abuse/dependence; course of the disorder. **Diagnostic interview for psychosis – Part 3** Type of hospital admittance; length of hospital stay; reason for attending emergency/casualty; number of referrals, contacts and occasions with a psychiatrist; presence of case manager; profession of case manager; outpatient attendances; type of outpatient clinic; reason for missing clinic appointments; health professional seen; receipt of service (e.g. mental health information, therapy, work, time management, housing, self-care); need for assistance (met/unmet); co-resident carer; carer relationship; carer pension; medication; side effects of medication; occasions of overdose; number of arrests and charges; access to services. **Additional variables** Recruitment source; age group.
Has there been variation over time in any of the above descriptors for this collection?	—
Are there any proposed developments relating to comorbidity in the near future for this collection?	—
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Alcohol use (includes questions about): • ever used • thoughts of cutting down • felt guilty about drinking • frequency and consumption • social problems due of drinking. Use of drugs—list of drugs includes: cannabis; amphetamines; tranquilizers; heroin; cocaine; LSD; PCP; inhalants/solvents; other drugs. Social problems due to drug use—categories include: work, family, police problems. Tobacco use (includes questions about): • ever used • number of cigarettes, cigars and pipes smoked per day. Alcohol abuse—lifetime diagnosis of dependence and dependence with psychopathology. Cannabis abuse—lifetime diagnosis of dependence and dependence with psychopathology.

(continued)

Substance use (continued)	Other substance abuse—lifetime diagnosis of dependence and dependence with psychopathology. Hospital type accessed—coding options include: public drug/alcohol unit; private drug/alcohol unit. Reason for attending emergency/casualty—coding options include: drug overdose; drug & alcohol problem. Outpatient clinic attended—reporting options include: public drug & alcohol outpatient clinic; private drug & alcohol outpatient clinic. Health professional seen—coding options include: drug & alcohol counsellor.
Mental health	Current psychiatric treatment status—not in treatment; inpatient; outpatient; day patient; residential care; non-residential care; not known. Main reason for absenteeism (from work)—coding options include: mental health; and physical & mental health. Main reason for incapacity for housework—coding options include: mental health; and physical & mental health. Several questions in relation to a number of mental health issues and experiences. Issues include: psychosocial stressors; premorbid personality disorder; dysphoria; loss of pleasure; suicidal ideation; diurnal variation; poor concentration; slow activity; loss of energy; diminished libido; poor appetite; increased appetite; weight loss; weight gain; initial insomnia; middle insomnia; early morning waking; excessive sleep; excessive self-reproach; delusions of guilt; delusions of poverty; nihilistic delusions; elevated mood; irritable mood; thoughts racing; distractibility; excessive activity; reduced need for sleep; reckless activity; increased sociability; increased self-esteem; non-affective hallucinations in any modality; any kind of auditory hallucinations; accusatory voices; running commentary; third-person auditory hallucinations; thought insertion; thought broadcast; thought withdrawal; thought echo; other primary delusions; delusions of passivity; persecutory delusions; delusions of influence; grandiose delusions; bizarre delusions; primary delusional perception; lack of insight. Hospital type accessed—coding options include: public psychiatric hospital; public psychiatric hospital unit (general hospital); private psychiatric hospital. Reason for attending emergency/casualty—coding options include: psychiatric problem. Profession of case manager—coding options include: psychologist. Outpatient clinic attended—coding options include: outpatient clinic in public psychiatric hospital; psychiatric outpatient clinic in general hospital; psychiatric outpatient clinic in private hospital; community mental health. Health professional seen—coding options include: psychiatrist; psychologist. Medication used for mental health problems (comprehensive list of drugs available). Diagnoses: ICD–10; DSM–IIIR; DSM–III; Research Diagnostic Criteria; Feighner; Carpenter; Schneider FRS; French classification; Taylor and Abrams; Tsuang and Winokur; Crow; Farmer. Confounding factors including alcohol/drug abuse, other substance abuse, coarse brain disorder, psychosocial stressor, multiple factors.
Comorbidity	Not directly, although a proxy for comorbidity can be derived using the data items described in the preceding two rows.
Age	Age group: 18–24, 25–34, 35–44, 45–54, 55–64.
Sex	Male, female.
Cultural and linguistic diversity	Country of birth: reported as Australia and other.
Indigenous status	Yes.
Geographic location of respondent	—

(continued)

Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Marital status: single, never married; married/de facto; separated/divorced/widowed. Parental status: have children; have children under 18 living at home; main carer for children. Residential setting: rented home (public, private); family home; own home; institution (hospital/nursing home); hostel; group home; supported housing/rooming house/crisis shelter/homeless. Income source: wages from employer/income from own business; government pension and other social benefits; disability pension.
Indicators of social participation (e.g. labour force status, education status)	Highest educational qualification: no school qualification; secondary education; trade or other certificate; undergraduate/postgraduate award; other. Employment status: no regular occupation, regular full-time work, regular part-time work, home duties, studies, other. Main occupation; occupation; and nature of main job.
Treatment outcomes	—
Collection management agency	Study coordinated by the University of Western Australia.
Title/name of contact	Chair, Low Prevalence Disorders Study Publication and Data Management Committee / Professor Assen Jablensky.
Address	UWA Psychiatry, Level 3, Medical Research Foundation Building, Rear 40 Murray Street, Perth, WA 6000.
Email	assen@cyllene.uwa.edu.au
Internet	—
Phone/fax	(08) 9224 0290
Data custodian/access	Vera Morgain (contact details as above).
Funding agency	The study was funded by the Commonwealth Department of Health and Aged Care (now DoHA) through the National Mental Health Strategy for those components carried out in Brisbane, Melbourne and Perth. The component carried out in Canberra was funded separately by the ACT Department of Health and Community Care, and the Psychiatric Epidemiology Research Centre at The Australian National University.
Output	Jablensky A, McGrath J. Herman H. Castle D. Gureje O. Morgan V & Korten A, on behalf of the Low Prevalence Disorders Study Group, 1999. People living with psychotic illness: an Australian study 1997–98. National Survey of Mental Health and Wellbeing. Report 4. Canberra: DoHA. Jablensky A, McGrath J et al. 2000. Psychotic disorders in urban areas: an overview of the methods and findings of the Study on Low Prevalence Disorders, National Survey of Mental Health and Wellbeing 1996–1998. Australian and New Zealand Journal of Psychiatry 34:221–36. Carr V, Neil A et al. 2002. Cost of psychosis in urban Australia. National Survey of Mental Health and Wellbeing: Bulletin 3. Canberra: DoHA.
References (for preparing this template)	Jablensky A, McGrath J. Herman H. Castle D. Gureje O. Morgan V & Korten A, on behalf of the Low Prevalence Disorders Study Group, 1999. People living with psychotic illness: an Australian study 1997–98. National Survey of Mental Health and Wellbeing. Report 4. Canberra: DoHA. Morgan V, Korten A, Valuri G, Waterreus A & Jablensky A, on behalf of the Low Prevalence Disorders Study Group, 2001. People living with psychotic illness: an Australian study 1997–98. Confidentialised Unit Record File, Technical paper. National Survey of Mental Health and Wellbeing. Canberra: DoHA.

(continued)

When will data from this reference period/survey be available?	Data are currently available (Confidentialised Unit Record File).
Other comments	An adult component of the National Survey of Mental Health and Wellbeing was conducted by the ABS in 1997 (see template), and a child and adolescent component was conducted in 1997–1998 by the University of Adelaide (see template).

20 ABS Survey of Disability, Ageing and Carers (SDAC)

Data source (title)	ABS Survey of Disability, Ageing and Carers (SDAC)
Brief description	The SDAC is the main national population survey of disability in Australia. It collects information about people with disabilities, older people and those who provide care for people because of their disability. The SDAC has two components—a household component and a cared accommodation (establishment) component.
Purpose(s)	To estimate the prevalence of disability among the Australian population and describe the population with disability and those providing care for them.
Collection methodology	A population survey using multistage sampling techniques.
Scope (theoretical coverage of relevant population)	The survey includes people in both urban and rural areas in all states and territories, except for those living in remote and sparsely settled parts of Australia. The scope of the survey includes all persons except visitors, overseas residents in Australia, prisoners, non-Australian diplomatic personnel and members of non-Australian defence forces (and their dependents) stationed in Australia.
Coverage (actual)	The household component of the survey covered people who lived in private dwellings (e.g. houses, flats, units, townhouses, tents etc., including dwellings in retirement villages which had no nursing home or hospital care on site) and non-private dwellings (e.g. hotels, motels, boarding houses and self-care components of retirement villages which had a cared accommodation component). The cared accommodation component covered residents of hospitals, nursing homes, aged care and disability hostels and other homes such as children's homes, who had been or were expected to be, living there for at least three months.
Geographic coverage	All states and territories, Australia.
Frequency/timing	1981, 1988, 1993, 1998, 2003.
Basic collection count (i.e. treatment episodes, separations etc.)	People.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	The SDAC collects a range of information from respondents, depending on the respondent's age and whether their responses indicate that they have a disability and/or are a carer. Data items are collected in the following broad areas: general demographics, household information, disability identification, carer identification, disabling conditions, self-perception of health and wellbeing, mobility, self-care, communication, principal carer, aids used/needed, assistance needed/received, transport, community activities and participation, housing, education, employment, employment limitations, income, carer information, carer's Self Perception of Health and Wellbeing (SF–12).
Has there been variation over time in any of the above descriptors for this collection?	There have been a number of minor additions, exclusions and variations to the survey over time. More substantial changes in the 1998 ABS SDAC appear to have resulted in greater identification of the number of people with a disability, especially with a severe or profound core activity restriction, compared with the 1993 survey (AIHW 2001; ABS: Davis et al. 2001). These changes included modifying the wording of screening questions (e.g. 'slow at learning or understanding' (1993 survey) was changed to 'difficulty learning or understanding' (1998 survey)) and varying the order in which questions were asked. Modifications in screening questions have resulted in an increase in the base disability population who were then asked questions to determine the severity of core activity restrictions. The 1998 survey was also the first in which questions were asked about the level of restriction experience by children aged less 5 years.

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Has there been variation over time in any of the above descriptors for this collection? (continued)	The 2003 ABS SDAC essentially repeated the 1998 survey methodology, with some minor additions to content in the areas of cognitive and emotional support, and computer and Internet use.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	All respondents are asked to detail their main and other long-term health conditions, which are coded according to ICD–10 (could include substance use disorders). A long-term health condition is one that has lasted, or is likely to last, for 6 months or more.
Mental health	All respondents are asked to detail their main and other long-term health conditions, which are coded according to ICD–10. A long-term health condition is one that has lasted, or is likely to last, for 6 months or more. All persons aged 15 years or more with a disability are also asked the questions from the SF–12 about self-perception of health and wellbeing ('In the last 4 weeks have you accomplished less than you would like as a result of any emotional problems, such as feeling depressed or anxious?', 'Did you not do work or other regular daily activities as carefully as usual as a result of any emotional problems, such as feeling anxious or depressed?').
Comorbidity	Information on comorbidity can be derived using information collected from the long-term health conditions data item.
Age	Age last birthday.
Sex	Sex.
Cultural and linguistic diversity	Country of birth (as classified in the SACC). Year of arrival in Australia.
Indigenous status	[Not collected since the 1993 survey.]
Geographic location of respondent	Capital city or rest of state.
Geographic location of agency or other relevant unit	Not applicable.
Treatment types	Information is collected (from specific subgroups of respondents with a disability, depending on their age and whether or not the person has a hearing loss only or speech difficulty only) about assistance needed in various areas (e.g. health care, guidance, household chores, home maintenance/gardening, meal preparation, reading and writing tasks). The ABS concept of 'guidance' includes need for assistance or difficulty with: making friendships, interacting with others and maintaining relationships; coping with feelings or emotions; making decisions or thinking through problems. Respondents are asked whether they receive/require formal or informal assistance in any of the above areas. Thus, a rough proxy for treatment for mental health problems might be receipt of formal assistance for 'guidance'.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Housing tenure type (e.g. owner without mortgage, public renter—renting from a state or territory housing authority). Living arrangements (whether the person lives alone, with other family members or with unrelated individuals; whether the person lives in a private dwelling, cared accommodation or other non-private dwelling). Marital status (married or de facto, separated or divorced, widowed, never married).

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Indicators of social participation (e.g. labour force status, education status)	Assistance needed with transport. Social and community participation (e.g. How often do you go out of your home? What is the main reason you do not go out as often as you would like?). Labour force status (employed, unemployed, not in the labour force) as well as whether the person is employed full-time or part-time and hours worked during a specified reference period. Occupation (classified according to the ASCO). Educational attainment (the highest level of qualification obtained). Total cash income (gross current usual (weekly equivalent) cash receipts). Principal source of cash income.
Treatment outcomes	Not applicable.
Collection management agency	Australian Bureau of Statistics.
Title/name of contact	Assistant Director / Ken Black
Address	ABS, PO Box 10, Belconnen, ACT 2616.
Email	ken.black@abs.gov.au
Internet	www.abs.gov.au
Phone/fax	(02) 6252 7430 / (02) 6252 8007
Data custodian/access	ABS
Funding agency	ABS
Output	ABS 2004. Disability, Ageing and Carers: Summary of findings 2003. ABS Cat. No. 4430.0. Canberra: ABS.
References (for preparing this template)	ABS 1998. Survey of Disability, Ageing and Carers. Questionnaire. March–May 1998. Canberra: ABS. ABS 1999. Disability, Ageing and Carers: summary of findings 1998. ABS Cat. No. 4430.0. Canberra: ABS. ABS 1999. Disability, Ageing and Carers Australia 1998. User guide. ABS Cat. No. 4431.0. Canberra: ABS. ABS 2004. Disability, Ageing and Carers: Summary of findings 2003. ABS Cat. No. 4430.0. Canberra: ABS. ABS: Davis E, Beer J, Gligora C & Thorn A 2001. Accounting for change in disability and severe restriction, 1981–1998. Working papers in Health and Welfare, no. 2001/1. Canberra: ABS. AIHW 2001. Australia's welfare: services and assistance 2001. Canberra: AIHW.
When will data from this reference period/survey be available?	Data from the 2003 SDAC were published in September 2004 and a Confidentialised Unit Record File was released in December 2004. Data tables on 'disability and long-term health conditions' and 'caring in the community' were released in early 2005.
Other comments	—

21 National Hospital Morbidity Database (NHMD)

Data source (title)	National Hospital Morbidity Database (NHMD)
Brief description	The NHMD is compiled by the AIHW from data supplied by the state and territory health authorities. It is a collection of electronic confidentialised summary records from admitted patient morbidity data collections for admitted patients separated from public and private hospitals in Australia from 1993–94.
Purpose(s)	To provide information on admitted patient care, such as demographic, diagnostic and care/procedure information, for all hospitals in Australia.
Collection methodology	The NHMD is a compilation of summary records from admitted patient morbidity data collection systems in Australian hospitals. The data supplied for the National Hospital Morbidity Database are mainly based on the National Minimum Data Set for Admitted Patient Care. These data are collected at the hospital level, forwarded to health departments in each jurisdiction and then to the AIHW.
Scope (theoretical coverage of relevant population)	The NHMD includes data from public acute hospitals, public psychiatric hospitals, private acute and psychiatric hospitals, and private free-standing day hospital facilities.
Coverage (actual)	The majority of public hospitals are included. Exceptions within the public sector are public hospitals not within the jurisdiction of a state or territory health authority or the Department of Veterans' Affairs (that is, hospitals operated by the Department of Defence, for example, and hospitals located in off-shore territories). In addition, data are not available for some years for a few small public hospitals in some jurisdictions. Exceptions within the private sector: a few small private hospitals in some jurisdictions. It is estimated that there is under-coverage of about 5% each year, but it varies between 2% and 6%.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Annually, from 1 July 1993.
Basic collection count (i.e. treatment episodes, separations etc.)	Separations. This refers to the episode of care, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care by being discharged, dying, transferring to another hospital or changing type of care. Separations do not always represent periods of 'hospitalisation' for patients because a new separation record follows a change in care type (which can occur with a transfer from, for example, a medical ward to a rehabilitation unit within a hospital), or a transfer from one hospital to another (for example from an acute care hospital to a rehabilitation hospital). In addition, data are not generally available on the number of patients who receive admitted patient care each year, as the information is not usually available to determine how many admissions occur for individual patients with multiple admissions.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	**Hospital-related data elements or data element concepts:** Hospital, version 1 (NHDD V12). **Agency-related data items:** Establishment identifier, version 4 (NHDD V12) comprising: Australian state/territory identifier, version 4 (NHDD V12 Supplement) Establishment number, version 4 (NHDD V12) Establishment sector, version 4 (NHDD V12 Supplement) Region code, version 2 (NHDD V12). **Patient-related data elements:** Activity when injured, version 3 (NHDD V12 Supplement) Additional diagnosis, version 5 (NHDD V12 Supplement)

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Data content (continued)	**Patient-related data elements (continued):** Admission date, version 4 (NHDD V12) Admitted patient election status, version 1 (NHDD V12) Area of usual residence, version 3 (NHDD V12) Care type, version 4 (NHDD V12) Country of birth, version 4 (NHDD V12 Supplement) Date of birth, version 5 (NHDD V12 Supplement) Diagnosis related group, version 1 (NHDD V12) External cause — admitted patient, version 4 (NHDD V12 Supplement) Funding source for hospital patient, version 1 (NHDD V12) Hospital insurance status, version 3 (NHDD V12) Indigenous status, version 5 (NHDD V12 Supplement) Infant weight, neonate, stillborn, version 3 (NHDD V12) Intended length of hospital stay, version 2 (NHDD V12) Inter-hospital contracted patient, version 2 (NHDD V12 Supplement) Major diagnostic category, version 1 (NHDD V12) Medicare eligibility status, version 1 (NHDD V12) Mental health legal status, version 5 (NHDD V12 Supplement) Mode of admission, version 4 (NHDD V12) Mode of separation, version 3 (NHDD V12) Number of days of hospital-in-the-home care, version 1 (NHDD V12) Number of leave periods, version 3 (NHDD V12) Number of qualified days for newborns, version 2 (NHDD V12) Person identifier, version 2 (NHDD V12 Supplement) Place of occurrence of external cause of injury, version 6 (NHDD V12 Supplement) Principal diagnosis, version 4 (NHDD V12 Supplement) Procedure, version 5 (NHDD V12 Supplement) Separation date, version 5 (NHDD V12) Sex, version 4 (NHDD V12 Supplement) Source of referral to public psychiatric hospital, version 3 (NHDD V12) Total leave days, version 3 (NHDD V12) Total psychiatric care days, version 2 (NHDD V12) Urgency of admission, version 1 (NHDD V12). **Patient-related data element concepts:** Acute care episode for admitted patients, version 1 (NHDD V12) Admission, version 3 (NHDD V12) Admitted patient, version 3 (NHDD V12) Diagnosis, version 2 (NHDD V12 Supplement) Episode of admitted patient care, version 2 (NHDD V12 Supplement) Hospital boarder, version 1 (NHDD V12) Hospital-in-the-home care, version 1 (NHDD V12) Live birth, version 1 (NHDD V12) Neonate, version 1 (NHDD V12) Newborn qualification status, version 2 (NHDD V12) Patient, version 1 (NHDD V12) Same-day patient, version 1 (NHDD V12) Separation, version 3 (NHDD V12).
Has there been variation over time in any of the above descriptors for this collection?	Information on diagnoses, procedures and external causes was provided using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD–9–CM) for the years 1993–94 to 1997–98. For 1998–99 South Australia, Western Australia, Tasmania, and Queensland provided data using ICD–9–CM; New South Wales, Victoria, the Northern Territory and the Australian Capital Territory used the International Statistical Classification of Diseases and Related

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Has there been variation over time in any of the above descriptors for this collection? (continued)	Health Problems, 10th Revision, Australian Modification (ICD–10–AM). From 1999–00 all states and territories used ICD–10–AM. Slight variations in coverage have occurred over time. The NHDD definitions form the basis of the NHMD. The actual definitions used by the data providers may vary from year to year. In addition, the scope of the data collection may vary from one jurisdiction to another.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions – how are the following concepts addressed and/or defined?	
Substance use	Collected through 'Principal diagnosis' and 'Additional diagnosis' data elements which are coded using ICD–10–AM codes. Includes the following relevant codes: Mental and behavioural disorders due to psychoactive substance use (F10-F19 ICD–10–AM) comprising alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine, other stimulants including caffeine, hallucinogens, tobacco, volatile solvents, multiple drug use and use of other psychoactive substances. Relevant subcategories for these codes include: harmful use, dependence syndrome and withdrawal state.
Mental health	'Principal diagnosis' and 'Additional diagnosis' are collected using ICD–10–AM codes. 'Mental health legal status' is also collected, as is 'psychiatric care days'.
Comorbidity	The inclusion of the 'Additional diagnosis' data element together with the 'Principal diagnosis' data element enables information on comorbidity to be provided. Records containing the following ICD–10–AM codes: Mental and behavioural disorders due to psychoactive substance use (F10-F19 ICD–10–AM) comprising alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine, other stimulants including caffeine, hallucinogens, tobacco, volatile solvents, multiple drug use and use of other psychoactive substances and subcategories for these codes of: harmful use, dependence syndrome and withdrawal state could be used with other mental health diagnosis, and/or mental health status and/or psychiatric care days.
Age	Date of birth, version 5 (NHDD V12 Supplement) is collected.
Sex	Sex, version 4 (NHDD V12 Supplement).
Cultural and linguistic diversity	Country of birth, version 4 (NHDD V12 Supplement) definitions with 4-digit codes as per the SACC (ABS Cat. No. 1269.0 (1998)).
Indigenous status	Indigenous status, version 5 (NHDD V12 Supplement).
Geographic location of respondent	State or territory and area of usual residence coded as state/territory and a 4-digit SLA code (ASGC for relevant year). Postcode is also available.
Geographic location of agency or other relevant unit	Hospital RRMA: For more information see *Rural, Remote and Metropolitan Areas Classification*, 1991 Census edition (DPIE & DHSH 1994). Hospital ARIA: For more information see: Department of Health & Aged Care Occasional Paper No. 6 *Accessibility/Remoteness Index of Australia* (ARIA), available from the Department's Internet site at: www.health.gov.au/pubs/hfsocc/hacocc6a.htm. State and territory reports are also available.
Treatment types	Care type: A phase of treatment within a hospital stay, indicating the type of care provided. Data domains are: 1.0 – acute care 2.0 – rehabilitation care (that cannot be further categorised) 2.1 – rehabilitation care delivered in a designated unit 2.2 – rehabilitation care delivered according to a designated program 2.3 – rehabilitation care, being principal clinical intent 3.0 – palliative care (that cannot be further categorised)

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Treatment types (continued)	3.1 – palliative care delivered in a designated unit 3.2 – palliative care delivered according to a designated program 3.3 – palliative care, being principal clinical intent 4.0 – geriatric evaluation and management 5.0 – psychogeriatric care 6.0 – maintenance care 7.1 – newborn – qualified days only 7.2 – newborn – qualified and unqualified days 7.3 – newborn – unqualified days only 8.0 – other admitted patient care 9.0 – organ procurement – posthumous 10.0 – hospital boarder 11.0 – unknown. Previous specialised treatment: First admission for psychiatric treatment. Definition: Whether a patient has had a previous admission or service contact for treatment in the specialty area within which treatment is now being provided. Data domains are: 1 – No previous admission(s) or service contact(s) for the specialised treatment now being provided 2 – Previous admission(s) but no service contact(s) for the specialised treatment now being provided 3 – previous service contact(s) but no admission(s) for the specialised treatment now being provided 4 – previous admission(s) and service contact(s) for the specialised treatment now being provided 5 – unknown/not stated Scope: Admitted patients receiving care in psychiatric hospitals or in designated psychiatric units in acute hospitals. Procedure code: A clinical intervention that is surgical in nature and/or carries a procedural risk and/or carries and anaesthetic risk and/or requires specialised training and/or requires special facilities or equipment only available in an acute care setting. These are coded using ICD–10–AM and multiple procedures can be reported for each separation.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Marital status (NHDD) provides information on both social and registered marital status. Scope: Admitted patients receiving care in psychiatric hospitals or in designated psychiatric units in acute hospitals.
Indicators of social participation (e.g. labour force status, education status)	Employment status – public psychiatric hospital admissions (NHDD). Definition: Self-reported employment status of a person, immediately prior to admission to a public psychiatric hospital. Type of (usual) accommodation. Scope: Admitted patients receiving care in psychiatric hospitals or in designated psychiatric units in acute hospitals.
Treatment outcomes	Not collected.
Collection management agency	AIHW
Title/name of contact	Head, Hospitals and Mental Health Services Unit / Ms Jenny Hargreaves
Address	GPO Box 570, Canberra, ACT 2601.
Email	jenny.hargreaves@aihw.gov.au
Internet	www.aihw.gov.au

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Phone/fax	(02) 6244 1121 / (02) 6244 1299
Data custodian/access	AIHW
Funding agency	AIHW
Output	AIHW 2004. Australian hospital statistics 2002–03. AIHW Cat. No. HSE 32. Canberra: AIHW (Health Services Series No. 22). AIHW 2005. Mental health services in Australia 2002–03. AIHW Cat. No. HSE 35. Canberra: AIHW (Mental Health Series No.6).
References (for preparing this template)	AIHW 2004. Australian hospital statistics 2002–03. AIHW Cat. No. HSE 32. Canberra: AIHW (Health Services Series No. 22). *National Health Data Dictionary* Version 12 and Version 12 Supplement
When will data from this reference period/survey be available?	Data from the 2002–03 collection period were published in June 2004 in the *Australian Hospital Statistics 2002–03* report. Data from the 2003–04 collection period will be published in May 2005 in the *Australian Hospital Statistics 2003–04* report.
Other comments	More information is available in the references used for this template.

22 Commonwealth State/Territory Disability Agreement National Minimum Data Set (CSTDA–NMDS)

Data source (title)	Commonwealth State/Territory Disability Agreement National Minimum Data Set (CSTDA–NMDS)
Brief description	The CSTDA–NMDS and its national collection provides information on all services funded under the CSTDA and the people receiving them. It is: • a set of nationally significant data items that are collected in all Australian jurisdictions • an agreed method of collection and transmission.
Purpose(s)	The purpose of the CSTDA–NMDS collection is to facilitate the annual collection of nationally comparable data about CSTDA-funded services, and to obtain reliable, consistent data with minimal load on the disability services field. Under the CSTDA, the disability administrators in all Australian jurisdictions are responsible for ensuring 'that information will be comparable across all jurisdictions and years'. The CSTDA–NMDS is a key way of fulfilling this responsibility.
Collection methodology	Service providers complete a service type outlet form and multiple service user forms to produce the data. In general, a service type outlet form is completed for each service type at each outlet. A service user form is completed for each person receiving each service type at the outlet over the collection period.
Scope (theoretical coverage of relevant population)	All service types funded under the CSTDA. Most agencies funded under the CSTDA are requested to provide information about: • each of the service types they are funded to provide (i.e. service type outlets they operate) • all service users who received support over a specified reporting period • the CSTDA–NMDS service type(s) the service user received. However, certain service type outlets (e.g. those providing advocacy or information/referral services) are not required to provide any service user details and other service type outlets (e.g. recreation/holiday programs) are only asked to provide very minimal service user details.
Coverage (actual)	155,000 over 6 months (1 January–30 June 2003). Outlet response rate ranges by jurisdiction from 60% to 100%.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Data are collected on a financial year basis. The transmission of data varies across the country (e.g. quarterly in some jurisdictions, annually in most). The data are forwarded to the jurisdiction funding department either as an electronic download or on paper forms. Data are forwarded annually to the AIHW for national collation.
Basic collection count (i.e. treatment episodes, separations etc.)	Service type outlet: is a unit of a funded agency that is funded to provide a particular CSTDA service type at a discrete location. A separate service type outlet form is completed (usually by funded agencies) for each service type outlet. Service user: is a person with a disability who received a CSTDA-funded service. A service user may receive more than one service over any time period. For each service type (and consequently for each service type outlet), a service user form is completed for every service user receiving a service of that type over the collection period. A statistical linkage key enables the number of service users to be estimated from the data collected at service type outlet or agency level.

