Mental health in South Australia

Monitoring access and outcomes

July 2020

Health Performance Council

Government of South Australia

Health Performance Council

Mental health in South Australia, monitoring access and outcomes, July 2020

Disclaimer

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Acknowledgment of the Aboriginal peoples of South Australia

The Health Performance Council acknowledges the Aboriginal peoples of South Australia and their ongoing contributions to and participation in the life of South Australia. We acknowledge and respect their spiritual relationship with their respective countries.

We also acknowledge the diversity of Aboriginal people in South Australia. Our Australian continent is known to have been inhabited for at least 55,000 years. The first inhabitants comprised over 270 different Aboriginal language/cultural groups across Australia, with 40 independent groups living in South Australia. Each group occupied its own territory and had its own unique culture, beliefs, laws, language, stories, ceremonies and art (Reconciliation SA, 2017). Aboriginal peoples in their diversity have demonstrated resilience and have made significant contributions to South Australia despite the ongoing effects of colonisation and dispossession.

Executive summary

The Health Performance Council commissioned this report to fill a gap in resources and provide findings to serve as a catalyst for action. It has four goals:

1. To inform the Minister for Health and Wellbeing on the extent of the state's mental health workforce, facilities, resources; service models and strategies.
2. To provide public monitoring and quantitative reporting of select health outcome measures for South Australians with mental health issues.
3. To provide a statistical resource that can be re-used by others as a template for future regular and publicly available monitoring and reporting.
4. To identify gaps, shortcomings and opportunities for improvement in relevant data collections.

This report monitors mental health access and outcomes by selecting *Report on Government Services 2020* mental health indicators—supplemented with other data sources—arranged into broad topic areas.

Key stakeholder organisations were consulted and assisted the Council make sense of mental health access and outcomes performance indicators. Stakeholder organisations included local health network governing boards, organisations representing Aboriginal health, veterans' health, culturally and linguistically diverse communities and people with lived experience as service users. Valued feedback was used to finalise advice, narrative and context. Feedback from this consultation was clear—there are gaps and shortfalls in the monitoring and reporting of the performance of the South Australian mental health system that must be addressed in areas of:

- Timeliness, availability, completeness and accuracy of data
- Collaboration and data sharing between government agencies and departments, the private sector and non-government organisations
- Consistent definitions of mental health and psychosocial needs when accessing services and, related to that, identification of levels of unmet need.

Importantly, it would be remiss of the Council not to highlight here that, during our consultation, we heard that stakeholder organisations who advocate for specific and vulnerable communities feel that the government is slow to respond in translating recommendations into policies and practices. Stakeholder organisations that engage willingly and in good faith want to see advice provided to government have an impact on improving outcomes.

OPPORTUNITIES FOR IMPROVEMENT

The Health Performance Council finds that monitoring and reporting of mental health access and outcomes in South Australia could be improved. Priority attention is required in three important areas:

1. **There is an inability to report multilayered, timely data for: (i) high-needs geographic areas; (ii) specific and vulnerable population groups; and (iii) distribution of workforce in a cohesive way. Data gaps in these areas need urgent attention before monitoring and reporting can claim to be representative of the population.**
2. **Consumer experience of mental health treatment and rehabilitation services is a critical gap in the state's monitoring and reporting of mental health outcomes. The Council could make no assessment of South Australia's performance in relation to consumer experience of mental health care in this state due to no data made available by the public health system.**
3. **Mental health outcomes would be improved with better collaboration and data sharing between government agencies and departments, the private sector and non-government organisations. This is hampered, in part, by data systems that are outdated and not compatible with other technological infrastructure.**

In relation to mental health access and outcomes in South Australia, the Council heard that:

- there are gaps in cultural competency training
- there is a greater need for mental health education awareness in the community to minimise stigma
- more should be done to enable partnerships between family, carers and service providers
- service models for special needs groups are lacking
- services are minimal and fragmented
- there is unmet need for appropriately accredited interpreters.

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Introduction

Australia responds to the mental health care needs of the general population through a mental health system comprising three broad sectors: (1) public and private emergency, inpatient, and outpatient specialist mental health services; (2) primary health care services; and (3) general community services, including school-based services.

At present there is no known publicly available, comprehensive, regular monitoring and reporting of access and outcomes in relation to the South Australian mental health system. Performance monitoring and reporting of Australian, state and territory governments' management of mental health and mental illnesses is currently done by national bodies such as the Australian Government's Productivity Commission.

In this report, the Health Performance Council monitors mental health access and outcomes by selecting *Report on Government Services 2020* mental health indicators that can be compared between states and territories and arranges them into broad topic areas. *Report on Government Services 2020* data is supplemented with other sources such as the Australian Institute of Health and Welfare, Australian Health Practitioner Regulation Agency, and SA Health where indicated.

This report also summarises what the Council heard from a consultation process with key stakeholder organisations.

Purpose of this monitoring report

This report fills a gap in available resources and its advice should be a call to action. Its purpose is four-fold:

- To inform the Minister for Health and Wellbeing on the extent of the state's mental health: (1) workforce; (2) facilities and resources; and (3) service models and strategies.
- To provide public monitoring and quantitative reporting of select health outcome measures for South Australians with mental health issues. Outcome measures will be timely, relevant and high-quality. Outcome measures will be compared by specific population groups and geography.
- To provide a statistical resource that can be re-used by SA Health, the primary health networks, the SA Mental Health Commission and other stakeholders as a template for future regular and publicly available monitoring and reporting.
- To identify gaps, shortcomings and opportunities for improvement in relevant data collections.

Consultation process

This monitoring report was released initially as a consultation draft with emerging findings from the populated indicators, seeking feedback from key stakeholders to finalise advice, narrative and context. The Health Performance Council wants to use this report to build and leverage synergies from joint interests of other professional bodies and advisory groups in co-operation with the South Australian Mental Health Commission.

The consultation process asked key stakeholder organisations to provide guidance on 3-5 measures they consider—from a consumer point-of-view—local health network governing boards should prioritise for monitoring and reporting on a regular basis. Organisations invited to provide feedback are listed as an appendix of this report. A summary of what we heard from the consultation process is provided at the front of this report.

Background

Towards the end of its 2015-2018 reporting period, the Health Performance Council completed—as one of its priority reviews for that period—an initial scoping of an approach to monitor health outcomes for people with mental health issues in South Australia. In 2019, the Council agreed to produce a short report of populated indicators along with relevant commentary, concentrating not just on outcomes but also on issues of access, quality and recommended improvements. Every year the Council publishes on its website a short statistical summary of select health indicators from the Productivity Commission's *Report on Government Services*, comparing South Australia to Australia. In March 2019, the Council included mental health indicators in that summary.

This report continues to build on the Council's monitoring of access and outcomes for people living with mental health issues such as our 2013 report, *Mental Health in Rural and Remote South Australian Communities* (HPC 2013). The Council recognises the important strategic frameworks of the SA Mental Health Commission's *Strategic Plan 2017-2022* (SAMHC 2017) and the *SA Mental Health Services Plan 2020-2025* (SA Health 2019a). This report will support the ongoing implementation, monitoring and reporting of those plans, but that was not the primary intent for commissioning this project.

What we heard from our consultation

This monitoring report was released initially as a consultation draft with emerging findings from the populated indicators, seeking feedback from key stakeholder organisations to finalise advice, narrative and context. The consultation process focussed on asking specific stakeholder organisations three key questions to help prioritise mental health monitoring and reporting of access and outcomes:

1. What do you want from a report that monitors indicators of mental health in South Australia?
2. What mental health indicators should SA Health local health network governing boards monitor on a monthly basis?
3. What are the biggest gaps or shortfalls in the state government's monitoring and reporting of mental health in South Australia?

What do you want from a report that monitors indicators of mental health in South Australia?

Respondents told us of a need for greater accountability and visibility in monitoring and reporting of mental health outcomes in South Australia. They want a reporting regime that has flexibility and scope to monitor services on a regional and timely basis to quickly target improvements across the mental health systems (primary, hospital, and community), and drill down to high-needs geographic areas and specific and vulnerable population groups. Population groups at increased risk of a range of social, behavioural, and mental health problems resulting from various intersecting stressful experiences include:

- Aboriginal persons
- Aged persons
- Lesbian, gay, bisexual, transgender, intersex and queer persons
- Persons from culturally and linguistically diverse backgrounds (including refugees and new migrants)
- Persons in custody
- Persons living with disability and co-morbidities
- Persons who reside in rural and remote areas of the state
- Persons who reside in socioeconomically disadvantaged areas of the state
- Veterans
- Young people with developmental disability.

People from these groups—in the words of one stakeholder organisations the Health Performance Council consulted with—"can be victims of inequality, often missing out on available resources, and often receiving services and treatment outcomes that are inferior in quality".

When identifying status of people from culturally and linguistically diverse backgrounds, respondents told us that data collection should include: (1) preferred language; and (2) need for and use of appropriately accredited interpreters. Further in relation to reporting by specific and vulnerable population groups, respondents told us that datasets should comply with national standards such as Australian Bureau of Statistics' definitions and data collection methods to ensure consistency in monitoring and reporting of comparisons and trends.

Respondents want monitoring and reporting that is a "single version of the truth" useful as a tool in engaging with various stakeholders—including the media—as evidence of the real state of play in mental health injury and treatment. Respondents want a statistical resource for policy setting, resource allocation, planning services, performance monitoring, tendering, and developing and operating integrated models of care. Current disparate sources of activity data often do not coalesce nor adequately reflect real time consumer activity, diagnosis, risk, or mental state. A single source of mental health data (e.g. inpatient, community, rehabilitation, recovery and health status) would vastly improve the capacity of the service to efficiently provide services to those most in need. Service efficiency gains would be significant and consequent health outcomes for consumers enhanced.

Indicators should include a balance of multifactorial causation/correlation measures (e.g. population health), outcomes (e.g. recovery), process (e.g. care plans), and structure (e.g. workforce).

