national mental health strategy

Fourth National Mental Health Plan

Measurement Strategy

First Edition – May 2011

Proposed data sources, specifications and targets for the Fourth Plan Progress Indicators

A report by the National Mental Health Performance Subcommittee

Mental Health Information Strategy Subcommittee

AHMAC Mental Health Standing Committee

The Fourth National Mental Health Plan Measurement Strategy 2011.

A report produced for the Australian Health Ministers Advisory Council Mental Health Standing Committee by the Mental Health Information Strategy Subcommittee National Mental Health Performance Subcommittee.

An electronic copy of this document is available at the Mental Health Standing Committee website www.health.gov.au/mhsc.

National Mental Health Performance Subcommittee.
C/- NMHPSC Secretariat.
Mental Health Information Unit.
Mental Health Alcohol and Other Drugs Directorate.
Queensland Health.
PO Box 2368.
Fortitude Valley BC.
QLD 4006.

Telephone 07 3328 9602.
Email nmhpsc@health.qld.gov.au.

Fourth National Mental Health Plan Measurement Strategy.
Online ISBN: 978-1-74241-437-9.
Publications Number: D0334.

FOREWORD

The whole-of-government approach underpinning the Fourth National Mental Health Plan (the Fourth Plan) recognises that the goal of achieving good mental health for Australians is not only the domain of clinical mental health services. Engaging with a range of sectors from across portfolios and the broader community is essential for promoting mental health and wellbeing, and assisting recovery for people who do experience mental illness. Significant increases in funding have been injected into the mental health sector, and appropriately, there is a high-level of public scrutiny on the performance of mental health services, and the outcomes for people with mental illness, their carers and families.

The Fourth Plan commits governments to a range of activities and actions that continue the progression of reform for the mental health sector. The role of the Fourth National Mental Health Plan Measurement Strategy (the Measurement Strategy) is to inform the public of the indicators and targets set for measuring governments' performance in relation to the activities and actions identified in the Fourth Plan to continue the progression of mental health sector reform.

The Fourth Plan has identified two distinct levels of focus for performance measurement. Firstly, the policy level, with a set of 25 indicators identified to measure the performance of governments in progressing reform, and an associated commitment to publicly report results against those indicators. This Plan also commits governments to developing appropriate targets that articulate desirable levels of performance. Secondly, the Fourth Plan commits to building on the work achieved under previous national mental health plans to improve service delivery level performance information, through further development of the National Mental Health Performance and Benchmarking Framework, and publicly reporting service-level performance.

The key purpose of this first edition of the Measurement Strategy is to describe the underlying principles and the approach taken in developing the technical details of the indicators and targets. Future data development activity will be articulated in the Mental Health Information Development Priorities Third Edition, and interpretative analysis and commentary in relation to reform progress will be provided with the published indicators via the National Mental Health Report.

It is worth noting that identification of performance indicators to measure change and outcomes is only the first step in monitoring mental health reform. The experience from previous national mental health plans is that there is significant work, and cost, to be undertaken to develop national data sources to the point that they can supply contemporary, timely data to populate identified performance indicators.

My sincere thanks to the numerous organisations and individuals who contributed to the development of the Measurement Strategy. I look forward to your continued support as we work cooperatively to improve the mental health of Australians.

Dr Aaron Groves.
Chair.
Mental Health Standing Committee.
Australian Health Ministers Advisory Council.
May 2011.

CONTENTS

SECTION 1: INTRODUCTION AND BACKGROUND

1.1 The Fourth National Mental Health Plan.

The Fourth National Mental Health Plan (the Fourth Plan) was agreed by Australia's Health Ministers in September 2009. The Fourth Plan follows on from the work of the previous three national mental health plans in collaboratively shaping mental health sector reform by identifying priority areas for reform and committing governments to a set of agreed actions. This plan also builds on previous national, state and territory initiatives, including the Council of Australian Governments (COAG) National Action Plan for Mental Health 2006-2011, and jurisdictions' mental health plans.

The Fourth Plan is based on a population health framework that focuses on a range of factors impacting on the mental health of all Australians across the life span, recognising that as well as biological and psychological factors, economic and social factors such as education, employment, housing and income, along with participating in the community and having social connections, are all vital to promote good mental health and wellbeing and prevent mental illness occurring. This plan also acknowledges that when mental illness does occur, access to assessment and treatment should be available at the earliest opportunity to prevent further deterioration and aid recovery.

Recognising that factors outside the health system impact on mental health and mental illness, the Fourth Plan commits governments to reform beyond the mental health sector and from portfolios outside of health. This whole-of-government approach articulates the collaboration required between agencies, and promotes greater awareness of mental health issues across human services at all levels of government and the community.

The Fourth Plan identifies five priority areas:

- Priority Area 1 – Social inclusion and recovery.
- Priority Area 2 – Prevention and early intervention.
- Priority Area 3 – Service access, coordination and continuity of care.
- Priority Area 4 – Quality improvement and innovation.
- Priority Area 5 – Accountability—measuring and reporting progress.

Desired outcomes and agreed actions are detailed within each priority area. Improving accountability for reform and service delivery is integral to the Fourth Plan, and each priority area contains indicators to monitor change. For the first time, the Fourth Plan also commits governments to the establishment of nationally agreed targets to drive reform and quality improvement.

1.2 A history of measuring and reporting progress.

Australia's mental health sector has been a world leader in reporting on its performance in implementing reform. A number of publications contribute to information available in the public domain.

National Mental Health Report. Having no international counterpart, eleven reports were released over the period 1994–2010, charting the progress of all governments in reforming their mental health service delivery. Each report provided detailed information about the performance of the Australian and state and territory governments in implementing the policy directions agreed under the Strategy.

Subsequent to the introduction of the National Mental Health Report, three additional national-level reports were developed that specifically covered the mental health sector:

1. The Mental Health Services in Australia report is prepared by the Australian Institute of Health and Welfare on an annual basis. To date, twelve reports have been released providing a detailed picture of the national response to the mental health care needs of Australians. Data from a wide range of collections are presented, both as annual snapshots and changes over time.
2. The Steering Committee for the Review of Government Service Provision, introduced the separate reporting of mental health service performance in its 1999 annual Report on Government Services. Previously, mental health services had only been included within the reporting of acute hospital performance. The data provided in this report has continued to be refined, and now includes a range of performance indicators covering three broad categories: equity, efficiency and effectiveness.
3. Following the agreement by COAG to the National Action Plan for Mental Health 2006–2011 in July 2006, annual reports are prepared for COAG on the progress of the Plan that summarise progress against 12 performance indicators. To date, two reports have been released covering progress to 2008–2009.

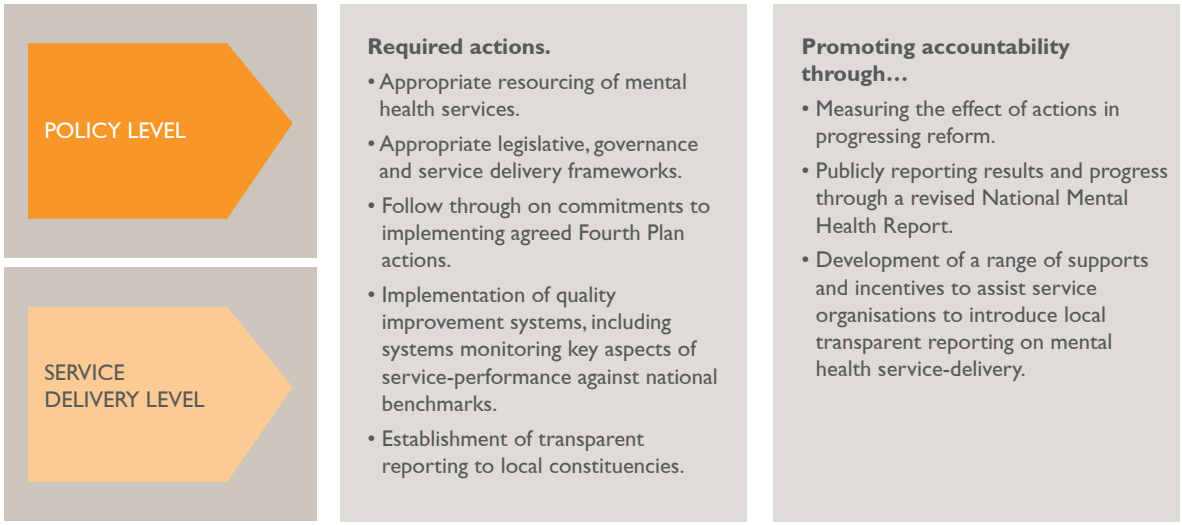
1.3 Building an accountable and transparent mental health system.