(continued)

Does the collection include a unique client identifier or statistical linkage key?	Yes—SLK. The SLK is a 14-character key made up of the following components: • second, third and fifth letters of the services user's last name • second and third letters of the services user's given name • service user's date of birth • sex of service user (1-male, 2-female). The SLK in the CSTDA–NMDS is used in analysis to reduce the incidence of multiple counting of service users across CSTDA-funded service types, and to enable an estimate of the actual number of service users at a point in time to be obtained. The SLK used in the CSTDA–NMDS was initially developed for the HACC MDS.
Data content (list of all data items)	**Service type outlet form** Funded agency ID; service type outlet ID; service type; service type outlet postcode; funding jurisdiction; service type outlet SLA; agency sector; total CSTDA funds; full financial year operation; weeks per year of operation; days per week of operation; hours per day of operation; staff hours (reference and typical week); number of service users. **Service user form** Selected letters of last name; selected letters of given name; date of birth; birth date estimate flag; sex; Indigenous status; country of birth; interpreter services required; communication method; living arrangements; service user postcode; residential setting; disability group (primary and other significant); support needs; carer arrangements; receipt of carer allowance (child); labour force status; main source of income; individual funding status. **Services received by service user in reporting period** Service start date; date service last received; snapshot date flag; service exit date; main reason for cessation of service; hours received (reference and typical week).
Has there been variation over time in any of the above descriptors for this collection?	Prior to 2002–03, the CSTDA–NMDS collection was known as the CSDA MDS and was collected on a snapshot day basis (i.e. information collected about service users who received services from a CSDA-funded service on a specified day in the year). A number of significant changes were made during the redevelopment of the collection, most notably the collection methodology (move from snapshot day to a full-year ongoing collection) and the introduction of new data items including those about service receipt and carers. (for more information see: *Australia's National Disability Services Data Collection: Redeveloping the CSTDA NMDS*. AIHW Cat. No. DIS 30. Canberra: AIHW).
Are there any proposed developments relating to comorbidity in the near future for this collection?	—
Definitions—how are the following concepts addressed and/or defined?	
Substance use	—
Mental health	Residential setting: 'psychiatric/mental health community care facility'—refers to community care units which provide accommodation and non-acute care and support on a temporary basis to people with mental illness or psychological disturbance. Primary (and other significant) disability group: 'psychiatric'—includes recognisable symptoms and behaviour patterns, frequently associated with distress, that may impair personal functioning in normal social activity. Includes the typical effects of conditions such as schizophrenia, affective disorders, anxiety disorders, addictive behaviours, personality disorders, stress, psychosis, depression and adjustment disorders.

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Comorbidity	—
Age	Date of birth.
Sex	Collected as per NCSDD data item
Cultural and linguistic diversity	Country of birth (coded to ABS SACC). Interpreter services required: yes—for spoken language other than English; yes—for non-spoken communication; no. Communication method (mappable to NCSDD data item).
Indigenous status	Collected as per NCSDD data item.
Geographic location of respondent	Postcode of the service users residential address (for nationally reporting SLA is derived from postcode).
Geographic location of agency or other relevant unit	Service type outlet postcode. Service type outlet SLA.
Treatment types	(None specific to substance abuse or mental health).
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Living arrangements (collected as per NCSDD data item). Residential setting: private residence; residence within an Aboriginal and/or Torres Strait Islander community; domestic-scale supported living facility; supported accommodation facility; boarding house/private hotel; independent living unit within a retirement village; residential aged care facility; psychiatric/mental health community care facility; hospital; short-term crisis, emergency or transitional accommodation facility; public place/temporary shelter; other (doesn't quite map to the NCSDD data item). Carer–existence of: yes; no. Carer–primary status: yes; no. Carer–residency status: yes, co-resident carer; no, non-resident carer (as per NCSDD data item). Carer–relationship to service user: wife/female partner; husband/male partner; mother; father; daughter; son; daughter-in-law; son-in-law; other female relative; other male relative; friend/neighbour–female; friend/neighbour–male. Carer–age group: under 15; 15–24; 25–44; 45–64; 65 and over. Receipt of carer allowance (child). Main source of income: Disability Support Pension; other pension or benefit; paid employment; compensation payments; other; nil income; not known.
Indicators of social participation (e.g. labour force status, education status)	Labour force status: employed; unemployed; not in the labour force (as per NCSDD data item). Support needs.
Treatment outcomes	—
Collection management agency	AIHW
Title/name of contact	Head, Functioning and Disability Unit / Ms Ros Madden
Address	GPO Box 570, Canberra, ACT 2601.
Email	ros.madden@aihw.gov.au
Internet	http://www.aihw.gov.au/disability
Phone/fax	(02) 6244 1000 / (02) 6244 1199
Data custodian/access	AIHW
Funding agency	For the management of the collection: FaCS.
Output	AIHW 2004. Disability support services: the first six months of data from the CSTDA NMDS (2003 data). Canberra AIHW.

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References (for preparing this template)	AIHW 2004. CSTDA NMDS data guide: data items and definitions 2004–05. Canberra: AIHW. (available online at www.aihw.gov.au/disability/csda_public/index.cfm)
When will data from this reference period/survey be available?	June 2006.
Other comments	In addition to the CSTDA–NMDS data items, many jurisdictions collect further data items of particular significance to them. For example, FaCS collects a range of additional questions in relation to clients receiving disability employment assistance (e.g. period of employment during the financial year, average standard hours worked during the financial year). None of the expanded collections conducted by states, territories and the Australian government include information about substance use. Due to data quality concerns only six months' worth of data are being reported on for 2002–03.

23 National Mortality Database (NMD)

Data source (title)	National Mortality Database (NMD)
Brief description	This database consists of de-identified unit record level data and contains much of the information collected by the states and territories' Registrars of Births, Deaths and Marriages. This database covers the period from 1964 to the present. It includes data elements, such as date of death, date of birth, underlying cause of death, multiple causes of death (1997 onwards), place of death by state and local government area (LGA), Indigenous status (for later years), and other information.
Purpose(s)	To provide mortality data to meet the AIHW work program and meet requests from researchers working outside of the AIHW.
Collection methodology	Death registration has been compulsory in all states since the mid-1850s and this information is registered with the respective Registrars of Births, Deaths and Marriages. Information about a death is recorded on the Death Certificate and the Death Information Form. The recorded information includes the disease or condition leading directly to death and the other contributing diseases or conditions, as well as demographic and administrative information. Demographic and administrative information about the deceased is collected on the Death Information Form, filled out by the deceased's next of kin in conjunction with the funeral director. The attending medical officer fills in the Death Certificate. Death certification can be completed in three ways: 1. If a medical practitioner has treated the deceased recently and the medical practitioner is certain of the cause of death, then the medical practitioner can provide the required certificate. 2. If no medical practitioner can certify the cause of death (e.g. unexplained deaths), then the case is referred to the government pathologist to conduct an autopsy to determine the cause of death. In many cases referred to the government pathologist, the Coroner determines the cause of death (e.g. many deaths resulting from accidents are referred to the Coroner). The disease or condition leading directly to death and the contributing diseases or conditions are recorded on the death certificate, from which the ABS determines the underlying and multiple causes of death using standardised coding rules set down in the ICD.
Scope (theoretical coverage of relevant population)	All people who die in Australia, including people from other countries. Does not include Australians who die abroad.
Coverage (actual)	Fairly good, as information comes from all deaths registered in the registries of births, deaths and marriages which should be almost all deaths.
Geographic coverage	All state and territories, Australia.
Frequency/timing	Updated annually as a block of data—all deaths for which the date of registration falls within the calendar year.
Basic collection count (i.e. treatment episodes, separations etc.)	Deaths.
Does the collection include a unique client identifier or statistical linkage key?	Yes—Mort ID which is a unique number (generated at the AIHW) given to each death record. The Mort ID is the key that links the multiple cause data (held in the multiple cause table) with the death record (held in the underlying cause of death table). Multiple cause information for each death record has been split off from the original death record for data storage reasons. The Mort ID also links to the National Death Index.
Data content (list of all data items)	Mortality table fields: record ID, year of registration, state of registration, registration district, month of registration, registration number, sex, age at death, age group, usual residence (5-digit), usual residence (9-digit), occupation, country of birth, duration of residence in Australia, marital status,

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Data content (continued)	age at first marriage, date of first marriage, place of first marriage, number of issue (number of children), date of death, certification, indigenous status, hospital, place of death, date of birth, query code, post mortem, drowning flag, cancer flag, maternal death flag, tuberculosis flag, leukaemia flag, AIDS flag, asthma flag, analgesic nephropathy flag, asbestosis flag, drug flag, Mort ID, RRMA residence, remoteness (5-fields), place of occurrence, activity code, firearms flag, underlying cause of death (numeric ICD–7, ICD–8, ICD–9), underlying cause of death (alpha-numeric ICD–10). Cause of death table fields: year (year of registration), state (state of registration), sex, age at death, age group, cause of death ICD–10, Indigenous status, COD number, Mort ID, usual residence.
Has there been variation over time in any of the above descriptors for this collection?	Associated causes of death were added to the collection in 1997. There have been changes in the ICD classification system over the years; this system has been used for the different causes of death elements. Other major classification systems are used with the cause of death data. The three main ones are: – Area of usual residence: the ASGC (ABS Cat. No. 1216.0) – Country of birth: the Australian Standard Classification of Countries for Social Statistics (ABS Cat. No. 1269.0) – Occupation of person: the ASCO (ABS Cat. No. 1220.0). For information about which classification version is being used for which years, see comments. Indigenous status: In 1998, a new range of codes were introduced as part of the effort to standardise and improve Indigenous identification in data collection nationally. For further details on differences in the collection of this data item across years and between states, see comments. For further details on changes to individual data items see comments.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Drug flag (from 1994)—(not currently in NHDD). A flag assigned by the coder to identify and broadly code those deaths where mention of a drug was made somewhere on the death certificate, regardless of whether the underlying cause of death assigned was drug related. This item is not of a publishable standard. For further details see comments.
Mental health	Not collected,—other than cause of death ICD codes that are mental health-related.
Comorbidity	Cause of death ICD–10 (multiple cause of death)—(not currently in NHDD). The diseases or conditions recorded on the death certificate consist of: the cause that led directly to the death (the underlying cause of death); the causes that gave rise to the underlying cause of death; and the causes of death that contributed to the death but were not related to the disease or condition causing it. For further details see comments. Multiple cause of death information is only available from 1997 onwards.
Age	Age at death—(not currently in NHDD). DEMOSS system. For further information, including changes to classification over time, see comments. Date of birth—(Different from ‘date of birth’ data element in NHDD). For further details see comments.
Sex	Sex—Different from ‘sex’ data element in NHDD). For further details see comments.

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Cultural and linguistic diversity	Country of birth—(NHDD) with 3-digit code pre- and 4-digit code post-1991. From 1991: the Australian Standard Classification of Countries for Social Statistics (1269.0). For further details see comments.
Indigenous status	Indigenous status—(Different from 'indigenous status' data element in NHDD). For further details see comments.
Geographic location of respondent	Place of death—(not currently in NHDD). LGA where the death occurred. For further details see comments. Place of occurrence—(not currently in NHDD). A numeric code given to identify the place where the external cause of injury, poisoning or adverse effect occurred. For further details see comments. Area of usual residence (5-digit)—(Different from 'area of usual residence' data element in NHDD) A 5-digit code (state code plus SLA) assigned to the address of the residence/home/residential institution last lived in prior to death. For further details see comments. Area of usual residence (9-digit)—(Different from 'area of usual residence' data element in NHDD). A nine-digit code given to the address of the residence/home/residential institution last lived in prior to death. For further details see comments. RRMA residence—(not currently in NHDD). The RRMA, based on the geographical location of usual residence of the person. The RRMA classification was developed in 1994 by the Department of Primary Industries and Energy and the Department of Health and Human Services, as a framework for analysing various data sources for metropolitan, rural and remote zones. For further details see comments. Remoteness area—(not currently in NHDD). ASGC, based on the geographical location of usual residence of the person. For further details see comments. Hospital—the hospital or institution where the death occurred. (Different from the data element 'Hospital' found in the NHDD). For further details see comments.
Geographic location of agency or other relevant unit	State of registration—(not currently in NHDD). The state or territory in which the death was registered. Registration district—(not currently in NHDD). A numeric code given to identify each Registrar of Births, Deaths and Marriages.
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Marital status—(Different from the data element 'Marital status' found in the NHDD).For further details see comments. Date of first marriage—not currently in NHDD). For further details see comments. Age at first marriage—(not currently in NHDD). The age of the person at first marriage in completed years. For further details see comments. Place at first marriage—(not currently in NHDD). This item is not currently recorded by any state or territory. For further details see comments. Number of issue (number of children)—(not currently in NHDD). Number of live births as defined by the World Health Organisation (WHO). For further details see comments.
Indicators of social participation (e.g. labour force status, education status)	Occupation of person—(NHDD). The job or duties in which the person was principally engaged in prior to death. ASCO Version 2 will be adopted for mortality data for 2003 data. For further details see comments.
Treatment outcomes	—
Collection management agency	ABS collects the data, and the AIHW gets a copy of which it is in charge.
Title/name of contact	Robert Van der Hoek or Krys Sadkowsky

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Address	GPO Box 570, Canberra, ACT 2601.
Email	robert.vanderhoek@aihw.gov.au or krys.sadkowsky@aihw.gov.au
Internet	www.aihw.gov.au
Phone/fax	Phone: (R. Van der Hoek) (02) 6244 1133, (K. Sadkowsky) (02) 6244 1059 Fax: (02) 6244 1299
Data custodian/access	AIHW – Paul Magnus.
Funding agency	AIHW.
Output	Information from the Mortality database is used in many publications across the AIHW. One of the most recent mortality-specific publications is: Harrex WK, Horsley KW, Jelfs P, Van der Hoek R, Wilson EJ. 2003. Mortality of Korean War veterans: the veteran cohort study. A report of the 2002 retrospective cohort study of Australian veterans of the Korean War. Canberra: Department of Veterans' Affairs.
References (for preparing this template)	Verbal conversation with Robert Van der Hoek. AIHW: Dunn CJ, Sadkowsky KR 2004. The AIHW Mortality Database documentation. Canberra: AIHW. Available at: http://intranet/documents/data%20dictionary_latest.doc (intranet)
When will data from this reference period/survey be available?	2002 data is available now, 2003 data will be available in December 2004.
Other comments	For further details on individual data element definitions and changes to them over time and for more detailed information about the database, see the AIHW National Mortality Database documentation http://intranet/documents/data%20dictionary_latest.doc (intranet)

24 Bettering the Evaluation and Care of Health (BEACH)

Data source (title)	**Bettering the Evaluation and Care of Health (BEACH)**
Brief description	The BEACH program is a continuous national study of general practice activity that began in April 1998. Previous reports from the BEACH program have described, and measured changes in, general practice activity on a national basis using each year's national random sample of general practice activity. A recent report also provides the first picture of the activities of general practice in each state and territory of Australia. It uses a combination of 5 years of BEACH data to provide sufficient sample size for independent study of each state and territory and compares their activities with the national average for the same period.
Purpose(s)	The purposes of the collection are to: • collect reliable and valid data about general practice which is responsive to the ever-changing needs of information users • establish an ongoing database of GP/patient encounter information • assess patient-based risk factors and the relationship these factors have with health service activity • provide accurate and timely data to a wide variety of users including government bodies, GP organisations, consumers, researchers and the pharmaceutical industry.
Collection methodology	An ongoing data collection process—20 GPs recording per week, 50 weeks per year. Random sample of 1000 GPs annually across Australia—from HIC Medicare records. 100 consecutive consultations from each GP. All consultations recorded—including indirect consultations (e.g. telephone)—which result in a management action e.g. prescription, referral, etc. Each of approximately 1,000 GPs per year records details about 100 doctor–patient encounters of all types. The information is recorded on structured encounter forms (on paper). It is a rolling sample, recruited about 3 weeks ahead. Approximately 20 GPs participate each week, 50 weeks a year.
Scope (theoretical coverage of relevant population)	General practice activity in urban, rural and remote areas of Australia.
Coverage (actual)	The BEACH survey of general practice activity encompasses about 100,000 GPs–patient encounters each year. The data from this survey is weighted to reflect national general practice activity patterns.
Geographic coverage	All states and territories of Australia.
Frequency/timing	Annual report. The BEACH survey is a continuous survey of general practice activity. It is a rolling sample, recruited about 3 weeks ahead. Approximately 20 GPs participate each week, 50 weeks a year.
Basic collection count (i.e. treatment episodes, separations etc.)	GP encounters.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Encounter characteristics: Medicare item number claimable/worker's compensation claimable/ indirect consultation. GP characteristics : age; gender; years in general practice; number of sessions per week; country of graduation; size of practice; computer use; hours worked and on call each week; location (rurality and state) of practice. Patient characteristics: age; sex; non-English-speaking background status; Aboriginality; Torres Strait Islander status; Health Care Card and Veterans' Affairs status; status to the practice (new/seen before). Patient reasons for encounter (up to three).

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Data content (continued)	Problems managed at the consultation (up to four): status of each problem to the patient (new/managed before); whether the problem was work related. Management—for each problem managed: drugs prescribed; over-the-counter advised; drugs supplied by the GP; status of the drug (new, continuation); dosage; regimen. Other treatments, including therapeutic procedures and counselling; referrals to specialist; referrals to allied health professionals; admissions. Tests and investigations: pathology and imaging ordered at this consultation. Supplementary Analysis of Nominated Data (SAND): Additional questions asked of patients in subsamples of encounters. Different questions may be asked in each recording block (5 weeks). Population risk factors investigated include: smoking status; alcohol consumption, body mass index. Specific interests of BEACH stakeholders are also investigated.
Has there been variation over time in any of the above descriptors for this collection?	The abovementioned SAND questions change every 5 weeks.
Are there any proposed developments relating to comorbidity in the near future for this collection?	Yes—plan to repeat National Health Priority Areas comorbidity SAND in 2005–06 (sample size probably about 6,000).
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Substance use-related codes in the ICPC, Version 2 with extended vocabulary of terms (ICPC–2 PLUS) can be used for each of the data items: reason for encounter, problems managed and procedures, other treatments, counselling (for example—Drug abuse (P19), Counselling; drug abuse (P58010)) Substance use related codes in the Coding Atlas for Pharmaceutical Substances can also be used for the data item ‘problems managed’. For a limited number of people data on smoking status and alcohol consumption (WHO Alcohol Use Disorders Identification Test) were collected using the SAND section of the survey.
Mental health	Mental health-related codes in the International Classification of Primary Care, Version 2 and ICPC–2 PLUS are used for the data items ‘reason for encounter’. ‘problems managed’ and ‘procedures, other treatments, counselling’ (for example–Depressive disorder (P76), Counselling; psychological (P58004). Mental health related codes in Coding Atlas for Pharmaceutical Substances can also be used for the data item ‘problems managed’. For a limited number of people data on depression, anxiety and perceived stress was collected using the SAND Supplementary Analysis of Nominated Data section of the survey.
Comorbidity	For a limited number of people data on comorbidity (of any conditions) have been collected using the SAND section of the survey, using different methods of questioning. Sample size of about 10,000 in one method, 6,000 in another. Method 1: How many times (approximately) has this patient consulted a GP at any practice in the last 12 months? What other significant diagnoses/problems does this patient have which are not being managed at today’s encounter? Method 2: A tick box form of chronic conditions that a patient has. Contains tick boxes for these psychological disorders: depression, anxiety, insomnia, and other psychological. No substance use disorders listed (but these could be if requested).
Age	Date of birth (DDMMYYYY).

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Sex	Sex (M/F).
Cultural and linguistic diversity	Non-English-speaking background (Y/N). For a limited number of people data on language and cultural background of patients were collected using the SAND section of the survey.
Indigenous status	Aboriginal (Y/N). Torres Strait Islander (Y/N).
Geographic location of respondent	Patient postcode.
Geographic location of agency or other relevant unit	Postcode of GP's major practice address.
Treatment types	Drug name(s) for problem (CAPS AND ATC codes) Where applicable, mental health or substance abuse related treatment type ICPC–2 PLUS codes are used for the data item procedures, other treatments, counselling this consult for problem. For example—Counselling; drug abuse (PLUS code P58010), Counselling; psychological (PLUS code P58004).
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Not collected.
Indicators of social participation (e.g. labour force status, education status)	Where applicable, ICPC–2 codes that are indicators of social participation are used for the data items reason for encounter, problems managed and procedures, other treatments, counselling. For example—Unemployment problem (Z06), Education problem (Z07), Social handicap (Z28). Health Care/Benefits card (Y/N). Veterans' Affairs Card (Y/N). For a limited number of people, data on employment status, occupation, workers' compensation claims and lifestyle status was collected using the SAND section of the survey.
Treatment outcomes	Not collected, except in the substudies of SAND, which measure outcomes of treatments for selected conditions that are the subject of the SAND questions.
Collection management agency	AIHW General Practice Statistics and Classification Unit.
Title/name of contact	A/Prof Helena Britt or Jan Charles
Address	AIHW General Practice Statistics and Classification Unit, University of Sydney, Acacia House, Westmead Hospital, Westmead, NSW 2145.
Email	fmrc@fmrc.org.au
Internet	http://www.fmrc.org.au/gpscu.htm
Phone/fax	(02) 9845 8151 / (02) 9845 8155
Data custodian/access	AIHW General Practice Statistics and Classification Unit.
Funding agency	DoHA, AstraZeneca Australia, MSD, Janssen-Cilag, Pfizer, Roche Products.
Output	AIHW 2004. Mental health services in Australia 2001–02. AIHW Cat. No. HSE 31. Canberra: AIHW (Mental Health Series No. 5). Britt H, Miller GC, Knox S, Charles J, Valenti L, Bayram C, O'Halloran J, Henderson J, Pan Y, Harrison C 2004. General practice activity in the states and territories of Australia 1998–2003. AIHW Cat. No. GEP 15. Canberra: AIHW (General Practice Series No. 15). Britt H, Miller GC, Knox S, Charles J, Valenti L, Pan Y, Henderson J, Bayram C,O'Halloran J, Ng A 2004. General practice activity in Australia 2003–04. AIHW Cat. No. GEP 16. Canberra: AIHW (General Practice Series No. 16). Britt H, Miller GC, Knox S, Charles J, Valenti L, Henderson J, Pan Y, Bayram C, Harrison C 2003. General practice activity in Australia 2002–03. AIHW Cat. No. GEP 14. Canberra: AIHW (General Practice Series No. 14).

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References (for preparing this template)	Britt H, Miller GC, Knox S, Charles J, Valenti L, Bayram C, O'Halloran J, Henderson J, Pan Y, Harrison C 2004. General practice activity in the states and territories of Australia 1998–2003. AIHW Cat. No. GEP 15. Canberra: AIHW (General Practice Series No. 15). AIHW 2004. Data collection guidelines 2004–05. Canberra: AIHW. AIHW 2004. Mental health services in Australia 2001–02. AIHW Cat. No. HSE 31. Canberra: AIHW (Mental Health Series No. 5). AIHW 2004. Community mental health care 2000–01. AIHW Cat. No. HWI 66. Canberra: AIHW (Resources Division Working Paper No. 2).
When will data from this reference period/survey be available?	Data from the 2002–03 collection period are scheduled to be published in the Mental health services in Australia 2002–03 report in February 2005. Data from the 2003–04 collection period is also available for analysis, as are data for 1 April 2004 – 30 September 2004.
Other comments	See attached link for additional information on SAND topics in the Survey. http://www.fmrc.org.au/publications/SAND_abstracts.htm

25 National Health Survey (NHS)

Data source (title)	Australian Bureau of Statistics 2001 National Health Survey (NHS)
Brief description	The 2001 NHS collected information regarding the health status of Australians, their use of health services and facilities and health-related aspects of their lifestyle. The survey is key in obtaining national benchmarks on a wide range of health issues and will enable changes in health to be monitored over time.
Purpose(s)	To collect information about the health status of Australians and their use of health services. To collect information on health-related issues of Australian's lifestyles including health risk factors.
Collection methodology	Personal interviews. Self-complete questionnaire. Four questionnaires were used in the 2001 survey: • Household form: used to collect basic demographic information about the usual residents of a household, as well as details about the relationship between individuals in each household (personal interview) • Personal interview adult questionnaire: used to collect information for adults about the demographic, socioeconomic and health characteristics. (information collected from 1 adult aged 18 years and over) (personal interview) • Personal interview child questionnaire: used to collect information about each child including their demographic information and for older children their socioeconomic characteristics. (Information collected from all children aged 0–6 years and one child aged 7–17 years) (personal interview) • Women's health supplementary form: used to collect further information from female respondents aged 18 years and over. The form contained questions relating to specific women's health issues (self-complete questionnaire).
Scope (theoretical coverage of relevant population)	The 2001 NHS was conducted on a sample of 17,918 private dwellings across Australia. Both urban and rural areas in all states and territories were included, but sparsely settled areas of Australia were excluded. Non-private dwellings such as hotels, motels, hostels, hospitals, nursing homes and short-stay caravan parks were not included in the survey.
Coverage (actual)	As above.
Geographic coverage	As above
Frequency/timing	The 2001 survey was in the field from February to November 2001. Previous surveys in the series were conducted in 1989–90 and 1995. Surveys conducted in 1977–78 and 1983, while not part of the NHS series, contain information similar to that collected in the 2001 NHS.
Basic collection count (i.e. treatment episodes, separations etc.)	Persons.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Household form (2001): relationships; sex; age; marital status; educational attendance; country of birth; year of arrival to Australia; scope; NHS selection; household type. Adult form (2001): sex; age; country of birth; year of arrival; household type; language; education; current labour force status; self-assessed health; weight/height; exercise; smoking; adult vaccinations; mental wellbeing;

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Data content (continued)	medications; nutrition; alcohol; asthma symptoms; asthma; cancer; heart/circulatory conditions; diabetes; eyesight; hearing; arthritis; long-term conditions; injuries; time off work/school; use of health services; private health insurance; income; spouse/partner income. Child form (2001): sex; age; country of birth; year of arrival; household type; language; proxy education; proxy current labour force status; labour force of child (15+ only); child income (15+ only); child immunisation; breastfeeding; assessment of child health (15+ only); height/weight (15+ only); exercise (15+ only); sun protection; nutrition (12+ only); asthma; cancer; heart and circulatory conditions; diabetes; eyesight; hearing; arthritis; long-term conditions; injuries; time off work/school; use of health services; private health insurance; proxy income; proxy partner/spouse income. Women's health supplementary form (2001): breast examinations; mammogram; pap smear test; hysterectomy; hormone replacement therapy; number of births; breastfeeding; contraceptives.
Has there been variation over time in any of the above descriptors for this collection?	The main differences between the 1995 and 2001 surveys are: • The sample from 1995 included some non-private dwellings and covered sparsely settled areas, whereas the 2001 survey included private dwellings in urban and rural areas only. • The 1995 survey included all persons in the sampled households whereas the 2001 survey subsampled persons within households. • Data relating to asthma, cancer and cardiovascular conditions were collected in detailed topic-specific question modules in 2001, whereas in 1995 the topics were covered in the context of long-term conditions. • The classifications and coding systems used for long-term conditions, type of medication and alcohol consumption differed between surveys. • The coverage of other health professionals has expanded within the NHS. Data about consultations with audiologists, hypnotherapists, occupational therapists and speech therapists were first collected in the 1995 survey. Aboriginal health worker (nec), accredited counsellor and alcohol and drug worker (nec) consultations were introduced in 2001. As a result data for consultations with other health professionals at the aggregate level are not directly comparable although the expanded coverage in parts reflects expanded use of other health professionals. • National information on psychological distress using the Kessler 10 scale (K10) was first collected in the SMHWB conducted by the ABS in 1997. The K10 was included in the 2001 NHS as it proved to be a better predictor of depression and anxiety disorders than the other short, general measures used in the 1997 SMHWB. • For more information about comparability across surveys, please contact the ABS.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No specific developments are proposed. The survey allows for self-reporting of multiple long-term conditions.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Smoking: • Current daily smoker • Other current smoker • Ex-regular smoker

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Substance use (continued)	• Never smoked regularly • Number of people in the household who smoke regularly. Alcohol: • Alcohol risk levels are based on the *National Health and Medical Research Council (NHMRC), 2001, Australian Alcohol Guidelines: Health Risks and Benefits* risk levels for harm in the long-term, and assumes the level of alcohol consumption recorded for the survey period is typical. Long-term conditions coded according to ICD–10. Use of health services: which services (codes include alcohol and drug worker nec). (NB: Long-term condition and use of health services asked in both the adult and child form.)
Mental health	Mental wellbeing uses the Kessler 10 scale. Medications for mental wellbeing: • Type of medication: sleeping tablets; tablets or capsules for anxiety or nerves; tranquillisers; antidepressants; mood stabilisers; other medication for your mental health. • Length of time on medication • How often in the last 2 weeks. Long-term conditions coded according to ICD–10. (NB: Long-term condition asked in both the adult and child form.)
Comorbidity	The survey allows for self-reporting of multiple long-term conditions.
Age	Age is outputted to age in months or age in years for children under 7 years. For those aged 7 years plus, age is outputted to age in years only.
Sex	Male, female.
Cultural and linguistic diversity	• Country of birth (coded to ABS SACC). • Language spoken at home (coded to ABS ASCL). • English proficiency (very well, well, not well, not at all).
Indigenous status	The NHS Indigenous Supplement is a separate survey
Geographic location of respondent	Classifications include: • State/territory of residence • Capital city/rest of state • ASGC remoteness classification • Some SEIFA.
Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	• Household composition (number of people in dwelling) • Number of bedrooms in dwelling • Living arrangements (relationships with members of household) • Type of dwelling: separate house; semi-detached (1 or 2 storey); flat attached to house; other flat/unit/apartment (in a 1 or 2 storey block, in a 3 storey block, in a 4 or more storey block); caravan/tent/cabin in a caravan park, houseboat in a marina; caravan not in a caravan park/houseboat not in a marina; improvised home/campers out; house or flat attached to a shop/office etc. • Both registered marital status and social marital status are collected.