What mental health indicators should SA Health local health network governing boards monitor on a monthly basis?

We heard clearly from our consultation that consumer experience of mental health treatment and rehabilitation services is THE most important factor to be monitoring and reporting if local health network governing boards want to see exactly what is working and what isn't. Linking health outcomes to consumer-reported experience of service provision gives the system capacity to adapt to increasing health and psychosocial community need and complexity.

Other indicators identified as important by consulted organisations for priority monitoring and reporting of mental health by SA Health LHN governing boards (listed alphabetically):

- Ambulatory indicators focusing on the specific domains of access, outcomes and quality of life. Proposed ambulatory indicators are: (1) Care Plan compliance; (2) Closed cases re-referred within 6 months; (3) Average length of case (days); (4) Average treatment days; (5) Average HoNOS[1] at case start; (6) YES[2] survey completion; (7) Average change in clinically significant HoNOS items; (8) Re-admission rates into inpatient and community mental health services.
- Intersection indicators looking at the links between mental health, specific populations and co-morbidities. For example, arthritis is often associated with chronic pain and disability often leading to long term emotional distress. Other intersection indicators include risk and resilience factors in the broader population, utilising wellbeing measures that provides predictive data on population health.
- Medicare Benefits Scheme data on mental health assessments and plans, counselling and provision of specific therapeutic interventions and strategies for psychological distress.
- Planned capacity versus actual utilisation by people needing mental health services at different levels—including hospital (emergency, inpatient, ICU and outpatient mental health services), primary mental health care services, and mental health community services, as well as by different diagnostic groups and treating needs (e.g. psychosis, borderline personality disorder, self-harm).
- Prevalence of diagnosed mental health conditions, disorders and problems.
- Suicide rates and attempted suicides.
- Tracking indicators monitoring outcomes at service interfaces and over the whole patient journey, including repeat and return visits. E.g. Tracking of re-admission rates into inpatient and community mental health services, transfers of children and young people to adult mental health services, tracking of health outcomes and ensuring service provision has capacity to adapt to increasing health and psychosocial community need and complexity.
- Utilisation rates of mental health services, including public and private hospital emergency, inpatient and outpatient specialist mental health services, primary health care services, and general community services (including school-based services).

[1] HoNOS (Health of the Nation Outcomes Scalesis a measure of the health and social functioning of people with severe mental illness. The scales contain 12 items measuring behaviour, impairment, symptoms and social functioning. The scales are completed after routine clinical assessments in any setting.

[2] Your Experience of Service

What are the biggest gaps or shortfalls in the state government's monitoring of mental health in South Australia?

We heard clearly from key stakeholder organisations consulted that one very big gap is the failure to capture and publicly report consumer experience of service information. There is virtually none to draw on. Very little is known about consumer experience, service satisfaction and even less about service efficacy, particularly as it pertains to specific and vulnerable population groups. Until this is addressed no decision maker can make an informed choice . When there is an increase in a particular cohort presenting with a mental illness, the system needs to find out why this is happening. If there is an increase in a particular area it needs to be looked at with a wide lens.

In terms of government monitoring and reporting of mental health in South Australia, respondents identified gaps and shortfalls in:

- Awareness, education and understanding amongst specific and vulnerable population groups to reduce stigma and improve access and equity.
- Collaboration and data sharing between government agencies and departments, the private sector and non-government organisations. Interfacing capacity between health data systems would provide real time collateral and corroborating health information that can assist with diagnosis care and discharge planning.
- Completeness and accuracy of data.
- Consistent definitions of mental health and psychosocial needs when accessing services and, related to that, identification of levels of unmet need.
- Outcomes of care and service integration for people with complex mental health needs. As one consulted organisation put it, “This cohort of consumers are heavy users of state funded health, social and justice services and yet we know almost nothing regarding the effectiveness of these services.”

On data collection, storage and usability, stakeholders told us that current collection of activity data is hampered by mental health data systems no longer fit for purpose. Some systems are outdated and not compatible with other technological infrastructure. Consumer and organisational activity data collected by some systems do not always accurately reflect consumer health status or outcomes, service use, workforce activity or health condition. Usability is also problematic for many users, and this is reflected in the often poor accuracy of collected data and reports.

Data systems must be person-focussed. Respondents told us that specific and vulnerable communities need to be better represented in government datasets generally. Not all consumers choose to identify themselves or their loved ones every time they interact with government mental health services, often for fear of discrimination. And mental health service providers may fail to ask the status of consumers from specific population groups, even where collection of this status field is mandatory. Issues of service access cannot be adequately addressed without the collection of accurate and informative data about the status of service users. Inadequate data collection systems continue to impede inclusive mental health service planning and development across the country.

Also, we heard that:

- there are gaps in cultural competency training
- there is a greater need for mental health education awareness in the community to minimise stigma
- more should be done to enable partnerships between family, carers and service providers
- service models for special needs groups are lacking
- services are minimal and fragmented
- there is unmet need for appropriately accredited interpreters.

What we found in the data

As at 30 June 2018 there were over 1.7m people in South Australia, representing 7.0% of Australia's total population of 24.8m. Around one in seven adults in South Australia is living with high or very high levels of psychological stress (anxiety and depression). Prevalence is much higher amongst persons who live in the lowest socio-economic status areas of the state (23.5%), persons living with a disability (33.1%), and Aboriginal persons (37.6%). Suicide deaths in South Australia account for 12.0 deaths per 100,000 population, or over 200 deaths per year in absolute numbers.

In this report, the Health Performance Council has summarised data available in the mental health management data tables of the *Report on Government Services 2020*—supplemented with data from other sources—and compares South Australia to the other states and territories and national averages across the domains of: risk and resilience factors; services activity; patient outcomes; workforce and carers; capacity and utilisation; safety, quality and consumer experience; and costs.

In summary, the Health Performance Council finds:

Risk factors

RANKED HIGHEST South Australia ranks first out of the states and territories for people with mental or behavioural problems living with arthritis.

RANKED LOWEST South Australia ranks eighth out of the states and territories for people with mental or behavioural problems at risk of long-term harm from alcohol.

TRENDS There has been an increase in the South Australian proportion of people with mental or behavioural problems living with arthritis.

Resilience factors

RANKED HIGHEST South Australia ranks first out of the states and territories for people with a mental illness who had recent (within the last week) face-to-face contact with family or friends living outside the household.

RANKED LOWEST South Australia ranks seventh out of the states and territories for people aged 16-64 years with mental or behavioural problems who are employed.

TRENDS could not be determined.

Services activity

RANKED HIGHEST South Australia ranks first out of the states and territories for rural and remote residents receiving clinical mental health services in the public system.

RANKED LOWEST South Australia ranks seventh out of the states and territories for mental health care specific Medicare Benefit Scheme (MBS) items processed for non-clinical psychologist services. South Australia also ranks seventh for new clients of MBS-subsidised mental health services.

TRENDS have been relatively steady.

Patient outcomes

RANKED HIGHEST South Australia ranks third out of the states and territories for people aged 0-17 years and 18-64 years who received mental health care provided by community care services and who significantly improved.

RANKED LOWEST South Australia ranks seventh out of the states and territories for people aged 18-64 years who received mental health care provided in hospital and who significantly improved.

TRENDS There has been an increase in the percentage of people aged 0-17 years who received mental health care provided in ongoing community care who significantly improved.

Workforce and carers

RANKED HIGHEST South Australia ranks second out of the states and territories for staff employed in direct care specialised mental health services.

RANKED LOWEST South Australia ranks eighth out of the states and territories for other allied health practitioners aged 65 years and over employed in the mental health sector as a percentage.

TRENDS have been relatively steady.

Capacity and utilisation

RANKED HIGHEST South Australia ranks second out of the states and territories for available beds in psychiatric hospitals .

RANKED LOWEST South Australia ranks seventh out of the states and territories for available beds in acute hospitals with psychiatric units or wards. South Australia also ranks seventh for length of stay in public hospital acute units–general mental health services.

TRENDS There has been a decrease in patient days recorded for admitted patients in non-acute units. Conversely, there has been an increase in length of stay for older persons mental health services in public hospital acute units.

Safety and quality

RANKED HIGHEST South Australia ranks first out of the states and territories for persons aged 75 years and over readmitted to hospital within 28 days of discharge.

RANKED LOWEST South Australia ranks eighth out of the states and territories for community follow-up within the first seven days of discharge from a psychiatric admission.

TRENDS have been relatively steady.

Costs

RANKED HIGHEST South Australia ranks first out of the states and territories for costs per inpatient bed day (average recurrent) for psychiatric hospitals–acute units, older persons mental health services and non-24 hour staffed units in community residential services.

RANKED LOWEST South Australia ranks sixth out of the states and territories for cost per treatment day of ambulatory mental health care.

TRENDS There has been an increase in costs per inpatient bed day for older persons' non-acute mental health services.

Data gaps

In reviewing the mental health management data tables of the *Report on Government Services 2020* for this report, the Health Performance Council finds that reporting for mental health could be improved with attention to making data more widely available in two important areas:

- Specific and vulnerable population groups—Some population groups are not well represented in government datasets. These groups can face particular mental health challenges and require tailored responses: Aboriginal persons, persons from culturally and linguistically diverse backgrounds, persons living with other disabilities and co-morbidities, carers, veterans, lesbian, gay, bisexual, transgender, intersex and queer persons, persons in custody, aged persons, persons who reside in socioeconomically disadvantaged areas of the state, persons who reside in rural and remote areas of the state. The Council recognises that persons from vulnerable communities may choose not to identify themselves or their loved ones every time they interact with government services.
- The Health Performance Council could make no assessment of South Australia's performance in relation to consumer experience of mental health care in this state due to no data made available by the public health system.

SOUTH AUSTRALIAN POPULATION MENTAL HEALTH AND WELLBEING

As at 30 June 2018—the time period when the majority of indicators in this indicator report applies—there were over 1.7m people in South Australia, representing 7.0% of Australia's total population of 24.8m. Population growth in this state (0.9% per annum) is around half the national average (1.6% per annum) (RoGS 2020).

