TECHNICAL SPECIFICATIONS FOR THE NEXT ADULT GENERAL NATIONAL SURVEY OF MENTAL HEALTH AND WELLBEING

Recommendations of the National Survey of Mental Health and Wellbeing 3 Technical Advisory Group

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RECOMMENDATIONS FOR THE NEXT ADULT GENERAL SURVEY

Information has been the driver of mental health reforms since the inception of the National Mental Health Strategy in 1992. In particular, data on mental health problems, the services used for these and people's perception of their needs have underpinned the development of policy and investment in mental health since this was first available from the first National Survey of Mental Health and Wellbeing in 1997. The 1997 survey was followed by a second, and the last, adult general population survey in 2007. This provided up-to-date information on the prevalence of mental disorders, suicide behaviours and the use of services to assess the impact of mental health reforms in the previous decade.

The size and complexity of these surveys exceeds any other national survey. The 2007 national survey comprised over 3,500 data items as necessary to determine if an individual might be diagnosed with a mental disorder if they were to see a health professional and their use of services for mental health problems. Whilst other surveys provide information on whether people believe they have a mental illness, have been diagnosed with a mental disorder or have sought services for mental health problems, this is only part of the picture. The 2007 showed that about a third of people with mental health problems of sufficient severity and duration for them to be diagnosed with a mental disorder in the previous year had used services for their mental health problems and, conversely, about one-fifth of those who used services for their mental health problems did not. No other surveys have sufficient detail to understand the mental health needs of the population, nor would additions to any other survey be sufficient to determine this.

A new National Survey of Mental Health and Wellbeing of the adult population is required to produce up-to-date comparable estimates of the prevalence and severity of mental disorders in the Australian population, and to determine the impact of programs and services implemented since 2007. These data are an essential input for work already proceeding on the *National Mental Health Service Planning Framework,* and will also inform the future development of national policy and other service reforms.

The gap between the first and second surveys was ten years. Should funding be secured and work begin immediately on commissioning an organisation or consortium to conduct the next survey, data would not be available for at least another four years - some fourteen years after the last survey. Given the long lead times with a survey of this nature, it is considered important that work to progress the survey proceed as soon as possible.

BACKGROUND

A Technical Advisory Group (TAG) was formed to provide advice on a third National Survey of Mental Health and Wellbeing of the adult population, which would inform development of technical specifications should the Government proved the Department of Health with the authority to proceed with commissioning work on the survey.

The Technical Advisory Group met five times from February to June 2018 to determine recommendations specifically in relation to key aspects of the design as identified in the Terms of Reference (Attachment 1) and that would meet the requirements identified by the Department in relation to the content and conduct of another survey (Attachment 2).

Membership

The Technical Advisory Group is comprised of experts in mental health data collection and analysis for both policy and planning purposes, as well as experience in various aspects of previous national surveys of mental health and wellbeing. The majority of members have either undertaken a leading role in or been an expert member of the reference group for one or more of the other national surveys of mental health and wellbeing.

Technical Advisory Group membership

Name	Position
Professor Harvey Whiteford (Chair)	Professor of Psychiatry and Population Mental Health, School of Public Health, University of Queensland Departmental adviser on mental health
Professor Philip Burgess	Professor, School of Public Health, University of Queensland Key adviser on service use data collection and analysis
s47F	
Professor David Lawrence	Principal Research Fellow, Graduate School of Education, University of Western Australia Project director of the second child and adolescent survey
s47F	
Associate Professor Tim Slade	Senior Researcher, National Drug and Alcohol Research Centre, University of New South Wales Principal technical adviser for the 2007 survey
s47F	
Mr Bill Buckingham	Departmental Technical Adviser, Mental Health
Ms Sue Saw	Technical Consultant Departmental manager of five national surveys of mental health and wellbeing

ATTACHMENT 1

Third National Survey of Mental Health and Wellbeing

Technical Advisory Group

TERMS OF REFERENCE

The Technical Advisory Group will advise on the preparation of technical specifications for a third National Survey of Mental Health and Wellbeing of the adult population that may be used by the Department as a basis for procuring a survey in the future. Advice on technical specifications will be developed in manner to meet imperatives to be articulated by the Department.

Areas for consideration and advice by the TAG include:

- providing advice to the Department on the imperatives for the next survey, including what is needed for continuity and what else can be incorporated;
- providing input on the diagnostics and other key content;
- providing input on more technical matters related to the psychometric properties and embedded instrumentation;
- considering issues impacting on the design, including the need for response rates to be maximised and in relation to sampling, including oversampling of any key sub-populations and sample top-ups;
- exploring opportunities for data linkage;
- providing advice in relation to various options for repeat surveying and capturing longitudinal data;
- outlining requirements in relation to data storage, data outputs and access; and
- highlighting areas in which the prospective organisation or consortium that undertakes the work is being asked to provide its own input.

The Technical Advisory Group is not responsible for the actual drafting of any documentation, but will be supported by a person with the necessary technical expertise required to prepare this document.

Input from external experts will also be sought when necessary as advised by the group.

ATTACHMENT 3

National Survey of Mental Health and Wellbeing

Determining the approach to a third adult general population survey

Background paper prepared to inform discussion by the Technical Advisory Group

MEETING 12 FEBRUARY 2018

This document provides a general overview of key issues in relation to development and conduct of another general adult National Survey of Mental Health and Wellbeing and the role of the Technical Advisory Group in progressing this work.

1. Introduction

The National Survey of Mental Health and Wellbeing initiative arose from the National Mental Health Strategy, a commitment by Australian governments to improve the lives of people with mental illness. The Strategy was endorsed in April 1992 by the Australian Health Ministers' Conference. A series of National Mental Health Plans has been developed under the strategy with the Fourth National Mental Health Plan released in November 2009.

In progressing the National Mental Health Strategy it was recognised early on that there was a lack of national data to inform the development of policy in the area. A series of surveys was commissioned under the National Survey of Mental Health and Wellbeing banner. The three main components are:

- A national population survey of adults, run in 1997 and again in 2007 by the Australian Bureau of Statistics.
- A low prevalence disorders study of people living with psychotic illness. This study was first run in 1997-98 by a consortium led by Professor Assen Jablensky at The University of Western Australia, and repeated in 2010 with Professor Vera Morgan leading the work.
- A national population survey of children and adolescents, first run in 1998-99 by a consortium led by Professor Michael Sawyer from the University of Adelaide, and repeated in 2010 with Professor David Lawrence and Professor Steve Zubrick of the University of Western Australia leading the work.