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Indicators of social participation (e.g. labour force status, education status)	Education: including items on current study and highest qualification. Labour force status: including items on current labour force status; business owner; working/payment arrangements; occupation; shift work; usual hours of work.
Treatment outcomes	—
Collection management agency	ABS
Title/name of contact	National Information and Referral Service
Address	Locked Bag 10, Belconnen, ACT 2616.
Email	client.services@abs.gov.au
Internet	www.abs.gov.au
Phone/fax	1300 135 070
Data custodian/access	ABS
Funding agency	ABS, DoHA, some state and territory health departments.
Output	4363.0 ABS National Health Survey, summary of results 2001 and other subject-specific publications.
References (for preparing this template)	4363.0.55.001–National Health Survey: User's Guide 4363.0–ABS National Health Survey, summary of results 2001. National health survey 2001 – adult form. National health survey 2001 – child's form. Women's supplementary health form, National Health Survey 2001. Household form, National Health Survey 2001.
When will data from this reference period/survey be available?	Data from the 2001 NHS are currently available.
Other comments	An Indigenous component was also included in the 2001 NHS. The purpose of this component was to collect information regarding the health status of Indigenous Australians, their use of health services and facilities, and health-related aspects of their lifestyle.

26 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)

Data source (title)	Australian Bureau of Statistics National Aboriginal and Torres Strait Islander Health Survey 2004–05 (NATSIHS)
Brief description	The NATSIHS collects information about a range of health topics from the Aboriginal and Torres Strait Islander population living in remote and non-remote areas of Australia. It includes topics such as health status indicators, health-related actions, health risk factors, supplementary child health topics, and supplementary women's health topics.
Purpose(s)	The principal objectives of the NATSIHS are to collect data on Australia's Indigenous population to: • measure change over time in health through comparisons with the 1995 and 2001 NHS Indigenous supplements and with future NATSIHS • enable comparisons of the health characteristics of Indigenous and non-Indigenous populations, particularly through common measure with the 2004–05 NHS • enable comparisons of the health characteristics of Aboriginal and Torres Strait Islander populations • provide timely information for monitoring and surveillance across a range of key Indigenous health issues at national and state/territory levels • provide information on health indicators for Indigenous health priority areas • explore relationships and linkages between health and population characteristics.
Collection methodology	The NATSIHS is collected by personal interview, conducted using CAI in non-remote areas and pen and paper interviewing (PAPI) in remote areas in Queensland, South Australia, Western Australia and Northern Territory. In non-remote areas personal interviews are conducted with a household spokesperson, up to two selected adults, and proxy (as applicable) for up to two selected children. Two self-enumerated forms (substance use and women's health) are also completed. In remote areas personal interviews are conducted with a household spokesperson, up to one selected adult, and proxy (as applicable) for up to one selected child.
Scope (theoretical coverage of relevant population)	Usual residents of private dwellings only in remote and non-remote areas. An Indigenous household is defined as a household where there is at least one adult or child of Aboriginal and/or Torres Strait Islander origin who is a usual resident.
Coverage (actual)	The 2004–05 NATSIHS is currently in the field (August 2004–July 2005).
Geographic coverage	Remote and non-remote areas of Australia—all states and territories.
Frequency/timing	The NATSIHS is planned on a six-yearly cycle to coincide with every second cycle of the three-yearly NHS.
Basic collection count (i.e. treatment episodes, separations etc.)	People; households.
Does the collection include a unique client identifier or statistical linkage key? (Describe its nature)	N/A
Data content (list of all data items)	The NATSIHS comprises the following data items: Household information: number of income units in the household; number of persons in the household; number of adults, Indigenous adults, children and Indigenous children in household; geographic information of residence (including state/territory, ASGC remoteness area); dwelling structure; number of bedrooms; household composition; dwelling location; household type; gross weekly income; tenure type; financial stress.

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Data content (continued)	Persons in household: age of household members; income of household members; sex of household members; source of cash income; survey status of household member; relationship in household; Indigenous status. Demographics: a range of data items focusing on the following areas: administration of the survey; demographics; education; employment; housing; child proxy. Health related actions: a range of data items focusing on the following areas: action summary; dental consultations; doctors consultation; days off work/study; other days of reduced activity; health insurance/cards; visits to hospital/casualty/emergency/ outpatients/day clinics; discrimination. Health risk factors: a range of data items focusing on the following areas: adult immunisation; alcohol consumption; breastfeeding; child immunisation; cultural identification; dietary behaviours; height, weight and body mass; smoking; substance use. Health status indicators: a range of data items focusing on the following areas: arthritis; asthma; cancer; heart and circulatory conditions; diabetes; kidney disease/dialysis; osteoporosis; cause of long-term conditions; long-term conditions; injuries; social and emotional wellbeing; oral health. Women's health: a range of data items focusing on the following areas: mammograms; pap smears; breastfeeding history; contraception/protection.
Has there been variation over time in any of the above descriptors for this collection?	On common data items there is broad comparability between the 2004–05 NATSIHS and the Indigenous supplement to the 2001 NHS. New topics have been included in the 2004–05 NATSIHS and in addition, unlike the 2001 survey, state/territory level information will be released from the 2004–05 survey. The definition of an Indigenous household has changed from a household with at least one Indigenous adult in the 2001 survey to a household with at least one Indigenous person of any age in the 2004–05 survey.
Are there any proposed developments relating to comorbidity in the near future for this collection?	The 2004–05 NATSIHS is the first ABS survey to collect information on the social and emotional wellbeing of Indigenous people.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Smoking (includes questions about): • regular smoker status and smoker status • age commenced daily smoking • age last ceased daily smoking • number of people in the household who smoke regularly • duration of daily smoking (years). Alcohol (includes questions about): • time since last consumed • days in last week consumed • day consumed • types of alcohol consumed • volume of alcohol consumed • frequency of consuming 7 to 10 drinks. Substance use (includes questions about): • ever used • types of substances ever used • whether used substances in last 12 months • types of substances used in last 12 months. Long-term conditions coded according to ICD–10, ICPC and ABS codes.

(continued)

Mental health	Social and emotion wellbeing (based on): • Kessler 10 (subset) • Impact questions from Kessler 10+ • SF–36 (subset) • Anger questions (AI-SUPERPFP). Long-term conditions coded according to ICD–10, ICPC and ABS codes.
Comorbidity	Information on comorbidity can be derived using the substance use and social and emotional wellbeing data items (as detailed above).
Age	Age in years. Age in months (0 to 40 months).
Sex	Male, Female.
Cultural and linguistic diversity	Main language spoken at home (coded to ABS ASCL).
Indigenous status	Collected as per NCSDD data item.
Geographic location of respondent	State/territory. ASGC remoteness area category.
Geographic location of agency or other relevant unit	N/A
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Housing indicators: including dwelling structure; number of bedrooms; household composition; dwelling location; household type. Income: including financial stress; household income; personal weekly income; source of personal cash income; type of government pension/allowance received. Social marital status.
Indicators of social participation (e.g. labour force status, education status)	Education: including highest year of school completed; type of educational institution currently attending; current educational status. Employment: including labour force status; status in employment; occupation; industry sector.
Treatment outcomes	—
Collection management agency	ABS.
Title/name of contact	Director National Centre for Aboriginal and Torres Strait Islander Statistics / Dan Black
Address	Locked Bag 10, Belconnen, ACT 2616.
Email	dan.black@abs.gov.au
Internet	www.abs.gov.au
Phone/fax	(02) 6252 6663
Data custodian/access	ABS
Funding agency	ABS with supplementary funding from DoHA.
Output	Main findings publication (ABS cat. no. 4715.0); state/territory summary tables; Confidentialised Unit Record File through the ABS Remote Access Data Laboratory.
References (for preparing this template)	ABS survey information – will be published close to the time of data release.
When will data from this reference period/survey be available?	Data from the 2004–05 NATSIHS will be available in 2006.
Other comments	—

27 National Aboriginal and Torres Strait Islander Social Survey (NATSISS)

Data source (title)	National Aboriginal and Torres Strait Islander Social Survey 2002 (NATSISS)
Brief description	The 2002 NATSISS is a multidimensional social survey of Australia's Indigenous population designed to enable analysis of the interrelationships of social circumstances and outcomes, including the exploration of multiple disadvantage that may be experienced by Aboriginal and Torres Strait Islander Australians.
Purpose(s)	The survey aims to: • provide broad information across key areas of social concern for Indigenous Australians aged 15 years or over, including information not previously available at the national, state/territory and broad regional levels • allow for inter-relationships between different areas of social concern to be explored and provide insight into the extent to which people face multiple social disadvantage • provide comparisons with results from the non-Indigenous population from the 2002 GSS and other surveys • measure selected changes over the eight years between this survey and the first National Aboriginal and Torres Strait Islander Survey (NATSIS) conducted in 1994.
Collection methodology	The NATSISS was collected by personal interview, conducted using CAI in non-community areas and PAPI in remote communities in Queensland, South Australia, Western Australia and the Northern Territory. CAI involves the use of a computer to collect, store and transmit data relating to interviews conducted between interviewers and respondents. Under CAI, all sequencing is performed automatically and the appropriate question wording is automatically displayed.
Scope (theoretical coverage of relevant population)	The survey included Indigenous persons aged 15 years or over who were usual residents of private dwellings in Australia. Private dwellings are houses, flats, home units and any other structures used as private places of residence at the time of the survey. Usual residents are those people who usually live in a particular dwelling and regard it as their own or main home.
Coverage (actual)	Sample: 9,400 Aboriginal and Torres Strait Islander persons aged 15 years or over in private dwellings. 30% community sample, 70% non-community sample. Over-sample in Torres Strait area to allow for reliable Torres Strait Islander estimates.
Geographic coverage	The 2002 NATSIS was conducted in non-remote and remote areas in all states and territories of Australia.
Frequency/timing	The first NATSIS was conducted in 1994, the second NATSISS in 2002.
Basic collection count (i.e. treatment episodes, separations etc.)	Person, household.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Household form—Remote Areas: relationship of people in residence; sex; age; educational attendance; indigenous status; scope exclusions of people in residence; household type; initial status. Household form—Non-remote areas: relationship of people in residence; sex; age; date of birth; educational participation; study status; type of educational institution; level of educational attainment; reason left school; work done; details of work done; cultural responsibilities; looking for work in last 4 weeks; want work; reasons for not looking for work; duration of unemployment; difficulties of getting work; looking for work in last 12 months; employment support services; vocational training; transport; mobility; self-perception of health; disability; smoking; alcohol consumption; access to child care; children ever born/children living; support in times of crisis; neighbourhood problems; stressors; voluntary work; computer use; Internet use; language; cultural participation/involvement in social activities; cultural identification; removal from family; legal services; police contact; victim of assault; personal income; access to money; bedrooms; telephones; household facilities; maintenance; tenure; landlord type and rent payments; mortgage; financial stress; income.

(continued)

Data content (continued)	Self enumerated substance use form: whether ever used substances; type of substances ever used; number of types of substances ever used; whether used in last 12 months; type of substances used in last 12 months; number of types of substances used in last 12 months. For further information see the Data Item list in Data Reference Package (4714.0.55.002).
Has there been variation over time in any of the above descriptors for this collection?	Sample (1): The 1994 NATSIS coverage included both private and non-private dwellings as well as, where possible, Indigenous people not living in a dwelling and Indigenous persons in prisons or other correctional facilities. The 2002 NATSISS is limited to persons living in private dwellings only. Sample (2): 1994 NATSIS covered urban and rural areas. The 2002 NATSISS covered remote and non-remote areas. Further, data from the 1994 NATSIS are not available by remoteness since there is currently no concordance between the geographic structure on which the survey was based and the ABS remoteness structure. Collection method: 1994 NATSIS collected information from all persons of any age in the household whereas the 2002 NATSISS collected information from up to three Indigenous persons aged 15 years or over in the household. Collection methodology: in 1994 NATSIS data were collected using PAPI only. In 2002, CAI for non-remote areas (and remote areas in New South Wales, Victoria and Tasmania) and PAPI for remote areas not covered by CAI.
Are there any proposed developments relating to comorbidity in the near future for this collection?	The next NATSISS is scheduled to be conducted in 2008.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Smoking (includes questions about): • currently smoking • smoke regularly • ever smoked regularly. Alcohol consumption (includes questions about): • alcohol consumption in last 12 months • how often • usual amount consumed in a day • alcohol consumption in last 2 weeks • type of drink and volume/quantity. Neighbourhood problems: ‘alcohol’, ‘illegal drugs’. Stressors: ‘alcohol or drug related problems’. Ever used: painkillers or analgesics; tranquillisers or sleeping pills; amphetamines or speed; marijuana/hashish/cannabis resin; heroin; cocaine; LSD/synthetic hallucinogens; naturally occurring hallucinogens; ecstasy/designer drugs; sniffed petrol; other inhalants; kava. Type of drug ever used for non-medical purposes: pain killers or analgesics; tranquillisers or sleeping pills. Types of drug used in the last 12 months: list as above for ‘ever used’.
Mental health (applicable to non-remote areas only)	Disability type: output categories include ‘psychological’ i.e. ‘any mental illness for which help or supervision is required’ and/or ‘a nervous or emotional condition that restricts everyday activities’. Personal stressors: including ‘mental illness’.

(continued)

Comorbidity	Yes, limited information can be derived using the 'psychological' disability type and substance abuse data items.
Age	Age in single years (at time of collection).
Sex	Male, female.
Cultural and linguistic diversity	Main language spoken at home: English; Aboriginal language; Torres Strait Islander language; other language. Difficulty communicating with service providers in English. Whether speaks an Indigenous language. Culture: series of 9 questions asking about identifying with Aboriginal or Torres Strait Islander culture.
Indigenous status	Codes used: non-Indigenous; Aboriginal; Torres Strait Islander; both Aboriginal and Torres Strait Islander.
Geographic location of respondent	State/territory of usual residence. ASGC remoteness structure. Capital city/balance of state.
Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Household composition. Housing characteristics. Income: including items on level of income; source of income.
Indicators of social participation (e.g. labour force status, education status)	Voluntary work. Education: including items on attainment; current study; education experience. Employment: including items on status; unemployment details; precariousness; Community Development Employment Project; barriers to employment; discouraged job seekers; employment support services.
Treatment outcomes	—
Collection management agency	ABS
Title/name of contact	Dan Black
Address	Locked Bag 10, Belconnen, ACT 2616.
Email	dan.black@abs.gov.au
Internet	www.abs.gov.au
Phone/fax	(02) 6252 6663
Data custodian/access	ABS
Funding agency	ABS
Output	National Aboriginal and Torres Strait Islander Social Survey 2002. ABS Cat. No. 4714.0
References (for preparing this template)	4714.0—ABS NATSISS 2002. 4714.0.55.002—NATSISS: data reference package. Indigenous Social Survey 2002 non-remote areas: CAI questions. NATSISS 2002: output data items.

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When will data from this reference period/survey be available?	It is anticipated that the Confidentialised Unit Record File for the NATSISS will be available from March-April 2005 through the ABS Remote Access Data Laboratory.
Other comments	The substance use questions in the 2002 NATSISS were based on the NDSHS and had a response rate of over 90%. In non-community areas, a voluntary self-enumerated form was used to collect this information whereas in community areas respondents were required to respond verbally to questions asked by an interviewer. The very low prevalence for substance use reported in community areas has been assumed to be the result of the use of direct questioning in community areas leading to significant adverse effect on both the level or response and the quality of responses to questions on substance use. For this reason, information on substance use in remote areas is considered to be unreliable and has not been released, pending further investigation by the ABS.

28 ABS General Social Survey (GSS)

Data source (title)	Australian Bureau of Statistics 2002 General Social Survey (GSS)
Brief description	The 2002 GSS collected information on a range of aspects of life relating to human wellbeing including: health, family relationships and engagements with wider social networks, educational opportunities and outcomes, employment and other work, financial resources, a place to live, personal safety and security, and access to transport.
Purpose(s)	To present data on a range of social dimensions of the Australian community at a point in time. To enable analysis of the interrelationship of social circumstances and outcomes, including the exploration of multiple advantage and disadvantage, and to provide a base for comparing social circumstances and outcomes over time and across population groups.
Collection methodology	Personal interviews at selected dwellings during March and July 2002. Interviews were conducted using a CAI questionnaire.
Scope (theoretical coverage of relevant population)	People who were usual residents of a private dwelling in urban and rural areas of Australia across all states and territories.
Coverage (actual)	15,510 people aged 18 years and over.
Geographic coverage	All states and territories, Australia.
Frequency/timing	2002, next survey scheduled for 2006 and every four years thereafter.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of persons and households.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Sex; relationships within dwelling; date of birth; country of birth; year of arrival; Indigenous status; registered marital status; main language spoken other than English at home; education (e.g. educational participation, full-time study, institution enrolled at, educational attainment); work (e.g. work done, details of work done, looking for work in last 4 weeks, time since last worked); transport (e.g. access to transport, transport to work); health (e.g. self-perception of health, disability); family and community (e.g. support for others outside household, small favours, support in times of crisis, stressors, voluntary work, involvement in social activities, contact with family and friends); crime (e.g. feelings of safety, victimisation); sports participation; culture/leisure activities and venues; information technology; financial stress; income unit income; household income; housing (e.g. tenure type, landlord type and rent payments, mortgage repayments); assets and liabilities.
Has there been variation over time in any of the above descriptors for this collection?	—
Are there any proposed developments relating to comorbidity in the near future for this collection?	Mental health status will be repeated in GSS 2006; no plans to include substance use.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Types of stressors experienced—coding option includes ‘Alcohol or drug related problems’.
Mental health	Disability—coding option includes ‘Any mental illness for which help or supervision is required’. Types of stressors experienced—coding option includes ‘Mental illness’.
Comorbidity	A low-level proxy can be derived using the substance use and mental health status data items.
Age	Date of birth.

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Sex	Male, female.
Cultural and linguistic diversity	Country of birth (coded to ABS SACC). Language spoken at home (coded to ABS ASCL).
Indigenous status	—
Geographic location of respondent	State/territory of residence.
Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Registered marital status. Relationship to household members. Tenure type. Landlord type and rent payments.
Indicators of social participation (e.g. labour force status, education status)	Education. Work. Transport. Sports participation. Culture/leisure activities and venues. Information technology.
Treatment outcomes	—
Collection management agency	ABS
Title/name of contact	Assistant Director, Family and Community Statistics / Elisabeth Davis
Address	Locked Bag 10, Belconnen, ACT 2616.
Email	elisabeth.davis@abs.gov.au
Internet	www.abs.gov.au
Phone/fax	(02) 6252 7880
Data custodian/access	ABS.
Funding agency	ABS.
Output	4159.0—ABS General Social Survey: summary results, Australia 2002. The equivalent 4159.0 information at a state/territory level is also available electronically as spreadsheets (4159.1.55.001 to 4159.8.55.001).
References (for preparing this template)	4159.0—ABS General Social Survey: summary results, Australia 2002. 4159.0.55.001 General Social Survey 2002 CAI questions, prompt cards and output data item list.
When will data from this reference period/survey be available?	The Basic and Expanded 2002 GSS confidentialised unit record files are currently available (4159.0.30.001 and 4159.0.30.002).
Other comments	—

29 2003 Survey of Entitled Veterans, War Widows and their Carers

Data source (title)	2003 Survey of Entitled Veterans, War Widows and their Carers
Brief description	Survey of veterans, war widows and their carers to get a snapshot of the lifestyles, health and wellbeing of Repatriation Health Care Cardholders.
Purpose(s)	To measure the health and level of independence of veterans and war widows. To assess the influence of existing programs on improving veteran health and lifestyle, and identify the needs of veterans and war widows. To identify ways that DVA could help veterans and war widows to achieve a healthy and more comfortable lifestyle.
Collection methodology	Face-to-face interview.
Scope (theoretical coverage of relevant population)	Survey of Repatriation Health Card holders (Gold Card for all health care conditions and White Card for specific health care conditions) and their carers. Survey excluded veterans and war widows who live outside Australia and those living in a residential aged care facility or in a hospital.
Coverage (actual)	2,190 veterans and war widows participated in the first questionnaire. 225 carers of veterans or war widows participated in the second questionnaire.
Geographic coverage	All states and territories, Australia.
Frequency/timing	2003, 1997–98, 1992, 1988–89.
Basic collection count (i.e. treatment episodes, separations etc.)	Individual level.
Does the collection include a unique client identifier or statistical linkage key?	Yes, for those participants who agreed to have their survey responses matched with their own health service usage and entitlement information held by the DVA (93.5%).
Data content (list of all data items)	Age group; sex; geographic location of residence; marital status; Australian Defence Force service; heath card type; living arrangements; residential setting; self-rated health; self-reported medical conditions; self-reported cancer; access to health care services; annual flu vaccination status; private health cover; medication taken; hospital services accessed; improving health; areas of health concern; frequency of driving; frequency of public transport use; organisation and club membership; activity participation; barriers to socialising; reason for changes in social activity; internet use; frequency of feeling happy or lonely; feeling of safety; concern about falling; perceptions of being a veteran or war widow; carer status; assistance and care requirements; use of aids and appliances; receipt of a community service; carer assistance; health of carers; use of respite care services.
Has there been variation over time in any of the above descriptors for this collection?	Broadly speaking, a core set of questions have been utilised across all surveys so that findings are able to be compared over time. Most of the questions from the 1992 survey were retained in the 1997–98 survey; however, additional questions on home and community type services, communication, perceived safety, hospitalisation, discharge planning, needs of carers and accommodation issues were also included in the 1997–98 survey. Further, the 2003 survey included additional questions on the profile of the veteran and war widow(er) population, Internet usage and veterans as carers.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No. The aim of the survey is to collect policy-relevant information about the DVA health card holder population, as identified at the time of each survey. Collecting comorbidity data is therefore not a specific objective of the survey. In the data analysis phase of the 2003 survey, however, the association between different medical conditions was investigated. For example, 22% of respondents reported that they currently had depression and, of those, 75% also stated that they currently had an alcohol or drug problem.
Definitions—how are the following concepts addressed and/or defined?	

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Substance use	Medical condition—coding option includes: alcohol or drug problem. Alcohol as a health concern—data item asking whether alcohol has been identified (by a doctor, counsellor or other health professional) as a health concern. Better health—coding options include: my smoking habits; my drinking habits.
Mental health status	Medical condition—coding option includes: panic disorder; anxiety disorder; depression; insomnia/sleep disturbance; dementia; post-traumatic stress disorder. Feelings—data item rating feelings of loneliness and happiness over the past year.
Comorbidity	A very low-level proxy can be derived using the above data items.
Age	Age group (reported as): under 60 years; 60–69; 70–79; 80+.
Sex	Male, female.
Cultural and linguistic diversity	—
Indigenous status	—
Geographic location of respondent	Geographic location of residence (state).
Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Marital status. Health card type: Gold or White Card. Living arrangements—codes include: live in separate house; retirement village. Household composition (number of people they live with).
Indicators of social participation (e.g. labour force status, education status)	Frequency of driving. Frequency of public transport use. Organisation and club membership. Activity participation: codes include go to restaurants/hotels; spend time with friends; phone family/friends they don't live with; spend time with family they don't live with.
Treatment outcomes	—
Collection management agency	AC Nielsen was commissioned to carry out the survey on behalf of the Australian Government Department of Veterans' Affairs.
Title/name of contact	Project Officer, Health Research and Development Section, DVA / Ms Diane Du Toit
Address	13 Keltie Street, Woden, ACT 2606.
Email	diane.dutoit@dva.gov.au
Internet	www.dva.gov.au
Phone/fax	(02) 6289 6706 / (02) 6289 4776
Data custodian/access	DVA
Funding agency	DVA

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Output	DVA 2004. 2003 Survey of Veterans, War Widows and their Carers–veterans and war widows report. Canberra: DVA. DVA 2004. 2003 Survey of Veterans, War Widows and their Carers–methodology report. Canberra: DVA DVA 2004. 2003 Survey of Veterans, War Widows and their Carers–veterans and war widows computer tables. Canberra: DVA. DVA 2004. Your lives, your needs 2003: findings from the 2003 Survey of Entitled Veterans, War Widows and their Carers. Canberra: DVA.
References (for preparing this template)	DVA 2004. Your lives, your needs 2003: findings from the 2003 Survey of Entitled Veterans, War Widows and their Carers. Canberra: DVA. DVA 2004. 2003 Survey of Veterans, War Widows and their Carers–veterans and war widows computer tables. Canberra: DVA.
When will data from this reference period/survey be available?	Data are available on request.
Other comments	All references to war widows also include war widowers.