Around one in seven (or 13.6%, age standardised) adults in South Australia is living with high or very high levels of psychological stress (anxiety and depression). Psychological distress is defined here using the Kessler 10 Item (K10) Psychological Distress Questionnaire—a checklist that measures to what extent a person has been affected by anxiety and depression during the previous 30 days. The South Australian rate (13.6%) is comparable to the Australian average (13.0%). However, prevalence is much higher amongst persons who live in the lowest socio-economic status areas of the state (23.5%), persons living with a disability (33.1%), and Aboriginal persons (37.6%). The South Australia rate of adults with high or very high levels of psychological stress for Aboriginal persons is ranked first of the states and territories (RoGS 2020).

Suicide deaths in South Australia account for 12.0 deaths per 100,000 population, or over 200 deaths per year in absolute numbers. The South Australian rate is comparable to the national average (12.1 deaths per 100,000 population). There is a disparity between the rates for metropolitan Adelaide (11.5) versus the rest of state (13.4). The rate of suicide deaths amongst Aboriginal persons, at 21.2 deaths per 100,000 population, is around double the overall rate in South Australia (RoGS 2020).

Table 1: Psychological distress (anxiety and depression) and suicide deaths in South Australia and Australia

SA rank (out of 8)	Selected *Report on Government Services* mental health management indicator	Reporting period	Unit of measurement	SOUTH AUSTRALIA	Australia	SA change from previous period	
3	**Adults with high or very high levels of psychological distress**	2017-18	Percentage of population (age-standardised)	**13.6**	**13.0**	*	**13.7**
1	Residents of lowest socio-economic status geographical areas			23.5	20.5	*	23.6
6	Persons living with a disability or restrictive long-term health condition			33.1	35.6	↓	39.1
1	Aboriginal persons	2017-19		37.6	31.2	*	34.3
5	**Suicide deaths**	2018	Deaths per 100,000 population	**12.0**	**12.1**	↓	**12.8**
5	Greater capital city			11.5	10.3	–	11.5
6	Rest of state/territory			13.4	15.9	↓	18.3
4	Aboriginal persons	2014-2018		21.2	23.7	n.a.	n.a.
6	Persons aged 5-17 years			2.0	2.4	↑	1.8

Source: RoGS 2020, Tables 13A.46, 48, 52-55. See the 'How to interpret tables in this report' appendix for information about headings, symbols and acronyms used.

SA Health population health data on psychological distress (anxiety and depression)

SA Health collects its own data on psychological distress (anxiety and depression) in the community via the South Australian Population Health Survey (SAPHS). As with data reported in the Report on Government Services (RoGS), SAPHS also uses the Kessler 10 Item (K10) Psychological Distress Questionnaire to measure the extent a person has been affected by anxiety and depression during the previous 30 days. However, the SAPHS and RoGS figures are not directly comparable (RoGS data has been age standardised). SAPHS data is presented here to show differences between SA Health regions (local health networks), age and sex, and socio-economic status.

High or very high levels of psychological distress (anxiety and depression) is more prevalent amongst metropolitan Adelaide residents (20.3%) than their Country SA counterparts (13.9%), and highest in the Northern Adelaide Local Health Network (27.6%). More than half (57.9%) of women aged 18 to 24 years have recently experienced high or very high levels of psychological distress. As with the RoGS data, SAPHS data reports higher prevalence amongst persons who live in the lowest socio-economic areas of South Australia (27.4%) (SA Health 2019b).

Table 2: High or very high levels of psychological distress (anxiety and depression) (ages 18+ years) by local health network, 2018

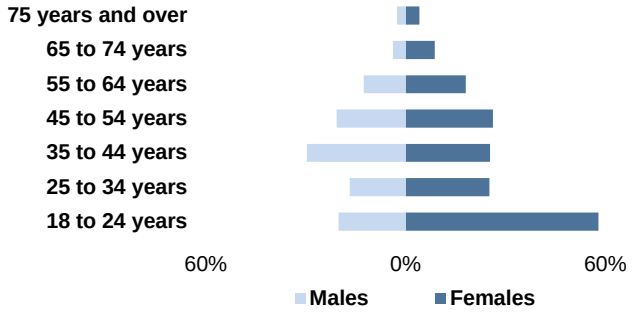
Local Health Network	Prevalence (%)
Northern Adelaide	27.6%
Central Adelaide	16.6%
Southern Adelaide	16.9%
Metropolitan Adelaide	20.3%
Barossa Hills Fleurieu	9.5%
Eyre and Far North	10.1%*
Flinders and Upper North	15.2%*
Limestone Coast	21.1%
Riverland Mallee Coorong	20.2%
Yorke and Northern	11.2%
Country SA	13.9%
SOUTH AUSTRALIA	**19.0%**

* Relative standard error is between 25% and 50%. Please treat the estimate with caution.

Note: Data are weighted which can result in rounding discrepancies.

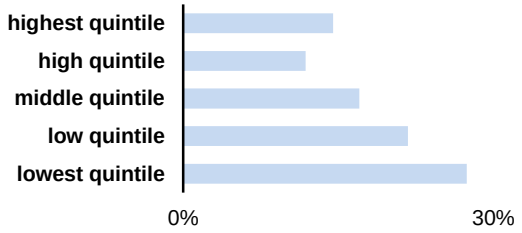
Source: SA Health 2019b

Figure 1: High or very high levels of psychological distress (anxiety and depression) (ages 18+ years) by age and sex, 2018



Source: SA Health 2019b

Figure 2: High or very high levels of psychological distress (anxiety and depression) (ages 18+ years) by socioeconomic status, 2018



Source: SA Health 2019b

SA Health population health data on adults living in the community with a doctor-diagnosed mental health condition

SA Health's South Australian Population Health Survey (SAPHS) also collects data on adults living in the community with a doctor-diagnosed mental health condition. This is the prevalence of adults living with doctor-diagnosed anxiety, depression, stress, or any other mental health problem. Around one in three (30.0%) respondents in 2018 said yes to this question. The prevalence of doctor-diagnosed mental health conditions is statistically significantly higher in metropolitan Adelaide (31.0%) than Country SA (25.8%), and highest in the Southern Adelaide Local Health Network. More than half (or 50.2%) women aged 25 to 34 years are living with a doctor-diagnosed mental health condition. SAPHS data reports higher prevalence amongst persons who live in the lowest socio-economic areas of South Australia (35.4%) (SA Health 2019b).

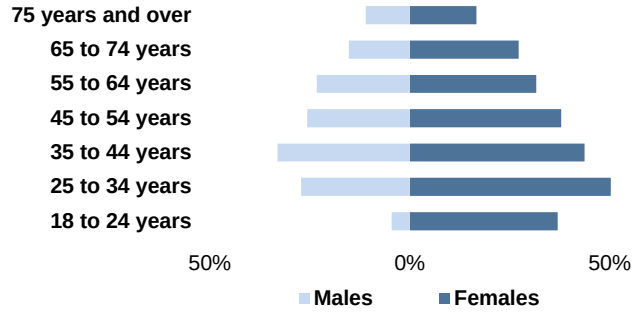
Table 3: Doctor-diagnosed mental health condition (ages 18+ years) by local health network, 2018

Local Health Network	Prevalence (%)
Northern Adelaide	32.5%
Central Adelaide	26.5%
Southern Adelaide	34.9%
Metropolitan Adelaide	31.0%
Barossa Hills Fleurieu	25.8%
Eyre and Far North	26.3%
Flinders and Upper North	29.8%
Limestone Coast	25.9%
Riverland Mallee Coorong	29.0%
Yorke and Northern	21.4%
Country SA	25.8%
SOUTH AUSTRALIA	**30.0%**

Source: SA Health 2019b

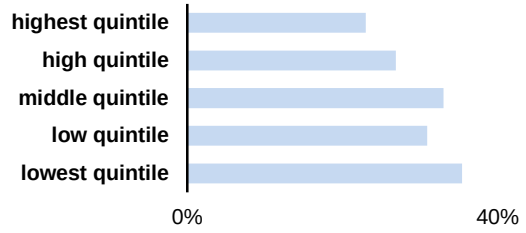
Note: Data are weighted which can result in rounding discrepancies.

Figure 3: Doctor-diagnosed mental health condition (ages 18+ years) by age and sex, 2018



Source: SA Health 2019b

Figure 4: Doctor-diagnosed mental health condition (ages 18+ years) by socioeconomic status, 2018



Source: SA Health 2019b

RISK AND RESILIENCE FACTORS

Risk factors

RANKED HIGHEST South Australia ranks first out of the states and territories for people with mental or behavioural problems living with arthritis, at 33.3% (age standardised), above the roughly one in five (19.2%, age standardised) of all persons in South Australia living with arthritis (RoGS 2020).

RANKED LOWEST South Australia ranks eighth out of the states and territories for people with mental or behavioural problems at risk of long-term harm from alcohol, at 12.6% (age standardised) of the population, below the roughly one in six (16.2%, age standardised) of all persons in South Australia at risk of long-term harm from alcohol (RoGS 2020).

TRENDS There has been a 7.4 percentage point increase in the South Australian proportion of people with mental or behavioural problems living with arthritis, from around one in four persons (25.9%, age standardised) in 2016-17 to a third (33.3%, age standardised) of persons in 2017-18 (RoGS 2020).

DATA GAPS Risk factor indicators for specific population groups—such as Aboriginal persons, persons from culturally and linguistically diverse backgrounds, aged persons, rural and remote residents, and residents of lowest socio-economic areas—are not published in the Report on Government Services 2020 mental health management data tables.