All of the surveys were commissioned and funded by the Commonwealth Department of Health or Department of Health and Aged Care as it was formerly known.

The information provided through these surveys has underpinned national work, Commonwealth policy and service planning work undertaken nationally. It has provided the foundation of people's understanding of the prevalence of mental illness and, in turn, the impetus for many major initiatives that have worked to reduce the stigma of mental illness, improve people's understanding and awareness, and promote help-seeking. It has also provided the evidence base for mental health funding and resource allocations for mental health services.

While the surveys did not cover all mental disorders, all aspects of help-seeking, satisfaction with services, access issues or a range of other important factors, each provided comprehensive information on the population, mental disorders, comorbidities and service use. Each was a major piece of work, with planning taking on average two to three years before the survey was in the field, six months or more for collection and a further one to two years for data collation, validation and analyses of preliminary results.

Each also asked a lot from respondents, with average interview times varying between one and several hours. Even with considerable efforts to rationalise the content to minimise respondent burden and remain firmly focused on the survey objectives, the 2007 National Survey of Mental Health and Wellbeing comprised some 1,500 items and averaged 90 minutes.

2. Australia's approach to mental health population surveys

Commencing in 1995, planning began for the first survey of what has become known as the National Survey of Mental Health and Wellbeing initiative. Prior to these data being available, estimates of the population's need for mental health care were based on a small number of local studies and overseas evidence.

The initiative comprises three main components, which complement each other and provide information on the mental health of the Australian population as a whole. These are focused on the adult general population, on the child and adolescent general population and on people with low prevalence disorders, primarily psychotic illnesses, who are receiving services.

The common focus of these surveys has been on determining disorder status (both the type of mental disorder and severity), assessing functioning and other impacts, identifying associated socio-demographic and risk factors and identifying what health services have been used by those with mental health problems.

These are diagnostic surveys that collect comprehensive information on the symptoms of the specific mental disorders that a participant experiences, their impact and duration. Through a complex set of algorithms it is then determined if the individual would meet the threshold to be diagnosed with a mental disorder according to either the International Classification of Diseases, Tenth Revision (ICD-10) or the and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) diagnostic classification systems, the same as if he or she were to visit a mental health professional.

To date there have been five surveys under the Initiative, with a second child and adolescent survey in the field in 2013. A summary of each of these is provided in Table 1.

Table 1: National Survey of Mental Health and Wellbeing components

Survey component	Year in field	Survey type and scope	Age group (years)	Duration average	Conducted or led by
Adult population	1997	Household	18+	90 minutes	Australian Bureau of Statistics
	2007	Household	16-85	90 minutes	Australian Bureau of Statistics
People living with psychotic illness	1997-98	State/Territory specialised mental health services Private practice sample Homeless sample	18-65	3-4 hours	University of Western Australia led consortium
	2010	State/Territory specialised mental health services General practice NGO mental health services	18-65	4-5 hours	University of Western Australia led consortium
Child and adolescent	1998	Household	4-17	60 minutes +15-20 minutes for self complete questionnaire	University of Adelaide led consortium
	2013	Household	4-17	~60 minutes +37 minutes for 11-17 year olds' questionnaire	Telethon Child Health Research Institute led consortium

The findings from these surveys have been used for both policy and planning purposes and the surveys have been designed in such a way as to provide basic information on a similar range of variables and for each component to provide complementary information on the population as a whole and for both common and low prevalence, but high impact disorders.

Table 2 summarises the evidence from the various components.

Table 2: Evidence from population surveys, definitions and data typically reported

Evidence	Definition	Typical data reported
Prevalence of mental disorders	Proportion of the population assessed as having mental disorders in a given period	
• ***Common mental disorders***	Affective (mood), anxiety[(a)] and substance use classes of mental disorders	12-month prevalence of common disorders Lifetime prevalence up to assessment Age of onset/Years experienced Population estimates by disorder class
• ***Other mental disorders***	Less prevalent disorders include personality, somatoform, eating and impulse-control disorders and problem gambling. Specific phobias and social anxiety[(a)] Low prevalence disorders including schizophrenia and other psychotic illnesses	12-month prevalence of low prevalence disorders estimated from *People Living with Psychotic Illness* study Note: No reportable data for other disorders as diagnostic modules for these not included in any surveys to date
Remission	Improvement in symptoms and other deficits to within normal range	Not available from National Surveys of Mental Health and Wellbeing to date
Relapse	Episode of mental disorder following period of remission	Not available from National Surveys of Mental Health and Wellbeing to date
Incidence	New cases of mental disorders in he population in a given period	Not available from National Surveys of Mental Health and Wellbeing to date
Impact on functioning	Ability to perform the usual ac ivities of everyday life	Severity Days out of role Psychological distress (K10)
Socio-demographic variables, risk and protective factors	Quantifiable sta istics that are more highly correlated with mental disorders and/or their severity, recovery or good mental health, and changes in mental disorder status	Prevalence and service use by variables including sex, age, educa ion, employment, homelessness, housing, alcohol and drug use, chronic physical conditions, family history of mental illness, stressful life events and abuse social participation and contact with family/friends
Suicidal behaviour	Suicidal thoughts, making a suicide plan and suicide attempts	Propor ion of sample Propor ion with mental disorders
Service use	Consultations with health professionals, hospital admissions and medica ion for mental health problems	Propor ion using services Professionals consulted Number of visits Medication use by disorder class
Perceived need	Perception of whether services or more services for mental health problems are needed	Met need Unmet need and demand for services Types of service needed

Evidence	Definition	Typical data reported
Costs	Financial costs include personal (out-of-pocket expenses and effects on employment), direct (Medicare and o her service costs) and indirect costs to government (income support and housing)	Private/Public service providers Private health insurance coverage Assessment of Quality of Life (AQoL) utility scores used in addi ional studies/analyses DALY calculated for Burden of Disease work
	Disease burden calculated as Disability-adjusted life years (DALY)	Note: Out-of-pocket costs, loss of income, indirect costs to government and absenteeism not covered previously

2.1 Details on the previous adult surveys

The 1997 and 2007 National Surveys of Mental Health and Wellbeing were cross-sectional surveys of the adult general population. While every effort was made to maintain comparability between these surveys, there are also a number of significant differences.

The three main questions the surveys aimed to address were the same, as follows:

1. How many Australians have which mental disorders?
2. What impact do mental disorders have on people, their families and society?
3. How many people have used services and what services have they used?

The 1997 sample was drawn from all persons living in households aged over 18 years, while in 2007 the target population was lowered to 16 years and restricted to people under 85 years.