30 Pharmaceutical Benefits Scheme (PBS)

Data source (title)	Pharmaceutical Benefits Scheme (PBS)
Brief description	The dataset comprises information on all scripts processed by the Health Insurance Commission from the PBS.
Purpose(s)	The PBS provides people with prescription medicines in an affordable, reliable and timely manner. The data set is used to determine and monitor the value (benefits) and volume (services) of PBS scripts that are processed by the Health Insurance Commission during a specified reporting period.
Collection methodology	Pharmacies submit claims of PBS activity.
Scope (theoretical coverage of relevant population)	PBS data is restricted to data recorded from prescriptions where the cost of pharmaceutical was greater than the patient contribution and where a pharmacist, in turn, requires reimbursement.
Coverage (actual)	All Australian residents and eligible overseas visitors.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Ongoing.
Basic collection count (i.e. treatment episodes, separations etc.)	The PBS collects information of each event where a claim is made by a pharmacy when a person has been supplied with a pharmaceutical that is subsidised by PBS.
Does the collection include a unique client identifier or statistical linkage key?	Yes, Medicare number.
Data content (list of all data items)	A number of variables are collected and these include patient, prescriber, pharmacy, date of supply, drug supplied, price details, etc.
Has there been variation over time in any of the above descriptors for this collection?	In 2002, stricter requirements were placed on recipients to prove their entitlements to subsidised pharmaceuticals, requiring recipients to produce their Medicare card at the time of dispensing. This change in requirement resulted in more reliable information regarding the recipient.
Are there any proposed developments relating to comorbidity in the near future for this collection?	—
Definitions—how are the following concepts addressed and/or defined?	
Substance use	For each claim the drug dispensed is known.
Mental health	PBS: Information for GPs, private psychiatrists and non-psychiatrist specialists is reported. Different information is requested for the following groups: Anatomical Therapeutic Chemical group for general practitioners and non-psychiatrist specialists: NO5A, NO5B, N05C, and N06A. Stematil is excluded in 2005 (prochlorperazine–ATC code N05AB04) from the antipsychotics (N05A) expenditure and script volume for general practitioners and non-psychiatrist specialists as it is prescribed mostly as an anti-nausea drug. Anatomical Therapeutic Chemical group for private psychiatrists: totals for ATC codes A, B, C, D, G, H, J, L, M, P, R, S and total. In addition, for chapter N, 4 character code level is requested (i.e. N05A, N05B, N05C, N06A and other) and within N05A, Stematil (prochlorperazine N05AB04) to be extracted separately.
Comorbidity	The PBS captures information about the drug supplied as opposed to the person's condition. In some instances, this could be implied.
Age	Yes.
Sex	Yes.
Cultural and linguistic diversity	No.

(continued)

Indigenous status	People are now able to indicate their Indigenous status.
Geographic location of respondent	Yes.
Geographic location of agency or other relevant unit	Location information is aggregated to various levels such as SLA, RRMA, state etc.
Treatment types	Information is collected at item level and this can be aggregated to various levels such as Anatomical Treatment Chemical Classification.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	—
Indicators of social participation (e.g. labour force status, education status)	—
Treatment outcomes	—
Collection management agency	Health Insurance Commission.
Title/name of contact	Manager, Information Strategy Section
Address	Information Services Branch, Health Insurance Commission, PO Box 1001, Tuggeranong DC, ACT 2901.
Email	hictstats@hic.gov.au
Internet	www.hic.gov.au
Phone/fax	1800 101 099
Data custodian/access	Manager, Privacy Policy Section (02) 6124 4113
Funding agency	Australian Government Department of Finance
Output	Pharmaceutical Benefits Scheme, annual report 2003–04: statistical tables.
References (for preparing this template)	Understanding the Health Insurance Commission's information, information services branch, March 2004. Canberra: HIC. Pharmaceutical Benefits Scheme, annual report 2003–04: statistical tables. Canberra: HIC
When will data from this reference period/survey be available?	Available on request.
Other comments	PBS data do not include items supplied under the Repatriation Pharmaceutical Benefits Scheme.

31 Medicare Benefits Scheme (MBS) data

Data source (title)	Medicare Benefit Scheme data
Brief description	The data set comprises information on all medical services funded through Medicare.
Purpose(s)	The purpose of the MBS is to provide people with subsidised medical services. The Medicare data provides information on the type of services provided and the benefit paid by Medicare for the service.
Collection methodology	Providers or patients submit claims of Medicare activity.
Scope (theoretical coverage of relevant population)	Medicare records only include services that quality for Medicare benefits and for which claims have been processed (they do not include services provided under the DVA National Treatment Account). Medicare data excludes: • services which have been provided in public hospitals to public patients, or • service provided in outpatient or emergency departments of public hospitals. Only claim information is collected; very limited diagnostic or clinical information is available.
Coverage (actual)	Australian residents and eligible overseas visitors.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Ongoing.
Basic collection count (i.e. treatment episodes, separations etc.)	Medicare collects information of each event where a person visits a doctor (and some allied health professionals) and the service provided.
Does the collection include a unique client identifier or statistical linkage key?	Yes, Medicare number.
Data content (list of all data items)	Eligible Medicare providers: provider information: name and location of practice(s), specialty by qualification, registered major specialty, derived major specialty based on type of claims, sex etc. Medicare: item number; Medicare benefit; period of service and processing and dates of request/referral–monthly/quarterly/yearly; indication of whether or not the service was provided in hospital; total number of services, rendered/referred; total number of patients; bill type etc. Medicare enrolment information: Medicare care information; name of cardholder; address of cardholder; date of birth; sex etc.
Has there been variation over time in any of the above descriptors for this collection?	Yes (too numerous to list in detail).
Are there any proposed developments relating to comorbidity in the near future for this collection?	—
Definitions—how are the following concepts addressed and/or defined?	
Substance use	—
Mental health status	—
Comorbidity	—
Age	Yes.
Sex	Yes.
Cultural and linguistic diversity	No.
Indigenous status	People are now able to indicate their Indigenous status.
Geographic location of respondent	Yes.

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Geographic location of agency or other relevant unit	Location information is aggregated to various levels such as SLA, RRMA, state etc.
Treatment types	Information is collected at item level and these can be aggregated to various levels such as broad type of service.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	—
Indicators of social participation (e.g. labour force status, education status)	—
Treatment outcomes	—
Collection management agency	Health Insurance Commission
Title/name of contact	Manager, Information Strategy Section
Address	Information Services Branch, Health Insurance Commission, PO Box 1001, Tuggeranong DC, ACT 2901.
Email	hictstats@hic.gov.au
Internet	www.hic.gov.au
Phone/fax	1800 101 099
Data custodian/access	Manager, Privacy Policy Section (02) 6124 4113
Funding agency	Australian Government Department of Finance
Output	Health Insurance Commission. Medicare, annual report 2003–04 statistics. Canberra: Health Insurance Commission.
References (for preparing this template)	Understanding the Health Insurance Commissions Information, Information Services Branch March 2004. Health Insurance Commission. Medicare, annual report 2003–04: statistical tables. Canberra: Health Insurance Commission.
When will data from this reference period/survey be available?	Available on request.
Other comments	The Health Insurance Commission information about claims processing is only held for the last five years. Data prior to this time are held by DoHA. Only a subset of information collected as part of the Medicare data set is routinely available via data request submissions.

32 National Coroners Information System (NCIS)

Data source (title)	National Coroners Information System (NCIS)
Brief description	The NCIS is an electronic national database of coronial information managed by the Victorian Institute of Forensic Medicine. The NCIS provides coroners and authorised third party users with information on deaths including coronial findings. Information is provided by each state and territory coronial office.
Purpose(s)	To provide a high-quality hazard identification and research tool for coroners, their death investigation staff and other users, such as researchers and policy makers. The NCIS aims to provide a means to systematically identify and retrieve clusters of similar cases around Australia, allowing users to identify patterns and trends on a national basis. By making reliable coronial data more accessible, the NCIS will contribute to a reduction in preventable death and injury. The aim of the NCIS Drugs Module project is to enhance the amount, consistency, accessibility and timeliness of data available on the role of drugs and alcohol in coronial deaths around Australia. This will be achieved by enhancing the information already available in the core data set of the NCIS to provide better information on drug-related deaths. The NCIS Drugs Module project is currently being implemented.
Collection methodology	Coronial files, police, toxicology and pathology reports.
Scope (theoretical coverage of relevant population)	All states and territories, excluding Queensland, from 1 July 2000, Queensland data from 1 January 2001.
Coverage (actual)	All deaths referred to a coroner.
Geographic coverage	Australia.
Frequency/timing	Data is uploaded to the NCIS from coronial jurisdictions and related organisations on a daily or weekly basis.
Basic collection count (i.e. treatment episodes, separations etc.)	Deaths referred to a coroner.
Does the collection include a unique client identifier or statistical linkage key?	No. However, name, address and date of birth are collected (though access is restricted).
Data content (list of all data items)	Case demographics including name, age, dates of birth and death, country of birth, marital status, place of usual residence, employment status and occupation; cause of death details including incident information, classification of intent, and classification of injury, location of incident leading to the death and activity being undertaken prior to the incident, ICD–10 coding of cause of death to be provided by ABS. The narrative of events obtained from police summary of circumstances, the coroner's finding, autopsy reports and toxicology reports are available in full text.
Has there been variation over time in any of the above descriptors for this collection?	Data definitions have been developed for system elements which has improved the analysability of the system over time.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	A drug-related death is defined as: any death which is caused wholly or partly, directly or indirectly, by one or more drugs, poisons and/or alcohol, being: • Any case in which positive toxicology is reported and is mentioned by the coroner as contributing to the death; or • Any case in which there is either no or negative toxicology but there is: – A known history of drug/poison/alcohol abuse; or – Any other reason for the pathologist and/or coroner to believe the death may have been related to one or more drugs, poisons or alcohol.

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Substance use (continued)	Coding for drugs (including alcohol and pharmaceuticals): P01 (Alcohol), P02 (Amphetamine), P03 (Cannabis), P04 (Heroin), P05 (Methadone), P98 (Other specified – including multiple substances), & P99 (Unspecified drugs–including alcohol and pharmaceuticals).
Mental health status	Not routinely collected. May be documented in full text reports.
Comorbidity	Not collected. May be collected in full text reports
Age	'Age at death' is defined as 'the age of the deceased person at time of death'. 'Date of birth' is defined as 'the date of birth of the deceased person'.
Sex	'Sex' is defined as 'the sex of the person', response codes are 'male', 'female', 'still enquiring' and 'unlikely to be known'. The latter categories are provided for when it is not yet possible for the sex to be determined (e.g. because of the state of the remains).
Cultural and linguistic diversity	'Country of birth' is defined as 'the country in which the deceased person was born'. 'Years in Australia' is defined as 'length of time in years that the deceased resided in Australia'.
Indigenous status	'Indigenous origin' is defined as 'An indigenous person is a person of Aboriginal or Torres Strait Islander descent who was identified as an Aboriginal or Torres Strait Islander and was accepted as such by the community in which he or she lived (High Court of Australia in Commonwealth V Tasmania (1983) 46 ALR)'. Coding options include: Aboriginal not Torres Strait Islander origin; Torres Strait Islander not Aboriginal origin; Both Aboriginal and Torres Strait Islander origin; Neither Aboriginal nor Torres Strait Islander origin; Still enquiring; Unlikely to be known. Indigenous origin information is entered into the NCIS, although access to this data must be separately approved by a relevant Indigenous body.
Geographic location of respondent	'Country', 'postcode', 'state', 'street' and 'suburb' provided for 'body found', 'death', 'incident', 'last seen alive' and 'residential address'. ASGC codes for residence to be sourced from ABS in the future.
Geographic location of agency or other relevant unit residence	See above.
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Marital status is defined as 'the marital status of the deceased at the time of death'. Coding options include: never married; widowed; divorced; separated; married (including de facto); still enquiring; unlikely to be known.
Indicators of social participation (e.g. labour force status, education status)	Employment status is defined as 'the employment status of the deceased'. Coding options include: child not at school; student; employed; unemployed; home duties; retired/pensioner; other (specify); prisoner; still enquiring; unlikely to be known. Occupation is coded as a free text field. ASCO codes to be sourced from the ABS in the future.
Treatment outcomes	—
Collection management agency	Victorian Institute of Forensic Medicine
Title/name of contact	Manager / Ms Jessica Pearse
Address	National Coroners Information System, Victorian Institute of Forensic Medicine, 57–83 Kavanagh Street, Southbank, VIC 3006.
Email	ncis@vifm.org
Internet	www.ncis.org.au
Phone/fax	(03) 9684 4414 / (03) 9682 7353

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Data custodian/access	The Australian Coroners retain ownership of the information in the database. Access to data is limited to nominated death investigation personnel and authorised third party users approved by the Victorian Department of Justice Ethics Committee and the Western Australian Coronial Ethics Committee (if access to identifying Western Australian data is required).
Funding agency	The NCIS is funded by the Australian Government and state/territory governments to cover operational costs. A user pays systems is applicable for access by third party users.
Output	Output is provided by a web enquiry interface over Internet connections to approved users. MUNCCI can also provide CD-based data extracts and research reports on requested topics.
References (for preparing this template)	NCIS Website – general material Data Dictionary for the National Coroners Information System (NCIS) Version 1, May 2001. Monash University National Centre for Coronial Information (MUNCCI) 2003. Annual Report 2002–2003. Victoria: MUNCCI.
When will data from this reference period/survey be available?	Data is available on application. There are currently no published reports relating to deaths due to drug use or mental health conditions.
Other comments	Authorised users of the NCIS will be required to enter into an NCIS Access Agreement that governs the use of NCIS data. The access rules have been determined by State and Chief Coroners of participating jurisdictions and have been endorsed by the Standing Committee of Attorneys-General. The rules provide for two levels of access to completed cases: Level 1 – all data; Level 2 – potentially-identifying data only. Compliance with the NCIS Privacy Protocols is a term of the Access Agreement. The NCIS Privacy Protocols are contained in Schedule 8 to the Agreement. This collection has real potential as an outcome measurement tool.

33 Australian Longitudinal Study on Women's Health (ALSWH)

Data source (title)	Australian Longitudinal Study on Women's Health (ALSWH)
Brief description	A longitudinal study looking at three cohorts over 20 years to explore the health of Australian women across the lifespan. A wide range of health and health-related issues are explored, including biological, psychological, social and lifestyle factors as well as use and satisfaction with health care services.
Purpose(s)	To determine the social, psychological, biological and environmental factors which determine good health, and those which cause ill health, in women throughout adult life. To provide an evidence base that contributes to the development of policy and practice that meets the needs of all Australian women.
Collection methodology	A random sample of women were selected from the Medicare database and were recruited into three cohorts (18–23; 45–50; and 70–75). Each cohort is surveyed every three years. Participants receive a questionnaire which they complete and send back to the study team. Telephone interviews are available for non-English-speaking respondents or when requested. Reminder letters, information brochures and newsletters are distributed regularly and a freecall number is available to participants for inquiries.
Scope (theoretical coverage of relevant population)	Urban, rural and remote areas.
Coverage (actual)	Younger survey 3–9,074 Mid-age survey 3–11,229 Older survey 3–8,647
Geographic coverage	All states and territories, Australia.
Frequency/timing	Each cohort is surveyed once every three years on a rolling basis.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of people (women).
Does the collection include a unique client identifier or statistical linkage key?	Each case (participant) was awarded a unique identification number at the time of the first survey. This number is used to link data across surveys.
Data content (list of all data items)	Consent is collected from all participants (stored separately). **Younger Survey 3 (aged 25–30 years, 2003):** Health service use (frequency, type, satisfaction, access, possession of Health Care Card, private insurance); medical conditions (e.g. diabetes, cardiovascular problems, low iron, asthma, depression, anxiety, endometriosis, urinary tract infection, sexually transmitted diseases, hepatitis, cancer); symptoms (e.g. allergies, pain, urinary, gastrointestinal & gynaecological symptoms, skin & sleep problems, depression & anxiety; help sought with symptoms, satisfaction with service); health status (SF–36); sexual & reproductive health (e.g. contraception, pregnancy, pap smears, fertility problems); medication use; psychological measures (anxiety & depression scales, revised Life Orientation Test); health-related information (e.g. height, weight, smoking status, alcohol use, non-medical drug use, physical activity, diet); stress (with own & family health & relationships, money, work & study; stressful life events); relationships with others (e.g. abuse, social support, provision of care & use of child care); time use (hours in different activities e.g. paid work, home duties, volunteering; time pressure); future aspirations; life satisfaction; employment (hours, type, security); demographics (sexual orientation, marital status, ATSI status, household composition, educational attainment, occupation, gross income, date of birth, postcode).

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Data content (continued)	**Mid-age Survey 3 (aged 50–55 years, 2001):** Health service use (frequency, type, satisfaction, access, possession of Health Care Card, private insurance); medical conditions (e.g. diabetes, cardiovascular problems, low iron, asthma, arthritis, osteoporosis, chronic fatigue syndrome, depression, anxiety, sexually transmitted diseases, HIV/AIDS, hepatitis, cancer); symptoms (e.g. allergies, pain, urinary, gastrointestinal & gynaecological symptoms, flushes; skin, hearing, eye & sleep problems; depression, anxiety & poor memory; help sought with symptoms, satisfaction with service); health status (SF–36); sexual & reproductive health (e.g. contraception, pap smears, fertility problems, menopause status); surgical procedures (gynaecological, breast & cosmetic surgery, cholecystectomy, endoscopy); medication use; psychological measures (depression & control scales); health-related information (e.g. height, weight, smoking status, alcohol use, physical activity, diet); stress (with own & family health & relationships, money, work & study; stressful life events); relationships with others (e.g. social support, local neighbourhood, provision of care & need for personal care); time use (hours in different activities e.g. paid work, home duties, volunteering; time pressure); life satisfaction; employment (hours, type); demographics (sexual orientation, marital status, ATSI status, household composition, occupation, gross income, date of birth, postcode). **Older Survey 3 (aged 76–81 years, 2002):** Health service use (frequency, type, satisfaction, access, private insurance); medical conditions (e.g. diabetes, cardiovascular problems, low iron, asthma, arthritis, osteoporosis, depression, anxiety, Alzheimer's Disease or dementia, cancer); symptoms (e.g. allergies, pain, urinary & gastrointestinal symptoms, skin problems, anxiety, poor memory, clumsiness, dizziness; help sought with symptoms); health status (SF–36); surgical procedures (endoscopy, eye, skin, knee, hip & heart survey, prolapse repair); medication use; psychological measures (memory, depression & control scales); sleeping problems; falls & accidents; daily living (e.g. mobility, access to transport, eyesight and hearing problems, ability to shop & cook); need for care or assistance; health-related information (e.g. height, weight, alcohol use, physical activity); stressful life events; relationships with others (e.g. social support, abuse, provision of care); demographics (marital status, ATSI status, household composition, gross income, source of income, housing type, date of birth, postcode).
Has there been variation over time in any of the above descriptors for this collection?	Yes. The changes between surveys that pertain to mental health and substance use are: **Younger cohort:** Postnatal depression, depression, anxiety were added to the medical conditions list at Survey 2 and remained for Survey 3. Depression, anxiety attacks (panic attacks) and palpitations were added to the symptoms list at Survey 2 and remained for Survey 3. A depression scale was added at Survey 2 and remained for survey 3. An anxiety scale was added at Survey 3. At Survey 1 women were asked about any medication prescribed by a doctor, bought over the counter, or taken for a long-term illness. At Survey 2 and 3 this was extended to: prescription medications for nerves, sleep, deprivation, 'other' prescribed medication, and/or any over-the-counter medication. At Survey 2 and 3 a measure of drug use for non-medical purposes was included. This measured age at first use, use in the last 12 months, and 'ever' used for; marijuana; analgesics (not in Survey 3); amphetamines; LSD; natural hallucinogens; tranquillisers; cocaine; ecstasy; inhalants; heroin; barbiturates; steroids (not in Survey 3). At Surveys 2 and 3, respondents were also asked if they had ever injected drugs, shared a needle and used any of the listed drugs in combination with alcohol or marijuana.

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Has there been variation over time in any of the above descriptors for this collection? (continued)	**Mid-age cohort:** Depression, anxiety and 'other' psychiatric disorders were added to the medical conditions list at Survey 2 and remained for Survey 3. Depression and anxiety were added to the symptoms list at Survey 2, and were included at Survey 3 as depression and 'episodes of intense anxiety'. At Survey 3, heart palpitations and poor memory were added to the symptoms list. A depression scale was added at Survey 2 and remained for Survey 3. At Survey 1 women were asked if they had taken medication prescribed by a doctor or over-the-counter medication; and if they had taken medication to help with nerves, sleep or chronic illness/condition. At Survey 2, women were asked the same questions about medication, with one additional question that asked about medication for depression. At Survey 3 women were asked if they had taken medication for nerves, stress, sleep, fatigue, depression, menopause, pain, arthritis, a chronic illness or condition, digestive/bowel or skin problems. **Older cohort:** Depression, anxiety disorder and Alzheimer's Disease or dementia were added to the medical conditions list at Survey 2, and remained for Survey 3. Anxiety/panic attacks were added to the symptoms list at Survey 2 and remained for Survey 3. A depression scale was added at Survey 2 and was replaced with an anxiety/depression scale at Survey 3. At Survey 1 women were asked if they had taken medication prescribed by a doctor or over-the-counter medication; and if they had taken medication for nerves, sleep or chronic illness/condition, or if they had taken hormone replacement therapy. At Survey 3 the medication list included medication for: hypertension, arthritis, pain, heart problems, asthma, osteoporosis, nerves, to help sleep, fatigue, depression, digestive/bowel problems, skin problems, diabetes, hormone replacement therapy, and chronic illness or conditions. Women were also asked how many different types of medication (prescribed or recommended by a doctor) they had taken in the previous four weeks. Women were not asked about smoking at Survey 3.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	**(YS3 & MS3)** Tobacco use (includes questions about): • how often • quantity (per day/week) • age when first started. **(YS3 & MS3)** Alcohol use (includes questions about): • how often **(& OS3)** • usual number of standard drinks in a day **(&OS3)** • how often 5 or more standard drinks on one occasion • types of alcohol consumed. **(YS3)** Illicit drug use—ever used, at what age and used in last 12 months for the following drug type 'marijuana', 'amphetamines', 'LSD', 'natural hallucinogens', 'tranquillisers', 'cocaine', 'designer drugs', 'inhalants', 'heroin', 'barbiturates'. **(YS3)** Injecting drug use—including 'injected yourself with illegal drugs' and 'shared a needle'. **(YS3)** Polydrug use.

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Mental health	**(YS3, MS3 & OS3)** Diagnosed or treated for—In YS3 coding options include 'postnatal depression', 'depression (not postnatal)' and 'anxiety disorder'. In the MS3, coding options include 'depression', 'anxiety/nervous disorder' and 'other psychiatric disorder'. In OS3 coding options include 'depression' and 'anxiety/nervous disorder'. **(YS3, MS3 & OS3)** Have, seek treatment for and satisfaction with treatment—coding options include 'depression' and 'episodes of intense anxiety'. In OS3 had sought treatment for coding option includes 'anxiety/panic attacks'. **(YS3, MS3)** Medications used—coding options include 'prescription medication for your nerves' and 'prescription medication for depression'. In the MAS4 further coding options include 'for nerves/anxiety/worry' and 'for stress (difficulty coping)'. In OS3 coding options include 'for nervous/anxiety/worries' and 'for depression'. **(YS3, MS3 & OS3)** How are you feeling —series of mental health indicators that form part of the SF–36 include: did you feel full of life, have you been a very nervous person, have you felt so down in the dumps that nothing can cheer you up, have you felt calm and peaceful, did you have lots of energy, have you felt down, did you feel worn out, have you been a happy person, did you feel tired. **(YS3 & MS3)** Current approach to life—series of mental health indicators revised from the Life Orientation Test, including: in uncertain times I usually expect the best, if something can go wrong for me it will, I'm always optimistic about my future, I hardly ever expect things to go my way, I rarely count on good things happening to me, overall I expect more good things to happen to me than bad. **(YS3 & MS3)** Stress—level of stress for a number of life areas including health, work/employment, money, relationships etc. **(YS3 & OS3)** Health and how you are feeling—series of mental health indicators from an anxiety and depression scale. Items include: have you felt keyed up or on edge; have you been worrying a lot; have you been irritable; have you had difficult relaxing; have you been sleeping poorly; have you had headaches or neck aches; have you had any of the following: trembling, tingling, dizzy spells, sweating, diarrhoea or needing to pass urine more often than usual; have you been worried about your health; have you had difficulty falling asleep. In OS3 there are more coding options: have you felt keyed up or on edge; have you been worrying a lot; have you been irritable; have you had difficulty relaxing; have you been sleeping poorly; have you had headaches or neck aches; have you had any of the following: trembling, tingling, dizzy spells, sweating, diarrhoea or needing to pass urine more often than usual; worried about your health; difficulty falling asleep; lacking energy; lost interest in things; lost confidence in yourself; felt hopeless; difficulty concentrating; lost weight due to poor appetite; waking early; slowed down; feel worse in the mornings. **(YS3 & MS3)** Felt and behaved—series of mental health indicators that are a short form of the CES-D, which measures depression. Items include: I was bothered by things that don't usually bother me; I had trouble keeping my mind on what I was doing; I felt depressed; I felt that everything I did was an effort; I felt hopeful about the future; my sleep was restless; I was happy; I felt lonely; I could not get going; I felt terrific. **(MS3)** Consultations for own health—coding options include 'counsellor/ psychologist/social worker'. **(OS3)** Groups sought advice or help from—coding options include 'counsellor or other mental health services'.
Comorbidity	Yes, can be derived using the information collected for substance use and menta health status.
Age	(YS3, MS3 & OS3) Date of birth.
Sex	Female.
Cultural and linguistic diversity	—

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Indigenous status	(YS3) Mappable to NHDD: no, yes Aboriginal, yes Torres Strait Islander (mark all that apply). [At Survey 1 all three groups (younger, mid-age and older) were asked if they were of Aboriginal or Torres Strait Islander origin. Therefore it is possible to identify Indigenous status for the mid-age and older groups by using data from Survey 1.]
Geographic location of respondent	(YS3, MS3 & OS3) Postcode of residence.
Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	(YS3 & MS3) Number of children (live births). (YS3, MS3 & OS3) Marital status (mappable to NCSDD): never married; married; de facto; separated; divorced; widowed. (YS3) Household composition: I live alone; self and partner/spouse only; self and partner/spouse with child or children; self with child or children; self and own parent/s; self and other adults; other. (MS3) coding options: partner or spouse; children under 16 years; children 16–18 years; children over 18 years; your parents or in-laws; other adult relatives; other adults. (OS3) coding options: no one, I live alone; spouse or partner; own children; other family members; non-family members. Average gross income. (OS3) Source of retirement funding. (OS3) Residential setting—house; flat/unit/apartment/villa/townhouse; mobile home/caravan/cabin/houseboat; retirement village/self-care unit; nursing home; hostel; other.
Indicators of social participation (e.g. labour force status, education status)	(YS3 & MS3) Type of paid work—codes include: paid shift work; paid work at night; paid work from home; self-employment; paid work in more than one job; casual paid work; paid work involving none of the above; I don't do any paid work. (YS3) Highest educational qualification—no formal qualifications; year 10 or equivalent; year 12 or equivalent; trade/apprenticeship; certificate/diploma; university degree; higher university degree. (YS3 & MS3) Current occupation. (MS3) Partner's current occupation. (YS3 & MS3) Participation in selected activities—paid work; home duties; work without pay; looking for work; unpaid voluntary work; active leisure; passive leisure; studying.
Treatment outcomes	—
Collection management agency	The Research Centre for Gender and Health at the University of Newcastle, and the University of Queensland
Title/name of contact	Deborah Loxton
Address	Australian Longitudinal Study on Women's Health, The University of Newcastle, Callaghan, NSW 2308.
Email	whasec@mail.newcastle.edu.au
Internet	http://www.newcastle.edu.au/centre/wha
Phone/fax	(02) 4923 6872 / (02) 4923 6888
Data custodian/access	Information not provided.
Funding agency	DoHA and the Office of the Status of Women

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Output	Women's Health Australia: what do we know? What do we need to know? Progress on the Australian Longitudinal Study of Women's Health 1995–2000. The Australian longitudinal study on women's health: data book for survey 3 of the older-age cohort 2001 (75–80 years). The Australian longitudinal study on women's health: data book for survey 3 of the mid-age cohort 2001 (50–55 years). Young A, Powers J with assistance from Brotherson R. Australian women and alcohol consumption—preliminary report (for the Alcohol Substance Misuse and Injury Prevention Section of DoHA).
References (for preparing this template)	Women's health Australia: the Australian Longitudinal Study on Women's Health annual report 2003. Women's health Australia: third survey for young women, March 2003. Women's health Australia: third survey for mid-age women, March 2001. Women's health Australia: third survey for women over 70, 2002.
When will data from this reference period/survey be available?	Data are currently available for the third survey for young women and the third survey for women over 70.
Other comments	Examples of mental health/substance use projects/papers that have been produced using data from the ALSWH: Who experiences poor mental health? (project funded by the Australian Government Department of Health and Ageing). Stress, health behaviours and the transition to adulthood among young women (University of Newcastle). Mishra GD, Brown WJ & Dobson AJ 2003. Physical and mental health: changes during menopause transition. Turner C, Russell A & Brown W 2003. Prevalence of illicit drug use in young Australian women, patterns of use and associated risk factors. Hillier L, DeVisser R, Kavanagh A & McNair R 2003. The association between drug use and sexuality in young women. Outram S, Murphy B & Cockburn J (in press). Factors associated with accessing professional help for psychological distress in midlife Australian women. Outram S, Murphy B & Cockburn J (in press). The role of general practitioners in treating psychological distress: a study of midlife Australian women.