Table 4: Health risk factors and mental illness status, South Australia compared to Australia

SA rank (out of 8)	Selected *Report on Government Services* mental health management indicator	Reporting period	Unit of measurement	SOUTH AUSTRALIA	Australia	SA change from previous period	
	Health risk factors and mental illness status	2017-18	Percentage of population (age-standardised)				
	Overweight/obese						
2	People with mental or behavioural problems			71.9	69.0	↑	66.2
2	All people			68.9	66.7	↑	64.5
	Arthritis						
1	People with mental or behavioural problems			33.3	25.9	↑	25.9
3	All people			19.2	17.7	*	20.2
	Asthma						
2	People with mental or behavioural problems			23.1	18.4	↑	16.9
4	All people			12.0	11.5	*	11.4
	Daily smoker						
6	People with mental or behavioural problems			19.6	22.2	*	20.0
6	All people			13.4	14.1	*	13.5
	At risk of long term harm from alcohol						
8	People with mental or behavioural problems			12.6	16.9	*	15.7
5	All people			16.2	16.1	*	16.7
	Diabetes						
3	People with mental or behavioural problems			9.1	7.6	*	9.2
2	All people			6.8	5.7	*	6.1
	Cardiovascular disease						
5	People with mental or behavioural problems			8.0	7.6	↓	10.8
3	All people			5.6	5.4	*	5.9
	Cancer						
3	People with mental or behavioural problems			3.0	3.0	*	3.5
6	All people			1.9	2.1	*	2.1

Source: RoGS 2020, Tables 13A.56-57. See the 'How to interpret tables in this report' appendix for information about headings, symbols and acronyms used.

Resilience factors

RANKED HIGHEST South Australia ranks first out of the states and territories for people with a mental illness who had recent (within the last week) face-to-face contact with family or friends living outside the household, at 81.7% (crude rate) of the population. However, while this is above the national average for people with a mental illness (76.5%) it is below the comparative 84.2% all-population rate for South Australia (RoGS 2020).

RANKED LOWEST South Australia ranks seventh out of the states and territories for people aged 16-64 years with mental or behavioural problems who are employed, at 59.1% (age-standardised) of the population. This is below both the national average for people with mental or behavioural problems (63.9%, age-standardised) and below the 77.3% (age-standardised) all-population rate for South Australia (RoGS 2020).

TRENDS cannot be determined clearly from the sample or data for the previous reporting period is not published in the Report on Government Service 2020 mental health management data tables (RoGS 2020).

DATA GAPS Resilience factor indicators for specific population groups—such as Aboriginal persons, persons from culturally and linguistically diverse backgrounds, aged persons, rural and remote residents, and residents of lowest socio-economic areas—are not published in the Report on Government Services 2020 mental health management data tables.

Table 5: Employment status, face-to-face contact with family and friends, and experience of discrimination, South Australia compared to Australia

SA rank (out of 8)	Selected *Report on Government Services* mental health management indicator	Reporting period	Unit of measurement	SOUTH AUSTRALIA	Australia	SA change from previous period	
	Employment status: Aged 16–64 years and are employed	2017-18	Percentage of population (age-standardised)				
7	People with mental or behavioural problems			59.1	63.9	*	62.9
5	All people			77.3	77.1	*	75.0
	Had face-to-face contact with family or friends living outside the household in the last week	2014	Percentage of population				
1	People with a mental illness			81.7	76.5	n.a.	n.a.
2	All people			84.2	77.0	n.a.	n.a.
	Experienced discrimination or been treated unfairly	2014	Percentage of population				
6	People with a mental illness			25.0	29.1	n.a.	n.a.
6	All people			17.5	18.6	n.a.	n.a.

Source: RoGS 2020, Tables 13A.59, 60, 64. See the 'How to interpret tables in this report' appendix for information about headings, symbols and acronyms used.

SERVICES ACTIVITY

RANKED HIGHEST South Australia ranks first out of the states and territories for rural and remote residents receiving clinical mental health services in the public system, at 3.3% (age standardised) of the population. Note that this is a Health Performance Council estimate from published data. At 7.1% (age-standardised), the South Australian rate for Aboriginal persons is higher than the Australian average for Aboriginal persons (5.3%) and is up from the 6.8% recorded in the previous period (RoGS 2020).

RANKED LOWEST South Australia ranks seventh out of the states and territories for mental health care specific Medicare Benefit Scheme (MBS) items processed for non-clinical psychologist services, at 73.8 services per 1,000 population. South Australia also ranks seventh for new clients of MBS-subsidised mental health services, at 29.8% of total clients (RoGS 2020).

TRENDS between reporting periods for indicators that the Health Performance Council classifies as services activity have been relatively steady (RoGS 2020).

DATA GAPS Proportion of people receiving clinical mental health services in the private system is not published in the Report on Government Services 2020 mental health management data tables.

Table 6: People receiving clinical mental health services, South Australia compared to Australia

SA rank (out of 8)	Selected *Report on Government Services* mental health management indicator	Reporting period	Unit of measurement	SOUTH AUSTRALIA	Australia	SA change from previous period	
	Proportion of people receiving clinical mental health services	2017-18	Percentage of population (age-standardised)				
3	**Public services**			**2.5**	**1.9**	—	**2.5**
2	Residents of lowest socio-economic status geographical areas			3.2	2.3	↓	3.3
2	Aboriginal persons			7.1	5.3	↑	6.8
1	Rural and remote residents (est.)			3.3	2.6	↑	2.9
n.a.	**Private services**			**n.p.**	**0.2**	**n.a.**	**n.p.**
n.a.	Residents of lowest socio-economic status geographical areas			n.a.	0.1	n.a.	n.a.
n.a.	Aboriginal persons			n.a.	n.a.	n.a.	n.a.
n.a.	Rural and remote residents (est.)			n.a.	0.1	n.a.	n.a.
5	**Total MBS and DVA services**			**10.3**	**10.6**	↑	**9.9**
	Total MBS and DVA services by population type						
n.a.	Residents of lowest socio-economic status geographical areas			n.a.	8.5	n.a.	n.a.
5	Aboriginal persons			11.8	10.6	—	11.8
5	Rural and remote residents (est.)			9.1	11.0	—	9.1
	Total MBS and DVA services by service type						
4	Psychiatrist			1.7	1.7	—	1.7
2	Clinical psychologist			2.9	2.2	↑	2.8
5	GP			8.2	8.7	↑	7.8
5	Other allied health			2.6	3.3	↑	2.4

Source: RoGS 2020, Tables 13A.7, 16, 17. See the 'How to interpret tables in this report' appendix for information about headings, symbols and acronyms used.

Table 7: Mental health care specific MBS items and clients, South Australia compared to Australia

SA rank (out of 8)	Selected *Report on Government Services* mental health management indicator	Reporting period	Unit of measurement	SOUTH AUSTRALIA	Australia	SA change from previous period
	Mental health care specific MBS items processed	2017-18	Number of services per 1,000 population			
5	Psychiatrist services			92.8	97.8	↓ 96.5
4	GP mental health specific services			130.9	146.3	↑ 125.6
2	Clinical psychologist services			116.0	93.0	↑ 113.1
7	Other psychologist services			73.8	117.3	↑ 72.5
2	Other allied health services			22.2	16.8	↑ 19.4
4	**Young people (persons aged less than 25 years) who had contact with MBS subsidised primary mental health care services**	2018-19	Percentage of people who had contact with MBS subsidised primary mental health care services	**9.0**	**8.9**	↑ **8.4**
	New clients	2017-18	New clients as a percentage of total clients			
5	Under the care of state or territory specialised public mental health services			40.7	41.7	↑ 40.2
7	Of MBS subsidised mental health services			29.8	30.5	↑ 29.2

Source: RoGS 2020, Tables 13A.8-10, 20. See the 'How to interpret tables in this report' appendix for information about headings, symbols and acronyms used.

PATIENT OUTCOMES

RANKED HIGHEST South Australia ranks third out of the states and territories for people aged 0-17 years and 18-64 years who received mental health care provided by community care services and who significantly improved, at 56.9% and 53.5%, respectively, of people discharged (RoGS 2020).

RANKED LOWEST South Australia ranks seventh out of the states and territories for people aged 18-64 years who received mental health care provided in hospital and who significantly improved, at 65.6% of people discharged (RoGS 2020).

TRENDS There has been a 5.1 percentage point increase in the percentage of people aged 0-17 years who received mental health care provided in ongoing community care who significantly improved, from over a quarter (27.7%) of people discharged in 2016-17 up to nearly a third (32.8%) in 2017-18 (RoGS 2020).

DATA GAPS Risk factor indicators for specific population groups—such as Aboriginal persons, persons from culturally and linguistically diverse backgrounds, select age groups, rural and remote residents, and residents of lowest socio-economic areas—are not published in the Report on Government Services 2020 mental health management data tables.

Table 8: People who received mental health care services and who significantly improved, South Australia compared to Australia

SA rank (out of 8)	Selected *Report on Government Services* mental health management indicator	Reporting period	Unit of measurement	SOUTH AUSTRALIA	Australia	SA change from previous period	
	People who received mental health care provided by state and territory public mental health services and who significantly improved	2017-18	Percentage of people				
	People discharged from hospital who significantly improved						
n.a.	Aged 0–17 years			n.p.	56.5	n.a.	n.p.
7	Aged 18–64 years			65.6	73.1	↓	67.5
n.a.	Aged 65 years or over			n.p.	70.5	n.a.	n.p.
	People discharged from community care who significantly improved						
3	Aged 0–17 years			56.9	53.9	n.a.	n.p.
3	Aged 18–64 years			53.5	53.0	n.a.	n.p.
n.a.	Aged 65 years or over			n.p.	47.7	n.a.	n.p.
	People in ongoing community care who significantly improved						
5	Aged 0–17 years			32.8	37.7	↑	27.7
6	Aged 18–64 years			20.4	24.6	↓	20.6
5	Aged 65 years or over			24.3	25.7	↓	24.7

Source: RoGS 2020, Table 13A.62. See the 'How to interpret tables in this report' appendix for information about headings, symbols and acronyms used.

WORKFORCE AND CARERS

RANKED HIGHEST South Australia ranks second out of the states and territories for staff employed in direct care specialised mental health services, at 128.7 full-time equivalent staff per 100,000 population, compared to the national average of 110.3 FTEs per 100,000 population (RoGS 2020).