The survey instruments were based on the latest version at the time of the World Mental Health Survey Initiative version of the Composite International Diagnostic Interview (WMH-CIDI Versions 2.1 and 3.0 in 1997 and 2007 respectively). Modules were selected from this instrument, adapted or written specifically for the survey as appropriate to the survey aims and the Australian cultural context.

The WMH-CIDI includes a series of diagnostic modules that determine whether an individual is sufficiently unwell to be diagnosed with a mental disorder if he or she were to be assessed by a clinician. The information collected through the diagnostic modules is processed through complex algorithms to determine whether the respondents meet diagnostic thresholds for the mental disorders as directed by both the International Classification of Diseases 10th Revision (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV). Modules are available for a broad range of mental disorders.

The 1997 and 2007 surveys both included diagnostic modules to assess three broad classes of the most common mental disorders as follows:

- Affective disorders - mild, moderate and severe depression, dysthymia, and bipolar affective disorder;
- Anxiety disorders - panic disorder, agoraphobia, social phobia, generalized anxiety disorder, obsessive-compulsive disorder and posttraumatic stress disorder; and

- Substance use disorders - abuse or harmful use and dependence on alcohol, cannabis, opioids, sedatives and stimulants.

Whilst all versions of the WMH-CIDI assess the prevalence of mental disorders, there are substantial differences between versions in relation to the number and content of questions used to tap the diagnostic criteria, changes to the structure of the interview specifically with regard to the placement of diagnostic screener questions in a separate early module, and changes to the sequencing of questions within diagnostic modules.

The greatest difference between the two instruments relates to the timeframe used to assess the diagnostic criteria for mental disorders. In the 1997 survey the timeframe was the 12 months prior to the survey. In the 2007 survey the timeframe was the respondent's entire lifetime. An estimate of 12-month prevalence was then derived from a combination of the lifetime prevalence of mental disorders and the presence of symptoms in the last 12 months. This estimate was not based on a comprehensive assessment of all diagnostic criteria within the 12 months prior to the survey. The difference in approaches to estimating 12-month prevalence between the 1997 and 2007 was suggested by some to significantly affect comparability between the surveys.

Information on general health care was collected, as well as more specific information on service use and medication taken for mental health problems. This varied between the two surveys, as this module was specially developed for the Australian context and was altered to reflect the current service environment at the time of each survey.

Information on perceived needs for help with mental health problems was also collected in both surveys. This section covered, firstly, whether people's needs for services were being met and, secondly, if they were assessed as having a disorder, whether they might need services that they were not receiving.

Functioning and disability were also assessed in both surveys using a number of standardised measures. The World Health Organisation Disability Assessment Schedule (WHO-DAS) and the Australian Bureau of Statistics' Short Form Disability Module reflect the concept of disability as described in the International Classification of Functioning, Disability and Health and provided comparability with international and Australian national surveys. Sheehan Disability Scales were used to examine the interference with life in a number of domains (home, work or study, close relationships and social life) in relation to each mental disorder. Days out of role, quantifying the impact of mental disorders and all health problems on day-to-day activities, were also asked in relation to specific disorders.

Both surveys collected information on people's levels of psychological distress using the Kessler 10 scale (K10), a standardised questionnaire commonly used in Australia, including in the National Health Surveys, and internationally.

2.2 Key findings of the adult surveys

The surveys provided evidence that has formed the foundation for policy and service planning over the last 15 years.

In summary, the main findings, primarily from the 2007 survey[1] were as follows:

- **Prevalence** and estimates of the numbers of Australians with anxiety, affective and substance use disorders by sex, age group and other socio-demographic variables in a 12-month period and across their lifetime

  The population burden of mental disorders is due largely to common, high prevalence disorders such as anxiety, depression and substance abuse.

  In 2007, one in five Australians aged 16 to 85 years experienced a mental disorder in the previous 12 months. This is the same prevalence of mental illness as was found in the Australian adult population in 1997 and this figure is very similar to that found in other countries.

  It was found that 43% of the general population aged 16 to 85 years experienced a mental disorder at some point in their lifetime. This figure is similar to that found in other countries, including New Zealand and the United States.

  One in 16 (6.2%) participants had affective (mood) disorders; one in seven (14.4%) had anxiety disorders; and one in 20 (5.1%) had substance use disorders. Based on these prevalence rates, it was estimated that in 2007 nearly 1 million Australians aged 16 to 85 years had affective disorders, over 2.3 million had anxiety disorders and over 800,000 had substance use disorders in the previous 12 months.

  Females were more likely than males to have experienced mental disorders in the previous 12 months (22.3%compared to 17.6%).

  The prevalence of mental disorders was highest in the youngest age group (16-24 years), with around one quarter (26.4%) experiencing a mental disorder in the previous 12 months. This very high rate was due, in part, to the relatively higher rates of episodic or 'binge' drinking in this age group. The prevalence of mental disorders in 18-24 year olds was 15.7% when harmful drinking was not included.

  The next highest prevalences of mental illness by age occurred in the 25-44 age group (20.1%) and the 45-64 age group (17.7%).

- **Age of onset**
  Two thirds (64%) of people who experience mental illness will first experience this before 21 years of age.

- **Comorbidity of mental disorders and chronic physical disorders**
  One quarter (25.4%) of people with mental disorders experienced more than one class of mental disorder, that is two or all three affective, anxiety and substance use disorders in the previous year.

  Mental disorders are more common among people with chronic physical conditions (28% compared with 17.6% of the general population without).

[1] Information drawn from Slade et al (2009) *The Mental Health of Australians 2* and additional analyses.

- **Impact of mental disorders** assessed in terms of severity (based on type of disorder, symptoms and their duration), days out of role and psychological distress

  Of the one in five (20.0%) Australians aged 16-85 years who had a mental disorder in the previous 12 months, one-fifth (20.5%) were classified as experiencing severe disorders, one third (33.2%) moderate disorders and just under half (46.3%) mild disorders.

  Common mental disorders can have significant impact on people's lives. Almost one quarter (22.2%) of people with affective disorders reported very high psychological distress (assessed by the Kessler 10), compared to 11.9% of people with anxiety disorders and 7.3% of people with substance use disorders.

  While two-fifths of the population will experience mental illness in their lifetime, only 3-4% of the population experience severe mental illness, which can have significant impact on their lives.

- **Suicidality of the general population and of those with mental disorders**
  At some point in their lives, 13.3% of Australians aged 16 to 85 years have had suicidal thoughts.

  Suicidality (thoughts, making plans and attempts) in the previous 12 months was reported by 8.6% of people with mental disorders in the previous 12 months. This is three and a half times higher than suicidality in the general population.