34 Kids Help Line Statistics (KHLS)

Data source (title)	Kids Help Line Statistics (KHLS)
Brief description	Kids Help Line is a confidential counselling service for children and young people age 5–18 years. Data obtained from phone calls and web and email counselling can be made available to assist research into youth problems and needs, including alcohol, drug and mental health issues.
Purpose(s)	The purpose of the help line is to provide confidential counselling service for young people. One of the key goals of the services is to collect, analyse and disseminate non-identifying information which contributes to research and reflects the issues and problems of Kids Help Line's clients.
Collection methodology	When a call is received by Kids Help Line through their free national telephone counselling service, the Help Line counsellor completes an electronic information sheet based on information that is provided throughout the counselling session. Callers are made aware of their right to confidentiality and can choose to withhold information or refuse it from being collected. Children and young people are also able to access Kids Help Online, via email or web-based counselling (in a chat room setting).
Scope (theoretical coverage of relevant population)	All callers who call Kids Help Line national phone counselling services and who access Kids Help Online email and web-counselling services.
Coverage (actual)	Received 1.1 million phone calls, answered 523,825 in 2003 (response rate 42%). Responded to 13,462 online counselling contacts (6,108 web-counselling and 7,354 emails).
Geographic coverage	All states and territories, Australia.
Frequency/timing	Nationally ongoing since May 1993.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of phone calls; number of emails; number of web-counselling sessions.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Transaction number (id for each call); date call received; start time of call; client's name/alias; city/town where client is calling from; client's postcode location; regional classification; sex of caller; age of caller; where client is contacting from; how did the caller hear about Kids Help Line; school status; ethnic background of client; who client is currently living with; marital/relationship status of client's parents; client's source of income; clients call sequence; agency client referred to; number of minutes spent talking to client; problem class; main reason/problem client called about; problem severity; secondary reason/problem client called; problem severity of the secondary problem; counsellor code; state client is calling from; outcomes of the call with the client; duty of care arrangements; contract to call back; outcome action; does the client self-injure.
Has there been variation over time in any of the above descriptors for this collection?	Information not provided.
Are there any proposed developments relating to comorbidity in the near future for this collection?	Information not provided.
Definitions—how are the following concepts addressed and/or defined?	

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Substance use	Problem class—coding options include: drug and alcohol use. Main reason/problem client called about—coding options include: alcohol use; and drug use. Severity of alcohol use problem—codes include: concerned about friend/other; caller experimenting/occasional use; concerned about behaviour while drunk; caller using frequently or bingeing; constant use/alcoholism—needs referral. Severity of drug use problem—codes include: seeking information; concerned about friend/other; caller experimenting/using occasionally; caller using frequently/habitually; urgent interview/referral required. Referral—coding options include: drug and alcohol counselling.
Mental health status	Problem class—coding options include: health problems; emotional problems. Main reason/problem client called about—coding options include: mental health; and suicide. Severity of mental health problem—codes include: seeking information; concerned about/caring for significant other; mild or occasional symptoms or concerns; clinically diagnosed mental health issue; severe distressed/major effects on life. Severity of suicide as a problem—codes include: seeking information; concerned about another person; suicidal thoughts or fears; immediate intention; current attempt at time of call.
Comorbidity	Yes, using a proxy of the above items. (Up to two problems are recorded only.)
Age	Age (in years).
Sex	Male, female.
Cultural and linguistic diversity	Ethnic background of client: Anglo-Australian; Indigenous Australian—Aboriginal; Indigenous Australian-Torres Strait Islander; Non-English-speaking background; other.
Indigenous status	As above for ethnic background.
Geographic location of respondent	City/town where client is calling from. Client's postcode location (regional classification then calculated using postcode). State client is calling from.
Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Living arrangements (coding options include residential setting codes). Length of time living in current living arrangements. Marital/relationship status of client's parents. Income source.
Indicators of social participation (e.g. labour force status, education status)	School status.
Treatment outcomes	—
Collection management agency	Kids Help Line
Title/name of contact	Senior Research Officer / Ian Thomas
Address	PO Box 376, Red Hill, QLD 4059.
Email	admin@kidshelp.com.au

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Internet	www.kidshelp.com.au
Phone/fax	(07) 3369 1588 / (07) 3367 1266
Data custodian/access	Kids Help Line retains intellectual property rights over data and generally will not supply raw data. Data summaries are available on request. Fixed costing exists for simple requests with costing for more complex requests to be negotiated.
Funding agency	The KHLS is funded by Boystown Lotteries, individual donations, fundraising events, trusts, various state and federal government funding, and supported by Optus.
Output	Kids Help Line 2003. Statistical Summary 2003. Infosheet 2. Most recent Infosheets: Infosheet 26: Callers from rural and remote Australia Infosheet 27: Online counselling.
References (for preparing this template)	Kids Help Line Phone Data: variable descriptions and definitions. Kids Help Line: Problem classification and severity code definitions. Kids Help Line Infosheet 2: Statistical Summary 2003.
When will data from this reference period/survey be available?	Information not provided.
Other comments	KHLS is currently helping the Australian National Council on Drugs on their 'Young people and drugs' research project, by asking young people to complete a survey about what they think about drug and alcohol use. KHLS has also been allocated funding from NSW Health to provide alcohol and other drug information, counselling, referral and other support to young people in NSW.

35 Lifeline Statistics

Data source (title)	Lifeline Statistics (Call Database–Client Service Management Information System)
Brief description	The Call Database records information about the people who call Lifeline's national phone counselling service
Purpose(s)	The main purpose for capturing data relating to calls received through Lifeline's National phone counselling service is to profile callers, to provide health and welfare government and non-government agencies with insights into population wellbeing as well as identify local and regional variations in caller needs and service usage and promote awareness of social trends and changing priorities.
Collection methodology	When a call is received by Lifeline through their national counselling phone number, the Lifeline counsellor completes a tally sheet of non-identifying information about the caller. This information is then entered into Lifeline's 'Client Service Management Information System'. The majority of information is collected/guessed throughout the duration of the call (i.e. assumptions are made).
Scope (theoretical coverage of relevant population)	All callers who call Lifeline's phone counselling service. Callers are able to contact Lifeline numerous times; therefore it is not possible to get a true indication of the number of people accessing the service.
Coverage (actual)	398,206 calls were received during the 2002–03 reporting period. Information collected from 42 centres across Australia.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Ongoing since July 2001.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of phone calls.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Caller focus; referral source; call issue; called Lifeline before—how often; called Lifeline before—how long; referrals general; referrals specific; relationship status; caller's own suicidality; bereavement following a suicide; third party possibly at risk; mental health under the care of; mental health called at suggestion of; mental health concerned about; time of call; support systems; age; postcode and suburb of where the call was made; sex; length of call.
Has there been variation over time in any of the above descriptors for this collection?	The system has been operational since 2000. There has been an increase in the number of phone calls relating to mental health over this time. Research on changes over the last 4 years is planned.
Are there any proposed developments relating to comorbidity in the near future for this collection?	The data system should provide easier statistical reporting of comorbidity.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Call issue—coding options include: drug misuse; problem drinking. Referrals general—coding options include: drug and alcohol referral. Recent experiences—coding options include: drinking or drug problems. Professional help the caller has received—coding options include: substance misuse.
Mental health	Referral source (what made them call)—coding options include: psychiatrist. Call issue—coding options include: war trauma; mental health issue; stress/trauma reaction; caller's suicidality; post-caller's suicidality. Referrals general—coding options include: mental health referral.

(continued)

Mental health (continued)	Recent experiences—coding options include: anxiety; depression; eating problems; mood swings; reaction to traumatic incident; other mental health problems. Professional help the caller has received—coding options include: manic depression (bipolar); depression; dementia; eating disorder; general anxiety disorders; panic attacks/phobias; post-traumatic stress disorder; personality disorder; schizophrenia; other mental health.
Comorbidity	A proxy can be derived for comorbidity based on information collected on substance use and mental health. (Up to two call issues are recorded only.)
Age	Estimated age, reported as: 0–14, 15–19, 20–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, 85+.
Sex	Male, female.
Cultural and linguistic diversity	—
Indigenous status	—
Geographic location of respondent	State where call was made. Region where call was made: rural or metropolitan.
Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Relationship status—code list includes: divorced; married; partnered; separated; single; widowed; unknown.
Indicators of social participation (e.g. labour force status, education status)	—
Treatment outcomes	—
Collection management agency	Lifeline Australia
Title/name of contact	Cath Blunt
Address	PO Box 173, Deakin West, ACT 2600.
Email	cath.blunt@lifeline.org.au
Internet	www.lifeline.org.au
Phone/fax	(02) 6215 9430 / (02)6282 6566
Data custodian/access	Lifeline Australia
Funding agency	Lifeline Australia and the DoHA
Output	Bruce Turley (Lifeline Australia) 2004. A report on Lifeline calls 2002–03. March 2004.
References (for preparing this template)	Bruce Turley (Lifeline Australia) 2004. A report on Lifeline calls 2002–03. March 2004. 2004. Lifeline Calls: an insight into community concerns. Profile No. 1. August. CSMIS Program codes file (July 2004). Telephone counselling service–CSMIS program user manual (June 2003).
When will data from this reference period/survey be available?	Data currently available, requests for data are to be made through Lifeline Australia.
Other comments	—

36 Outpatient Care National Minimum Date Set (OC NMDS)

Data source (title)	(OC NMDS)
Brief description	A national minimum data set for outpatient care.
Purpose(s)	To describe outpatient care activities.
Collection methodology	Data are collected at hospital level, and then state and territory health authorities provide the OC NMDS data to the AIHW for national collation on an annual basis.
Scope (theoretical coverage of relevant population)	Services provided to non-admitted, non-emergency department patients registered for care in outpatient clinics of public hospitals that are classified as either Peer Group A or B (principal referral and specialist women's and children's hospitals and large hospitals) as reported in the AIHW's *Australian Hospital Statistics* publication for the preceding financial year. Includes all arrangements made to deliver specialist care to non-admitted patients whose treatment has been funded through the hospital, regardless of the source from which the hospital derives these funds. In particular, DVA, compensable and other patients **funded through the hospital** (including Medicare ineligible patients) are included. Also includes outreach services which are funded through acute hospitals, and provided to the patient in the home, place of work or other non-hospital site. Excluded from scope are: • Services provided through community health settings (such as community and child health centres) • Outreach services which are not funded through the acute hospital and/or which deliver non-clinical care (activities such as home cleaning, meals on wheels, home maintenance) • All private specialist services delivered under private practice arrangements which are not funded through the hospital, regardless of whether or how these services may be funded by third party arrangements. • All services covered by OC NMDS for: o Admitted patient care o Admitted patient mental health care o Alcohol and other drug treatment services o Community mental health care o Non-admitted patient emergency department. Though admitted patient services are excluded from scope, outpatient services booked for reasons independent of or distinct from the admitted patient episode are in scope.
Coverage (actual)	Unknown. Data not provided until 31 December 2006.
Geographic coverage	All states and territories, Australia.
Frequency/timing	State and territory health authorities provide the data to the DoHA and AIHW on an annual basis by 31 December each calendar year, for the previous financial year.
Basic collection count (i.e. treatment episodes, separations etc.)	Occasions of service. Group sessions. Aggregate-level data only will be provided initially, with progression toward patient-level data occurring within the 2003–08 period.
Does the collection include a unique client identifier or statistical linkage key?	Not collected.
Data content (list of all data items)	**Agency-related data elements:** Establishment identifier, version 4 (NHDD V12) comprising:

(continued)

Data content (continued)	Australian state/territory identifier, version 4 (NHDD V12 Supplement) Establishment number, version 4 (NHDD V12) Establishment sector, version 4 (NHDD V12 Supplement) Region code, version 2 (NHDD V12). **Patient-related data elements:** Occasions of service, version 2 (NHDD V12) Group sessions (NHDD V12) Outpatient clinic type (new data element). **Patient-related data element concepts:** Non-admitted patient (NHDD V12) Non-admitted patient service mode (NHDD V12) Individual/group session (NHDD V12) Outpatient clinic services (New data element concept).
Has there been variation over time in any of the above descriptors for this collection?	New collection.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Not collected.
Mental health status	Not collected.
Comorbidity	Not collected.
Age	Not collected.
Sex	Not collected.
Cultural and linguistic diversity	Not collected.
Indigenous status	Not collected.
Geographic location of respondent	Not collected.
Geographic location of agency or other relevant unit	Not collected.
Treatment types	Not collected but the 'Outpatient clinic type' data element may provide some information on possible type of treatment. Note: there are no psychiatric or drug and alcohol clinics within the scope of the OC NMDS.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Not collected.
Indicators of social participation (e.g. labour force status, education status)	Not collected.
Treatment outcomes	Not collected.
Collection management agency	AIHW
Title/name of contact	Head, Hospitals and Mental Health Services Unit / Ms Jenny Hargreaves
Address	GPO Box 570, Canberra, ACT 2601.
Email	jenny.hargreaves@aihw.gov.au
Internet	www.aihw.gov.au
Phone/fax	(02) 6244 1121 / (02) 6244 1299
Data custodian/access	AIHW
Funding agency	AIHW

(continued)

Output	None as yet. Possibly in *Australian Hospital Statistics 2005–06* to be released in May 2007.
References (for preparing this template)	Draft of NMDS Submission to Statistical Information Management Committee.
When will data from this reference period/survey be available?	First data delivery is due 31 December 2006.
Other comments	The OC NMDS is scheduled to begin collection from 1 July 2005.

37 National Non-admitted Patient Emergency Department Care Database (NAPEDCD)

Data source (title)	National Non-admitted Patient Emergency Department Care Database—based on the Non-admitted Patient Emergency Department Care National Minimum Data Set
Brief description	A collection of data on non-admitted patient emergency department care.
Purpose(s)	To describe emergency department activities in major public hospitals.
Collection methodology	Data are collected at hospital level, then state and territory health authorities provide the NAPEDCD data to the AIHW for national collation on an annual basis.
Scope (theoretical coverage of relevant population)	Non-admitted patients registered for care in emergency departments in selected public hospitals that are classified as either Peer Group A or B in the AIHW *Australian Hospital Statistic's* publication from the preceding financial year. The care provided to patients in emergency departments is, in most instances, recognised as being provided to 'non-admitted' patients. Patients being treated in emergency departments may subsequently become 'admitted'. The care provided to non-admitted patients who are treated in the emergency department prior to being admitted is included in the NAPEDCD. Care provided to patients who are being treated in an emergency department site as an admitted patient (e.g. in an observation unit, short-stay unit, 'Emergency department ward' or awaiting a bed in an admitted patient ward of the hospital) are excluded from the NAPEDCD since the recording of the care provided to these patients is part of the scope of the Admitted Patient Care National Minimum Data Set.
Coverage (actual)	Unknown. Data for the first year not yet finalised.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Financial years, ending 30 June each year. Extraction of data for a financial year is based on the date of the end of the non-admitted emergency department service episode.
Basic collection count (i.e. treatment episodes, separations etc.)	Non-admitted patient emergency department service episodes.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Agency-related data items: Establishment identifier, version 4 (NHDD V12) comprising: Australian state/territory identifier, version 4 (NHDD V12 Supplement) Establishment number, version 4 (NHDD V12) Establishment sector, version 4 (NHDD V12 Supplement) Region code, version 2 (NHDD V12). Service episode related data items: Area of usual residence, version 3 (NHDD V12) Compensable status, version 3 (NHDD V12) Country of birth, version 4 (NHDD V12 supplement) Date of birth, version 5 (NHDD V12 supplement) Date patient presents, version 2 (NHDD V12) Department of Veterans' Affairs patient, version 1 (NHDD V12) Emergency department arrival mode – transport, version 1 (NHDD V12) Emergency department departure status, version 2 (NHDD V12) Emergency department waiting time to service delivery, version 2 (NHDD V12) Indigenous status, version 5 (NHDD V12 supplement) Length of non-admitted patient emergency department service episode, version 1 (NHDD V12) Person identifier, version 2 (NHDD V12 supplement) Sex, version 4 (NHDD V12 supplement)

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Data content (continued)	Service episode related data items (continued): Time patient presents, version 2 (NHDD V12) Triage category, version 1 (NHDD V12) Type of visit to emergency department, version 2 (NHDD V12). Data element concepts: Emergency department – public hospital, version 1 (NHDD V12) Non-admitted patient emergency department service episode, version 1 (NHDD V12) Patient presentation at emergency department, version 1 (NHDD V12).
Has there been variation over time in any of the above descriptors for this collection?	New collection.
Are there any proposed developments relating to comorbidity in the near future for this collection?	Yes. Information on diagnosis is being considered. This may include items for presenting problem and/or diagnosis.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Presenting problem—this is a new data element relating to an initial diagnosis that is under development. Diagnosis—this is a new data element relating to a final diagnosis that is under development.
Mental health	Presenting problem— this is a new data element relating to an initial diagnosis that is under development. Diagnosis— this is a new data element relating to a final diagnosis that is under development. The classification to be used for both is likely to include categories relevant to substance use (and) relevant to mental health.
Comorbidity	Not yet known. Could be yes if F10–F19 equivalents are included, i.e., Mental and behavioural disorders due to psychoactive substance use.
Age	Date of birth, version 5 (NHDD V12 supplement).
Sex	Sex, version 4 (NHDD V12 supplement).
Cultural and linguistic diversity	Country of birth, version 4 (NHDD V12 supplement).
Indigenous status	Indigenous status, version 5 (NHDD V12 supplement).
Geographic location of respondent	Area of usual residence, version 3 (NHDD V12) State/territory of residence.
Geographic location of agency or other relevant unit	Australian state/territory identifier, version 4 (NHDD V12 Supplement). Region code, version 2 (NHDD V12).
Treatment types	Not collected.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Not collected.
Indicators of social participation (e.g. labour force status, education status)	Not collected.
Treatment outcomes	Not collected.
Collection management agency	AIHW
Title/name of contact	Head, Hospitals and Mental Health Services Unit / Ms Jenny Hargreaves
Address	GPO Box 570, Canberra, ACT 2601.
Email	jenny.hargreaves@aihw.gov.au

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Internet	www.aihw.gov.au
Phone/fax	(02) 6244 1121 / (02) 6244 1299
Data custodian/access	AIHW
Funding agency	AIHW
Output	To be reported in *Australian Hospital Statistics 2003–04*. Release date late May 2005.
References (for preparing this template)	National Health Data Dictionary, Version 12 and Version 12 Supplement. Health Data Standards Committee, February 2005 meeting.
When will data from this reference period/survey be available?	States and territories are required to provide this data by 31 December each year in respect of the previous financial year. The first data will be available late May 2005 in *Australian Hospital Statistics 2003–04*.
Other comments	—

38 Supported Accommodation Assistance Program National Data Collection (SAAP NDC)

Data source (title)	Supported Accommodation Assistance Program National Data Collection (SAAP NDC)
Brief description	The SAAP NDC collects a range of information from all agencies funded under the SAAP. SAAP is Australia's major program response to the needs of people who are homeless or at risk of being homeless. The overall aim of the program is to provide transitional supported accommodation and related support services to help homeless people achieve the maximum possible degree of self-reliance and independence.
Purpose(s)	The SAAP NDC was established so that reliable, nationally consistent information about SAAP would be available to SAAP program administrators, service providers and other interested organisations. The SAAP NDC aims to provide reliable information about SAAP to agencies and program administrators to assist them in their work so that services for homeless people can be improved. In addition, the collection aims to provide reliable information about SAAP to peak groups, community groups and interested researchers to assist in debates about homelessness.
Collection methodology	[The following information is based on the 2004–05 SAAP collection.] Paper forms for client, casual client and unmet demand for accommodation (information collected at the agency). SAAP Management and Reporting Tool (SMART) (which enables collection and transmission of SAAP NDC). The SAAP NDC comprises a number of different collections: Client collection: collects information on all clients receiving ongoing or substantial support under SAAP. Unmet demand for accommodation collection: operates over a one-week period, twice a year. It is designed to measure the level of unmet demand for SAAP services, and so collects information about the number of people who request SAAP accommodation but, for whatever reason, are not provided with the desired service. Casual client collection: information about one-off types pf assistance provided to casual clients is collected for a two-week period each year. Casual clients are defined as those who receive only one-off assistance requiring less than one hour of a SAAP worker's time and do not establish an ongoing relationship with the agency. Administrative data collection: contains descriptive information (such as the number, size, structure, target group and service delivery model) about the 1,200 or so non-government and community organisations providing accommodation and support services to people who are homeless, in crisis or at risk of becoming homeless.
Scope (theoretical coverage of relevant population)	All SAAP-funded agencies and their clients. People who receive support or assistance from a SAAP-funded agency, are accommodated by a SAAP agency, or enter into an ongoing support relationship with a SAAP agency. Scope for the unmet demand for accommodation collection: potential clients who are turned away.
Coverage (actual)	In 2003–04, 1,125 SAAP agencies were required to participate in the SAAP Client collection; of these 92.7% participated.
Geographic coverage	National.
Frequency/timing	Data are reported on a financial year basis since 1996–97. (Collection and transmission of data varies based on which component of data is being collected and how it's being collected.)

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Basic collection count (i.e. treatment episodes, separations etc.)	Number of clients, SAAP closed support periods, SAAP ongoing support periods, SAAP services requested.
Does the collection include a unique client identifier or statistical linkage key?	Yes—alpha code. The alpha code is a 6-letter code used by NDCA (in conjunction with year of birth) to provide estimates of the number of people assisted by SAAP across the country, and how many occasions of support are required, on average, by SAAP clients. The alpha code is made up of: • the second and third letters of the client's first name • the first and second letters of the client's last name • the last letter of the client's last name • M if the client is male or F if the client is female. The year of birth is then added to the end of the alpha code, e.g. HRPSSF1977. The SAAP NDC has approval for implementing the SLK (used in the CSTDA–NMDS) from 1 July 2005.
Data content (list of all data items)	**General client form (2004–05)** Agency number; support period (date commenced and finished); support not ended (at 30 June) flag; consent obtained; alpha code; year of birth of client; source of referral/information; person(s) receiving assistance; gender of client; country of birth; Indigenous status; main language spoken; English proficiency; cultural identity; labour force status before and after support period; main income source before and after support period; student status before and after support period; presenting reasons for seeking assistance; main presenting reason; current period of unsafe, insecure or inadequate housing; location before the period of unsafe, insecure or inadequate housing; type of housing/accommodation immediately before and after this support period; living arrangements immediately before and after this support period; client subject to a legal order or legal processes before or after support; case management/support plan agreed to by the end of the support period; extent the client's case management goals have been achieved by the end of the support period; SAAP/CAP (Crisis Accommodation Program) accommodation provided (type of accommodation and dates of accommodation); support to client. **Accompanying and/or assisted children (from general client form)** Presence of child(ren); alpha code of child; year of birth of child; country of birth of child; number of homes the child has lived in during the past year; age of child; gender of child; support to child. **Demand for accommodation** Agency number; date accommodation sought; contact made; person(s) requesting accommodation; number of adults seeking accommodation in each age group; number of accompanying children under 18 require accommodation with their parent/guardian; how soon accommodation is needed; first time today that the person/group has tried to get accommodation; if tried earlier to get accommodation why were they unsuccessful; was any accommodation offered; was offer of accommodation taken up; reason accommodation offered not taken up; how many of the person/group will your agency accommodate; main reason accommodation not offered; referral for accommodation; Indigenous status; country of birth; offer of one-off assistance. **Casual client collection** Agency name; today's date; person receiving assistance; number of persons aged 18 and over and under 18; gender of primary contact; age of primary contact; assistance provided. **Administrative data collection** NDCA ID; state ID; agency name; auspice name; agency contact details; location (region, SLA, LGA); service delivery model; primary target group; secondary target group; other secondary target group; number of SAAP

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Data content (continued)	accommodation places; funding start date; funding end date; temporary closure and reopen dates; total SAAP recurrent commitments (agency level); total other SAAP recurrent commitments (state/territory level).
Has there been variation over time in any of the above descriptors for this collection?	From 1 July 2004, agencies that were considered 'high volume' (that is, agencies that had a high turnover of clients) switched from using 'high volume' forms which collected only a subset of the SAAP NDC to the 'general client form'.
Are there any proposed developments relating to comorbidity in the near future for this collection?	—
Definitions—how are the following concepts addressed and/or defined?	
Substance use	**General client form** Presenting reasons for seeking assistance: 'drug/alcohol/substance abuse'—should be selected if the client was homeless or sought assistance as a result of his/her drug or alcohol related problem. This does not include a situation in which the client sought assistance as a result of drug or alcohol abuse by another person. Main presenting reason: 'drug/alcohol/substance abuse'—as defined above. Type of housing/accommodation immediately before and after support period: 'detoxification unit/rehabilitation centre'—refers to a public or private institution for the care, treatment and/or rehabilitation of patients with drug or alcohol related conditions. Support to client: 'drug/alcohol support or intervention'—refers to support and assistance specifically to address problems related to the client's drug or alcohol abuse.
Mental health	**General client form** Source of referral: 'psychiatric unit'—includes information and referrals from dedicated psychiatric hospitals and psychiatric units. Presenting reasons for seeking assistance: 'psychiatric illness'—should be selected if the client was homeless or sought assistance as a result of his/her psychiatric problem. This does not include a situation in which the client sought assistance as a result of another person's psychiatric problem. Main presenting reason: 'psychiatric illness'—as defined above. Type of housing/accommodation immediately before and after support period: 'hospital/psychiatric institution'—refers to a public or private institution for the medical care and treatment or patients with psychiatric conditions. Support to client: 'psychiatric services'—refer to support or assistance from a qualified psychiatrist.
Comorbidity	Yes, can be derived from the substance use and mental health status data items.
Age	**General client form**: year of birth. (Date of birth piloted October 2004). **Demand for accommodation**: Adults seeking accommodation: under 12 years, 12–14, 15–17, 18–19, 20–24, 25–44, 45–64, 65 years and over. Accompanying children: under 12 years, 12–14, 15–17. **Casual client form**: 18 and over, under 18.
Sex	M – male, F – female.