RANKED LOWEST South Australia ranks eighth out of the states and territories for other allied health practitioners aged 65 years and over employed in the mental health sector as a percentage, at 0.5% of full-time equivalents (RoGS 2020).

TRENDS between reporting periods for indicators that the Health Performance Council classifies as workforce and carers have been relatively steady (RoGS 2020).

DATA GAPS Workforce and employment indicators for specific population groups—such as Aboriginal persons and persons from culturally and linguistically diverse backgrounds—are not published in the Report on Government Services 2020 mental health management data tables.

Table 9: Mental health services workforce–staff, consumer workers, and paid carers, South Australia compared to Australia

SA rank (out of 8)	Selected *Report on Government Services* mental health management indicator	Reporting period	Unit of measurement	SOUTH AUSTRALIA	Australia	SA change from previous period
2	**Staff employed in direct care specialised mental health services**	2017-18	Full-time equivalent (FTE) staff per 100,000 population	**128.7**	**110.3**	↑ **125.3**
4	Admitted patient services			61.5	55.2	↑ 59.9
3	Ambulatory services			55.3	46.4	↓ 56.1
5	Residential services			11.9	8.8	↑ 9.2
	Staff aged 65 years and over, employed in the mental health sector	2018	Percentage of full-time equivalents (FTEs)			
5	Medical practitioners			13.0	12.9	↑ 12.2
3	Nurses			6.1	5.1	↑ 5.0
4	Psychologists			8.3	7.9	↓ 9.0
8	Other allied health practitioners			0.5	1.5	↓ 0.7
	Consumer and carer participation	2017-18	Number of full-time equivalents (FTEs) per 1,000 paid direct care workers			
3	Paid consumer workers			7.7	6.4	↑ 7.4
3	Paid carer workers			2.2	2.4	↑ 2.0

Source: RoGS 2020, Tables 13A.12, 23, 35. See the 'How to interpret tables in this report' appendix for information about headings, symbols and acronyms used.

Workforce data —Australian Institute of Health and Welfare

The Australian Institute of Health and Welfare—as part of its *Mental Health Services in Australia* web report—publishes mental health workforce tables by state and territory. In 2017, South Australia recorded 14.8 psychiatrist FTEs, 88.4 mental health nurse FTEs, and 67.3 psychologist FTEs per 100,000 population. The psychologist workforce in South Australia (67.3 FTEs per 100,000 population, including 50.4 FTEs per 100,000 population for clinical psychologists) is below the comparable national average (91.1 and 66.5 per 100,000 population, respectively) (AIHW 2020)

Workforce figures by geography at the state and territory level are not published in the Institute's mental health workforce data tables. However, Australia-wide 87.6% of psychiatrists, 76.2% of mental health nurses, and 83.0% of psychologists are employed in the major cities (AIHW 2020).

Table 10: Employed mental health workforce, South Australia compared to Australia

Mental health workforce, 2017	SOUTH AUSTRALIA				AUSTRALIA	
	FTEs (number)	Clinical FTE (number)	FTEs (per 100k popn.)	Clinical FTEs (per 100k popn.)	**FTEs (per100k popn.)**	**Clinical FTEs (per 100k popn.)**
Employed psychiatrists	255.4	212.6	14.8	12.3	**13.3**	**11.0**
Employed mental health nurses	1,523.2	1,410.1	88.4	81.8	**85.8**	**79.0**
Employed psychologists	1,160.3	869.1	67.3	50.4	**91.1**	**66.5**

Source: AIHW 2020

Workforce data —Australian Health Practitioner Regulation Agency

The Australian Health Practitioner Regulation Agency in its October-December 2019 *Performance Report*, reported 1,840 registered psychologists in South Australia, representing 3.2% of the 57,957 registered health practitioners in South Australia, and 4.8% of the 38,167 registered psychologists in Australia. During October-December 2019 there were 56 applications for registration finalised for psychologists in South Australia, representing 5.5% of the national total (AHPRA 2020).

The Agency receives notifications for management that identify concerns about a practitioner. From the time that the Agency first receives a notification, it evaluates the types and magnitude of risks that a practitioner might pose to the public. In the October-December 2019 quarter in South Australia there were 9 notifications received (5.6% of the national total), 12 notifications closed (8.6%), 6 notifications considered for acceptance (4.3%), 16 assessments completed (9.1%), one investigation completed (3.7%), one criminal offence completed (7.1%), and 15 monitoring cases open (9.4%) relating to registered psychologists (AHPRA 2020).

CAPACITY AND UTILISATION

RANKED HIGHEST South Australia ranks second out of the states and territories for available beds in psychiatric hospitals, at 9.1 available beds per 100,000 population (RoGS 2020).

RANKED LOWEST South Australia ranks seventh out of the states and territories for available beds in acute hospitals with psychiatric units or wards, at 17.8 beds per 100,000 population. South Australia also ranks seventh for length of stay in public hospital acute units–general mental health services, at an average of 10.1 days (RoGS 2020).

TRENDS There has been a decrease of 9.9 patient days per 1,000 population recorded for admitted patients in non-acute units, from 26.7 patient days per 1,000 population in 2016-17 to 16.8 in 2017-18. Conversely, there has been an increase of 8.2 days in length of stay for older persons mental health services in public hospital acute units, from an average of 28.6 days in 2016-17 to 36.8 days in 2017-18 (RoGS 2020).

DATA GAPS Capacity and utilisation indicators for specific population groups—such as Aboriginal persons and persons from culturally and linguistically diverse backgrounds—are not published in the Report on Government Services 2020 mental health management data tables.

Table 11: Mental health available hospital beds, hospital patient days and length of hospital stay, South Australia compared to Australia

SA rank (out of 8)	Selected *Report on Government Services* mental health management indicator	Reporting period	Unit of measurement	SOUTH AUSTRALIA	Australia	SA change from previous period
4	**Available beds in state and territory governments' specialised mental health services**	2017-18	Beds per 100,000 population	**36.7**	**38.2**	↓ **39.7**
2	Psychiatric hospitals			9.1	6.5	↓ 13.1
7	Acute hospitals with psychiatric units or wards			17.8	21.4	↑ 17.6
6	Community-based residential units			9.8	10.3	↑ 9.0
	Mental health patient days	2017-18	Patient days per 1,000 population			
4	Admitted patient — acute units			70.8	68.4	↓ 72.2
3	Admitted patient — non-acute units			16.8	22.1	↓ 26.7
5	24-hour staffed community residential			24.2	23.7	↑ 22.7
7	**Length of stay in public hospital acute units**	2017-18	Average number of days	**11.5**	**13.1**	↑ **10.3**
7	General mental health services			10.1	11.8	↑ 9.3
5	Child and adolescent mental health services			4.1	10.0	↑ 3.3
4	Older persons mental health services			36.8	34.9	↑ 28.6

Source: RoGS 2020, Tables 13, 14, 39. See the 'How to interpret tables in this report' appendix for information about headings, symbols and acronyms used.

SA Health hospital inpatient activity

In South Australian public and private hospitals during 2018-19 there were 15,751 hospitalisations (inpatient separations) coded under the major diagnostic category (MDC) of 'mental diseases and disorders' (MDC 19). Around 90% of all mental health inpatient hospital activity (14,106 hospitalisation) is undertaken in the public hospital system. Public hospital mental health inpatient activity has seen a declining trend over recent years, down 12.9% from the 16,192 recorded in 2015-16 (SA Health 2020b).

Of the 13,597 public hospital hospitalisations (inpatient separations) coded as mental diseases and disorders for South Australian residents, around two thirds (62.5%) are for residents of metropolitan Adelaide and around one in three (33.9%) hospitalisations for rural and remote residents. On a per capita basis, the highest rate of public hospital inpatient activity coded as mental diseases and disorders was in the Flinders and Upper Norther Local Health Network (LHN), at 143.1 hospitalisations (inpatient separations) per 10,000 population and Limestone Coast LHN at 142.8 hospitalisations per 10,000 population (SA Health 2020b).

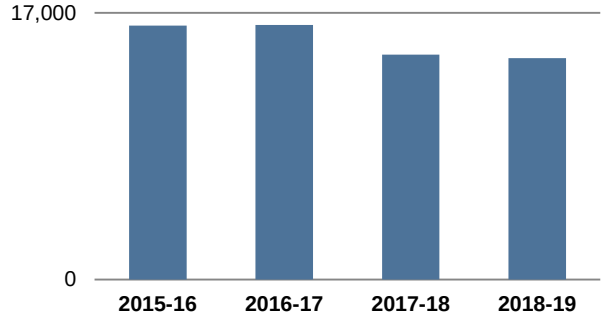
Over a quarter (27.8%) of public hospital hospitalisations (inpatient separations) coded as mental diseases and disorders were for residents in the bottom quintile socioeconomic status geographic areas of South Australia, 13.6% for persons aged 65 years and over, 7.7% for persons from culturally and linguistically diverse (CALD) backgrounds and 6.2% for Aboriginal persons (SA Health 2020b).

Table 12: Public hospital hospitalisations (inpatient separations) coded as mental diseases and disorders by local health network, 2018-19

Local health network of resident	Number	Percent of total	Rate per 10,000 population
Northern Adelaide	2,671	18.9%	65.7
Central Adelaide	3,233	22.9%	68.8
Southern Adelaide	2,914	20.7%	78.5
Metropolitan Adelaide	8,818	62.5%	70.7
Barossa Hills Fleurieu	1,321	9.4%	65.0
Eyre and Far North	410	2.9%	101.1
Flinders and Upper North	628	4.5%	143.1
Limestone Coast	506	3.6%	75.4
Riverland Mallee Coorong	1,039	7.4%	142.8
Yorke and Northern	875	6.2%	113.6
Country SA	4,779	33.9%	94.7
SOUTH AUSTRALIA	**13,597**	**96.4%**	**77.6**
Overseas/interstate resident or unknown local health network	509	3.6%	

Source: SA Health 2020b

Figure 5: Public hospital hospitalisations (inpatient separations) coded as mental diseases and disorders, 2015-16 to 2018-19



Source: SA Health 2020b

Table 13: Public hospital hospitalisations (inpatient separations) coded as mental diseases and disorders by specific population group, 2018-19

Specific population group	%
Rural and remote residents	33.9%
Residents of lowest SES quintile	27.8%
Aged persons	13.6%
CALD persons	7.7%
Aboriginal persons	6.2%

Source: SA Health 2020b

SA Health hospital emergency department activity

In South Australian public hospital emergency departments during 2018-19 there were 31,308 presentations coded under the reason of 'psychosocial'. Public hospital mental health emergency department activity has seen an increasing trend over recent years, up 21.7% from the 25,735 recorded in 2015-16 (SA Health 2020a).