  Although experiences of suicidality are much more common in people with mental disorders, these experiences are not confined solely to this group. The prevalence of suicidality in people without a mental disorder in the previous 12 months was 0.8%.

- **Service use for mental health problems**
  Only one third (34.9%) of people assessed as meeting the diagnostic threshold for a mental disorder had used services for mental health problems, but the proportion was far higher for females, those who were experiencing more severe disorders, those with depression and those who were suicidal.

  - Two-fifths (40.7%) of females with 12-month mental disorders used services for mental health problems in the previous 12 months compared to just over one quarter (27.5%) of males.
  - Almost two thirds (64.8%) of people with severe mental disorders used services in the previous 12 months.
  - Service use was highest among people with severe affective disorders (66.1%).
  - Two thirds (67.0%) of people who had had suicidal thoughts and 79.9% who had made a suicide plan reported using services for mental health problems.

  General practitioners were the most commonly consulted group of health care professionals (70.8%), followed by psychologists (37.7%).

- **Perceptions of care**
  People with mental disorders who used services generally felt that their needs had been met, especially in the areas of medication (86.7%) and, to a lesser extent, talking therapy (68.2%).

Two thirds of people with mental disorders who used services felt that their needs had not been met for skills training (66.0%) and social intervention (68.7%).

The majority (85.7%) of people with mental disorders who had not used services reported that they did not need any help.

- **Costs**
  Evidence from all surveys shows the indirect costs for people with mental illness and how it is associated with higher rates of homelessness, poor health outcomes, premature mortality and other serious adverse social outcomes, such as isolation from family and friends, unemployment, stigma and exclusion.

2.3 What the previous adult surveys did not cover

The 1997 and 2007 surveys were one-off surveys of the general population living in private residential dwellings, with interviews conducted the Australian Bureau of Statistics interviewers. This is the best methodology for determining national estimates, but is not usually considered the best methodology for collecting information on sub-sections of the population or less common conditions. It also does not allow for certain types of information to be collected. What was not covered is outlined as follows.

- **People who were homeless or living in institutions**

The 1997 and 2007 surveys were household surveys. Homeless people and people living in institutions, including those residents in nursing homes, hostels and hospices, and those in psychiatric in-patient units or residential facilities, prison or other correctional service facilities, were not surveyed. Although these groups comprise relatively small proportions of the total adult Australian population, it is known that the prevalence of mental disorders is higher in these groups. Tailored survey content and collection methods would be required to collect good quality information and report data on these groups.

- **Low prevalence mental disorders**

The previous adult general surveys did not attempt to detect less common or low prevalence mental disorders, such as somatoform disorders, eating disorders, impulse-control disorders, personality disorders, and schizophrenia and other psychotic disorders,. Information on lower prevalence disorders or other sub-populations is not best gathered in a general door-to-door survey, where the numbers in a random sample of the general population will be relatively low and therefore data cannot be reported with the same level of confidence as that on more prevalent conditions or, on occasion, at all.

Surveys with tailored sampling strategies and, in some cases, clinician or other specifically skilled interviewers are required to obtain good quality data on lower prevalence disorders. That is why evidence on low prevalence, primarily psychotic, disorders was gathered separately in the 1997-98 and 2010 surveys, not through a household survey, but by surveying the treated population, who were primarily sampled through specialised mental health services from which they received services.

- **Dementia**

The surveys also did not cover dementia. This is traditionally not within scope of mental health surveys and certainly not general population surveys, as a survey of dementia would require both a tailored sampling technique, covering non-household dwellings and

specifically nursing homes and hospices, and also tailored collection methods and processes, particularly in terms of assessing and dealing with participants with impaired cognitive functioning. It may also require clinician or other specifically skilled interviewers.

- **Changes over time**

In terms of design, the 1997 and 2007 surveys were one-off cross-sectional surveys and therefore could not provide evidence about changes over time, including those people with disorders who recover without treatment, and those who experience symptoms, but not at a level that meets the threshold for diagnosis of a particular disorder (sub-threshold or sub-syndromal), who go on to have an episode of mental illness.

In 2007 respondents were asked about their history of mental illness and were assessed as to whether what they experienced met the diagnostic threshold for a mental disorder. The 2007 survey also collected data on age of onset, when people recalled first experiencing the symptoms of the mental disorder they were assessed as having at the time of the survey. Whilst this provides insight into when various disorders develop, it is considered a relatively crude measure, relying upon the recall of people up to 85 years. Information on the actual incidence of mental disorders, that is the number of people who experience an episode of mental illness for the first time within a defined period, was not able to be determined.

- **Association between changes in mental disorder status and service use**

These one-off retrospective surveys have also not been able to show, at a population level, the differences in outcomes over time for those that receive services, not only in terms of remission and changes in severity and functioning, but also in terms of various aspects of social inclusion, including studying, employment and social participation.

- **Why people with mental disorders do not use or believe they need services**

In terms of broader content issues, the 1997 and 2007 surveys only just began to explore the concept of perceptions of need. These surveys provided the first population-based evidence that issues of access and means are not the key reasons two-thirds of the population with common mental disorders are not using services, but rather the majority (90%) of people with common mental disorders not using services for their mental health problems do not believe that they need or want to use services. More detailed information on barriers to receiving services and demands for these could be collected in a cross-sectional survey, but the amount of information collected is limited by what can be reasonably asked of a respondent.

3. What has been done overseas

Just over thirty countries in all regions of the world have conducted population surveys to determine the prevalence and impact of mental illness in their populations. The majority of these countries have conducted one-off population surveys using the WMH-CIDI.

New Zealand, the United States, the United Kingdom, Canada, The Netherlands, Norway and Sweden, like Australia, have invested in gathering additional evidence on their populations by conducting further surveys of the same or new samples. The methodology used to collect this additional evidence has varied from repeated one-off surveys containing detailed diagnostic modules through to a longitudinal survey spanning decades in which standardised measures have been supplemented by clinical assessments by psychiatrists.

A number of common themes can be identified in their various approaches as follows:

- There is no methodology for determining the prevalence of mental illness in populations that does not involve surveying large numbers of the population and a comprehensive interview with diagnostic content.
- Increasing problems with response rates and, more generally, maintaining samples, are being experienced around the world. This trend has major implications for the design of surveys.