Central to the Fourth Plan is a commitment by governments to improve accountability and transparency within the mental health sector through a multi-level approach – at the policy level of governments and central mental health administrations; and at the service delivery level. Figure 1 summarises the approach agreed in the Fourth Plan for strengthening accountability at both levels. Together, the two levels of reporting will provide coverage of the mental health sector and will place a wide range of performance information into the public domain.

The policy level.

For the first time, this national mental health plan specifically identifies a set of indicators that focus on measuring and reporting performance at the policy level, to monitor progress towards reform of the mental health sector. In line with the whole-of-government approach underpinning the Fourth Plan, the indicators will also measure and report on other health areas and more broadly from other portfolios, using a range of data sources including population and service data. The Fourth Plan commits governments to strengthen the foundation for accountability for the mental health sector by reporting against the 25 indicators in a revised National Mental Health Report.

Figure 1: Multi-level approach to building an accountable and transparent mental health system.



The service delivery level.

The Fourth Plan also commits governments to publicly report service delivery performance. Under previous national mental health plans there was significant development of mental health information and performance measurement systems, principally in public state and territory services and the private hospital sector. The National Mental Health Performance Framework[1] provides a platform for mental health services to measure their own performance and benchmark against the performance of their peers. However, despite the progress made, there has not been widespread public reporting of this performance information. The 2010 COAG National Health and Hospitals Reforms include the establishment of a National Performance Authority to publicly report service delivery performance. It is anticipated that the extensive work already undertaken by the mental health sector will contribute to the work of the National Performance Authority once it is established.

[1] Details of the *National Mental Health Performance Framework* and associated national mental health key performance indicators are available from www.health.gov.au/mhsc.

1.4 The Measurement Strategy.

The Measurement Strategy focuses on the policy level performance indicators, and represents the culmination of extensive collaborative work by representatives from jurisdictions, a number of Australian Government agencies, the private and non-government sectors, consumers and carers, and clinical experts.

This initial edition of the Measurement Strategy describes the approach taken by the mental health sector to develop the Fourth Plan indicators and targets. It provides a high-level overview of the indicators and targets, details on indicator specifications, and planned developments.

Appendix 1 provides detailed technical information for each of the indicators with agreed specifications. It is important to note that the specifications will be enhanced over time as technical conventions are determined and the outcome of data development activity becomes available. Future editions of the Measurement Strategy will communicate these enhancements to facilitate consistent construction of the indicators and improve the comparability of results.

The Measurement Strategy has been produced by the National Mental Health Performance Subcommittee (NMHPSC) on behalf of the Mental Health Standing Committee's Mental Health Information Strategy Subcommittee (MHISS). Information on the committees and their reporting structure is contained in Appendix 2.

SECTION 2: APPROACH TO INDICATOR AND TARGET DEVELOPMENT

2.1 Indicator development.

Fourth Plan indicator development was underpinned by the following principles:

- **Be inclusive of all components of the mental health sector.**

  Under the National Mental Health Strategy there has been significant expansion in mental health services available to the community from public, private and non-government agencies in both primary and specialist sectors. The scope of the Fourth Plan indicators includes all components of the mental health sector. Notwithstanding the broad scope of the Fourth Plan, it is recognised that people experiencing severe and enduring mental illnesses are among the most disadvantaged in our community, so in addition to reporting on the general population, two *social inclusion and recovery* indicators will also be reported for consumers of state and territory public mental health services.

- **Utilise existing national data and specifications where available.**

  There has been significant investment in the development of a nationally agreed and endorsed mental health performance framework and a set of key performance indicators. Wherever possible, the Fourth Plan indicators will utilise existing national data sets and indicator specifications to build on the capacity of existing frameworks, provide consistency, allow comparison and reduce collection burden.

- **Indicator specifications should meet recognised quality selection criteria.**

  The National Health Performance Framework provides a set of desirable criteria for health sector performance indicators. Details of the criteria are contained in Appendix 3.

- **Use of interim indicators where new data sources need to be developed.**

  Under the Fourth Plan, governments committed to public reporting of the 25 indicators. However, it is acknowledged that there is a need for extensive data development to populate some indicators. For those indicators that do not currently have a suitable data source, interim indicators have been identified for reporting during the period in which the required data and reporting arrangements are being developed.

To measure the influence of cross-sectoral reform, key intersections are targeted. For example, *Proportion of primary and secondary schools with mental health literacy component included in curriculum* is an indicator of whether health promotion strategies are reaching into the education sector while *Proportion of front-line workers within given sectors who have been exposed to relevant education and training* indicates whether a desirable increase in early intervention capacity within the community has been achieved.

Performance measurement generally uses four main types of indicators (Table 1), described as input, process, output, and outcome measures. Historically the health sector has focused on measures of efficiency—inputs and outputs. The mental health sector is now placing a greater emphasis on *outcome measures*—what impact on consumers' health and wellbeing occurred as a result of receiving a mental health service? Population-based indicators are considered broad outcome measures—what impact on the broader community has occurred? All four types of performance indicators are included in the Fourth Plan, providing a broad range of information on the sector.

Table 1 Types of performance indicators.

Input	Measurement of the resources used to create a service (such as funding, capital works or human resources).
Process	Actions that convert inputs into outputs.
Output	Measurement of services provided (such as the number of consumers seen by a service).
Outcome	Measurement of the impact as a result of the service or intervention (such as reduction of symptoms or engaging in employment).

2.2 Target development.

The Fourth Plan commits governments to agreeing to national targets where appropriate, against the indicators. Whereas performance indicators are the tools used to measure and gauge the extent to which a goal is met, targets represent 'markers' on the measurement scale that define desired levels of performance.

Target setting is an evolving process and typically must be based on imperfect evidence. It also needs to be approached with reference to the political and economic contexts, recognising that not all jurisdictions are at the same point nor have the same capacity to achieve reform goals.

The targets proposed in this document have been informed by international and local research where available, and/or consultation with relevant experts and stakeholders. Targets have not been set for those indicators requiring new data or further specification, and other indicators for which there is no evidence basis or body of opinion available on which to base credible targets. Where possible, interim targets have been set where additional work is planned. Targets will be the subject of periodic review, informed by ongoing analysis of relevant data.

A systematic process was applied to evaluate and select potential targets, following three steps:

1. Determining the best evidence base that is available to set a target.
2. Determining the type of target.
3. Assessing any proposed target against the 'SMART' criteria.

The target evaluation process is summarised below:

Step 1	Step 2	Step 3
Evidence base (on what is the target based?)	**Type of target (how should the target be expressed?)**	**Overall assessment of suitability 'SMART'**
• Based on evidence. • Based on consensus/opinion. • Based on community values/ aspirations.	• Rate. • Range. • Movement or shift. • Difference.	**S**pecific. **M**easurable. **A**chievable. **R**ealistic. **T**imely.