Of the 29,763 public hospital emergency department presentations coded as psychosocial for South Australian residents, around three quarters (73.1%) are for residents of metropolitan Adelaide and around one in four (22.0%) hospitalisations for rural and remote residents. On a per capita basis, the highest rate of public hospital emergency department presentations for psychosocial reasons was in the Flinders and Upper Norther Local Health Network (LHN), at 332.1 hospitalisations (inpatient separations) per 10,000 population and the Southern Adelaide LHN at 206.9 presentations per 10,000 population (SA Health 2020a).

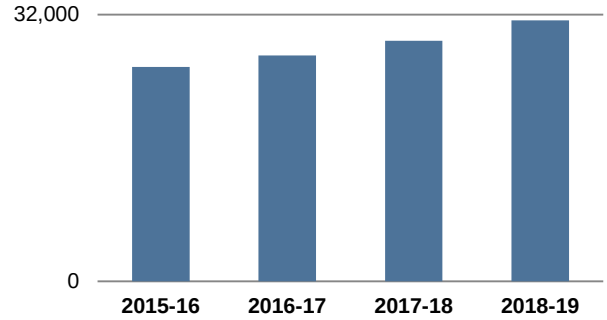
Around a third (32.2%) of public hospital emergency department presentations for psychosocial reasons were for residents in the bottom quintile socioeconomic status geographic areas of South Australia, 10.0% for Aboriginal persons, 6.0% for persons from culturally and linguistically diverse (CALD) backgrounds and 5.9% for persons aged 65 years and over (SA Health 2020a).

Table 14: Public hospital emergency department presentations for psychosocial reasons by local health network, 2018-19

Local health network of resident	Number	Percent of total	Rate per 10,000 population
Northern Adelaide	7,047	22.5%	173.3
Central Adelaide	8,154	26.0%	173.6
Southern Adelaide	7,678	24.5%	206.9
Metropolitan Adelaide	22,879	73.1%	183.4
Barossa Hills Fleurieu	2,024	6.5%	99.5
Eyre and Far North	501	1.6%	123.6
Flinders and Upper North	1,457	4.7%	332.1
Limestone Coast	1,065	3.4%	158.7
Riverland Mallee Coorong	1,023	3.3%	140.6
Yorke and Northern	814	2.6%	105.7
Country SA	6,884	22.0%	136.4
SOUTH AUSTRALIA	**29,763**	**95.1%**	**169.9**
Overseas/interstate resident or unknown local health network	1,545	4.9%	

Source: SA Health 2020a

Figure 6: Public hospital emergency department presentations for psychosocial reasons, 2015-16 to 2018-19



Source: : SA Health 2020a

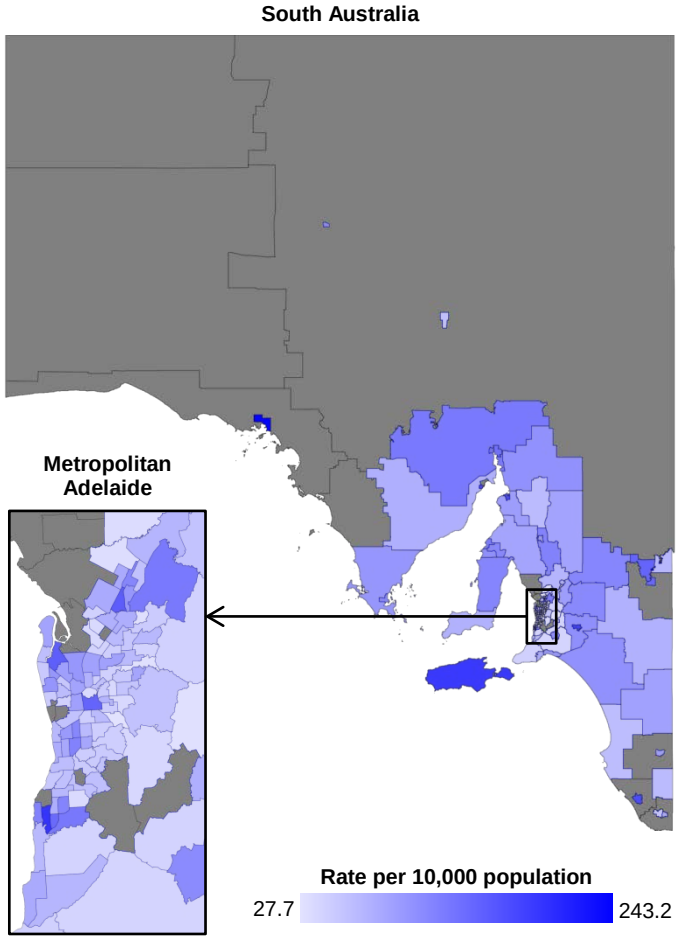
Table 15: Public hospital emergency department presentations for psychosocial reasons by specific population group, 2018-19

Specific population group	%
Residents of lowest SES quintile	32.2%
Rural and remote residents	22.0%
Aboriginal persons	10.0%
CALD persons	6.0%
Aged persons	5.9%

Source: : SA Health 2020a

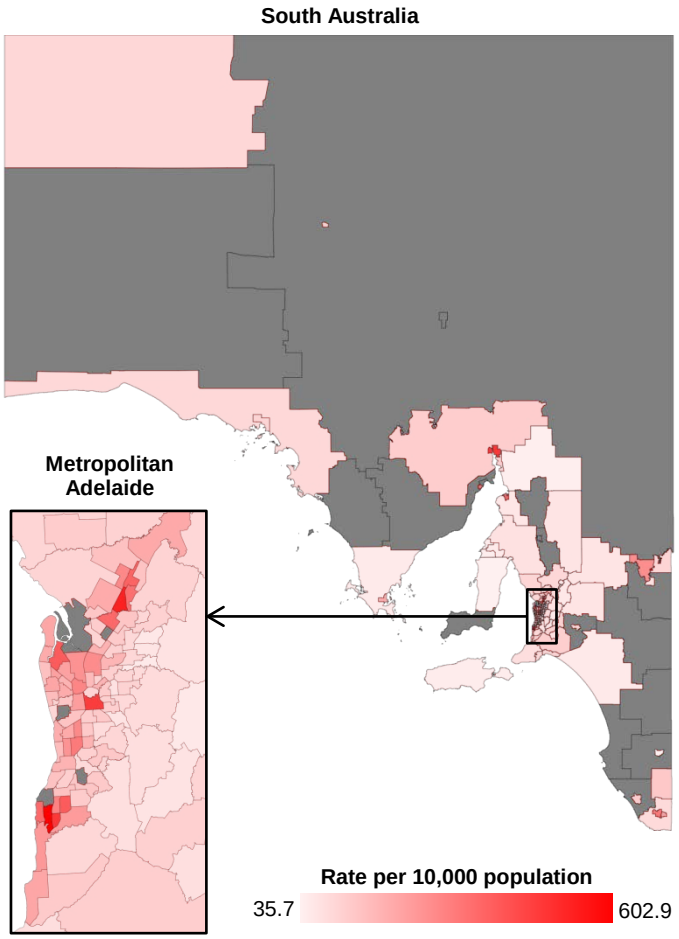
The two figures below show South Australian public hospital hospitalisations (inpatient separations) coded under the major diagnostic category (MDC) of 'mental diseases and disorders' (MDC 19) and public hospital emergency department presentations coded under the reason of 'psychosocial' per 10,000 population during 2018-19. Data is mapped at the Australian Bureau of Statistics' Statistical Area 2 (SA2) geographic level. Higher activity is correlated with geographic areas of lower socioeconomic status.

Figure 7: Map of public hospital hospitalisations (inpatient separations) coded as mental diseases and disorders by SA2, 2018-19



Source: SA Health 2020b Grey shaded areas denote no or insufficient data

Figure 8: Map of public hospital emergency department presentations for psychosocial reasons by SA2, 2018-19



Source: SA Health 2020a Grey shaded areas denote no or insufficient data

SAFETY, QUALITY AND CONSUMER EXPERIENCE

Safety and quality

RANKED HIGHEST South Australia ranks first out of the states and territories for persons aged 75 years and over readmitted to hospital within 28 days of discharge, at 8.3% of overnight hospitalisations (inpatient separations) from psychiatric acute inpatient services that were followed by a readmission to psychiatric acute inpatient service within 28 days of discharge. However, the rate for persons aged 75 years and over is around half the overall comparable readmission rate of 15.7% (ranking South Australia third) (RoGS 2020).

RANKED LOWEST South Australia ranks eighth out of the states and territories for community follow-up within the first seven days of discharge from a psychiatric admission, with two thirds (66.6%) of overnight hospitalisations (inpatient separations) from acute psychiatric inpatient services with community mental health contact recorded in the seven days following discharge (RoGS 2020).

TRENDS between reporting periods for indicators that the Health Performance Council classifies as safety and quality have been relatively steady (RoGS 2020).

DATA GAPS Safety and quality indicators for persons from culturally and linguistically diverse backgrounds are not published in the Report on Government Services 2020 data tables.