  Countries with unique personal identifiers are able to get around these problems by tracking individuals using administrative records, and also obtaining service use and other data irrespective of actual participation, subject to consent being given. Where these are not available, there can be major issues with the representativeness of the sample over time and maintaining response rates at a credible level.
- The United Kingdom, the United States and The Netherlands have undertaken followup surveys. In each of these a baseline survey was conducted and then the original respondents were re-interviewed either face-to-face or by telephone once or twice within a relatively tight timeframe of no more than six years. The aim of these followups was primarily to elicit information on changes over time in mental disorder status and to collect data on the incidence of mental disorders in the intervening period.
- Longitudinal surveys are not common, but provide substantial additional information to that gathered in one-off cross-sectional surveys. In particular they can be used to collect information on changes in mental disorder status over time and how these relate to various factors, including service use. Those large scale, mental health focussed, longitudinal studies that are still running were established between 30 and 60 years ago and targeted the populations of discrete geographical areas. Research teams have largely been constant throughout these studies.

Table 3 summarises the population surveys undertaken in New Zealand, Canada, the United Kingdom, the United States, the Netherlands, Norway and Sweden.

Table 3: International population surveys of mental health

Country	Study title	Year in field	Methodology	Mental health related content	Diagnostic methodology	Sample size and target
New Zealand	New Zealand Mental Health Survey	2003-04	Retrospective cross-sectional	Diagnostics Service use	WMH-CIDI Version 3.0	12,992 16 & older
	Christchurch Health and Development Study[b]	1977 ongoing Assessed at birth, 4 months, 1 year, annually to 16, 18, 21, 25 & 30 years	Longitudinal Birth cohort	General health, behaviour Prevalence stability and continuity of disorders Risk and aetiological factors Suicidal ideation/attempt	Content drawn from 1993 WMH-CIDI - major depression; anxiety disorder; conduct disorder; substance use disorders	1,265 at birth
	Dunedin Multidisciplinary Health and Development Study[b]	1972 ongoing Bir h then followup at age 3, 5, 7, 9, 11, 13, 15, 18, 21, 26, 32 and 38 years	Longitudinal Birth cohort - not originally conceived as longitudinal survey	Nature and prevalence of developmental and health problems in 3-year-olds Broad health issues Content for DSM-IV diagnoses Suicidal ideation/attempt	Phase VI (11 years) DISC Phases XIII, XV, XVIII, XXI, XXVI Mental health - major depression, anxiety, conduct, substance use Phases XXXII and XXXVIII Emotional wellbeing	1,037 base sample Established at 3 years
Canada	Canadian Community Health Survey (CCHS) - Mental Health and Well-being CCHS - Mental Health	2002 (Cycle1 2) 2012	Repeated cross-sectional	Mental health status Functioning, disability Service use Perceived need	Statistics Canada based on WMH-CIDI with disorder specific modules, lifetime and 12-month prevalences	36,984 ~27,000 15 & older
	National Population Health Survey - Household Component - Longitudinal (NPHS)	1994/95 to 2010/11 9 cycles Now finished	First 3 cycles cross-sectional sample top up, Longitudinal	Mental health Health professionals seen Cycle 6: Depression personal and family history	Kessler 6+ last month CIDI – Short form for Major Depression	17,276 in 1994/95 12 & older
United Kingdom	Adult Psychiatric Morbidity Survey Second survey United Kingdom Followup at 18 months Subsample telephone followup Third and fourth surveys England only	1993 2000 2001 2002-2003 2007 2014	Retrospective cross-sectional survey series 2000 survey with followup	Diagnostics Social disabilities Health and social services Association with potential environmental risk factors PTSD, autism and low prevalence disorders included in 2014	Clinical Interview Schedule (CIS) revised in 2000 Positive on psychosis screener interviewed by psychiatrist using SCAN[c] NFCAS-C[d]	1993: 10,108 16-65 years 2000:8,580 2001: 3,536 16-74 years 2007: 12,815 16+ 2014: 7,500 16+

Country	Study title	Year in field	Methodology	Mental health related content	Diagnostic methodology	Sample size and target
United States	National Comorbidity Survey (NCS-1) National Comorbidity Followup (NCS-2) National Comorbidity Survey Replication (NCS-R)	1992 2001-02 2001-2003	Retrospective Repeat sample	Diagnostics Suicidality Service use	University of Michigan modified CIDI Clinical Reappraisal interviews - Structured Clinical Interview for DSM-III-R (SCID)	1 Part I: 8,098 1 Part II: 5,877 15-54 years 2: 5,001 NCS-R: 9,282 18 & older
	National Epidemiologic Survey on Alcohol And Related Conditions (NESARC)	Wave 1 2001-02 Wave 2 2004-05 Re-interview NESARC-III 2012 New sample	Nationwide household survey with followup in 2004-05	Focus alcohol consumption Psychiatric classification of alcohol and other substance use disorders, mood, anxiety and personality disorders	NIAAA Alcohol Use Disorder and Associated Disabilities Interview Schedule – DSM-IV Version (AUDADIS-IV)	1: 43,093 2: 34,653 NESARC-III: ~46,500 18 & older
The Netherlands	The Netherlands Mental Health Survey and Incidence Study NEMESIS 1 NEMESIS 2	1996-97, 1997-98 2007-09, 2010-12 Another wave at 3-year interval	Prospective study of psychiatric disorders	Incidence, course and sub-syndromal disorders Life stressors, family history, personality/vulnerability traits	WMH-CIDI 1.1 WMH-CIDI 3.0	1: 7,076 Re-interview 5,618 2: 6,646 18-64 years
Scandinavia	Nord-Trøndelag Health Study (HUNT), Norway[b]	1984-1986 1995-1997 2008	Repeated cross-sectional Longitudinal tracking	Mental health problem questions PIN used to match health and administrative data	Hospital Anxiety and Depression Scale (HADS)	~120,000 people 20 years & older in database
Sweden	Lundby Study	1947, 1957, 1972,1997-2000, 2001-2003	Longitudinal Prospective study of psychiatric morbidity	Case ascertainment by psychiatrist interviews, registers, case notes and key informants Swedish PIN gives virtually 100% coverage of health care system	Nottingham Health Profile, Hopkins Symptom Check List-25 Sense of Coherence Scale Interview Schedule for Social Interaction	2,550 in 1947 rising to 3,563 Total Lundby population

a) WMH-CIDI World Mental Health Composite International Diagnostic Interview
b) Not national, but large scale study with mental health focus
c) SCAN Schedules for Clinical Assessment in Neuropsychiatry
d) NFCAS-C Needs for Care Assessment

Longitudinal - Initial sample or a selected subset of the initial sample is resurveyed two or more times

Retrospective - Asks respondents to recall information from the past

4. Development of technical specifications

The Technical Advisory Group is to provide advice on the preparation of technical specifications for a third National Survey of Mental Health and Wellbeing of the adult population that may be used by the Department as a basis for procuring a survey in the future.