Steps 1 and 2 are hierarchical, with the most desirable criteria highest on the list. This process allowed for ranking of potential targets when there were competing candidates. All targets were required to meet the five SMART criteria.

For those indicators identified by the NMHPSC as suitable for target development, the approach used was to propose targets that will present a challenge rather than simply reflecting a level of performance that is easily achievable within the life of the Fourth Plan. In this way, the proposed targets have been developed to assist in driving reform by reflecting the sectors' desire to improve in agreed directions, and at an agreed rate or level of performance. This level of performance may not be achieved by the end of the Fourth Plan, but the targets are aimed at providing an objective reference point by which to judge progress to date and the extent to which further reform is required.

2.3 Defining mental illness for measurement purposes.

Developed separately and for different requirements, the data sources for the indicators utilise different definitions, parameters, terminologies and tools with which to identify and describe mental ill-health. This variation poses a challenge for effective reporting, analysis and interpretation. However, even with this limitation, the available data does provide considerable information relevant to the reform agenda set out in the Fourth Plan.

Regardless of the exact terminology of each data source, this document utilises the following terms adopted in the Fourth National Mental Health Plan[2] to describe mental ill-health:

- Mental health problem:

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

- Mental illness:

  "A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD)."

[2] Australian Health Ministers' Conference (2009) *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009–2014,* Commonwealth of Australia, p. 84.

SECTION 3: INDICATORS AND TARGETS

3.1 Indicators and targets.

Section 3.2 provides a high-level overview of the status of each Fourth Plan indicator and target. The indicators have been numbered for ease of reference. In summary:

- Two social inclusion and recovery indicators are partitioned for separate reporting at the general population level and for state and territory consumers. Subsequently, the total number of indicators to be reported increases from 25 to 27.
- Of the 27 indicators:
  - 14 are identified as having suitable data sources and capable of being reported in full over the course of the Fourth Plan;
  - Two (indicators 6 and 20) are identified as having suitable data sources for part of the indicator and have been split into components that (a) can be reported now, and (b) cannot yet be reported; and
  - For all remaining indicators, except one (indicator 10), work has been identified to develop suitable data sources, and/or work is in progress to develop such sources.
- Targets are proposed for seven of the 27 indicators. For the majority of the remaining indicators, further work is ongoing to specify meaningful targets, or indicator specifications are to be finalised once data sources have been developed. For a small number of indicators (four), meaningful targets are not seen as possible within the life of the Fourth Plan.

Section 3.3 provides statements of the rationale underpinning each indicator and a description of the indicator in terms of data source(s), baseline year and frequency of reporting as well as the proposed data and indicator development activities.

The Fourth Plan acknowledges that a number of indicators do not have existing data sources. This section describes the issues and the approaches to progress development of suitable data sources for these indicators.

For the 16 indicators with specifications, targets have either been agreed to or it has been identified that a target is not appropriate. There are a small number of indicators where a target has been agreed, however, refinement or development is still in progress. This section also provides the rationale underpinning agreed targets and the level of evidence and output type for each.

Indicators and targets will be reviewed and refined as data sources and understanding of performance improves. As technologies advance so too will the opportunities for collection and linkage of data.

There are a number of known interpretation, quality and scope issues with data from the national mental health administrative data and outcomes sets, and steps to resolve these are being progressed through collaborative processes led by the Mental Health Information Strategy Subcommittee (MHISS).

Issues of data quality and appropriateness are contained in the appendices, and will be further expanded and updated in subsequent editions of the Measurement Strategy.

The progress in data, indicator and target development and changes from this baseline edition will be detailed in subsequent editions of the Measurement Strategy.

3.2. Overview of indicator and target status.

NMHP performance indicators.			Indicators.	Targets.
PRIORITY AREA 1: SOCIAL INCLUSION AND RECOVERY.				
1.	Participation rates by people with mental illness of working age in employment.	1a – General population.	●○○	○●○
		1b – Public mental health service consumers.	○●○	..
2.	Participation rates by young people aged 16–30 with mental illness in education and employment.	2a – General population.	●○○	○●○
		2b – Public mental health service consumers.	○●○	..
3.	Rates of stigmatising attitudes within the community.		○●○	..
4.	Percentage of mental health consumers living in stable housing.		●○○	○●○
5.	Rates of community participation by people with mental illness.		○●○	..
PRIORITY AREA 2: PREVENTION AND EARLY INTERVENTION.				
6.	Proportion of primary and secondary schools with mental health literacy component included in curriculum.	6a – Secondary schools.	●○○	○●○
		6b – Primary schools.	○●○	..
7.	Rates of contact with primary mental health care by children and young people.		●○○	●○○
8.	Rates of use of licit and illicit drugs that contribute to mental illness in young people.		●○○	○○●
9.	Rates of suicide in the community.		●○○	○●○
10.	Proportion of front-line workers within given sectors who have been exposed to relevant education and training.		○○●	..
11.	Rates of understanding of mental health problems and mental illness in the community.		○●○	..
12.	Prevalence of mental illness.		●○○	○○●
PRIORITY AREA 3: SERVICE ACCESS, COORDINATION AND CONTINUITY OF CARE.				
13.	Percentage of population receiving mental health care.		●○○	●○○
14.	Readmission to hospital within 28 days of discharge.		●○○	●○○
15.	Rates of pre-admission community care.		●○○	●○○
16.	Rates of post-discharge community care.		●○○	●○○
17.	Proportion of specialist mental health sector consumers with nominated GP.		○●○	..
18.	Average waiting times for consumers with mental health problems presenting to emergency departments.		○●○	..

19.	Prevalence of mental illness among homeless populations.			..
20.	Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities.	20a – Adult prisoners.		
		20b – Juvenile detainees.		..
PRIORITY AREA 4: QUALITY IMPROVEMENT AND INNOVATION.				
21.	Proportion of total mental health workforce accounted for by consumer and carer workers.			
22.	Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards.			
23.	Mental health outcomes for people who receive treatment from state and territory services and the private hospital system.			
24.	Proportion of consumers and carers with positive experiences of service delivery.			..
PRIORITY AREA 5: ACCOUNTABILITY – MEASURING AND REPORTING PROGRESS.				
25.	Proportion of services publicly reporting performance data.			..