Table 16: Emergency department presentations seen on time, seclusion events, readmissions, and community follow-up, South Australia compared to Australia

SA rank (out of 8)	Selected *Report on Government Services* mental health management indicator	Reporting period	Unit of measurement	SOUTH AUSTRALIA	Australia	SA change from previous period
7	**Mental health-related emergency department presentations seen within clinically recommended waiting times**	2017-18	Percentage of total mental health-related emergency department presentations	**52.1**	**66.8**	↓ **55.8**
	Seclusion events in public specialised mental health acute inpatient units	2018-19				
3	Rate of seclusion events		Number of events per 1,000 bed days	9.1	7.3	↓ 9.4
8	Duration of seclusion events		Average number of hours	1.8	4.2	n.a. n.a.
3	**Readmissions to hospital within 28 days of discharge**	2017-18	Percentage of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	**15.7**	**15.1**	↓ **15.8**
4	Aboriginal persons			17.5	17.3	n.a. n.a.
4	Non-Aboriginal persons			15.8	14.9	n.a. n.a.
2	Males			15.0	13.9	n.a. n.a.
3	Females			16.5	16.3	n.a. n.a.
1	Persons aged 75 years and over			8.3	6.4	n.a. n.a.
4	Residents of lowest socio-economic status geographical areas			14.1	14.4	n.a. n.a.
8	**Community follow-up within first seven days of discharge from a psychiatric admission**	2017-18	Percentage of overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	**66.6**	**75.2**	↑ **66.4**
8	Aboriginal persons			60.7	72.4	↓ 66.6
8	Non-Aboriginal persons			67.7	75.7	↑ 67.5
8	Males			64.4	73.1	↑ 63.4
8	Females			69.0	77.3	↓ 69.6
7	Persons aged 65 years and over			72.5	78.9	↓ 77.3
7	Residents of lowest socio-economic status geographical areas			68.9	76.6	↓ 70.5

Source: RoGS 2020, Tables 13A.19, 25, 30-34. See the 'How to interpret tables in this report' appendix for information about headings, symbols and acronyms used.

Consumer experience

DATA GAPS The Health Performance Council could make no assessment of South Australia's rank compared to the other state and territories, or trends between reporting periods in relation to consumer experience of mental health care in this state due to missing data. There is no information in the public domain from the public health services about South Australian consumer experience of mental health services.

The Report on Government Services 2020 data tables records that in South Australia completed consumer outcome measures were collected from between 6.5% (those discharged from community-based ambulatory care) and 30.5% (those discharged from hospital) people discharged. However, no consumer experience of service data is available for South Australia . The Report on Government Services 2020 data tables only report consumer experience of service (consumers with a positive experience of service) data for the states of New South Wales, Victoria, and Queensland (RoGS 2020).

Rollout of the Your Experience of Service (YES) collection in South Australia: The Health Performance Council is advised by the Office of the Chief Psychiatrist that "at this stage the implementation of YES is evolutionary and while we have some collections, we have not yet undertaken any internal analysis regarding data quality and to this end have not yet submitted any extracts to the Australian Institute of Health and Welfare for national reporting, though this will certainly be our intent. That is, the data has not yet been publically available."

Table 17: Consumer experience of service, and consumer outcomes measures, South Australia compared to Australia

SA rank (out of 8)	Selected *Report on Government Services* mental health management indicator	Reporting period	Unit of measurement	SOUTH AUSTRALIA	Australia	SA change from previous period
n.a.	**Consumer experience of service**	2017-18	Percentage of consumers with a positive experience of service	**n.a.**	**n.a.**	**n.a.**
	Specialised public mental health services episodes with completed consumer outcomes measures collected	2017-18	Percentage of people discharged with completed consumer outcomes measures collected			
5	People discharged from hospital			30.5	36.8	↓ 30.6
6	People discharged from community-based ambulatory care			6.5	27.3	↑ 4.2
5	People in ongoing community-based ambulatory care			23.8	34.8	↑ 22.8

Source: RoGS 2020, Tables 13A.29, 61. See the 'How to interpret tables in this report' appendix for information about headings, symbols and acronyms used.

COSTS

RANKED HIGHEST South Australia ranks first out of the states and territories for costs per inpatient bed day (average recurrent) for psychiatric hospitals–acute units ($1,401), older persons mental health services ($1,321) and non-24 hour staffed units in community residential services ($352) (RoGS 2020).

RANKED LOWEST South Australia ranks sixth out of the states and territories for cost per treatment day of ambulatory mental health care at an average of $330. This cost is associated with an average 5.4 days of ambulatory treatment days per episode of ambulatory care (RoGS 2020).

TRENDS There has been an increase of $1,785 in recurrent cost per inpatient bed day for older persons mental health services–non-acute, from an average of $848 in 2016-17 to $2,633 in 2017-18. This represents an increase in real terms of 10.5% (RoGS 2020).

DATA GAPS Cost indicators for non-acute units, general acute hospitals with a psychiatric unit or ward are not available for South Australia.

Table 18: Expenditure and costs, mental health services, South Australia compared to Australia

SA rank (out of 8)	Selected *Report on Government Services* mental health management indicator	Reporting period	Unit of measurement	SOUTH AUSTRALIA	Australia	SA change from previous period
3	**Expenditure on state and territory governments specialised mental health services (real estimated recurrent)**	2017-18	Dollars per person (2017-18 dollars)	**268**	**244**	↑ **262**
	Cost per inpatient bed day (average recurrent)	2017-18	Dollars (2017-18 dollars)			
2	**Psychiatric hospitals**			**1,309**	**1,083**	↑ **1,148**
1	Acute units			1,401	1,351	↑ 1,304
2	Non-acute units			1,233	932	↑ 1,056
3	**General acute hospital with a psychiatric unit or ward**			**1,444**	**1,207**	↑ **1,291**
3	Acute units			1,444	1,240	↑ 1,291
n.a.	Non-acute units			n.a.	971	n.a. n.a.
3	**General mental health services**			**1,415**	**1,163**	↑ **1,268**
3	Acute			1,451	1,243	↑ 1,279
2	Non-acute			**1,157**	**884**	↓ **1,188**
2	**Child and adolescent mental health services**			**2,706**	**2,116**	↑ **2,462**
2	Acute			2,706	2,126	↑ 2,462
n.a.	Non-acute			n.a.	1,997	n.a. n.a.
1	**Older persons mental health services**			**1,321**	**1,031**	↑ **1,076**
2	Acute			1,271	1,053	↑ 1,250
1	Non-acute			2,633	929	↑ 848
4	**Forensic mental health services**			**1,266**	**1,215**	↑ **1,211**
4	Acute			1,528	1,353	↑ 1,434
2	Non-acute			1,217	1,104	↑ 1,168
	Cost per patient day for community residential services (average recurrent)	2017-18	Dollars (2017-18 dollars)			
5	24-hour staffed units			561	577	↑ 537
1	non-24-hour staffed units			352	222	↑ 325
	Ambulatory care, treatment days and cost	2017-18				
6	Treatment days		Avg. treatment days per ep. of ambulatory care	5.4	6.7	– 5.4
6	Cost		Avg. cost per treatment day of ambulatory care	330	334	↓ 335

Source: RoGS 2020, Tables 13A.6, 36-38, 40, 41. See the 'How to interpret tables in this report' appendix for information about headings, symbols and acronyms used.

Consultation questions and list of organisations invited to provide feedback

This monitoring report was released initially as a consultation draft with emerging findings from populated indicators. The Health Performance Council sought feedback from key stakeholder organisations to finalise advice, narrative and context.

The following key stakeholder organisations were invited to provide feedback:

- Aboriginal Health Council of South Australia
- Australian Migrant Resource Centre
- Multicultural Communities Council of South Australia
- Multicultural Youth South Australia
- SA Health – The ten Local Health Network Governing Boards and Rural and Remote Mental Health Services
- South Australian Mental Health Commission – The Commissioners and Community Advisory Committee members
- Veterans Health Advisory Council
- Wardliparingga Aboriginal Research Unit, South Australian Health and Medical Research Institute.

The Council approached these organisations via e-mail, inviting responses to three questions:

1. What would your organisation want from a report that monitors indicators of mental health in South Australia, and how would you use it? (You can also tell us if you would not find such a report useful.)
2. What would your organisation's TOP 3 mental health indicators be for SA Health local health network governing boards to monitor on a monthly basis?
3. What, in the opinion of your organisation, are the biggest gaps or shortfalls in the state government's monitoring of mental health in South Australia? (For example, indicators that should be monitored by decision makers but are not available or limited in their usability.)

The Council did not want the request on the three main topics to limit responses. Organisations were encouraged to tell us *anything* they thought we should know regarding issues with monitoring and reporting of mental health access and outcomes in South Australia.

The Council thanks these organisations for their important contributions that helped shape this final report. Feedback received during the consultation process is summarised at the front of this report. To maintain confidentiality, individual responses are not attributed.

How to interpret tables in this report

This report uses—as its principal data source—indicators published in data tables supplementing Part E (Health), Section 13 (Mental health management) of the Australian Government's Productivity Commission *Report on Government Services 2020* (henceforth abbreviated here simply as RoGS) released on 31 January 2020. If you want to view the original source, these RoGS tables can be downloaded in Microsoft Excel format via: https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/health/mental-health-management/rogs-2020-parte-section13-data-tables.xlsx

For this monitoring report, the Health Performance Council reviewed RoGS mental health management data for indicators that can be compared between states and territories. Of the 66 data tables published by RoGS for mental health management, the Council used 41. The Council then arranged the indicators into chapters that, in the Council's view, align to broad topic areas—such as resilience factors or patient outcomes.

To keep this monitoring report easy to digest, the Council does not present all data available in the RoGS source. South Australia is compared against states and territories and the Australian average but for space reasons not all states and territories' data are recreated here.

Each chapter of this monitoring presents a table summarising RoGS mental health management data organised into eight columns:

SA rank (out of 8): Rank of the South Australian figure among those of the 8 states and territories, where rank 1 is the numerically highest and rank 8 the numerically lowest. In ranking the jurisdictions, no account has been taken of any margin of error that may be present in figures for each jurisdiction and a high or low rank should not be taken alone as necessarily indicative of relative performance.