The Technical Advisory Group is not responsible for the actual drafting of any documentation, but will be supported by a consultant with the necessary technical expertise required to prepare the necessary documentation.

Input from external experts will also be sought when necessary.

It is essential for all TAG members to be aware that the development of technical specifications does not imply that the conduct of a third adult survey will follow automatically. The Department has indicated that it will need to seek policy approval for this, given its significant funding implications. The technical specifications to be developed with TAG input are best regarded as providing a basis for the Department to consider whether a survey will go ahead, and determine how procurement of such might best occur.

4.1 Areas to be covered

In developing this documentation particular attention should be paid to national mental policy priorities as outlined in the Department of Health statement of 'imperatives'.

The technical specifications will need to cover the following:

- aims for the survey;
- principles to guide decisions on methodological issues, content and data outputs;
- an indicative timeline for conduct of the survey, specifying each of the collections to be undertaken;
- issues in relation to sampling, including oversampling of any key sub-populations and sample top ups;
- specification of methods to be used for collection, where relevant;
- major content areas to be covered, including aspects in relation to the diagnostics;
- expectations around data linkage;
- requirements in relation to data storage, data outputs and access; and
- information products to be produced that are based upon priorities for the Government, in terms of both reporting needs and information to further build the evidence base for future policy decisions and resource allocations.

Clear demarcation of those items that the Department considers non-negotiable requirements and the areas in which the prospective organisation or consortium that undertakes the work is being asked to provide its own input - where necessary placing boundaries around these, will be required.

5. Survey design and methodological issues

There are a number of design and methodological issues that need to be resolved. The technical specifications are to clearly identify a proposed approach to each of these.

5.1 Aims

The 1997 and 2007 surveys aimed to address the same three main questions:

1. How many Australians have which mental disorders?
2. What impact do mental disorders have on people, their families and society?
3. How many people have used services and what services have they used?

Revision of these aims may be warranted to reflect the focus of the new survey and any major areas that might be covered.

5.2 Scope

The 2007 survey sampled people in households aged 16-85 years.

This allowed for cross-over with the child and adolescent survey for those aged 16-17 years.

People not living in households
People in households were usual residents of private dwellings in Australia, excluding very remote areas. Private dwellings are houses, flats, home units and any other structures used as private places of residence at the time of the survey.

People living in institutions, nursing homes, prisons, and other specialist settings were not interviewed in 1997 and 2007.

While these non-household groups cover populations known to have a higher likelihood of mental disorders, these people make up a relatively small proportion of the total population aged between 16 and 85 years and therefore non-inclusion of these groups has been assessed as not greatly affect the overall prevalence of mental disorders.

Very remote areas
The one percent most remote SA1s in Australia were excluded from the survey. This is considered standard practice for national surveys.

State and territory breakdowns
Samples sizes to produce even state level estimates are prohibitively large. These would also be at the expense of breakdowns of the data on issues that are considered important from a policy and planning perspective, namely by disorder groupings, severity and type of service use.

Indigenous comparisons
Aboriginal and Torres Strait Islander status has been collected in the national surveys, but has only been used for administrative purposes.

Random sampling alone with the number of participants for this survey is not considered sufficient for generation of these data within acceptable confidence intervals and, as such, data have not been made available for any of the publications or in any confidentialised record files for Aboriginal and Torres Strait Islander peoples or comparing estimates of mental disorders or other variables with the non-Indigenous population.

5.3 Survey methodology

The 1997 and 2007 were household surveys undertaken by well trained, lay interviews.

All interviews were conducted face-to-face.

The Australian Rural Mental Health Study, a large scale, longitudinal study of the mental health of persons living in rural and remote New South Wales, undertook its baseline survey in 2008, with followup surveys 12 months, three years and five years later. This survey used the same methodology for determining mental disorder status as the 2007 National Survey of Mental Health and Wellbeing, the WMH-CIDI, but the initial surveys were conducted by phone rather than in person. Whilst the response rate was fairly low, this was a pragmatic solution to interviewing across rural and remote areas.

- Just 27% of people selected participated in the survey initially, however, between a half and two thirds of the sample continued to participate in the next phase (64.5% at 12 months; 47.8% or 68.7% who completed the 12-month completed the three year, as well as 9.9% of those from the 12-month followup).

More recently, the 2013 child and adolescent survey was returning to households up to six times to complete an interview with parents and carers, and the end response rate was still relatively low at 55%. Tablets were, however, used highly successfully for completion of questionnaires by young people whose parents or carers had given permission for them to participate, resulting in an 88% response rate.

Adaptation of the standard methodology or a mixed methodology might be a necessary strategy for the next survey to improve response rates and/or for followup, particularly in relation to select topics or requiring less intensive input.

5.4 Development, testing and training

Instruments may need to be adapted for use in Australia, updated for the current service delivery environment or particular policy requirements, or specially developed.

Allowances for development of modules, pre-testing, cognitive testing of any specially developed content and field testing are to be built into the survey timeline.

Substantial training of interview personnel outside what would normally be undertaken, including sensitivity training and mental health background, is also to be factored in. This is important so that interviewers are able to respond appropriately if participants become upset and so that they are able to deal with disclosures that may occur during the course of the interview. Training has also been found to create a greater investment in the conduct of the interview, which may in turn impact on participation.

5.5 Sample design – oversampling, top-up and split sampling

The focus of all the National Surveys of Mental Health and Wellbeing to date has been on the production of national estimates.

Response rates, whilst less than anticipated or desirable, have not been sufficiently low for top-up sampling of particular population groups to be undertaken to date.

Examination by the Australian Bureau of Statistics of the 2007 results, and more particularly the characteristics of respondents showed that the survey was representative of the

Australian population in terms of standard demographic factors. It also did not indicate any areas for which there were extremely low response rates that might have had a major impact on the results, so as to suggest oversampling of a particular population group might be warranted in another survey.

Both top ups and oversampling of 16-17 year olds were necessary in the second child and adolescent survey. The impact of these strategies on the final response rate should be carefully considered before any such strategies are employed.

In 2007, consideration was given to a design methodology that involved split sampling. This was not considered viable at the time due to an emphasis on data being available by key variables for which a full sample was needed. Instead the strategy of rationalising content was adopted.

5.6 Length

The 2007 National Survey of Mental Health and Wellbeing was designed to have a length of up to 90 minutes. In reality respondents meeting disorder status spent 2-3 hours, and some up to 6-7 hours, to complete the survey.