Indicator key

 Data source and specifications developed

 No current data source, work is in progress

 No foreseeable data source within the life of the Fourth Plan

Target key

 Target agreed

 Target in development

 Target not appropriate for this indicator

.. Indicator not sufficiently described to establish if a target is appropriate

3.3 Indicator, planned data development and target details.

NMHP PI 1 – Participation rates by people with mental illness of working age in employment.	
PRIORITY AREA 1: SOCIAL INCLUSION AND RECOVERY.	
This indicator will be reported in two parts.	
NMHP PI 1a – General population.	
Status.	
Rationale.	A range of evidence highlights that people with mental illness are over-represented in national unemployment statistics and that untreated mental illness is a major contributor to lost economic productivity. An increasing body of evidence is accumulating that employment rates for people affected by mental illness can be improved substantially, leading to better health outcomes.
Description.	Proportion of population aged 16–64 years with mental illness who are employed (as defined by standard Australian Bureau of Statistics definition).
Data source.	National Health Survey (NHS) will be the primary source for population level data on this indicator, supplemented by the Household, Income and Labour Dynamics in Australia (HILDA) survey in the intervening years between NHS collections.
Baseline year.	2007-2008.
Frequency of data availability.	Triennially.
Indicator type.	Outcome.
Future developments.	The Household, Income and Labour Dynamics in Australia (HILDA) survey periodically includes a health module that measures self-reported mental illness. Data from HILDA will be used to provide comparable data to the National Health Survey (NHS), and subsequently an opportunity to report additional time points within the life of the Fourth Plan.
Development timeframes.	2011.
Target.	
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 1b – Public mental health service consumers.	
Status.	○●○
Rationale.	Labour force participation rates by people who use state and territory mental health services are very low, and estimated to be about one quarter to one third that of the general population. For this population, mental illness can act as a barrier to the person gaining or holding a job. Additionally, the absence of meaningful vocational roles can compromise recovery from mental illness through the associated impacts of social exclusion, long-term poverty, unstable housing and welfare dependency. An increasing body of evidence is accumulating that vocational outcomes for people with severe mental illness can be improved substantially, leading to better health outcomes.
Description.	Proportion of state and territory mental health consumers aged 16–64 years who are employed (as defined by standard Australian Bureau of Statistics definition).
Data source.	-
Baseline year.	-
Frequency of data availability.	-
Indicator type.	Outcome.
Future developments.	Details on employment status are not contained in existing national data sets covering state and territory services. Work has commenced to fill this gap through development of a survey instrument that will cover the range of *social inclusion* indicators targeted in the Fourth Plan that do not currently have suitable data sources.
Development timeframes.	2014.
Target.	..
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Following determination of indicator specifications, further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 2 – Participation rates by young people aged 16–30 with mental illness in education and employment.	
PRIORITY AREA 1: SOCIAL INCLUSION AND RECOVERY.	
This indicator will be reported in two parts.	
NMHP PI 2a – General population.	
Status.	
Rationale.	Mental illness is more prevalent in early adult years, frequently having onset in late adolescence or early adulthood. For those affected, education can be disrupted causing premature exit from school or tertiary training, or disruptions in the transition from school to work. When this occurs, the impact can be long lasting, restricting the person's capacity to participate in a range of social and vocational roles over their lifetime.
Description.	Proportion of population aged 16–30 years with mental illness who are employed (as defined by standard Australian Bureau of Statistics definition) and/or are enrolled for study in a formal secondary or tertiary qualification.
Data source.	National Health Survey (NHS) will be the primary source for population level data on this indicator, supplemented by the Household, Income and Labour Dynamics in Australia (HILDA) survey in the intervening years between NHS collections.
Baseline year.	2007–2008.
Frequency of data availability.	Triennially.
Indicator type.	Outcome.
Future developments.	The HILDA survey periodically includes a health module, which measures self-reported mental illness. Data from HILDA will be used to provide comparable data to the NHS, and provide an opportunity to report additional time points within the life of the Fourth Plan.
Development timeframes.	2011.
Target.	
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 2b – Public mental health service consumers.	
Status.	
Rationale.	Mental illness is more prevalent in early adult years, frequently having onset in late adolescence or early adulthood. For those affected, education can be disrupted causing premature exit from school or tertiary training, or disruptions in the transition from school to work. When this occurs, the impact can be long lasting, restricting the person's capacity to participate in a range of social and vocational roles over their lifetime. Public mental health service consumers are among the most disadvantaged people in our community, and evidence shows that collaborative relationships and early referral between mental health services and appropriate education facilities and employment agencies improves the outcomes for consumers, and their carers and families.
Description.	Proportion of state and territory mental health consumers aged 16–64 years who are employed (as defined by standard Australian Bureau of Statistics definition) and/or are enrolled for study in a formal secondary or tertiary qualification.
Data source.	-
Baseline year.	-
Frequency of data availability.	-
Indicator type.	Outcome.
Future developments.	Details on education and employment status are not contained in existing national data sets covering state and territory services. Work has commenced to fill this gap through development of a survey instrument that will cover the range of *social inclusion* indicators targeted in the Fourth Plan that do not currently have suitable data sources.
Development timeframes.	2014.
Target.	..
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Following determination of indicator specifications, further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 3 – Rates of stigmatising attitudes within the community.	
PRIORITY AREA 1: SOCIAL INCLUSION AND RECOVERY.	
Status.	○●○
Rationale.	Consumers, their families, and mental health professionals advise that stigmatising attitudes are prevalent in the community, reducing the level of social inclusion experienced by people affected by mental illness, despite previous community education and awareness campaigns.
Description.	-
Data source.	-
Baseline year.	-
Frequency of data availability.	-
Indicator type.	Outcome.
Future developments.	National surveys of mental health literacy and stigma have been conducted in Australia in 1995, 2003–2004 and 2006. Using Department of Health and Ageing funding, work is underway to implement a further national survey in 2011 that will allow comparison to previous results.
Development timeframes.	2011.
Target.	..
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Following determination of indicator specifications, further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 4 – Percentage of mental health consumers living in stable housing.	
PRIORITY AREA 1: SOCIAL INCLUSION AND RECOVERY.	
Status.	
Rationale.	People with mental illness are at greater risk of being or becoming homeless than the general population. Having unstable housing is also a significant destabilising factor and may contribute to the risk of developing or exacerbating mental illness. Evidence suggests that collaboration and coordination between mental health services, housing providers, and accommodation support services contributes to better outcomes for consumers, and their carers and families.
Description.	Percentage of public mental health service consumers who are considered, at baseline rating, to have no significant problems with their accommodation as rated on Scale 11 ('Problems with living conditions') of the HONOS/65+.
Data source.	National Outcomes and Casemix Collection.
Baseline year.	2009–2010.
Frequency of data availability.	Annually.
Indicator type.	Outcome.
Future developments.	Specific details on housing are not contained in national data sets covering state and territory mental health services. Work has commenced to fill this gap through development of a survey instrument that will cover the range of *social inclusion* indicators targeted in the Fourth Plan that do not currently have suitable data sources. In the interim, use of HoNOS data provides a suitable proxy for this indicator.
Development timeframes.	2014.
Target.	
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 5 – Rates of community participation by people with mental illness.	
PRIORITY AREA 1: SOCIAL INCLUSION AND RECOVERY.	
Status.	○●○
Rationale.	People affected by mental illness experience high-levels of social exclusion, including reduced participation in day to day community activities. Maximising opportunities to participate in a range of community activities, and contribute to the community are important factors in recovering from mental illness.
Description.	-
Data source.	-
Baseline year.	-
Frequency of data availability.	-
Indicator type.	Outcome.
Future developments.	Implementation of this indicator will initially focus on gathering relevant data in relation to consumers of state and territory mental health services. Currently, details on community participation are not contained in existing national data sets covering state and territory services. Work has commenced to fill this gap through development of a survey instrument that will cover the range of *social inclusion* indicators targeted in the Fourth Plan that do not currently have suitable data sources. In parallel, the next ABS General Social Survey (GSS) scheduled for 2014 provides potential to generate a broad population-level assessment of the impact of mental illness on community participation. Exploratory work has commenced to determine whether the definition of mental illness used by the ABS in its GSS will be suitable.
Development timeframes.	2014.
Target.	..
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Following determination of indicator specifications, further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 6 – Proportion of primary and secondary schools with mental health literacy component included in curriculum.	
PRIORITY AREA 2: PREVENTION AND EARLY INTERVENTION.	
This indicator has been split into two parts.	
NMHP PI 6a Secondary schools.	
Status.	
Rationale.	Evidence suggests that mental health literacy programs in schools enhances resilience in young people, promotes early detection and intervention, whilst decreasing stigma. Substantial investment has been made in Australia to implement school-based mental health literacy programs.
Description.	Proportion of secondary schools using MindMatters within their curriculum.
Data source.	Principals Australia survey of MindMatters.
Baseline year.	2010.
Frequency of data availability.	Periodic.
Indicator type.	Output.
Future developments.	Scheduling of a further survey in the life of the Fourth Plan to be resolved.
Development timeframes.	-
Target.	
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 6b Primary schools.	
Status.	○●○
Rationale.	Evidence suggests that mental health literacy programs in schools enhances resilience in young people, promotes early detection and intervention, whilst decreasing stigma. Substantial investment has been made in Australia to implement school-based mental health literacy programs.
Description.	Proportion of primary schools using KidsMatter or an equivalent mental health literacy program in their curriculum.
Data source.	-
Baseline year.	-
Frequency of data availability.	-
Indicator type.	-
Future developments.	The Department of Health and Ageing is currently negotiating with Principals Australia to conduct a 2011 survey of mental health literacy programs used in Australian primary schools.
Development timeframes.	2011.
Target.	..
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Following determination of indicator specifications, further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 7 – Rates of contact with primary mental health care by children and young people.	
PRIORITY AREA 2: PREVENTION AND EARLY INTERVENTION.	
Status.	●○○
Rationale.	Early identification and intervention of mental illness results in better outcomes, however young people have low rates of help seeking for mental health problems.
Description.	Proportion of the population <25 years who have contact with primary mental health care services subsidised through the Medicare Benefits Schedule.
Data source.	Medicare Benefits Schedule administrative data.
Baseline year.	2008–2009.
Frequency of data availability.	Annually.
Indicator type.	Output.
Future developments.	It is acknowledged that primary mental health care for children and young people extends beyond MBS-subsidised services, and that other providers should be included in estimates for this indicator, including community health centres, school counsellors and health nurses, and university and TAFE counselling services. Lack of available data relating to the mental health activity of these service streams prevents their inclusion. Additionally, a component of the work carried out by state and territory specialised public mental health services can be construed as primary mental health care but this cannot be reliably differentiated from other service provision.
Development timeframes.	2011.
Target.	○●○
Target.	-
Rationale.	
Level of evidence.	-
Output.	-
Development.	A two-stage approach is being adopted for this indicator, initially using MBS data to provide a baseline and establishing a 'general improvement' target. Enquiries have been initiated to inform further discussion on a target utilising a population approach.