Selected Report on Government Services mental health management indicator: The indicator as described in the RoGS source. For example, *Adults with high or very high levels of psychological distress*.

Reporting period: The time period that the indicator applies to. For example, 2018-19.

Unit of measurement: A contextual description of the number values in the columns for South Australia and Australia. For example, percentage of people or dollars.

South Australia: The latest available RoGS indicator for South Australia. For example, 56.9 (percent of people).

Australia: The national average. The South Australian indicator can be compared to the Australian average as well as its rank in relation to the other states and territories (SA rank).

SA change from previous period: An arrow (↑ ↓) or dash (—) indicating the direction (up, down, or no change) in trend of the value of indicator between consecutive time periods, e.g. 2017-18 to 2018-19.

Symbols used in the tables:

n.a. Not available

n.p. Not published. Data may be available, but its publication has been suppressed in RoGS (e.g. for confidentiality reasons).

* Estimates based on survey samples. Small apparent changes may not be statistically significantly large when taking into account sample margin of error.

Report on Government Services data presented in this monitoring report is supplemented with other public reports such as released by the Australian Institute of Health and Welfare, and summary analysis of internal data sources such as SA Health customised data extracts.

Definitions

Aboriginal persons

The Health Performance Council respectfully uses the term 'Aboriginal', rather than 'Indigenous', to refer to people who self-identify as Aboriginal, Torres Strait Islander, or both. The Council recognises Aboriginal and Torres Strait Islander people as two separate groups. However, this document refers to Aboriginal persons in recognition that Aboriginal people are the original inhabitants of South Australia. We also acknowledge the complexity and diversity of the Aboriginal communities of South Australia, recognising each has its own beliefs and practice.

Aged persons

Persons aged 65 years and older.

Average

A central value of a set of numbers, calculated by adding the numbers together and dividing by how many numbers there are.

Culturally and linguistically diverse (CALD) persons

Defined by the Health Performance Council as persons born in non-main English speaking countries. These are countries other than Australia, Canada, Ireland, New Zealand, South Africa, the United Kingdom, and the United States of America.

Hospitalisation (inpatient separation)

A hospital inpatient 'separation' is a completed episode of care of an admitted patient, generally concluding with their discharge from hospital (mostly to home), transfer to another healthcare facility or in-hospital death. It can also include other types of separation, such as 'administrative separation' applied for hospital activity payment purposes.

Lowest socio-economic status (SES) residents

The Health Performance Council defines lowest socio-economic status residents as people who reside in the lowest quintile (lowest 20%) socio-economic status geographic areas of South Australia, identified using the Australian Bureau of Statistics' (ABS) Socio-economic Index for Areas (SEIFA), Index of Relative Socio-economic Disadvantage (IRSD) (ABS 2018).

ABS Statistical Areas-Level 2 (SA2s) in the lowest quintile SES areas of South Australia are:

> Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, Berri, Christie Downs, Christies Beach, Coober Pedy, Davoren Park, Elizabeth East, Elizabeth, Enfield – Blair Athol, Hackham West – Huntfield Heights, Mannum, Millicent, Morphett Vale – West, Mount Gambier – West, Murray Bridge, Outback, Parafield Gardens, Paralowie, Peterborough – Mount Remarkable, Pooraka – Cavan, Port Adelaide, Port Augusta, Port Pirie, Quorn – Lake Gilles, Renmark, Salisbury North, Salisbury, Smithfield – Elizabeth North, The Parks, Virginia – Waterloo Corner, Wallaroo, Whyalla.

Rural and remote residents

Defined by the Health Performance Council as persons who reside within SA Health's regional local health network boundaries. That is, residents of the Flinders and Upper North, Eyre and Far North, Barossa Hills Fleurieu, Riverland Mallee Coorong, Limestone Coast or Yorke and Northern Local Health Networks.

Statistically significant

A determination via statistical hypothesis testing that observed differences between survey estimates are not explainable by chance alone.

Data sources

Australian Health Practitioner Regulation Agency

The Australian Health Practitioner Regulation Agency works with the National Boards of 16 health professions to protect the public by regulating health practitioners efficiently and effectively in the public interest to facilitate access to safer healthcare. The Agency publishes quarterly performance reports summarising data for each state and territory over a three-month period. These reports cover the Agency's main areas of activity—managing registration, managing notifications and offences against the National Law, and monitoring health practitioners and students with restrictions on their registration.

Australian Institute of Health and Welfare

The Australian Institute of Health and Welfare is an independent statutory agency producing authoritative and accessible information and statistics to inform and support better policy and service delivery decisions, leading to better health and wellbeing for all Australians. The Institute publishes the *Mental health services in Australia* report as a web report with supporting data tables, providing a picture of the national response of the health and welfare service system to the mental health care needs of Australians. *Mental health services in Australia* is updated progressively throughout each year as data becomes available.

Report on Government Services

The Productivity Commission is the Australian Government's principal review and advisory body on microeconomic policy, regulation and a range of other social and environmental issues. It publishes an annual *Report on Government Services* that provides information on the equity, effectiveness and efficiency of government services in Australia—including health. *Report on Government Services 2020* was released 23 January to 4 February 2020.

SA Health – Emergency Department Data Collection

The Emergency Department Data Collection details presentations for emergency departments (EDs) in public hospitals across South Australia.

A key aspect of measuring and understanding what is happening within an emergency department is use of triage categories. These categorise the urgency of the patient's need for medical and nursing care as set by the Australian College of Emergency Medicine:

- Triage 1 (resuscitation): Patient must be seen within 2 minutes of presentation time
- Triage 2 (emergency): Patient must be seen within 10 minutes of presentation time
- Triage 3 (urgent): Patient must be seen within 30 minutes of presentation time
- Triage 4 (semi-urgent): Patient must be seen within 60 minutes of presentation time
- Triage 5 (non-urgent): Patient must be seen within 120 minutes of presentation time

To ensure consistency, the Health Performance Council applies pre-defined business counting rules and limits reporting ED activity to the following major South Australian public hospitals: The Lyell McEwin Hospital, Modbury Hospital, Royal Adelaide Hospital, The Queen Elizabeth Hospital, Flinders Medical Centre, Noarlunga Hospital, Gawler Health Service, Port Lincoln Health Service, Port Augusta Hospital and Regional Health Service, Whyalla Hospital and Health Service, Mount Gambier and Districts Health Service, Riverland General Hospital (Berri), Port Pirie Regional Health Service, and the Women's and Children's Hospital.

SA Health – Integrated South Australian Activity Collection

The Integrated South Australian Activity Collection covers all public and private hospitals in South Australia. It records details of inpatient "episodes of care" commencing with admission to hospital and concluding with a “separation” (discharge, transfer or death). This collection is the means by which admitted patient activity can be monitored, funded, evaluated, planned for, researched and reviewed to ensure that SA Health continues to deliver efficient and equitable health services.

To ensure consistency, the Health Performance Council applies pre-defined business counting rules to the hospital activity data before extraction and further analysis. Standard business counting rules include grouping, or “bundling”, episodes that experience multiple care type changes during a hospital stay into a single record. Bundling provides a more accurate picture of the number of patients actually discharged from a hospital. Standard business counting rules also excludes sameday endoscopy and chemotherapy activity.

From 1 July 2017, SA Health adopted new state-wide business counting rules to hospital admitted activity data and this may affect time series reported in this document. Hospitalisation (inpatient separation) totals presented in this report may not match exactly with nationally reported figures due to timing differences in the extraction of data and subsequent updates to the data warehouse.

Identification of culturally and linguistically diverse (CALD) persons in the collection is based only on their country of birth. New CALD data elements—preferred language, religious affiliation and appropriately accredited interpreters required—have been piloted in the collection from 1 July 2017 (a Health Performance Council initiative). However, these new data elements are not currently supplied to the collection consistently by the hospitals at a suitable quality for reporting.

SA Health – South Australian Population Health Survey

The South Australian Population Health Survey is a state-wide population health survey, which aims to monitor the health of all South Australians. Data is collected every month and anyone with access to a phone can participate in the survey. In one year, around 7,000 South Australians are interviewed about their health and wellbeing. You cannot be identified by the data that is collected.

Data quality

This report sources data from internal government enterprise datasets provided with the approval of their custodians. Where the Health Performance Council extracted data itself from enterprise systems, it applies standardised business counting rules where applicable. Data sources, definitions and other technical information is provided so that results can be replicated.

It is standard Council practice to validate its reports prior to publication with data custodians, relevant experts and key stakeholders to sense-check findings, and confirm robustness of method, accuracy of findings and clarity of presentation.

Missing data and under-reporting

Despite the quality assurances of data providers and others, the Health Performance Council recognises that there is data missing, under-reported and misreported in administrative datasets that can and do impact the analysis in this report. The Council can only report self-identified data as-is.

The Council wanted to include SA Mental Health Commission Youth Advisory Group members in its consultation. However, the group's term of appointment ended before consultation commenced.

Identification of Aboriginal people

The Council recognises that not all Aboriginal people are correctly identified in the data and acknowledges that not all Aboriginal people choose to identify themselves or their loved ones every time they interact with government services. Aboriginal leaders have told the Council that many Aboriginal health consumers do not identify as Aboriginal for fear of discrimination. Aboriginal leaders have also told the Council that health service providers frequently fail to ask about the Aboriginal status of health consumers, even where collection of this status field is mandatory. The Council is working to report on systemic racism in the health system as part of its forward review program.

Identification of culturally and linguistically diverse persons

The issue of integrity, variability and quality of self-reported data in administrative datasets applies to other specific population groups as well—often for fear of discrimination just as for Aboriginal people—such as persons from culturally and linguistically diverse (CALD) backgrounds.

Identification of CALD persons in the SA Health-sourced data of this report is based only on their country of birth. CALD identification would be improved if preferred language, religious affiliation and appropriately accredited interpreters required were also available.

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