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Cultural and linguistic diversity	Country of birth (coded to Australian Standard Classification of Countries for Social Statistics). Main language spoken* (coded to ABS classification). English proficiency*: very well, well, not well, not well at all. Cultural identity* (coded to ABS classification). * These three data items will no longer be collected in the SAAP NDC as of 1 July 2005.
Indigenous status	Codes used: no; yes, Aboriginal person; yes, Torres Strait Islander person; yes, both.
Geographic location of respondent	—
Geographic location of agency or other relevant unit	Region. SLA. LGA.
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Person receiving assistance: person with child(ren); couple with child(ren); person alone or with unrelated person(s); couple without child(ren). Main income source: no income; government payments; other income (each category has a subset of codes). Living arrangements (immediately before and after support period): alone; with both parents; with one parent and parent's spouse/partner; with one parent; with a foster family; with relative(s)—temporary; with relative(s)—long term; with spouse/partner; with spouse/partner and child(ren); alone with child(ren); with friend(s)—temporary; with friend(s)—long term; living with other unrelated persons; other; don't know (codes are mappable to NCSDD data item). Residential setting (immediately before and after support period): (major headings) SAAP/CAP funded accommodation; non-SAAP housing accommodation; institutional setting (each category has a set of subcodes).
Indicators of social participation (e.g. labour force status, education status)	Labour force status: employed full-time; employed part-time; employed casual; unemployed (looking for work); not in labour force; don't know. (Codes are mappable to NCSDD data item.) Student status: not a student; primary/secondary student; post-secondary student/employment training; don't know.
Treatment outcomes	Support to client: provided, referral arranged.
Collection management agency	National Data Collection Agency, AIHW
Title/name of contact	Head, Supported Accommodation and Crisis Services Unit / Mr Justin Griffin
Address	GPO Box 570, Canberra, ACT 2601.
Email	justin.griffin@aihw.gov.au
Internet	http://www.aihw.gov.au
Phone/fax	(02) 6244 1000 / (02) 6244 1199
Data custodian/access	AIHW
Funding agency	FaCS and each state and territory jointly funded the SAAP NDC and the SAAP NDCA as negotiated under the SAAP Act (most recently SAAP IV 2000–2005).
Output	AIHW 2003. Homeless people in SAAP: SAAP National Data Collection annual report 2002–03 Australia. Canberra: AIHW. AIHW 2003. Homeless people in SAAP 2002–03 state/territory tables. Canberra: AIHW. AIHW 2004. Children accompanying homeless clients 2002–03. Canberra: AIHW.

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Output (continued)	AIHW 2004. SAAP NDCA demand for assistance 2002–03 Australia. Canberra: AIHW.
References (for preparing this template)	Client form July 2004 – June 2005. Casual client form 3 March – 16 March 2004. SAAP administrative data collection classification and procedures May 2004. Demand for accommodation form 5 May – 11 May 2004.
When will data from this reference period/survey be available?	It is anticipated that data for 2004–05 will be available from December 2005.
Other comments	Several 'high volume' agencies in New South Wales, Victoria, South Australia and the Northern Territory (mostly those dealing with men) currently do not collect information on presenting reasons and main reason for seeking assistance. These items will be collected from these agencies in the 2004–05 collection (therefore, currently there may be an underestimate of the people seeking assistance because of psychiatric illness or drug/alcohol/substance abuse).

39 Commonwealth–State Housing Agreement National Minimum Data Set (CSHA–NMDS)

Data source (title)	CSHA–NMDS—Public housing and State Owned and Managed Indigenous Housing (SOMIH) 2002–03
Brief description	A set of nationally significant data items agreed for mandatory collection and reporting at the national level under the Commonwealth–State Housing Agreement (CSHA). The CSHA–NMDS is a subset of data from the CSHA Public and State and Territory Owned and Managed Indigenous Housing annual data collections. The collections have been driven by the National Housing Data Agreement (NHDA) framework, which sets out data standards for housing data and a care set of consistent performance indicators for benchmarking. The CSHA–NMDS is stored as part of the National Housing Data Repository at the AIHW.
Purpose(s)	To produce comparable national information on key housing issues reflected in performance indicator reporting
Collection methodology	States and territories provide the AIHW with 4 files containing information on: dwellings, households, persons and person incomes. For each file, the data items are standardised or used to derive new items that are comparable across jurisdictions and amalgamated to a national level.
Scope (theoretical coverage of relevant population)	National information on all households (and members) who received assistance through the public housing or SOMIH programs during the financial year.
Coverage (actual)	Public housing collection—public rental housing tenancies covered by the CSHA. Included are households residing in public rental properties where the property is owned by the state/territory housing authority or leased from the private sector or another housing program area and used for the provision of public rental housing. SOMIH collection—properties where ownership and management reside with the state government and allocation is specifically identified for Indigenous households only. This also includes properties managed by an Indigenous housing government agency for allocation to Indigenous tenants.
Geographic coverage	Public housing collection—all states and territories. SOMIH collection—states only. The Australian Capital Territory was not included because it does not have a separately identified or funded SOMIH program—Indigenous people are housed as part of the public housing program. The Northern Territory was not included because it is not able to differentiate between funding sources—unique funding arrangements exist in there under the Indigenous Housing Authority of the Northern Territory.
Frequency/timing	Annual collection on a financial year basis. However, most data items are collected as a snapshot as at 30 June.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of households; number of people in households; number of dwellings.
Does the collection include a unique client identifier or statistical linkage key?	Variables are used to link data between NMDS data files (state/territory IDs, program type, dwelling ID, household ID and person ID).
Data content (list of all data items)	Dwelling data items: state/territory ID; program type; dwelling ID; dwelling tenantability status; dwelling occupancy status; number of bedrooms; dwelling structure; market rent value of dwelling. Household data items: state/territory ID; program type; dwelling ID; household ID; date assistance commenced; date assistance completed; new allocation status; transfers status; Indigenous household; disability household; market rent value of dwelling; rent charged to tenant; rebated household (flag); rebate amount of household; income—gross (household); income—assessable; number of persons in household. Person data items: state/territory ID; program type; household ID; person ID; income unit ID; sex; age; disability status; Indigenous status; relationship to reference person; relationship within income unit.

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Data content (continued)	Person income data items: state/territory id; program type; household ID; person ID; income unit ID; income—gross (person); income—assessable; income source. For details see Commonwealth–State Housing Agreement User Guide for 2002–03 data.
Has there been variation over time in any of the above descriptors for this collection?	No.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions— how are the following concepts addressed and/or defined?	
Substance use	—
Mental health	Not collected (only disability status of person and households available).
Comorbidity	—
Age	Age in years as at 30 June.
Sex	Sex (male; female; not stated/inadequately described).
Cultural and linguistic diversity	—
Indigenous status	Indigenous status of person (Indigenous; neither Aboriginal nor Torres Strait Islander; not stated/inadequately described). Indigenous household (Indigenous person/s present in household; no Indigenous person/s present in household; not stated/inadequately described).
Geographic location of respondent	Postcode information is collected for dwellings (but not included in the NMDS). The information is used to derive the ASGC categories or remoteness required for performance indicator reporting.
Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Disability status of person; disability status of household; Indigenous status of person; Indigenous status of household; amount of rent charges; relationship within household; gross/assessable income amounts are collected for household and persons; source of income of person.
Indicators of social participation (e.g. labour force status, education status)	—
Treatment outcomes	—
Collection management agency	AIHW
Title/Name of contact	Janice Miller
Address	GPO Box 570, Canberra, ACT 2601.
Email	janice.miller@aihw.gov.au
Internet	http://www.aihw.gov.au/housing/assistance/index.html http://www.aihw.gov.au/housing/assistance/data_collections/index.html
Phone/Fax	(02) 6244 1285
Data custodian/access	David Wilson
Funding agency	AIHW and state/territory housing authorities jointly fund to administer the collection under the CSHA National Housing Agreement..
Output	Commonwealth–State Housing Agreement national data reports 2002–03: public rental housing; Commonwealth–State Housing Agreement national data reports 2002–03: State Owned and Managed Indigenous Housing.

(continued)

References (for preparing this template)	Commonwealth–State Housing Agreement User Guide for 2002–03 data, and reports listed above.
When will data from this reference period/survey be available?	Available. 2003–04 data to be published in 2005.
Other comments	This template covers 2 of 6 housing assistance data collections under the CSHA National Housing Data Agreement. Summary and performance indicators produced by the AIHW also draw information from the National Social Housing Survey of Public Housing Tenants.

40 Commonwealth–State Housing Agreement Community Housing (CSHA–CH)

Data source (title)	Commonwealth–State Housing Agreement community housing collection 2003–04
Brief description	A set of nationally significant data items collected in all Australian jurisdictions relating to the CSHA.
Purpose(s)	To produce comparable national information on key housing issues reflected in performance indicator reporting.
Collection methodology	A combination of methodologies is used—some data are from administrative sources, whilst other are from survey data.
Scope (theoretical coverage of relevant population)	National information on community housing. For the purpose of this collection community housing includes dwellings where: • funding (capital and/or recurrent) is provided fully or partly through the CSHA • the tenancy management functions are undertaken by a community provider or local government • a principle of the community provider is to provide medium-to long-term housing tenure to tenants • it specifically excludes dwellings funded under the CAP.
Coverage (actual)	Survey data are a sample of providers and dwellings (response rate ranged from 49–100% in 2003–04). Administrative data are based on all CSHA community housing data providers and dwellings.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Annual collection conducted since 1999.
Basic collection count (i.e. treatment episodes, separations etc.)	Various—number of households; number of applicants; number of dwellings.
Does the collection include a unique client identifier or statistical linkage key?	No—not a person-based collection.
Data content (list of all data items)	Broad headings for indicators: affordability (4 items); match of dwelling to household size (2); low income (4); special needs (2); priority access to those in greatest need (2); direct cost per unit (4); occupancy rates (2); turnaround time (2); rent arrears (2). Summary data items: number of new households; number of new Indigenous households; new applicants; total applicants; tenantable dwellings; untenantable dwellings; rent charged as a proportion of income ranges; number of households with known income details; number with moderate overcrowding; number with under utilisation; ASGC of dwellings (number in each location). Provider-level data—number of providers with target of: Indigenous; people with a disability; non-English speaking background; under 25; over 54; over 64; over 74; homeless people; those escaping domestic violence; multiple target groups; primary target group not specified; total number of targeted providers. Household-level data (same for targeted and non-targeted providers): number of Indigenous households assisted; number of disability households assisted; number of non-English speaking background households assisted; number with principal tenants under 25; number with principal tenant over 64; number with multiple target groups; number with primary target not specified above; total number in a target group; total number with no specific need. Dwelling descriptors: number of head-leased dwellings (private); number of boarding/rooming/lodging house buildings; number of boarding/rooming/lodging house units; number of boarding/rooming/lodging house rooms.
Has there been variation over time in any of the above descriptors for this collection?	Some variation over time in counting rules and definitions for various items. ASGC replaced RRMA for geographic location of dwellings.

(continued)

Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	National Housing Assistance Data Dictionary v2 is used to define concepts in the collection.
Substance use	—
Mental health	Not collected (only 'disability households' and disability target groups for providers).
Comorbidity	—
Age	—
Sex	—
Cultural and linguistic diversity	—
Indigenous status	Indigenous household numbers and target groups.
Geographic location of respondent	—
Geographic location of agency or other relevant unit	Location of dwelling based on ASGC.
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	'Greatest need' indicator.
Indicators of social participation (e.g. labour force status, education status)	Not collected (however, the National Social Housing Survey does collect labour force status—this is only a sample).
Treatment outcomes	—
Collection management agency	AIHW
Title/name of contact	Kristy Raithel
Address	GPO Box 570, Canberra, ACT 2601.
Email	kristy.raithel@aihw.gov.au
Internet	http://www.aihw.gov.au/housing/assistance/index.html http://www.aihw.gov.au/housing/assistance/data_collections/index.html
Phone/fax	(02) 6244 1158
Data custodian/access	David Wilson
Funding agency	AIHW and state and territory housing authorities jointly fund the collection under the CSHA NHDA.
Output	Commonwealth–State Housing Agreement Data Reports 2003–04: CSHA community housing.
References (for preparing this template)	CSHA Community Housing Data Manual 2003–04, and above report.
When will data from this reference period/survey be available?	2005.
Other comments	Indicators on community housing produced by AIHW also draw information from the National Social Housing Survey, which is a sample of community housing tenants.

41 Commonwealth–State Housing Agreement Home Purchase Assistance (CSHA–HPA)

Data source (title)	Commonwealth–State Housing Agreement home purchase assistance data collection
Brief description	A set of nationally significant data items collected in all Australian jurisdictions relating to the provision of home purchase assistance under the CSHA.
Purpose(s)	To produce comparable national information on key housing issues reflected in outcome reporting.
Collection methodology	Jurisdictions collect aggregate information on home purchase assistance programs in their state or territory, and forward this to AIHW.
Scope (theoretical coverage of relevant population)	CSHA home purchase assistance programs for households in all states and territories.
Coverage (actual)	Existing types of programs vary between jurisdictions. There are 6 main types of programs existing in the following jurisdictions during 2003–04: • Direct lending (Vic, Qld, WA, SA, Tas, NT) • Deposit assistance (Qld, Tas, NT) • Interest rate assistance (Qld, WA, SA, NT) • Home purchase advisory and counselling (NSW, WA) • Mortgage relief (NSW, Vic, Qld) • Other (Vic, Qld, WA). Each program is reported under 4 forms of assistance: one-off assistance; ongoing assistance; repayable assistance; and non-repayable assistance.
Geographic coverage	All states and territories.
Frequency/timing	Annual collection, since 1999.
Basic collection count (i.e. treatment episodes, separations etc.)	Various—number of new households assisted; value of assistance ($'000); value of outstanding repayable monies ($'000).
Does the collection include a unique client identifier or statistical linkage key?	No—not a person-based collection.
Data content (list of all data items)	There are 9 data items in all. Not all data items are asked for all program types. The data items are: • Total number of new households assisted for year ending 30 June • Total number of new Indigenous households assisted for year ending 30 June • Total value of assistance provided for year ending 30 June • Total number of all households assisted for year ending 30 June • Total number of all Indigenous households assisted for year ending 30 June • Total number of households with outstanding repayable monies at 30 June for assistance provided in a previous financial year • Total value of outstanding repayable monies at 30 June for assistance provided in a previous financial year • Total number of unrecoverable debts written-off for year ending 30 June • Total value of unrecoverable debts written-off for year ending 30 June.
Has there been variation over time in any of the above descriptors for this collection?	No.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	

(continued)

Substance use	—
Mental health	—
Comorbidity	—
Age	—
Sex	—
Cultural and linguistic diversity	—
Indigenous status	Total number of new Indigenous households assisted and total number of all Indigenous households assisted.
Geographic location of respondent	—
Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	—
Indicators of social participation (e.g. labour force status, education status)	—
Treatment outcomes	—
Collection management agency	AIHW
Title/name of contact	Brendan Brady
Address	GPO Box 570, Canberra, ACT 2601.
Email	brendan.brady@aihw.gov.au
Internet	http://www.aihw.gov.au/housing/assistance/index.html http://www.aihw.gov.au/housing/assistance/data_collections/index.html
Phone/fax	(02) 6244 1164 / (02) 6244 1199
Data custodian/access	David Wilson
Funding agency	AIHW and state and territory housing authorities jointly fund the collection under the CSHA NHDA.
Output	Commonwealth–State Housing Agreement Data Reports 2003–04: Home purchase assistance
References (for preparing this template)	CSHA Home Purchase Assistance Data Manual 2003–04, and above report
When will data from this reference period/survey be available?	March 2005.
Other comments	—

42 Commonwealth–State Housing Agreement Crisis Accommodation Program (CSHA–CAP)

Data source (title)	Commonwealth–State Housing Agreement Crisis Accommodation Program
Brief description	A set of nationally significant data items collected in all Australian jurisdictions relating to the provision of CPAs under the CSHA.
Purpose(s)	To produce comparable national information on key housing issues reflected in outcome indicators.
Collection methodology	Jurisdictions collect aggregate information on CPAs in their state or territory, and forward this to AIHW.
Scope (theoretical coverage of relevant population)	Crisis accommodation covered by the CSHA.
Coverage (actual)	Scope of programs included varies between states and territories (see data manual for more details). All states and territories are included in the collection, but some do not provide all data items.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Annual collection, since 1999.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of households assisted; number of crisis accommodation dwellings.
Does the collection include a unique client identifier or statistical linkage key?	No—not a person-based collection.
Data content (list of all data items)	Total number of new households assisted for year ending 30 June Total number of new Indigenous households assisted for year ending 30 June Total number of all households assisted for year ending 30 June Total number of all Indigenous households assisted for year ending 30 June Total number of crisis accommodation dwellings at 30 June (previous year) Total number of crisis accommodation dwellings at 30 June (current year) Total number of additional crisis accommodation dwellings for year ending 30 June Total number of new constructions for year ending 30 June Total number of crisis accommodation dwellings deleted from stock for year ending 30 June Total capital expenditure for year ending 30 June.
Has there been variation over time in any of the above descriptors for this collection?	No.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	—
Mental health	—
Comorbidity	—
Age	—
Sex	—
Cultural and linguistic diversity	—

(continued)

Indigenous status	Total number of new Indigenous households assisted and total number of all Indigenous households assisted.
Geographic location of respondent	—
Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	—
Indicators of social participation (e.g. labour force status, education status)	—
Treatment outcomes	—
Collection management agency	AIHW
Title/name of contact	Brendan Brady
Address	GPO Box 570, Canberra, ACT 2601.
Email	brendan.brady@aihw.gov.au
Internet	http://www.aihw.gov.au/housing/assistance/index.html http://www.aihw.gov.au/housing/assistance/data_collections/index.html
Phone/fax	(02) 6244 1164 / (02) 6244 1199
Data custodian/access	David Wilson
Funding agency	AIHW and state and territory housing authorities jointly fund the collection under the CSHA NHDA.
Output	Commonwealth–State Housing Agreement Data Reports 2003–04: Crisis Accommodation Program
References (for preparing this template)	CSHA Crisis Accommodation Program Data Manual 2003–04, and above report
When will data from this reference period/survey be available?	March 2005.
Other comments	—

43 Commonwealth–State Housing Agreement Private Rental Assistance (CSHA–PRA)

Data source (title)	Commonwealth–State Housing Agreement private rental assistance
Brief description	A set of nationally significant data items collected in all Australian jurisdictions relating to the provision of private rental assistance under the CSHA.
Purpose(s)	To produce comparable national information on key housing issues reflected in performance indicator reporting
Collection methodology	Jurisdictions collect aggregate information on private rental assistance in their state or territory, and forward this to AIHW.
Scope (theoretical coverage of relevant population)	CSHA private rental assistance for households in all Australian states and territories.
Coverage (actual)	Existing types of programs vary between jurisdictions. There are 4 main types of programs existing in the following jurisdictions during 2003–04: • Bond loans (NSW, Vic, Qld, WA, SA, Tas, ACT, NT) • Rental grants/subsidies (NSW, Vic, Qld, SA, Tas) • Relocation expenses (NSW, Vic, Tas) • Other one-off grants (NSW, Vic, Tas). Each program is reported under 4 forms of assistance: one-off assistance; ongoing assistance; repayable assistance; and non-repayable assistance.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Annual collection, since 1999.
Basic collection count (i.e. treatment episodes, separations etc.)	Total number of new households assisted, total value of assistance provided, total value of outstanding repayable monies for assistance provided.
Does the collection include a unique client identifier or statistical linkage key?	No—not a person-based collection.
Data content (list of all data items)	There are 9 data items in all. Not all data items are asked for all program types. The data items are: • Total number of new households assisted for year ending 30 June • Total number of new Indigenous households assisted for year ending 30 June • Total value of assistance provided for year ending 30 June • Total number of all households assisted for year ending 30 June • Total number of all Indigenous households assisted for year ending 30 June • Total number of households with outstanding repayable monies at 30 June for assistance provided in a previous financial year • Total value of outstanding repayable monies at 30 June for assistance provided in a previous financial year • Total number of instances where outstanding monies were written-off for year ending 30 June • Total value of outstanding monies written-off for year ending 30 June.
Has there been variation over time in any of the above descriptors for this collection?	No.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	—
Mental health	—
Comorbidity	—

(continued)

Age	—
Sex	—
Cultural and linguistic diversity	—
Indigenous status	Total number of new Indigenous households assisted and total number of all Indigenous households assisted.
Geographic location of respondent	—
Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	—
Indicators of social participation (e.g. labour force status, education status)	—
Treatment outcomes	—
Collection management agency	AIHW
Title/name of contact	Brendan Brady
Address	GPO Box 570, Canberra, ACT 2601.
Email	brendan.brady@aihw.gov.au
Internet	http://www.aihw.gov.au/housing/assistance/index.html http://www.aihw.gov.au/housing/assistance/data_collections/index.html
Phone/fax	(02) 6244 1164 / (02) 6244 1199
Data custodian/access	David Wilson
Funding agency	AIHW and state and territory housing authorities jointly fund the collection under the CSHA NHDA.
Output	Commonwealth–State Housing Agreement Data Reports 2003–04: Private rent assistance.
References (for preparing this template)	CSHA Private Rent Assistance Data Manual 2003–04, and above report.
When will data from this reference period/survey be available?	March 2005.
Other comments	—

44 Longitudinal Data Set 1% sample (LDS)

Data source (title)	Longitudinal Data Set 1% Sample (LDS)
Brief description	The LDS contains fortnightly extracts of the operational databases held by Centrelink, including customer's characteristics and payment details.
Purpose(s)	To enable policy analysts and researchers, both within and outside the Australian Government Departments of: • Family and Community Services (FaCS) • Employment and Workplace Relations (DEWR) • Education, Science and Training (DEST) to research and monitor the outcomes of a large sample of FaCS, DEWR and DEST customers, according to the research objective of respective departments.
Collection methodology	Administrative by-product data.
Scope (theoretical coverage of relevant population)	The LDS population includes FaCS, DEWR and DEST customers administered under the *Social Security Act 1991* and the *Family Assistance Act 1999*, their partners and their eligible children. Everyone in the LDS is either: • a Centrelink customer who is currently in receipt of an income support payment • a Centrelink customer who is currently in receipt of a non-income support payment • a partner or child of the above.
Coverage (actual)	Not applicable.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Ongoing.
Basic collection count (i.e. treatment episodes, separations etc.)	People.
Does the collection include a unique client identifier or statistical linkage key?	Yes, each customer/partner and child record on the LDS has a unique identifier known as the Customer Identifier that enables them to be traced over time. This data is de-identified, which means the LDS identifier is not linkable to personal details.
Data content (list of all data items)	The LDS 1% sample contains the following data items and spans the period from January 1995 to March 2003: • Customer and their partner's demographics such as date of birth, gender and postcode • A customer's child details where the child is eligible for a family-related benefit • Benefit/s a customer is receiving and the time spent on benefit • Private income such as employment and investments for a customer and their partner (as reported to Centrelink) • Asset/s held by a customer and their partner (as reported to Centrelink); • Activity and breach information • Youth and student information such as student status and education level • Cancellation information where a customer's benefit is cancelled • Indication of customers who have made a compensation claim.

(continued)

Has there been variation over time in any of the above descriptors for this collection?	During the year 2002 the LDS 1% was redesigned to expand the customer population to include all FaCS, DEWR and DEST customers administered under the *Social Security Act 1991* and the *Family Assistance Act 1999*, their partners and their eligible children. Before the redesign the LDS 1% contained a subset of these FaCS, DEWR and DEST customers. The criterion for selection was that a customer be in receipt of an income support payment (e.g. their primary income). Where a customer met the criterion, details of their income support payment, their partner (if any), payments received by their partner (if any) and the numbers of their eligible children were included. Since the redesign, every benefit, not just income support, that a customer receives, has been reported. For example, where a customer is receiving Parenting Payment Single, Family Tax Benefit and Child Disability Allowance, all are reported in the LDS 1%. People who receive a benefit to supplement their private income (e.g. Family Tax Benefit) have been added to the LDS 1% population. Information for a customer's child/ren, where the child/ren is eligible for at least one child-related payment such as Child Disability Allowance, has also been included. The redesigned changes took effect from 29 June 2001.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	In relation to Newstart payments (e.g. sickness allowance), up to 4 of the most recent medical conditions are recorded using the Centrelink classification for health conditions/disability. Some information is also collected in relation to Disability Support Pension (DSP) recipients. This information is more limited as there are only 22 codes used for granting DSP. It is only mandatory to record one primary health condition although it is possible to record additional health conditions.
Mental health	As for substance use.
Comorbidity	Proxy can be derived using information on substance use and mental health problems.
Age	Date of birth.
Sex	Sex.
Cultural and linguistic diversity	Country of birth (non-NHDD/ABS codes).
Indigenous status	Aboriginal and Torres Strait Islander indicator (non-NHDD codes but mappable)—note this is not a 100% population map as not a compulsory data input field.
Geographic location of respondent	Postcode.
Geographic location of agency or other relevant unit	—
Treatment types	Not applicable.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Home ownership: non-home-owner (e.g. non-home-owner lives in nursing home, purchased life tenancy, special residence non-home-owner), home-owner (e.g. home-owner, purchasing own home, home-owner lives elsewhere); marital status (i.e. couple, single); real estate/superannuation/foreign/share investment/other assets (dollars).
Indicators of social participation (e.g. labour force status, education status)	Highest education level (e.g. secondary school, tertiary level, associate diploma); duration of unemployment (days); duration on current payment (days); duration in income security (days).

(continued)

Treatment outcomes	Not applicable (in terms of comorbidity).
Collection management agency	FaCS, on behalf of FaCS, DEWR and DEST which all support the LDS.
Title/name of contact	Section Manager, Customer Data Services Section, Research and Data Management Branch / Mr John Forsey,
Address	GPO Box 7788, Canberra Mail Centre, ACT 2906.
Email	john.forsey@facs.gov.au
Internet	www.facs.gov.au
Phone/fax	(02) 6244 5208
Data custodian/access	FaCS produces the LDS, custodian of the data spans FaCS, DEWR and DEST. DEWR and DEST are now parties of interest to the LDS; access to the data set for new research is under review between these agencies.
Funding agency	FaCS, DEWR and DEST.
Output	—
References (for preparing this template)	LDS 1% Sample User documentation for SAS Format (Version Number: 2.1), Version Date: 22/08/03. Produced by Customer Data Services Section, Research Data and Management Branch, FaCS.
When will data from this reference period/survey be available?	Up to March 2003.
Other comments	The LDS is only made available for commissioned or sponsored research as directed by FaCS, DEWR or DEST. Each of these agencies has different requirements concerning the use and publishing of research that uses its data.

45 General Customer Survey (GCS)

Data source (title)	General Customer Survey (GCS)
Brief description	The GCS is a panel survey of a representative sample of FaCS customers, developed and conducted by FaCS. The GCS complements the LDS as survey answers from the GCS can be linked to an individual's income support history as far back as 1995. This aspect enables the examination of people's pathways into and out of the income support system, providing detailed information on the circumstances of individuals when they are not on payment including longer term outcomes experienced after ceasing to receive a benefit.
Purpose(s)	To meet FaCS' needs for quantitative customer research.
Collection methodology	All respondents are interviewed once in each year of the three years of the survey. Those respondents who enter the survey in receipt of an employment-related payment, such as Newstart, had an additional three interviews in the first year (i.e. one each quarter). The GCS has three cohorts, one each from the 2000, 2001 and 2002 customer populations, with around 3,000 respondents in each cohort.
Scope (theoretical coverage of relevant population)	All income support and non-income support customers.
Coverage (actual)	As above.
Geographic coverage	Australia.
Frequency/timing	3 cohorts, 2000, 2001 and 2002. Respondents interviewed once a year for 3 years, with customers on employment-related payments interviewed every quarter in the first year. The last wave of the 2002 cohort is being conducted in 2004.
Basic collection count (i.e. treatment episodes, separations etc.)	Individual customers.
Does the collection include a unique client identifier or statistical linkage key?	Each customer has a unique ID.
Data content (list of all data items)	Information collected by the GCS includes: • Personal details • Household details: including housing tenure; information about other household members; and perceptions of the local community • Education: including details of educational qualifications; current or planned study; and barriers to undertaking further education • Employment: including current and past employment; and barriers to undertaking work • Retirement: including plans for and experience of • Children and childcare: including childcare arrangements for children up to 12 years and characteristics of children living away from home • Youth: including parental support provided • Disability and caring: including type of condition; limitations faced and care provided • Community and emergency services: including use of supported accommodation • Other services and entitlements: including awareness of Centrelink services and use of concession cards • Awareness of entitlements and incentives: including awareness of the income and assets test, taper rates and cut-out amounts • Income, assets and expenditure: including perceptions of financial position • Activities and participation: including details of volunteering and club membership.