NMHP PI 8 – Rates of use of licit and illicit drugs that contribute to mental illness in young people.	
PRIORITY AREA 2: PREVENTION AND EARLY INTERVENTION.	
Status.	●○○
Rationale.	Evidence suggests that high rates of substance use and abuse in young people contributes to the onset of, and poor recovery from, mental illness.
Description.	Proportion of the population aged 14 or over that use specific licit and illicit drugs in the preceding 12 months.
Data source.	National Drug Strategy Household Survey.
Baseline year.	2007.
Frequency of data availability.	Triennially.
Indicator type.	Outcome.
Future developments.	Nil.
Development timeframes.	Not applicable.
Target.	○○●
Target.	A target is not appropriate for this indicator.
Rationale.	This indicator provides important contextual information and is considered a global indicator. Advice from the National Drug and Alcohol Research Centre suggests that, similar to other prevalence indicators, any change cannot be directly attributed to a single action.
Level of evidence.	-
Output.	-
Development.	-

NMHP PI 9 – Rates of suicide in the community.	
PRIORITY AREA 2: PREVENTION AND EARLY INTERVENTION.	
Status.	
Rationale.	Suicide is a leading cause of death among the general population, and people with mental illness are at even greater risk. Suicide rates are a commonly used global indicator of community mental health.
Description.	Proportion of the population for whom suicide was the cause of death.
Data source.	Australian Bureau of Statistics (ABS) Causes of Death.
Baseline year.	2005–2010 (aggregate five year reference period).
Frequency of data availability.	Annually.
Indicator type.	Outcome.
Future developments.	Nil.
Development timeframes.	Not applicable.
Target.	
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	The advice of the Australian Suicide Prevention Advisory Council is being sought to inform if setting a target is feasible.

NMHP PI 10 – Proportion of front-line workers within given sectors who have been exposed to relevant education and training.	
PRIORITY AREA 2: PREVENTION AND EARLY INTERVENTION.	
Status.	○○●
Rationale.	Supporting front line workers in education, emergency, health and human services sectors to recognise mental illness, know how to react, and where to seek further help will improve early intervention and better outcomes for people with mental illness, their carers and families.
Description.	-
Data source.	-
Baseline year.	-
Frequency of data availability.	-
Indicator type.	-
Future developments.	There are currently no readily available data sources to populate this indicator. Work to identify a method to collect comparable, national data is being progressed with the relevant sectors.
Development timeframes.	-
Target.	..
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Following determination of indicator specifications, further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 11 – Rates of understanding of mental health problems and mental illness in the community.	
PRIORITY AREA 2: PREVENTION AND EARLY INTERVENTION.	
Status.	○●○
Rationale.	Better understanding of mental illness by the community reduces stigma and discrimination, increases social inclusion and supports earlier identification and intervention, leading to better outcomes for consumers, and their carers and families.
Description.	-
Data source.	-
Baseline year.	-
Frequency of data availability.	-
Indicator type.	Outcome.
Future developments.	National surveys of mental health literacy and stigma have been conducted in Australia in 1995, 2003–2004 and 2006. Using Department of Health and Ageing funding, work is underway to implement a further national survey in 2011 that will allow comparison to previous results.
Development timeframes.	2011.
Target.	..
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Following determination of indicator specifications, further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 12 – Prevalence of mental illness.	
PRIORITY AREA 2: PREVENTION AND EARLY INTERVENTION.	
Status.	
Rationale.	Prevalence rates provide a global indication of the mental health of Australians.
Description.	Percentage of the population who meet the criteria for a diagnosis of a mental illness in the past 12 month.
Data source.	National Survey of Mental Health and Wellbeing (NSMHWB).
Baseline year.	2007.
Frequency of data availability.	Ten-yearly.
Indicator type.	Outcome.
Future developments.	Analysis of other household surveys that rely on self reported mental illness will be undertaken to establish if a reliable comparison can be made to report interim data in subsequent years. The NSMHWB focuses on high-prevalence disorders and does not include severe mental illnesses such as schizophrenia, and is based on assessment of mental illness against independent diagnostic criteria.
Development timeframes.	-
Target.	
Target.	A target is not appropriate for this indicator.
Rationale.	Targets are not considered appropriate for prevalence rates, as there is little empirical evidence available to reliably estimate the level of change that could be achieved if all actions of the Fourth Plan were fully implemented. There is not expected to be a second data collection within the life of the Fourth Plan to monitor change.
Level of evidence.	-
Output.	-
Development.	-

NMHP PI 13 – Percentage of population receiving mental health care.	
PRIORITY AREA 3: SERVICE ACCESS, COORDINATION AND CONTINUITY OF CARE.	
Status.	●○○
Rationale.	The issue of unmet need has become prominent since the ABS 1997 National Survey of Mental Health and Wellbeing indicated that a majority of adults and younger persons affected by a mental disorder do not receive treatment. Access issues figure prominently in concerns expressed by consumers and carers about the mental health care they receive. More recently, these concerns are being echoed in the wider community.
Description.	Proportion of population receiving clinical mental health care.
Data source.	State and territory community mental health care data, Private Mental Health Alliance (PMHA) Centralised Data Management System, Medicare.
Baseline year.	2009–2010.
Frequency of data availability.	Annually.
Indicator type.	Outcome.
Future developments.	The potential introduction of a statistical linkage key to the proposed data sources would allow a count of unique individuals receiving clinical mental health care. Currently, for public mental health services, a distinction between assessment and treatment cannot be made from existing data sources. This remains a conceptual issue that may be resolved for state and territory public mental health services by the introduction of an intervention classification into the Community Mental Health Care NMDS.
Development timeframes.	-
Target.	●○○
Target.	Increase to approximately 12%.
Rationale.	Treatment rates of 12% of the population correspond with targets established or proposed by three independent sources[3] and correspond to providing treatment to two out of every three (66%) people who meet criteria for mental illness. Based on ABS National Health Survey data, this figure also corresponds to providing treatment to all people who self-report that they have a mental health or behavioural problem that has lasted six months or more.
Level of evidence.	Consensus-based, using results of population surveys (National Survey of Mental Health and Wellbeing, National Health Survey), and jurisdictional data.
Output.	Movement or shift.
Development.	An analysis and comparison of surveys and review of the literature will be undertaken to facilitate identification of more appropriate targets. The proposed approach will stratify targets by service 'tier', to allow a comprehensive 'set' of evidence based targets that match the relevant part of the sector, ie the target would be different for people with high prevalence disorders receiving primary mental health care, to people with low prevalence severe disorders receiving public specialist mental health care. Tiered targets will be published in subsequent editions of the Measurement Strategy. This target will be the subject of periodic review and will be informed by analysis of the data.