The survey was necessarily long, unlike any other household survey up until that time, to accommodate a suite of modules as required for policy and planning purposes – diagnostic modules for affective disorders, anxiety and substance abuse disorders, measures of functioning and service use. This left very little room for additional content and necessitated strict rationalisation of additional content.

Advice from the Australian Bureau of Statistics suggested that the response rate was not significantly impacted by drop-outs. However, there is a prima facie case to suggest that the indicative length of the survey would have impacted on people's initial agreement to participate.

Since 2007, there has been another child and adolescent household survey and evidence from other household surveys shows ever decreasing response rates to levels that would have previously been considered unacceptable.

It is unrealistic to assume that stakeholders will not be asking for inclusion of even more content as interest in mental health has grown, but careful consideration is required regarding what is a reasonable limit on survey time (for both those completing the basic survey and for the many people with comorbid mental disorders who complete multiple diagnostic modules) and what can fit within those constraints.

5.7 Maximising response rates

The 2007 survey had a sample of approximately 8,800 people and a response rate of 60%, compared to the 78% in 1997 with a sample of approximately 10,600 people.

Each survey has employed a suite of measures to contact and seek subjects' agreement to participate. These have included various methods of inviting participation, endorsements and multiple call backs.

Although the sampling frame was obviously different for the child and adolescent survey in 2013-14, a total of 76,606 households were approached and those eligible households with children in the age range were visited up to a maximum of six times to collect information

from 5,500 randomly sampled families. In total 6,310 parents and carers or 55% of eligible households responded.

Reasons for non-response
Interviewers indicated that the majority of persons who refused to participate in 2007 were 'too busy' or 'not interested' in the survey. People also refused to participate as the survey was 'not compulsory', the content was 'too personal', or they expressed an anti-government or anti-survey sentiment (such as invasion of privacy).

A non-response follow-up study conducted in 2008 in Sydney and Perth did not yield any results that could conclusively account for the low response rate or particular populations that were more inclined to refuse. The K10 scores of respondents were slightly higher for non-responders (15.6 compared with 14.4), but these are not exclusively associated with higher rates of mental disorders.

Measures to counter these negative sentiments, to the extent that it might be possible, should be considered. Limitations on the length and changing other aspects related to the design, as well techniques for maximising and improving response rates more generally, are also important, and even more so if repeat surveying is to be viable and further attrition of the sample minimised.

5.8 Data linkage

Consent to linkage with Medicare Benefits Schedule and Pharmaceutical Benefits Scheme data provides supplementary information across the survey period and can also be used to provide some insight into future service and medication use.

Preliminary agreements were sought for linkage with the 2007 survey, but this was not finalised in time for the survey. Consent to access Medicare data, however, was sought as part of the second child and adolescent survey towards the very end of the survey so as to reduce the potential impact of this on participation in the survey.

The process for gaining agreement to data linkage, clearance of consent protocols and trialling these are all integral parts of the conduct of the survey. The period over which this is tracked may also significantly impact on a respondent's consent.

5.9 Biological samples

Physical examinations and blood samples were undertaken as part of the 2010 survey of people with psychotic illness. Ongoing storage of bloods was made possible as part of the Australian Schizophrenia Research Bank (ASRB), which is a medical research database and storage facility that links clinical and neuropsychological information, blood samples and structural MRI brain scans from people with schizophrenia and healthy non-psychiatric controls. The ASRB already had the necessary protocols in place for this to be undertaken as part of the study as well as a facility to accommodate samples long term.

The possible collection of biological materials, specifically saliva, which is a simple method for collecting DNA that can be examined for the genetic correlates of mental illness, was suggested for the 2007 survey. Although costs of processing this material have reduced dramatically since then, ethical clearances are still rigorous and the impact of this addition on response rates also requires careful consideration.

5.10 Longitudinal data

Australian now is investing in three longitudinal health surveys of the population – of women, children and more recently men. Each has mental health content. However, this content is limited within these broader health surveys.

A number of other countries have invested in longitudinal population health studies, some with more comprehensive mental health content, such as the Christchurch Health and Development Study, which included content from the WMH-CIDI on major depression; anxiety disorder; conduct disorder; substance use disorders from 1993 and the Dunedin Multidisciplinary Health and Development Study that includes content for determining some DSM-IV diagnoses. However, the Lundby Study in Sweden, which began in 1947, is a true longitudinal mental health survey, prospectively determining psychiatric morbidity.

These surveys are broadly characterised by the restricted geographical catchments in which they are undertaken, and the ability to track and link data on individuals, particularly when they do not participate in later phases of surveying.

Repeat surveys have been used more often in other countries than longitudinal studies to determine changes in mental disorder status. These have been undertaken in the United Kingdom (Adult Psychiatric Morbidity Second Survey in 2000 with a followup at 18 months and a subsample telephone followup another year later) and the United States (National Comorbidity Surveys in 1992 and 2001-02, and the National Comorbidity Survey-Replication in 2001-2003).

The information collected in these was still largely retrospective. However, The Netherlands Mental Health Survey and Incidence Study (NEMESIS 1 and NEMESIS 2), which began in 1996-97, was designed to look at changes over time (course and sub-syndromal disorders, life stressors, family history, personality/vulnerability traits) in re-interviewed respondents either face-to-face or by telephone once or twice within a relatively tight timeframe of no more than six years, to determine the incidence of mental disorders.

Whilst it is highly desirable to have longitudinal data, decreasing response rates over the years and other investments by government make investment in another longitudinal health survey in Australia highly unlikely. Notwithstanding this, surveys in other countries demonstrate the ability to still explore changes in mental illness through repeat surveying and, where possible, supplementation with other health and service use data.

Most countries have invested in followup surveys within relatively short timeframes and using different methods to supplement the more traditional household interview. Other surveys undertaken in Australia also provide examples of techniques for followup (and maintenance of samples). In particular the Women's Health Australia project, formerly the Australian Longitudinal Study on Women's Health, has been very successfully doing this since 1995.

Various models for repeat surveying (strategies for relatively quick call-backs on key issues, methods and response rate targets) and indicative timelines in which this might be viable are areas that will need to be explored if the survey is to provide any evidence on changes over time.

6. Content

Decisions on specific content, and the design used to collect it, should be guided by a number of key questions:

- What is necessary for comparability in key policy areas?
- What is imperative from the perspective of the Department, as potential funder?
- What is no longer essential?
- What else needs to be included?
- Can additional content be accommodated?

An outline of each of the major content areas of the 2007 survey is provided in the following sections.

Further information on these areas is provided in the Users' Guide[2].