(continued)

Has there been variation over time in any of the above descriptors for this collection?	There has been some variation in the questions asked in each wave of the collection. For example, questions on the perceptions of your local community were included in Wave 1 but not in subsequent waves and specific questions about employment (e.g. been in paid work before) were included only from Wave 2 onward.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	—
Mental health	Not collected although the question on type of condition/disability may detect some mental health conditions.
Comorbidity	—
Age	Age.
Sex	Sex (male, female).
Cultural and linguistic diversity	Country of birth. Year arrived in Australia.
Indigenous status	Indigenous indicator.
Geographic location of respondent	Address including postcode.
Geographic location of agency or other relevant unit	N/A
Treatment types	N/A
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Household details (e.g. number of bedrooms, ownership situation, length at address, rating of standard of accommodation). Income, assets and expenditure (e.g. Centrelink payments, other sources of income, assets and liabilities).
Indicators of social participation (e.g. labour force status, education status)	Education (e.g. age left school, trade/other qualifications since leaving school, highest qualification). Employment (e.g. currently in paid work, why not currently in job, occupation, length of time in job, barriers to working, earnings per week/fortnight from work). Activities and participation (e.g. membership of clubs/associations, social/community/sporting activities participated in during last fortnight).
Treatment outcomes	N/A
Collection management agency	FaCS
Title/name of contact	Manager, General Customer Survey / Sue Sutton
Address	Research and Data Management Branch, FaCS, GPO Box 7788, Canberra Mail Centre, ACT 2610.
Email	customer.survey.team@facs.gov.au
Internet	www.facs.gov.au
Phone/fax	(02) 6244 5203 / (02) 6244 6531
Data custodian/access	These data sets are made available to organisations outside FaCS only for projects approved by FacS, where the organisation can meet FaCS security requirements.
Funding agency	FaCS
Output	customer.survey.team@facs.gov.au

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References (for preparing this template)	FaCS personal communication.
When will data from this reference period/survey be available?	Complete data for all three cohorts is now available.
Other comments	—

46 Household, Income and Labour Dynamics in Australia (HILDA) Survey

Data source (title)	Household, Income and Labour Dynamics in Australia (HILDA) Survey
Brief description	The HILDA Survey is a household-based panel survey, which aims to track all members of an initial sample of households over an indefinite period. In Wave 1 of the survey, data were collected on a wide range of issues, including: household structure, family background, marital history, family formation, education, employment history, current employment, job search, income, health and wellbeing, child care and housing.
Purpose(s)	The HILDA Survey has been designed to address research questions in three main areas: economic and subjective wellbeing, labour market dynamics and family dynamics.
Collection methodology	Wave 1 of the survey involved administration of four questionnaires. Two of these—the Household Form and the Household Questionnaire—were administered by personal interview to at least one adult member of the household. A Person Questionnaire was then administered, again via personal interview, to all household members aged 15 years and over. Finally, a Self-Completion Questionnaire was provided to all persons completing the Person Questionnaire and collected by the interviewer at a later date. For waves 2 to 8 this basic format has been retained. The sample is automatically extended over time by 'following rules' that add to the sample any new children of members of the selected households well as new household members resulting from changes in the composition of the original households.
Scope (theoretical coverage of relevant population)	Australian population.
Coverage (actual)	The initial sample selected for the first wave of the HILDA Survey comprised 12,252 households selected from 488 different neighbourhood regions across Australia, of which 11,693 were subsequently identified as in-scope. Interviews were successfully conducted with 13,969 members of 7,682 households, giving a household response rate of 66%.
Geographic coverage	All states and territories, Australia.
Frequency/timing	The first wave of the survey was conducted in the second half of 2001 and the survey is currently funded for 8 waves.
Basic collection count (i.e. treatment episodes, separations etc.)	People.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Wave 4 of HILDA includes the following data items, collected via five instruments: i. Household Form This collects administrative information on address, dwelling characteristics, reasons for refusal etc. as well as household composition (name, date of birth, age and sex of all household members), information about people joining and leaving the household since the previous interview and other selected personal characteristics of household members aged over 15 years (e.g. marital status, employment status), health/disability status of all household members, and relationship between household members. ii. Household Questionnaire This collects information about child care (e.g. which type(s) are used for school-aged children and children not yet at school? which types are used during school holidays? does anyone in the household currently receive the Child Care Benefit?; housing (e.g. do you or any other household member own this home, rent it, or live here rent free?); household spending; household income; household details (e.g. separate house, flat/unit/apartment in a one-storey block).

(continued)

Data content (continued)	iii. Continuing Person Questionnaire Administered to every household member aged 15 years and over, who has completed a personal questionnaire in previous wave. It has 25 sections on country of birth & visa; education; employment status; current employment; persons not in paid employment; activity calendar (of work and study activities); income; family formation; partnering/relationships; private health insurance; living in Australia (e.g. health/disability); youth issues (e.g. importance of having lots of friends now and at age 35 years); tracking information. iv. New Person Questionnaire Administered to every household member aged 15 years and over, who has never completed a personal questionnaire in previous wave. It has 24 sections on: country of birth & visa; education; employment status; current employment; persons not in paid employment; activity calendar (of work and study activities); income; family formation; partnering/relationships; private health insurance; living in Australia (e.g. health/disability); youth issues (e.g. importance of having lots of friends now and at age 35 years); tracking information. iv. Self Completion Questionnaire Completed by all people who completed the Person Questionnaire (i.e. 15 years and over), this comprises 6 main sections: general health and wellbeing (SF–36 Health Survey); lifestyle and living situation, personal and household finances; your job and the workplace; parenting; sex, age and comments.
Has there been variation over time in any of the above descriptors for this collection?	There have been minor variations and/or changes to survey question ordering in each wave. The core content of the survey remains largely unchanged across each wave. However, some new questions are included in each wave on a rotational basis. In Wave 2, a module of questions on household and personal wealth was included. In Wave 3, a module of questions on retirement transitions was included. In Wave 4, a series of questions relating to the impact of disability, religion, take-up of private health insurance and aspirations of young people was included.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	As part of the Self Completion Questionnaire, all household members aged 15 years and over are asked: whether they smoke cigarettes or any other tobacco products (and if so, the frequency); whether they drink alcohol (and if so, the frequency).
Mental health	As part of the Household Form, household members (including those aged under 15 years) with a long-term health condition, disability or impairment are identified. As part of the Person Questionnaire, all household members aged 15 years and over are asked 'Do you have any long-term health condition, impairment or disability that restricts you in your everyday activities, and has lasted or likely to last, for 6 months or more' (using a prompt card that details the components of the ABS definition of disability, as used in the ABS Survey of Disability, Ageing and Carers 1998). Possible responses that might suggest a mental health problem are 'a nervous or emotional condition which requires treatment' or 'a mental illness which requires help or supervision'. As part of the Self Completion Questionnaire, all household members aged 15 years and over are asked a series of questions relating to general emotional/mental health and wellbeing (e.g. 'how much of the time during the past 4 weeks: did you feel full of life, have you been a nervous person, have you been a happy person etc.?').
Comorbidity	A low-level proxy can be derived from the information collected for substance use and mental health.
Age	Date of birth.
Sex	Sex.

(continued)

Cultural and linguistic diversity	Country of birth (using ABS codes). Is English the first language you learned to speak as a child? In what year did you first come to Australia to live for 6 months or more (even if you have spent time abroad since)?
Indigenous status	Are you of Aboriginal or Torres Strait Islander origin? (as per NHDD).
Geographic location of respondent	Full street address.
Geographic location of agency or other relevant unit	Not applicable.
Treatment types	Not applicable.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Household Form: household composition and interrelationships, employment status, health/disability status. Household Questionnaire: housing tenure (i.e. own/currently paying off mortgage, rent (or pay board), involved in a rent-buy scheme, live here rent free/life tenure), household income and spending; household details (i.e. is the type of dwelling a nursing home? Separate house? Semi-detached house/row or terrace house/townhouse, number of bedrooms etc.). Continuing Person Questionnaire and New Person Questionnaire: Family formation and partnering/relationship questions (e.g. are you currently living with someone in a relationship?).
Indicators of social participation (e.g. labour force status, education status)	Continuing Person Questionnaire and New Person Questionnaire: Highest year of school completed; type of school attended; qualifications currently underway or completed; employment status.
Treatment outcomes	N/A
Collection management agency	The Melbourne Institute of Applied Economic and Social Research (University of Melbourne), the Australian Council for Educational Research and the Australian Institute of Family Studies are responsible for the design and management of the survey. Data collection has been subcontracted to ACNielsen, a private market research company.
Title/name of contact	Professor Mark Wooden, Professorial Research Fellow Director, Household, Income and Labour Dynamics in Australia (HILDA) Survey The Melbourne Institute of Applied Economic and Social Research
Address	University of Melbourne, Parkville, Victoria 3010.
Email	m.wooden@unimelb.edu.au
Internet	http://www.melbourneinstitute.com/hilda/
Phone/fax	(03) 8344 2089 / (03) 8344 2111
Data custodian/access	The Melbourne Institute of Applied Economic and Social Research. A confidentialised unit record data file is available for research purposes. An order form can be accessed at http://www.melbourneinstitute.com/hilda/data.html. In addition, all persons seeking to use the data must submit a signed Deed of Licence (also available from the above web page), which constitutes a legal contract between the user and the Commonwealth of Australia and specifies conditions that users of the HILDA unit-record data agree to abide by. Fees apply.
Funding agency	The HILDA Survey is funded by the Commonwealth Government through FaCS.
Output	See http://www.melbourneinstitute.com/hilda/biblio/default.html for a full list of journal articles, working papers, conference papers and other papers using HILDA data.
References (for preparing this template)	http://www.melbourneinstitute.com/hilda/ (at 21/02/2005)
When will data from this reference period/survey be available?	Data from waves 1, 2 and 3 are currently available.
Other comments	—

47 Juvenile Justice National Minimum Data Set (JJ NMDS)

Data source (title)	Juvenile Justice National Minimum Data Set (JJ NMDS) (Version 1.3)
Brief description	The JJ NMDS aims to provide a national picture of the juvenile justice system and its clients in Australia.
Purpose(s)	The key purposes of the JJ NMDS are to: provide a national picture of the juvenile justice system in Australia; provide a profile of juvenile justice clients; measure relative performance against agreed indicators; monitor national service standards in the juvenile justice area; examine national trends over time; and monitor and evaluate juvenile justice policies and programs.
Collection methodology	Administrative by-product data collected by relevant juvenile justice departments in each jurisdiction and then forwarded to the AIHW.
Scope (theoretical coverage of relevant population)	The JJ NMDS is designed to capture information about all young people involved in the juvenile justice system in Australia.
Coverage (actual)	n/a
Geographic coverage	All states and territories, Australia.
Frequency/timing	Annually, with the first report relating to the period 2000–01 to 2003–04.
Basic collection count (i.e. treatment episodes, separations etc.)	Information relating to juvenile justice clients, juvenile justice episodes and juvenile justice supervision periods is collected as unit record data. Information about juvenile justice remand/detention centres is aggregated data collected annually. A Juvenile Justice client is a person who is under the supervision or case management of the juvenile justice department as a result of: having committed or allegedly committed an offence between the ages of 10 and 17 years; or having committed or allegedly committed an offence at an age greater than 17 years, and who is treated as a juvenile due to his or her vulnerability or immaturity. A Juvenile Justice episode is a period of time during which a Juvenile Justice client is under the supervision of, or is case managed by, a state or territory juvenile justice department, as a result of having committed or allegedly committed an offence, and where there is no change in the type of supervision provided or the specific Juvenile Justice agency responsible. A Juvenile Justice supervision period is a period of time during which a Juvenile Justice client is under the supervision of, or is case managed by, a state or territory juvenile justice department, as a result of having committed or allegedly committed an offence. Supervision periods are a conceptual unit of analysis, derived from episode data, rather than being data elements specifically collected. Supervision periods allow the analysis of repeated contacts with the juvenile justice system through recidivism. This is in contrast to Juvenile Justice episodes which allow for analysis of progression through the Juvenile Justice system within Juvenile Justice supervision periods. A Juvenile Justice remand/detention centre is a secure detention or remand facility run by, or on behalf of, the juvenile justice department for the purpose of detaining juvenile justice clients who are either on police arrest, remanded in custody or on a detention order.
Does the collection include a unique client identifier or statistical linkage key?	Yes. Selected letters of name, date of birth and sex.
Data content (list of all data items)	Client-related data items: client ID (a jurisdictionally based code), letters of name (specific combination of letters used for statistical linkage purposes), date of birth, sex, statistical linkage key (derived from letters of name, sex and date or birth), Indigenous status. Episode-related data items: entry date, episode type (e.g. pre-court community supervision or detention), transfers (i.e. within/between jurisdictions, between juvenile and adult systems), young person's last known home location and postcode, juvenile justice agency name and postcode, reason for exit (e.g. sentence completed, transfer), exit date.

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Data content (continued)	Juvenile justice centre-related: centre name, centre postcode, design capacity (sum of daily design capacity over 12 months), number of detainees (sum of daily number of detainees held over 12 months), escapes.
Has there been variation over time in any of the above descriptors for this collection?	No.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	—
Mental health status	—
Comorbidity	—
Age	Date of birth (NCSDD).
Sex	Sex (NCSDD).
Cultural and linguistic diversity	Yet to be defined.
Indigenous status	Indigenous status (NCSDD).
Geographic location of respondent	Last known home suburb/town/locality name (NCSDD) (this is an alternative to SLA, which is usually more difficult to collect directly). Last known home postcode (NCSDD).
Geographic location of agency or other relevant unit	Juvenile justice agency postcode (postcode of the organisational unit within the Juvenile Justice department that is responsible for the direct supervision or case management of the Juvenile Justice client). Centre postcode (postcode of the location of the Juvenile Justice remand or detention centre).
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Last known suburb/town/locality enables some estimate of whether the young person was homeless prior to entering the Juvenile Justice system (agencies are advised to record 'no fixed abode' in this case).
Indicators of social participation (e.g. labour force status, education status)	—
Treatment outcomes	—
Collection management agency	AIHW
Title/name of contact	JJ NMDS Project Manager / Ingrid Johnston
Address	GPO Box 570, Canberra, ACT 2601.
Email	ingrid.johnston@aihw.gov.au
Internet	www.aihw.gov.au
Phone/fax	(02) 6244 1157 / (02) 6244 1199
Data custodian/access	AIHW
Funding agency	Funding is provided by the states and territories, through the Australian Juvenile Justice Administrators, to the AIHW to act as data custodian.
Output	n/a
References (for preparing this template)	AIHW 2004a (unpublished). Juvenile Justice National Minimum Data Set Version 1.3 data collection manual (draft) August 2004. AIHW 2004b (unpublished). Juvenile Justice National Minimum Data Set Version 1.3 data dictionary (draft) August 2004.

(continued)

When will data from this reference period/survey be available?	Data from the 2000–01 to 2003–04 period are expected to be published in November 2005.
Other comments	The AIHW was invited to undertake the initial development of a JJ NMDS in early 2000, on behalf of the Australasian Juvenile Justice Administrators and the National Community Services Information Management Group. The outcomes of this first stage of development are detailed in: AIHW: Broadbent A 2001. Report on the development of a Juvenile Justice National Minimum Data Set. AIHW Cat. No. CWS 14. Canberra: AIHW. Field and pilot testing (Stage 2 of development) were conducted during 2001–03.The implementation of an ongoing JJ NMDS was endorsed by the Australasian Juvenile Justice Administrators in November 2003 and commenced during 2004.

48 National Police Custody Survey (NPCS)

Data source (title)	National Police Custody Survey (NPCS)
Brief description	Information is collected and recorded by police officers at the station-level in each state and territory regarding all detainees in police cells during August of specific years.
Purpose(s)	To provide information about patterns and trends in police custody in Australia, as was recommended by the Royal Commission into Aboriginal Deaths in Custody and agreed to by all jurisdictions.
Collection methodology	For the 1988, 1992 and 1995 surveys data forms were completed by police for each detainee and sent to the Australian Institute of Criminology (AIC). For the 2002 survey some jurisdictions provided completed data forms while other jurisdictions provided electronic data.
Scope (theoretical coverage of relevant population)	Every occasion on which a person was taken into police custody and physically lodged in a police cell, for any period of time, at any location in Australia during a one-month period. For the 1988, 1992 and 1995 surveys this was during the month of August in the specified year. In the 2002 survey this was during the month of October.
Coverage (actual)	Information not provided.
Geographic coverage	All states and territories, Australia.
Frequency/timing	1988, 1992, 1995, 2002
Basic collection count (i.e. treatment episodes, separations etc.)	Number of people.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Gender, age, Indigenous status, name and postcode of police station or watchhouse; date and time when detainee was lodged in cells; reason for being lodged in cells; most serious offence; date and time when detainee was released from cells; reason for release and whether or not the detainee was still in police cells at the end of the survey period.
Has there been variation over time in any of the above descriptors for this collection?	No.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	N/A
Mental health status	N/A
Comorbidity	N/A
Age	Specific age in years (i.e. 34).
Sex	Male or female.
Cultural and linguistic diversity	N/A
Indigenous status	Aboriginal, Torres Strait Islander, Other.
Geographic location of respondent	Postcode of watchhouse or police station.
Geographic location of agency or other relevant unit	Postcode of watchhouse or police station.
Treatment types	N/A

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Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	N/A
Indicators of social participation (e.g. labour force status, education status)	N/A
Treatment outcomes	N/A
Collection management agency	AIC (1992, 1995, 2002), Royal Commission into Aboriginal Deaths in Custody (1988).
Title/name of contact	Project Manager / Natalie Taylor
Address	GPO Box 2944, Canberra, ACT 2601.
Email	natalie.taylor@aic.gov.au
Internet	www.aic.gov.au/research/projects/0026.html#about
Phone/fax	(02) 6260 9254 / (02) 6260 9201
Data custodian/access	AIC
Funding agency	AIC
Output	See www.aic.gov.au/publications for a list of related publications.
References (for preparing this template)	Carcach C & McDonald D 1997. National Police Custody Survey August 1995. Research and Public Policy Series No. 9. Canberra: AIC. Taylor N & Bareja M 2005. 2002 National Police Custody Survey. Technical and Background Paper No. 13. Canberra: AIC.
When will data from this reference period/survey be available?	Most recent survey findings available on AIC website.
Other comments	A National Police Custody Survey was conducted in October 2002. A report outlining the findings is forthcoming.

49 National Prisoner Census (NPC)

Data source (title)	Australian Bureau of Statistics—National Prisoner Census 2003
Brief description	A census of all adult prisoners in Australia at midnight on 30 June every year.
Purpose(s)	To provide information on all adult prisoners in custody on 30 June each year.
Collection methodology	The ABS sends a request for data to each department responsible for corrective service agencies in each jurisdiction. The department extracts the required information from an administrative data set (often from a centralised data set containing information on all prisoners in corrective services within a jurisdiction) and forwards unit record data on each individual prisoner to the ABS. Data is not collected directly from corrective service facilities.
Scope (theoretical coverage of relevant population)	All persons remanded or sentenced to adult custody in a gazetted adult prison in Australia, operated or administered by state or territory correctional agencies, including those operated by private sector providers. The types of correctional facilities and programs where prisoners are held vary between the states and territories. The census includes (for example): • gazetted prisons in all jurisdictions • periodic detention centres in NSW and ACT • community custody centres and work outreach camps in Queensland • lock-ups in WA operated by police but designed as a prison. The types of correctional facilities and programs excluded from the census include: • police lock-ups, police prisons and cells in court complexes not administered and controlled by corrective services • immigration detention centres • home detention programs • military prisons.
Coverage (actual)	Information not provided.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Annually, point in time survey (30 June each year)—since 1982.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of prisoners.
Does the collection include a unique client identifier or statistical linkage key? (Describe its nature)	—
Data content (list of all data items)	Age; sex; Indigenous status; country of birth; previous imprisonment; most serious offence/charge; legal status (sentenced/unsentenced); court of sentence/remand; date of reception; earliest date of release; expected time to serve; level of education.
Has there been variation over time in any of the above descriptors for this collection?	Changes made since the last census include: • the definition of episode was changed in the 2003 survey to maximise data comparability across states and territories • the 2003 census includes those prisoners who are held in community custody centres and work outreach camps in Queensland.
Are there any proposed developments relating to comorbidity in the near future for this collection?	—
Definitions— how are the following concepts addressed and/or defined?	

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Substance use	—
Mental health status	—
Comorbidity	—
Age	Age (reported as under 18; 18; 19; 20–24; 25–29; 30–34; 35–39; 40–44; 45–49; 50–54; 55–59; 60–64; 65+).
Sex	Males, females.
Cultural and linguistic diversity	Country of birth (coded to ABS SACC).
Indigenous status	Indigenous; non-Indigenous; not known.
Geographic location of respondent	State/territory of prison.
Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	—
Indicators of social participation (e.g. labour force status, education status)	Level of education.
Treatment outcomes	—
Collection management agency	ABS, Crime and Justice Statistics
Title/name of contact	National Centre for Crime and Justice Statistics / Chris Libreri
Address	—
Email	chris.libreri@abs.gov.au or crime.justice@abs.gov.au
Internet	www.abs.gov.au
Phone/fax	(03) 9615 7374 / (03) 9615 7373
Data custodian/access	ABS
Funding agency	ABS
Output	ABS 2003. Prisoners in Australia ABS Cat. No. 4517.0. Canberra: ABS.
References (for preparing this template)	ABS 2003. Prisoners in Australia ABS Cat. No. 4517.0. Canberra: ABS. ABS—Australian Standard Offence Classification
When will data from this reference period/survey be available?	Data currently available.
Other comments	The AIC was responsible for the census from 1982–1993. In 1995 the Corrective Services Ministers' Council shifted responsibility for the collection and dissemination of corrective services statistics from the AIC to the ABS. The AIC ceased publishing the Australian Prisoners series after June 1993 and the ABS began publication of these statistics from June 1994 onwards.

50 Drug Use Careers of Offenders (DUCO)

Data source (title)	Drug Use Careers of Offenders (DUCO)
Brief description	The DUCO survey investigates the intersection of drug use careers and criminal careers and explores issues concerning pathways to drug use and offending.
Purpose(s)	The main purpose of DUCO is to examine the relationship between illicit drug use and violent and property crime in the adult and juvenile incarcerated population. Other important objectives are to: • examine the links between family background/mental health on criminal careers (among adult females and juveniles) • determine the nature of alcohol and other drug treatment (AODT) both within and outside of prison.
Collection methodology	There have been three stages of collection: sentenced males (2001), sentenced females (2003) and sentenced and long-term remanded juveniles (2003). For the adult male component of the project, data were collected from randomly selected inmates through an interviewer-administered survey questionnaire (i.e. face-to-face interviews) and a supplementary self-completion survey questionnaire as well as corrective services administrative data (routinely collected as part of the incarceration process for all sentenced prisoners). A total of 2135 male offenders were interviewed in four jurisdictions (Western Australian, Queensland, Tasmania and the Northern Territory). For the adult female component, a census of all sentenced female offenders was attempted. A total of 470 women were interviewed in six jurisdictions (Western Australian, Queensland, South Australia, Victoria, Tasmania and the Northern Territory). Face-to-face interviews were conducted using a questionnaire similar to the male component, but with some additional questions pertinent to women. Administrative data was not collected. Face-to-face interviews were completed with juveniles across all jurisdictions. A census was attempted. A questionnaire similar to the male DUCO was used with some additional questions pertinent to juveniles.
Scope (theoretical coverage of relevant population)	Offenders sentenced to prison (adult, males and females). Sentenced and remanded juveniles (males and females).
Coverage (actual)	In the male component of the study, in the Northern Territory, Queensland and Western Australia, a geographically stratified systematic random sample was used. A full census of Tasmania was attempted. There was a 73% response rate from approached prisoners in the 2001 study. Due to the small number of women in prison at any one time, a complete census of the sentenced female prison population in each jurisdiction was attempted. Eighty-four per cent of prisoners approached for an interview agreed to participate. At this time interviews have been completed for the juveniles in all jurisdictions across Australia.
Geographic coverage	2001 sentenced males: Queensland, Northern Territory, Western Australia, Tasmania. 2003 sentenced females: Western Australian, Queensland, South Australia, Victoria, Tasmania and the Northern Territory. 2004 sentenced juveniles: all states and territories.
Frequency/timing	Male DUCO conducted in 2001, female DUCO in 2003 and Juvenile DUCO in 2004.
Basic collection count (i.e. treatment episodes, separations etc.)	People.

(continued)

Does the collection include a unique client identifier or statistical linkage key? (Describe its nature)	No.
Data content (list of all data items)	The interviewer-administered questionnaire comprises items on: • sociodemographics, including age, education level, employment status, legal and illegal income and drug use history and history of criminal offending. The adult female questionnaire included additional elements such as drug and alcohol problems among family members, childhood and adult experiences of physical and sexual abuse, and mental health indicators • past criminal history for 13 offence categories (11 for females), including ages of first and regular commission, frequency of being caught by the police and numbers of charges, convictions and sentences • past drug use history for 11 illicit drug categories (plus alcohol), including ages of first and regular use and perceptions of dependency. The adult female questionnaire focused on 9 drug categories and differentiated legal and illegal use of three drug types. A standardised scale was used to measure dependency on alcohol and drugs • illicit drug market characteristics (adult males only) • offender decision-making processes (adult males only) • estimates of financial costs of drug use • use of alcohol and other drug treatment services, including perceptions of effectiveness of treatment currently received. Administrative data: The administrative data on the adult male component comprise further information on demographics (e.g. ethnicity and marital status) and sentencing histories. The main purpose of collecting administrative data is to provide cross-validation information for the self-report sentencing histories and to allow weighting of the raw data to adjust for any maldistribution. Addendum questionnaires (males only): Addendum questionnaires for jurisdiction-specific items, which do not form part of the DUCO study, are permitted at the end of DUCO-specific components. Western Australia requested this option to include a series of questions on self-harm.
Has there been variation over time in any of the above descriptors for this collection?	The juvenile version of the survey included questions concerning 10 offence categories and 7 drug categories. Unlike the female survey, the juveniles questionnaire asked about licit and illicit use of dexamphetamines.
Are there any proposed developments relating to comorbidity in the near future for this collection?	Analysis of data.
Definitions— how are the following concepts addressed and/or defined?	
Substance use	In the adult male and female studies: Offenders were generally asked to select drugs they used illegally (ever used, used in the last six months, current regular user) from a list of selected drugs. In some cases, offenders were asked open-ended questions about the drugs they used. In this latter case, drugs were coded using the ABS Standard Classification of Drugs of Concern. Offenders who indicated that they used a drug 'regularly' were asked to indicate the frequency (less than monthly, one to several times a month, one to several times a week, once a day, several times a day). Offenders were asked to indicate their preferred (illegal) drug of choice. Offenders were asked to indicate the age at which they first used drugs and the age at which they first used them regularly (age at onset). Offenders were asked to indicate how much they spent each week on drugs.