[3] See Hickie et al (2005), Australian mental health reform: time for real outcomes, Medical Journal of Australia, 182, 401-406; NSW Centre for mental health (2001), Mental Health Clinical Care and Prevention Model (MH-CCP): A Population Mental Health Model, NSW Department of Health; Andrews G et al (2007), Tolkien II: A needs-based, costed stepped-care model for mental health services, WHO Collaborating Centre for Classification in Mental Health.

NMHP PI 14 – Readmission to hospital within 28–days of discharge.	
PRIORITY AREA 3: SERVICE ACCESS, COORDINATION AND CONTINUITY OF CARE.	
Status.	●○○
Rationale.	Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall care system. Admissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital.
Description.	Percentage of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) that are followed by a readmission to the same or to another public sector psychiatric inpatient unit within 28 days of discharge.
Data source.	State and territory clinical mental health services admitted patient data systems.
Baseline year.	2009–2010.
Frequency of data availability.	Annually.
Indicator type.	Outcome.
Future developments.	Nil.
Development timeframes.	Not applicable.
Target.	●○○
Target.	12%.
Rationale.	It is acknowledged that there is a large spread of readmission rates between jurisdictions. To create a 'stretch' target for those jurisdictions with low rates will mean a 'significant leap' for other jurisdictions with higher rates.
Level of evidence.	Evidence from the National Mental Health Benchmarking Project, and current jurisdictional performance.
Output.	Rate.
Development.	This target will be the subject of periodic review and will be informed by analysis of the data.

NMHP PI 15 – Rates of pre-admission community care.	
PRIORITY AREA 3: SERVICE ACCESS, COORDINATION AND CONTINUITY OF CARE.	
Status.	●○○
Rationale.	The majority of clients admitted to public sector mental health acute inpatient units are known to public sector community mental health services and it is reasonable to expect community teams should be involved in pre-admission care.
Description.	Percentage of admissions to the mental health service organisation's acute inpatient unit(s) for which a community ambulatory service contact was recorded in the seven days immediately preceding that admission.
Data source.	State and territory clinical admitted patient and community mental health services data systems.
Baseline year.	2009–2010.
Frequency of data availability.	Annually.
Indicator type.	Process.
Future developments.	Nil.
Development timeframes.	Not applicable.
Target.	●○○
Target.	70%.
Rationale.	It is reasonable that services have a high rate of contact with existing consumers prior to being admitted to hospital. The rate for new consumers is known to be significantly less than existing consumers who are currently being case managed.
Level of evidence.	Consensus informed by the National Mental Health Benchmarking Project, and current jurisdictional performance.
Output.	Rate.
Development.	This target will be the subject of periodic review and will be informed by analysis of the data.

NMHP PI 16 – Rates of post-discharge community care.	
PRIORITY AREA 3: SERVICE ACCESS, COORDINATION AND CONTINUITY OF CARE.	
Status.	●○○
Rationale.	Transition in care from hospital to the community is identified as a critical time in the treatment continuum. Evidence suggests that immediately following discharge is a period of increased vulnerability, and that timely follow-up mitigates the risk of relapse. A responsive community support system for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission.
Definition.	Percentage of separations from the mental health service organisation's acute inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated, was recorded in the seven days immediately following that separation.
Data source.	State and territory clinical admitted patient and community mental health services data systems.
Baseline year.	2009–2010.
Frequency of data availability.	Annually.
Indicator type.	Process.
Future developments.	Nil.
Development timeframes.	Not applicable.
Target.	●○○
Target.	75%.
Rationale.	Despite known examples of individual service organisations that rate highly on this indicator, no jurisdictions were considered to be performing well. There is limited data to support determination of a target therefore it is based on consensus. The following limitations should be considered. • This indicator only measures follow-up by state and territory public mental health services. Existing data collections do not identify consumers appropriately followed up by other providers, including individuals such as private psychiatrists, General Practitioners (GPs), or other mental health practitioners in private practice or private hospitals; • The indicator specifications require that the consumer must participate in the contact to be included in the count. It is acknowledged that differences will be experienced between target populations, ie child and adolescent or older person services may contact a parent or carer to monitor progress rather than the identified consumer; and • An unknown proportion of consumers will refuse follow-up.
Level of evidence.	Consensus.
Output.	Rate.
Development.	This target will be the subject of periodic review and will be further informed by analysis of the data.

NMHP PI 17 – Proportion of specialist mental health sector consumers with nominated GP.	
PRIORITY AREA 3: SERVICE ACCESS, COORDINATION AND CONTINUITY OF CARE.	
Status.	○●○
Rationale.	People with severe mental illness often suffer from poor physical health and have significantly reduced life expectancy. GPs are identified as central to providing primary health care and coordinating non-mental health specialist care. GPs are pivotal in the provision of ongoing mental health care, and an established relationship with a regular GP improves outcomes for consumers, and their carers and families.
Description.	-
Data source.	-
Baseline year.	-
Frequency of data availability.	-
Indicator type.	-
Future developments.	Details on consumers' relationship and level of involvement with general practitioners are not contained in national data sets covering state and territory mental health services. Work has commenced to fill this gap through development of a survey instrument that will cover the range of *social inclusion* indicators targeted in the Fourth Plan that do not currently have suitable data sources. Data in relation to indicator 17 will be included in this development.
Development timeframes.	2014.
Target.	..
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Following determination of indicator specifications, further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 18 – Average waiting times for consumers with mental health problems presenting to emergency departments.	
PRIORITY AREA 3: SERVICE ACCESS, COORDINATION AND CONTINUITY OF CARE.	
Status.	○●○
Rationale.	Over the last ten years there has been an increase in emergency department presentations for mental health problems. This may be due to a number of reasons: 'mainstreaming' mental health acute inpatient units into acute general hospitals has appropriately positioned the emergency department as an assessment point to gain admission to acute mental health units; an increase in community awareness that mental health care can be sought from an emergency department; and perceived lack of access to other forms of mental health assessment or intervention, such as community crisis teams or community mental health care. There are concerns regarding the capacity of mental health services to provide adequate resources to meet demand within the emergency department environment. The issue is very difficult to measure, however one window of opportunity identified is to examine waiting times in order to begin to gain an insight into the issue.
Description.	-
Data source.	-
Baseline year.	-
Frequency of data availability.	-
Indicator type.	-
Future developments.	Details on waiting times for consumers presenting with mental health problems to emergency departments are not currently available from existing national data sets. Negotiations with the appropriate national health data committees are being undertaken to establish whether appropriate data elements can be added to the relevant NMDS, in order to be able to identify a mental health-related *presenting problem*, and the *time of presentation* and *time seen* populate this indicator.
Development timeframes.	-
Target.	..
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Following determination of indicator specifications, further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 19 – Prevalence of mental illness among homeless populations.	
PRIORITY AREA 3: SERVICE ACCESS, COORDINATION AND CONTINUITY OF CARE.	
Status.	○●○
Rationale.	There is a perception that people with mental illness are disproportionately represented in homeless populations compared with the general population. Unstable housing is a significant destabilising factor and may contribute to the risk of developing or exacerbating mental illness. Evidence suggests that collaboration and coordination between mental health services, housing providers, and accommodation support services contribute to better outcomes for consumers, and their carers and families.
Description.	-
Data source.	-
Baseline year.	-
Frequency of data availability.	-
Indicator type.	-
Future developments.	Identification of mental health consumers in existing housing assistance and homeless person service data collections has always been problematic. The Australian Institute of Health and Welfare is currently developing a new *homelessness* data collection for the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). It is anticipated that data will be collected from 1 July 2011 and that suitable data to populate this indicator will be available in the second half of 2012.
Development timeframes.	2012.
Target.	..
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Following determination of indicator specifications, further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 20 – Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities.	
PRIORITY AREA 3: SERVICE ACCESS, COORDINATION AND CONTINUITY OF CARE.	
This indicator is split into two parts.	
NMHP PI 20a Adult prison populations.	
Status.	●○○
Rationale.	Prison populations have higher rates of mental illness than the general population, and are highlighted as an 'at risk' group. An over-representation of people in mental illness may indicate failure to deliver appropriate intervention services to people with mental illness who are at risk of offending.
Definition.	The proportion of adult prisoners who self report they have been told by a doctor or mental health professional that they have a mental illness.
Data source.	National Prisoner Health Data Collection.
Baseline year.	2009.
Frequency of data availability.	Annually.
Indicator type.	Outcome.
Future developments.	Further work is warranted to refine the methods used for identifying mental illness in the National Prisoner Health Data Collection.
Development timeframes.	-
Target.	○○●
Target.	A target is not appropriate for this indicator at this time.
Rationale.	This indicator measures self-reported lifetime prevalence, and will be important to monitor to assess the progress of overall system reform. This data was first collected in 2009, and further experience with the national collection is needed to build a suitable evidence base for target setting.
Level of evidence.	-
Output.	-
Development.	-