6.1 Diagnostic modules

The survey used the World Mental Health Survey Initiative version of the World Health Organization's Composite International Diagnostic Interview, version 3.0 (WMH-CIDI 3.0).

This determines both the lifetime prevalence and the 12-month prevalence of disorders based on the respondent meeting the diagnostic criteria for a mental disorder at any point in the respondent's lifetime and having symptoms of the disorder in the 12 months prior to interview.

The following mental disorder modules were included:

Anxiety disorders

- Panic Disorder
- Agoraphobia
- Social Phobia
- Generalised Anxiety Disorder
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder

Affective disorders

- Depressive Episode
- Dysthymia
- Bipolar Affective Disorder

Substance use disorders

- Alcohol Harmful Use/Abuse
- Alcohol Dependence
- Drug Use Disorders (includes Harmful Use/Abuse and Dependence)

[2] ABS • NATIONAL SURVEY OF MENTAL HEALTH AND WELLBEING USERS' GUIDE • 4327.0 • 2007

This provided an assessment of mental disorders based on the definitions and criteria of two classification systems:

- Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM–IV); and
- WHO International Classification of Diseases, Tenth Revision (ICD–10).

The WMH–CIDI 3.0 was also used to collect information on:

- onset of symptoms and mental disorders;
- the courses of mental disorders – episodic, clusters of attacks and fairly persistent;
- impact on home management, work life, relationships and social life.

6.2 Severity, functioning and disability

For people who were diagnosed with a lifetime mental disorder and had symptoms in the 12 months prior to interview the level of the severity of their impairment was calculated. This was measured through Sheehan Disability Scales administered in each diagnostic section, and through disorder-specific clinical severity scales.

Assessment of severity
A person was considered to have a severe level of impairment if any one of the following occurred in the 12 months prior to interview:

- a diagnosis of Bipolar I Disorder;
- Substance Dependence with serious role impairment;
- a suicide attempt and any mental disorder;
- at least two areas of severe role impairment in the Sheehan Disability Scale domains because of a mental disorder; or
- overall functional impairment at a level found in the National Comorbidity Survey Replication (NCS–R) to be consistent with a Global Assessment of Functioning (GAF) Score of 50 or less, in conjunction with a mental disorder.

A person was considered to have a moderate level of impairment if they had a 12–month mental disorder and they:

- were not classified as severe;
- reported at least moderate interference in any Sheehan Disability Scale domains; or
- had Substance Dependance without substantial impairment.

A person was considered to have a mild level of impairment if they had a 12–month mental disorder and they were not classified as severe or moderate.

Other measures
Three measures related to functioning were included:

- WHO Disability Assessment Schedule (WHO-DAS);
- Assessment of Quality of Life (AQoL) instrument; and
- Days out of role.

A range of other scales and measures providing general assessments of mental and physical health were also included in the 2007, and 1997, surveys:

- Kessler Psychological Distress Scale (K10);
- Delighted–Terrible Scale;
- Self-assessed health rating;
- Main problem;
- Psychosis screener; and
- Mini-Mental State Examination (MMSE).

These were placed at different points in the survey to reduce repetitiveness for the respondent. However, feedback from cognitive testing and the initial field study were that respondents found these highly repetitive and could not distinguish how these differed.

Although each measure was relatively brief and was included to fit a particular purpose, collectively they accounted for a substantial amount of survey time. Rationalisation of this content is a key area for potential change.

6.3 Suicidal behaviour

Suicidality, which covers suicidal ideation (serious thoughts about taking one's own life), suicide plans and suicide attempts, was assessed both across the lifetime and in the previous 12 months.

Participants in 2007 were asked their age the first time, their age the last time and if they had experienced suicide ideation, made a plan or attempted suicide in the previous 12 months.

For those who had attempted, they were asked the number of times that they did so in the previous 12 months, the methods used and whether their attempt resulted in an injury or poisoning, required medical attention and/or required overnight hospitalisation. In addition, they were asked to select one of the following three statements that best described their situation when they first attempted suicide:

- I made a serious attempt to kill myself and it was only luck that I did not succeed;
- I tried to kill myself, but knew that the method was not foolproof; or
- My attempt was a cry for help, I did not intend to die.

Given the increased emphasis by all governments on suicide prevention as a priority, including in the 5th National Mental Health and Suicide Prevention Plan, information on suicide and associated risk factors is even more critical.

6.4 Comorbidity

The 2007 survey identified comorbidity between classes of mental disorders (affective, anxiety and substance use disorders) and between mental disorders and the six chronic physical conditions recognised as National Health Priority Areas. These are diabetes, asthma, coronary heart disease, stroke, cancer and arthritis.

6.5 Service use

Information in relation to service use was collected in a number of related modules:

- services used for mental health problems (includes consultations with health professionals, hospital admissions and self-management strategies);
- medications; and
- perceived need for help.

People were defined as having used services for mental health problems if they had at least one consultation with a health professional or hospital admission in relation to mental health problems in the 12 months prior to interview.

The list of providers in 2007 was the same as 1997 and included general practitioners; mental health professionals, such as psychologists, psychiatrists and mental health nurses; health professionals not working in mental health services, such as other medical doctors, social workers and nurses; and practitioners of complementary and alternative medicine.

Perceived need covered whether people who had received services or particular types of help over the previous 12 months felt their needs had been met. For people who did not receive services the survey examined whether there were services or types of help that they felt they needed but had not received categorised as follows:

- information about mental illness, its treatment and available services;
- medication;
- talking therapy, such as cognitive behaviour therapy, psychotherapy and counselling;
- social intervention, such as help to meet people and sort out accommodation or finances; and
- skills training to improve the ability to work, self-care or manage time effectively.

7. Survey products

Access to data in a format that is useful to inform national policy and service planning is particularly important if the survey is to meet its aims.

7.1 Publications

There were four initial publications from both the 1997 and 2007 surveys:

- Summary of Results
- Users' Guide
- Technical Manual
- Summary publication covering key statistics in all policy areas.

7.2 Access to the data

Basic and Expanded Confidentialised Unit Record Files (CURF) were developed.

Data are also made available on request to meet individual requirements subject to confidentiality and sampling variability constraints.

The key issue here was that, in spite of the methodology and design supporting national estimates, data would normally be broken down to the state level, in this case at the expense of disaggregation by disorder and severity.

Considerable work and negotiations were undertaken to develop these files, particularly in terms of confidentialising the records in line with departmental and national mental health data requirements rather than standard Australian Bureau of Statistics' protocols.

There were also issues at the time around whether the response rate of 60%, considerably lower than for other household surveys at the time, was sufficient for data release.