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Substance use (continued)	Offenders were asked if they were addicted to illegal drugs or alcohol during the 6 months prior to arrest (male offenders) or asked a series of questions used to determine drug or alcohol dependency (females) and whether they were intoxicated with illegal drugs or alcohol at the time of committing the most serious offence for which they were now in prison. A standardised scale was used to determine dependency for females.
Mental health	Not collected in the male component. A number of mental health indicators were included in the adult female study: • had mental health problems while growing up (7 items) • sought help for mental health problems • received a diagnosis for a mental health problem • had emotional problems that significantly interfered with their lives. Standardised instruments were not used. These were designed simply as indicators of mental health problems.
Comorbidity	Analysis of comorbid drug and alcohol problems and mental health problems (for females only).
Age	Actual age at time of interview.
Sex	Sex (male, female).
Cultural and linguistic diversity	Not collected.
Indigenous status	Indigenous status: Aboriginal or Torres Strait Islander. Juveniles survey: Aboriginal origin, Torres Strait Islander origin, or both.
Geographic location of respondent	Postcode and state/territory of prison. Analysis completed by the AIC is at the national level only.
Geographic location of agency or other relevant unit	As for geographic location of respondent.
Treatment types	Male component includes broad questions on treatment (ever and current). For the adult female component: types of treatment received (ever and current), how did they enter treatment (e.g. court order, police diversion, voluntary), type of substance being treated for, perceptions of effectiveness, length of enrolment. In the juveniles study questions are asked about the perceived usefulness of detoxification services, rehabilitation services, outpatient/counselling, support groups (e.g. Alcoholics Anonymous, Narcotics Anonymous, church etc.) and general practitioners.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	All respondents are living in prison. Type of housing prior to prison, marital status, household composition, source of income.
Indicators of social participation (e.g. labour force status, education status)	Education attainment (never went to school, completed some primary school, primary school, Year 10, apprenticeship, Year 12, TAFE/technical college, tertiary). Prior juvenile detention (Yes/No).
Treatment outcomes	Not applicable.
Collection management agency	AIC
Title/name of contact	Jason Payne (males), Holly Johnson (females), Jeremy Prichard (juveniles)
Address	Australian Institute of Criminology, GPO Box 2944, Canberra, ACT 2601.
Email	jason.payne@aic.gov.au ; holly.johnson@aic.gov.au; jeremy.pritchard@aic.gov.au
Internet	www.aic.gov.au/research/projects/0019.html
Phone/fax	(02) 6260 0255
Data custodian/access	AIC

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Funding agency	AIC
Output	Directly related publications are listed at http://www.aic.gov.au/research/projects/0019.html. Further related monographs, annual reports and journal articles available at www.aic.gov.au by entering 'DUCO' in the search function. Johnson H 2005. Drugs and crime: a study of incarcerated female offenders. Research and Policy Series No. 63. Canberra: AIC. Johnson H 2005. Key findings from the drug use careers of female offenders study. Trends and Issues in Crime and Criminal Justice No. 289. Canberra: AIC.
References (for preparing this template)	AIC 2002. Introducing DUCO — Drug Use Careers of Offenders: an information paper. Canberra: AIC. www.aic.gov.au/research/projects/0019.html. Makkai T & Payne J 2003. Key findings from the Drug Use Careers of Offenders (DUCO) Study. Trends and Issues in Crime and Criminal Justice No. 267. Canberra: AIC. Makkai T & Payne J 2003. Drugs and crime: a study of incarcerated male offenders. Research and Public Policy Services No. 52. Canberra: AIC.
When will data from this reference period/survey be available?	The full report on the juveniles component is expected to be publicly available late 2005.
Other comments	DUCO had its genesis in a 1998 pilot of 222 sentenced property offenders in four Queensland prison facilities. Both DUCO and the 1998 pilot were funded under the Australian Government's National Illicit Drugs Strategy initiative.

51 Drug Use Monitoring in Australia (DUMA)

Data source (title)	Drug Use Monitoring in Australia (DUMA)
Brief description	The DUMA project seeks to measure drug use among those people who have been recently apprehended by police.
Purpose(s)	The main purpose of the DUMA program is to measure recent drug use and crime among police detainees. DUMA data are used to examine issues such as the relationship between drugs, property and violent crime, monitor patterns of drug use across time, and help assess the need for drug treatment among the offender population. The stated aims of DUMA are to: • collect illicit drug prevalence data on offenders at selected sites in Australia; • provide aggregated data in a timely fashion to state and territory law enforcement agencies and federal agencies such as the Australian Federal Police and Customs about the level of illicit drug use within the offender population • provide a mechanism for local and national law enforcement agencies to evaluate policy initiatives • provide an early warning system for changes in patterns of illicit drug use.
Collection methodology	Trained local staff conduct interviews with detainees who have been arrested in the previous 48 hours and are being held in custody. As part of the interview, detainees are asked to complete a questionnaire and provide a urine sample. Both the questionnaire and the provision of the urine sample are voluntary.
Scope (theoretical coverage of relevant population)	All states and territories, Australia.
Coverage (actual)	In 2003, 90% of detainees agreed to be interviewed, of whom 84% agreed to provide a urine sample.
Geographic coverage	Southport and Brisbane, Queensland; East Perth, Western Australia; Bankstown and Parramatta, New South Wales; Adelaide and Elizabeth, South Australia.
Frequency/timing	Quarterly (1999–2004) ongoing.
Basic collection count (i.e. treatment episodes, separations etc.)	People.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	General demographics; offender characteristics; previous arrests; prison history; education; type of housing; income; mental illness; gambling behaviour; drug use data; drug market data; treatment history.
Has there been variation over time in any of the above descriptors for this collection?	DUMA has been in place since 1999. In 2002, it was expanded from four to seven sites across Australia.
Are there any proposed developments relating to comorbidity in the near future for this collection?	Analysis of the DUMA data is an ongoing process.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Offenders were generally asked to select drugs they used illegally (ever used, used in the past 12 months, past 30 days & past 48 hours), cannabis, cocaine, heroin, morphine, methadone, benzodiazepines, amphetamines, ecstasy, hallucinogens and inhalants as well as alcohol. Urine results test for opiates, cocaine, amphetamines—further tests are done for heroin and methamphetamines.
Mental health status	Detainees are asked if they have been a patient in a psychiatric hospital for at least one overnight stay.
Comorbidity	Analysis of comorbid drug and alcohol dependency, and mental health status.

(continued)

Age	Age and date of birth.
Sex	Sex (Male, Female).
Cultural and linguistic diversity	Not collected.
Indigenous status	Indigenous status: Aboriginal or Torres Strait Islander.
Geographic location of respondent	Postcode of the offenders usual place of residence—taken from police records.
Geographic location of agency or other relevant unit	Location of police station/watchhouse and suburb of offence location is also collected.
Treatment types	Drug or alcohol treatment received (ever and current), type of treatment program; how did they enter treatment (e.g. court order, police diversion, voluntary); type of substance being treated for and length of enrolment; and if they had been turned away from treatment due to a lack of spaces.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Type of housing in past 30 days, marital status, household composition, source of income.
Indicators of social participation (e.g. labour force status, education status)	Education attainment (never went to school, completed Year 10 or less, completed year 11 or 12, Still in school, still in TAFE/technical college, still in university, some TAFE but did not complete, some university but did not complete, completed a university or higher degree). Work status (working fulltime, part-time, have a job but out due to illness/leave/strike seasonal work, unemployed and looking for work, unemployed but not looking for work, full-time homemaker, full-time education, retired, disabled for work).
Treatment outcomes	Not applicable.
Collection management agency	AIC
Title/name of contact	Dr Jenny Mouzos
Address	Australian Institute of Criminology, GPO Box 2944, Canberra, ACT 2601.
Email	duma@aic.gov.au or Jenny.Mouzos@aic.gov.au
Internet	www.aic.gov.au/research/duma/
Phone/fax	(02) 6260 9255 / (02) 6260 9201
Data custodian/access	AIC
Funding agency	The Australian Government Attorney-General's Department and the South Australian Attorney-General's Department.
Output	For a full list of DUMA-related publications see http://www.aic.gov.au/research/duma/docs.html Key stakeholders also have access to quarterly data on a secure section of the DUMA website.
References (for preparing this template)	AIC Milner L, Mouzos J & Makkai T 2004. Drug Use Monitoring in Australia. 2003 annual report on drug use among police detainees. Research and Public Policy Series No. 58. Canberra: AIC. http://www.aic.gov.au/research/duma/.
When will data from this reference period/survey be available?	Data from 2004 are expected to be available in May 2005.
Other comments	If you would like to discuss gaining access to the DUMA data, please contact Dr Jenny Mouzos (02) 6260 9250 or jenny.mouzos@aic.gov.au.

52 New South Wales Inmate Health Survey (NSW–HIS)

Data source (title)	2001 New South Wales Inmate Health Survey (NSW–IHS)
Brief description	A survey conducted in all NSW prisons, to look at the health status of a sample of the inmate population.
Purpose(s)	To provide reliable epidemiological data on the health status of the prisoner population. To identify changes in health status and trends in key health indicators across surveys.
Collection methodology	A cross-sectional random sample of inmates in NSW participated in the survey which involved a blood/urine test, physical health measurements, physical health questionnaire, intellectual disability testing, mental health questionnaire, psychiatric assessment and interviews. The survey was conducted between July and November 2001.
Scope (theoretical coverage of relevant population)	A sample of male and female inmates in full custody within the NSW corrections system.
Coverage (actual)	29 correctional facilities in New South Wales and 7,674 inmates (7,160 male and 514 female). 85% response rate for sampled inmates.
Geographic coverage	New South Wales.
Frequency/timing	Surveys conducted in 1996 and 2001. Next survey is planned for 2006.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of prisoners/inmates.
Does the collection include a unique client identifier or statistical linkage key?	—
Data content (list of all data items)	Age; region of birth; non-English-speaking background; marital status; living situation; educational attainment; occupation and employment status; prison work; childcare experiences; Aboriginal removal from family; juvenile detention; children of prisoners; parenting; relationships. Series of data items under the following headings: offending behaviour; physical health status; self-reported health status; health service utilisation; dental health; injury; respiratory function; infectious disease; sexually transmitted infections; health-related behaviours; diet and nutrition; men's health; women's health; intellectual disability; mental health; suicide and self-harm; behavioural risks; sexual health.
Has there been variation over time in any of the above descriptors for this collection?	A number of new topics were included in the 2001 survey: intellectual disability, head injury and mental health.
Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Alcohol: consumption. Smoking: age when first started; tobacco consumption; prison and community tobacco consumption; smoking reduction strategies. Drug use: lifetime and regular illicit drug use; time since last injected drugs; age when first injected; drug and alcohol use in prison; alcohol consumption in prison; injecting equipment shared in prison; ease of obtaining drugs in prison; drug use and offending. Previous psychiatric diagnosis (by a doctor) including drug dependence, alcohol dependence.

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Mental health	Beck Hopelessness Scale Beck Depression Inventory Referral Decision Scale Composite International Diagnostic Interview (including): SF–12 and BDQ (disability measures); International Personality Disorder Examination (personality disorder measure); GHQ-12 (general psychiatric morbidity); and Kessler 10 (psychological distress). SF–26 Previous psychiatric diagnosis (by a doctor) including depression, anxiety, ADHD, schizophrenia, personality disorder, manic-depressive psychosis. Current psychiatric medication and treatment: antidepressants, major tranquillisers—tablet, major tranquillisers—injection, minor tranquilliser, psychostimulant, lithium.
Comorbidity	Yes, can be derived from the substance use and mental health status data items.
Age	Age groups: under 25 years, 25–40, and over 40 years.
Sex	Sex.
Cultural and linguistic diversity	Country of birth (coded using ABS SACC). English-speaking status (based on country of birth).
Indigenous status	Aboriginal; not Aboriginal.
Geographic location of respondent	—
Geographic location of agency or other relevant unit	Location of prison.
Treatment types	Drug treatment programmes and pharmacotherapies within prisons: methadone, naltrexone, LAAM and buprenorphine. Organisations used for drug problem in the community: e.g. rehabilitation, detoxification, AA, NA, drug court, Salvation Army. Health service utilisation: mental health problems. Health professional consultations: including drug and alcohol counsellor; psychiatrist; mental health nurse. Aboriginal health service use: including Aboriginal drug and alcohol worker. Mental health telephone line: 1800 number that covers symptomology, counselling, mental health service options, treatment referral and follow-up issues.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Marital status (mappable to NCSDD item). Living situation (not consistent with NCSDD item). Number of dependents (children under 16 years).
Indicators of social participation (e.g. labour force status, education status)	Educational attainment: qualification level; schools attended; school expulsions. Labour force status prior to imprisonment and occupation.
Treatment outcomes	—
Collection management agency	NSW Justice Health
Title/name of contact	Research Manager, Epidemiologist / Dr Tony Butler
Address	Centre for Health Research in Criminal Justice Suite 302, Westfield Office Towers Eastgardens Shopping Centre, Pagewood, NSW 2035.
Email	tony.butler@justicehealth.nsw.gov.au
Internet	www.justicehealth.nsw.gov.au/index.html
Phone/fax	(02) 8372 3010 / (02) 9344 4151

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Data custodian/access	CEO, NSW Justice Health.
Funding agency	NSW Justice Health with contributions from the NSW Department of Corrective Services and NSW Health
Output	Butler T & Milner L 2003. The 2001 NSW Inmate Health Survey. Sydney: Corrections Health Service.
References (for preparing this template)	Butler T & Milner L 2003. The 2001 NSW Inmate Health Survey. Sydney: Corrections Health Service.
When will data from this reference period/survey be available?	Data currently available.
Other comments	NSW Justice Health are in the process of producing a publication on comorbidity using the data collected from the NSW Inmate Health Survey.

53 Queensland Women Prisoners' Health Survey (QLD–WPHS)

Data source (title)	2002 Queensland Women Prisoners' Health Survey (QLD–WPHS)
Brief description	A survey conducted in all custodial correction centres for women in Queensland, to look at the health status of a sample of the inmate population.
Purpose(s) *(taken directly from materials)*	• To provide a description of the physical and mental health status of women prisoners in Queensland correctional facilities. • To facilitate strategic input into the planning of the clinical services for health and medical services. • To develop indicators allowing for comparisons between the health status of the general population and prison inmates. • To provide information for comparison with New South Wales and to contribute to a national information system on prisoners' health. • To examine specific hypotheses relating to prisoners' health arising from the findings of the New South Wales study, and from the strategic priorities of the Women's Policy Unit within the Queensland Department of Corrective Services.
Collection methodology	The survey involved a number of methodologies and materials including: a questionnaire incorporating a broad spectrum of health and implemented through a face-to-face interview; physical assessment; blood sample; and a review of medical records. Additional information was also obtained from the Health and Medical Services database and the Correctional Information System database.
Scope (theoretical coverage of relevant population)	All women incarcerated in Queensland prisons during 26 February and 26 March 2002. Both sentenced and remand prisoners were considered in scope.
Coverage (actual)	212 inmates participated in the survey (77% response rate). 4 correctional facilities.
Geographic coverage	Queensland prisons.
Frequency/timing	To date only one survey has been conducted (2002).
Basic collection count (i.e. treatment episodes, separations etc.)	Number of prisoners/inmates.
Does the collection include a unique client identifier or statistical linkage key?	—
Data content (list of all data items)	Age group; Indigenous status; country of birth; most serious offence; amount of time served; level of education; labour force status; occupation; health status; SF–36 general health and wellbeing; long-term illness and disability; health service utilisation; asthma; blood sugar; exercise and body image; diet and nutrition; skin protection; dental health; injury; smoking; alcohol consumption; illicit drug use; injecting drug use; drug treatment; tattooing and body piercing; gambling; mental health; reproductive health; sexual history; sexual abuse; physical and emotional abuse; Aboriginal removal from families.
Has there been variation over time in any of the above descriptors for this collection?	—
Are there any proposed developments relating to comorbidity in the near future for this collection?	Further analysis of collected data is planned in specific areas of study, for example illicit drug use.
Definitions—how are the following concepts addressed and/or defined?	

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Substance use	Smoking: ever smoked; smoking status; age first smoked; tobacco consumption; strategies to quit. Alcohol consumption: AUDIT (drinking behaviour tool); alcohol consumption; frequency of consumption; parental and partner drinking behaviour. Illicit drug use: ever used illicit drugs; frequency using regularly in 12 months before imprisonment; type of drug used. Injecting drug use: ever injected illicit drugs; age at first injection; type of drug injected; needle sharing behaviours.
Mental health	Psychiatric history: treatment or assessment from psychiatrist or doctor; diagnosis. Beck Depression Inventory.
Comorbidity	Yes, can be derived from the substance use and mental health status data items.
Age	Age groups: 17–24 years, 25–39 and over 40.
Sex	Female.
Cultural and linguistic diversity	Country of birth (coded using ABS SACC).
Indigenous status	Indigenous, non-Indigenous.
Geographic location of respondent	—
Geographic location of agency or other relevant unit	Location of correctional facility.
Treatment types	Drug treatment: participation in methadone treatment in past; help or treatment (including detoxification, rehabilitation etc.)
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	—
Indicators of social participation (e.g. labour force status, education status)	Educational attainment; age finished school. Labour force status and occupation prior to imprisonment.
Treatment outcomes	—
Collection management agency	Queensland Government Department of Corrective Services and the School of Population Health, University of Queensland.
Title/name of contact	Dr Anthony Falconer
Address	Qld Department of Corrective Services, GPO Box 1054, Brisbane 4001.
Email	Tony.Falconer@dcs.qld.gov.au
Internet	www.dcs.qld.gov.au
Phone/fax	(07) 3227 6501 / (07) 3405 6301
Data custodian/access	Queensland Government Department of Corrective Services
Funding agency	Queensland Government Department of Corrective Services
Output	Hockings BA, Young M, Falconer A & O'Rouke PK 2002. Queensland Women Prisoners' Health Survey. Brisbane: Department of Corrective Services.
References (for preparing this template)	As above.
When will data from this reference period/survey be available?	Data currently available.
Other comments	The survey used in the Queensland Women Prisoners' Health Survey was a modified version of the tool used in the New South Wales Inmate Health Survey.

54 Crime and Safety Survey (CSS)

Data source (title)	Australian Bureau of Statistics—2002 Crime and Safety Survey (CSS)
Brief description	The survey collects information from people aged over 15 years, on reported and unreported crimes, to provide a greater understanding of crime and the criminal justice system in Australia. The focus of the survey is on personal crime and safety issues.
Purpose(s)	To provide a more comprehensive picture of the way that crime affects the Australian community, and to provide a resource for helping agencies involved in law enforcement, crime prevention and victim support services. To enable planning to formulate policies and strategies tailored to the overall incidence of crime, rather than just the number of incidents reported to police.
Collection methodology	Self-enumerated mail-back survey. The survey was conducted throughout Australia during April to July 2002 as part of the Monthly Population Survey as a supplement to the April Labour Force Survey. Following the Labour Force Survey, respondents who fell within scope of the crime and safety survey were provided with a self-completion questionnaire for them to complete and mail back to the ABS.
Scope (theoretical coverage of relevant population)	The survey was conducted on all persons aged 15 years and over who were usual residents of private dwellings.
Coverage (actual)	Information was collected from 41,200 persons (76% response rate). Data relating to households were received by 20,900 household (75% response rate).
Geographic coverage	All states and territories, Australia.
Frequency/timing	Surveys conducted in 2002, 1998, 1993, 1998 and 1975. Next survey scheduled for 2005.
Basic collection count (i.e. treatment episodes, separations etc.)	Number of households; number of victims; all persons.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	State/territory of usual residence; area of usual residence; region of usual residence; household type; number of children aged under 15 years; sex; age groups; marital status; relationship in household; country of birth; period of arrival; whether attending educational institution; level of highest educational attainment; level of highest non-school qualification; level of highest school qualification; labour force status; full-time or part-time status of employment; status in employment; hours worked; occupation; industry; duration of unemployment; all problems in neighbourhood; whether victim of household/personal crime in last 12 months; feelings of safety at home alone during the day; feelings of safety at home alone after dark; whether victim of break-in in last 12 months; number of incidents (including making known to police, when it occurred, how was it reported to police, main reason did not tell police); offenders actions in recent break-in; victim of attempted break-in (including signs of most recent attempt); number of vehicles owned by household; victim of motor vehicle theft; victim of robbery (including reporting to police, location, use of weapons, physical injuries); number of offenders (including age, known to victim); robbery (including what was taken, nature of robbery; emotional impact of most recent incident); victim of assault (including report to police, danger of being hurt, how offender of assault is known, day of week of assault, time of day, support services accessed, nature of assault, assault typology); victim of sexual assault.
Has there been variation over time in any of the above descriptors for this collection?	Significant definitional changes to ‘robbery’ and ‘assault’ between the 1993, 1998 and 2002 surveys. In the 1998 survey personal crime of sexual assault was collected on a voluntary basis for female respondents only. The 2002 survey asks both males and females aged 18 years and over to complete the voluntary questionnaire on sexual assault.

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Has there been variation over time in any of the above descriptors for this collection? (continued)	Household crimes are comparable between surveys; however, changes in respondents' attitudes towards crime in the last nine years may have affected their responses over time. New crime data items in the 2002 survey include: • feelings of safety • victim experience including type of support services accessed and how police were told about the incident • offender information including sex and approximate age • nature of the incident including when, where, who etc. • seriousness of incident including whether the victim considers the incident a crime. Demographic data items new in 2002: • employment status. educational attainment
Are there any proposed developments relating to comorbidity in the near future for this collection?	—
Definitions—how are the following concepts addressed and/or defined?	
Substance use	—
Mental health	—
Comorbidity	—
Age	Age groups: 15–17, 18–19, 20–24, 25–34, 35–44, 45–54, 55–64, 65+.
Sex	Males, females.
Cultural and linguistic diversity	Country of birth (coded to ABS SACC).
Indigenous status	—
Geographic location of respondent	State/territory of usual residence. Area of usual residence. Region of usual residence.
Geographic location of agency or other relevant unit	—
Treatment types	—
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Marital status: married, not married (2 out of 6 NCSDD codes). Household type (not collected as per NCSDD item). Relationship on household (mappable to NCSDD item).
Indicators of social participation (e.g. labour force status, education status)	Whether attending educational institution. Level of highest educational attainment. Level of highest non-school qualification. Level of highest school qualification. Labour force status (as per NCSDD item).
Treatment outcomes	—
Collection management agency	ABS, Crime and Justice Statistics.
Title/name of contact	National Centre for Crime and Justice Statistics / Chris Libreri

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Address	—
Email	chris.libreri@abs.gov.au or crime.justice@abs.gov.au
Internet	www.abs.gov.au
Phone/fax	(03) 9615 7374 / (03) 9615 7373
Data custodian/access	ABS.
Funding agency	ABS.
Output	ABS 2002. Crime and Safety. ABS Cat. No. 4509.0. Canberra: ABS
References (for preparing this template)	ABS 2002. Crime and Safety. ABS Cat. No. 4509.0. Canberra: ABS 4524.0.55.001—Information paper expanded Confidentialised unit record file, national crime and safety survey 2002. Themes—National Centre for Crime and Justice Statistics. About the 2002 Crime and Safety Survey.
When will data from this reference period/survey be available?	Data currently available.
Other comments	Survey only covered selected types of household crimes (specifically break-ins, attempted break-ins and motor vehicle theft) and personal crimes (specifically robbery, assault and sexual assault).

55 National Child Protection Data Collection (NCPDC)

Data source (title)	National Child Protection Data Collection (NCPDC)
Brief description	The national data provide information about children who come into contact with the community services departments for protective reasons. The three areas of the child protection system for which national data are reported are: • child protection notifications, investigations and substantiations • children on care and protection orders • children in supported overnight out-of-home care.
Purpose(s)	To provide information about the numbers and characteristics of children coming into contact with the child protection system.
Collection methodology	Data for each of these collections are forwarded to the AIHW each year by the relevant state and territory community services departments according to specified definitions, data items, classifications and counting rules. Data are supplied in aggregate form for each collection. For example, in the case of data relating to child protection notifications, investigations and substantiations, jurisdictions provide specified tables using agreed data definitions.
Scope (theoretical coverage of relevant population)	All children who come into contact with the community services departments for protective reasons.
Coverage (actual)	The coverage is the same as the scope: all children who come into contact should be included in the collection.
Geographic coverage	All states and territories, Australia.
Frequency/timing	Annually, from: • 1990–91 (child protection notifications, investigations and substantiations) • 1990–91 (children on care and protection orders). • 1995–96 (children in supported overnight out-of-home care).
Basic collection count (i.e. treatment episodes, separations etc.)	Child protection notifications, investigations and substantiations: child concern reports, child protection notifications, investigations, substantiations. Children on care and protection orders: children admitted to and discharged from care and protection orders. Children in supported overnight out-of-home care: children admitted to and discharged from supported overnight out-of-home care.
Does the collection include a unique client identifier or statistical linkage key?	No.
Data content (list of all data items)	Child protection notifications, investigations and substantiations: age of child, family of residence (e.g. two-parent families where both parents are either the biological or adoptive parents of the child, single parent – male), Indigenous status, investigation outcome, relationship to child of the person believed responsible, source of notification, type of abuse or neglect and type of action (for child protection notifications). Children on care and protection orders: age of child, sex of child, type of care and protection order, living arrangements (e.g. parents or relatives who are not being reimbursed for their care, foster care, home-based out-of-home care, residential care), Indigenous status. Children in supported overnight out-of-home care: age of child, sex of child, type of placement (e.g. home-based care, residential care), whether child on care and protection order, length of time in placement, Indigenous status of child, Indigenous status of caregiver.
Has there been variation over time in any of the above descriptors for this collection?	Yes, for example the major counts for the child protection notifications, investigations and substantiations collection were revised in 1996–97.

(continued)

Are there any proposed developments relating to comorbidity in the near future for this collection?	No.
Definitions—how are the following concepts addressed and/or defined?	
Substance use	Not collected.
Mental health status	Not collected.
Comorbidity	Not collected.
Age	Age groups (less than 1 year, 1–4, 5–9, 10–14, 15–16 years). Data are collected in single age groups but reported in these groups.
Sex	Girls, boys.
Cultural and linguistic diversity	Not collected.
Indigenous status	Indigenous, other, unknown.
Geographic location of respondent	State/territory only.
Geographic location of agency or other relevant unit	State/territory only.
Treatment types	Not applicable.
Indicators of social context (e.g. living arrangements, residential setting, marital status, household composition)	Child protection notifications, investigations and substantiations: family of residence (e.g. two-parent families where both parents are either the biological or adoptive parents of the child, single parent – male). Children on care and protection orders: living arrangements (e.g. parents or relatives who are not being reimbursed for their care, foster care, home-based out-of-home care, residential care), Indigenous status. Children in supported overnight out-of-home care: type of placement (e.g. home-based care, residential care), whether child on care and protection order, length of time in placement, Indigenous status of caregiver.
Indicators of social participation (e.g. labour force status, education status)	Not collected.
Treatment outcomes	Not applicable.
Collection management agency	AIHW.
Title/name of contact	Susie Kelly
Address	GPO Box 570, Canberra, ACT 2601.
Email	susan.kelly@aihw.gov.au
Internet	www.aihw.gov.au
Phone/fax	(02) 6244 1182 / (02) 6244 1199
Data custodian/access	AIHW
Funding agency	AIHW and state/territory community services departments
Output	AIHW 2005. Child protection Australia 2003–04. AIHW Cat. No. CWS 24. Canberra: AIHW (Child Welfare Series No. 36).
References (for preparing this template)	AIHW 2004. Child protection Australia 2002–03. AIHW Cat. No. CWS 22. Canberra: AIHW (Child Welfare Series No. 34). AIHW 2003. Child protection notifications, investigations and substantiations Australia: data collection standards, tables and counting rules, 2003–04. <http://www.aihw.gov.au/childyouth/childprotection/countingrules.html>.
When will data from this reference period/survey be available?	Financial year data are published in January each year.
Other comments	—