NMHP PI 20b Juvenile detainees.	
Status.	○●○
Rationale.	Prison populations have higher rates of mental illness than the general population, and are highlighted as an 'at risk' group.
Definition	-
Data source.	-
Baseline year.	-
Frequency of data availability.	-
Indicator type.	-
Future developments.	There is no data source for young people in detention equivalent to the adult survey. Alternative data sources to provide proxy data are being investigated with juvenile justice departments. Data linkage between mental health and juvenile justice National Minimum Data Sets is being investigated. Progress will be detailed in subsequent editions of the Measurement Strategy.
Development timeframes.	2012.
Target.	..
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Following determination of indicator specifications, further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 21 – Proportion of total mental health workforce accounted for by consumer and carer workers.	
PRIORITY AREA 4: QUALITY IMPROVEMENT AND INNOVATION.	
Status.	●○○
Rationale.	Consumer and carer involvement in the planning and delivery of mental health services is considered essential to adequately represent the views of consumers and carers, advocate on their behalf, and promote the development of consumer responsive services.
Definition.	Proportion of the state and territory mental health workforce who are consumer and carer workers.
Data source.	Mental Health Establishments NMDS.
Baseline year.	2009–2010.
Frequency of data availability.	Annually.
Indicator type.	Input.
Future developments.	Jurisdictions have adopted different approaches to employing consumers and carers in mental health services, and despite the availability of a nationally agreed definition, jurisdictions report different interpretations to the Mental Health Establishments NMDS. Work is under way to revise the definition to achieve greater consistency.
Development timeframes.	-
Target.	●○○
Target.	1%.
Rationale.	There are a range of roles for consumers within mental health services, and models adopted by jurisdictions differ in their approach, including advisory roles on committees, working within clinical teams, and directly with consumers and carers. Notwithstanding these differences, the proposed 1% target is based on an expectation that the current consumer and carer workforce should triple over the period of the Fourth Plan.
Level of evidence.	Consensus-based.
Output.	Rate.
Development.	A revised national definition will impact on the scope of data included. This target will be the subject of periodic review and will be informed by analysis of the data.

NMHP PI 22 – Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards.	
PRIORITY AREA 4: QUALITY IMPROVEMENT AND INNOVATION.	
Status.	●○○
Rationale.	• Implementation of the National Standards for Mental Health Services (National Standards) has been agreed by all jurisdictions. • Service quality has been a driving force for the National Mental Health Strategy.
Definition.	Percentage of the mental health service organisation's services (weighted by expenditure) that have been reviewed against the National Standards for Mental Health Services—the indicator grades services into four categories. • Level 1 – Services have been reviewed by an external accreditation agency and judged to have met all National Standards. • Level 2 – Services have been reviewed by an external accreditation agency and judged to have met some but not all National Standards. • Level 3 – Services: (i) are in the process of being reviewed by an external accreditation agency but the outcomes are not known, or (ii) are booked for review by an external accreditation agency. • Level 4 – Mental health services that do not meet criteria detailed under Levels 1 to 3.
Data source.	Mental Health Establishments NMDS.
Baseline year.	2009–2010.
Frequency of data availability.	Annually.
Indicator type.	Process.
Future developments.	New National Standards have been developed and work is underway to establish a method of measuring compliance. This indicator is based on the current national indicator *National Service Standards Compliance*, which will be reviewed in 2011. This indicator will be revised to reflect any subsequent changes.
Development timeframes.	2012.
Target.	●○○
Target.	100% of services at Level 1.
Rationale.	All jurisdictions committed to implementation of the current national standards under previous national mental health plans.
Level of evidence.	Consensus.
Output.	Rate.
Development.	This target will require review when the indicator specifications are revised following the implementation of the new National Standards.

NMHP PI 23 – Mental health outcomes for people who receive treatment from State and Territory services and the private hospital system.	
PRIORITY AREA 4: QUALITY IMPROVEMENT AND INNOVATION.	
Status.	
Rationale.	Improvement in clinical outcomes, measured by a reduction in the severity of symptoms and improvements in functioning, is a core objective of mental health services. The implementation of routine mental health outcome measurement in Australia provides the opportunity to monitor the effectiveness of mental health services across services and jurisdictions. Identifying the comparative effectiveness of mental health services informs benchmarking between services and related service quality improvement activities.
Definition.	The proportion of episodes of care, or partial episodes, partitioned by mental health setting where either. • significant improvement. • significant deterioration. • no significant change. was identified between baseline and follow-up of completed outcome measures.
Data source.	National Outcomes and Casemix Collection.
Baseline year.	2009–2010.
Frequency of data availability.	Annually.
Indicator type.	Outcome.
Future developments.	This indicator is new, and future revisions will be informed by its use.
Development timeframes.	2012.
Target.	
Target.	A target is not appropriate for this indicator at this time.
Rationale.	Public reporting of this indicator is considered to be an important and significant step. This indicator is new and has not been 'field tested' by services and the results are not yet well understood. It is statistically difficult to construct, and services cannot recreate it to compare their own data. It requires monitoring to inform future discussions.
Level of evidence.	-
Output.	-
Development.	-

NMHP PI 24 – Proportion of consumers and carers with positive experiences of service delivery.	
PRIORITY AREA 4: QUALITY IMPROVEMENT AND INNOVATION.	
Status.	○●○
Rationale.	Consumers and their carers perceptions and experiences of care received from public mental health services are vital to inform service quality improvement. At a jurisdiction level, this information provides a global indicator of meeting the expectations of consumers and their carers.
Description.	-
Data source.	-
Baseline year.	-
Frequency of data availability.	-
Indicator type.	-
Future developments.	Although surveys have been introduced by several jurisdictions, there are currently no national-level collections of consumer or carer experiences of care. Victoria will lead a national project, funded by DoHA, to investigate the potential for a nationally agreed methodology and measure, informed by similar work being undertaken by a number of jurisdictions and the private sector.
Development timeframes.	2014.
Target.	..
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Following determination of indicator specifications, further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

NMHP PI 25 – Proportion of services publicly reporting performance data.	
PRIORITY AREA 4: QUALITY IMPROVEMENT AND INNOVATION.	
Status.	○●○
Rationale.	Community interest and scrutiny of public health services, including mental health services, is the highest it has ever been. Government policy has reflected this, with major initiatives to increase the information available to the public underway. Increasing accountability and transparency is a key component of the Fourth Plan, at both the policy level and service delivery level.
Description.	-
Data source.	-
Baseline year.	-
Frequency of data availability.	-
Indicator type.	-
Future developments.	There are no data sources to populate this indicator. An extensive review of published and 'grey' literature has been commissioned to examine public reporting of health service-level data. The chosen approach will inform development of this indicator. The proposed National Performance Authority announced as part of the COAG National Health and Hospitals reform may supersede the utility of this indicator by publicly reporting health service performance information.
Development timeframes.	-
Target.	..
Target.	-
Rationale.	-
Level of evidence.	-
Output.	-
Development.	Following determination of indicator specifications, further work will be required to identify a meaningful target for this indicator, based on Australian and internationally comparable data.

SECTION 4: APPENDICES

4.1 Appendix 1: Indicator technical specifications.

Technical specifications for the following 16 indicators are contained in this appendix:

NMHP PI 1a	Participation rates by people with mental illness of working age in employment–General population.
NMHP PI 2a	Participation rates by young people aged 16–30 with mental illness in education and employment.
NMHP PI 4	Percentage of mental health consumers living in stable housing.
NMHP PI 6a	Proportion of secondary schools with mental health literacy component included in curriculum.
NMHP PI 7	Rates of contact with primary mental health care by children and young people.
NMHP PI 8	Rates of use of licit and illicit drugs that contribute to mental illness in young people.
NMHP PI 9	Rates of suicide in the community.
NMHP PI 12	Prevalence of mental illness.
NMHP PI 13	Percentage of population receiving mental health care.
NMHP PI 14	Readmission to hospital within 28 days of discharge.
NMHP PI 15	Rates of pre-admission community care.
NMHP PI 16	Rates of post-discharge community care.
NMHP PI 20a	Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities.
NMHP PI 21	Proportion of total mental health workforce accounted for by consumer and carer workers.
NMHP PI 22	Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards.
NMHP PI 23	Mental health outcomes for people who receive treatment from state and territory services and the private hospital system.

Additional indicator specifications will be included in future editions of the Measurement Strategy as suitable data sources and specifications are developed.

NMHP PI 1a – Participation rates by people with mental illness of working age in employment–General population.	
Strategic issue.	Social Inclusion and Recovery.
Rationale.	A range of evidence highlights that people with mental illness are over-represented in national unemployment statistics and that untreated mental illness is a major contributor to lost economic productivity. An increasing body of evidence is accumulating that employment rates for people affected by mental illness can be improved substantially, leading to better health outcomes.
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.
Date last updated.	January 2011.
Indicator details.	
Description.	Proportion of the Australian population aged 16–64 years with a mental illness who are employed.
Numerator.	Number of people aged 16–64 years with mental illness with a labour force status of employed.
Denominator.	Number of people aged 16–64 years with mental illness.
Computation.	(Numerator ÷ Denominator) x 100.
Calculation conditions.	Coverage/Scope. People aged 16–64 years identified as having a clinically diagnosable mental illness.
	Methodology.
Definitions.	• Mental illness defined as self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. • Employed defined as per the ABS quarterly Labour Force Survey as persons who had a job or business, or who undertook work without pay in a family business for a minimum of one hour per week. Includes persons who were absent from a job or business • Age range 16-64 years inclusive.
Presentation.	• Percentage. • The equivalent calculation for people without a mental health condition will be published for comparative purposes.
Disaggregation.	State/Territory, and age, subject to sample size.
Notes.	-
Is specification interim or long-term?	Long-term.
Reported in.	COAG National Action Plan Progress Reports (Indicator 9 'Participation rates by people with mental illness of working age in employment').

NMHP PI 1a – Participation rates by people with mental illness of working age in employment–General population.				
National Mental Health Performance Framework.				
Tier.	Tier 1 – Health Status and Outcomes.			
Primary domain.	Human functioning.			
Secondary domain(s).	-			
Mental health sub-domain.	-			
Type of measure.	Outcome.			
Level at which indicator can be useful for benchmarking.	Service Unit.	☐	Mental Health Service Organisation.	☐
	Regional group of services.	☐	State/Territory.	☑
Related performance indicators and performance benchmarks.	-			
Data collection details.				
Data source(s).	Numerator.	National Health Survey.		
	Denominator.	National Health Survey.		
Data source(s) type.	Numerator.	Face-to-face survey (Computer Assisted Personal Interview).		
	Denominator.	Face-to-face survey (Computer Assisted Personal Interview).		
Frequency of data source(s) collection.	Numerator.	Triennially.		
	Denominator.	Triennially.		
Data development.	Short-term:	-		
	Medium-term:	-		
	Long-term:	-		

NMHP PI 2a – Participation rates by young people aged 16-30 with mental illness in education and employment.	
Strategic issue.	Social Inclusion and Recovery.
Rationale.	Mental illness is more prevalent in early adult years, frequently having onset in late adolescence or early adulthood. For those affected, education can be disrupted causing premature exits from school or tertiary training, or disruptions in the transition from school to work. When this occurs, the impact can be long lasting, restricting the person's capacity to participate in a range of social and vocational roles over their lifetime.
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.
Date last updated.	January 2011.
Indicator details.	
Description.	Proportion of population aged 16–30 years with mental illness who are employed and/or are enrolled for study in a formal secondary or tertiary qualification.
Numerator.	Number of people aged 16–30 years with mental illness with a labour force status of 'employed' and/or still at school and/or at another educational institution (studying full-time or part-time).
Denominator.	Number of people aged 16–30 years with mental illness.
Computation.	(Numerator ÷ Denominator) x 100.
Calculation conditions.	Coverage/Scope. People aged 16–30 years identified as having any mental illness. Methodology.
Definitions.	• Mental illness defined as self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for 6 months or more. • Employed defined as per the ABS quarterly Labour Force Survey as persons who had a job or business, or who undertook work without pay in a family business for a minimum of one hour per week. Includes persons who were absent from a job or business. • Participating in education includes people currently enrolled (secondary school, university/other higher education, TAFE/technical college, business college, industry skills centre, other) whether full-time or part-time. Enrolment in adult education courses, hobby and recreation courses is excluded. • Age range 16–30 years inclusive.
Presentation.	• Percentage. • The equivalent calculation for people without a mental illness will be published for comparative purposes.
Disaggregation.	State/Territory and age, subject to sample size.
Notes.	-

NMHP PI 2a – Participation rates by young people aged 16-30 with mental illness in education and employment.				
Is specification interim or long-term?	Long-term.			
Reported in.	COAG National Action Plan Progress Reports (Indicator 10 'Participation rates by young people aged 16–30 with mental illness in education and employment').			
National Mental Health Performance Framework.				
Tier.	Tier 1 – Health Status and Outcomes.			
Primary domain.	Human functioning.			
Secondary domain(s).	-			
Mental health sub-domain.	-			
Type of measure.	Outcome.			
Level at which indicator can be useful for benchmarking.	Service Unit.	☐	Health Service Organisation.	☐
	Regional group of services.	☐	State/Territory.	☑
Related performance indicators and performance benchmarks.	-			
Data collection details.				
Data source(s).	Numerator.	National Health Survey.		
	Denominator.	National Health Survey.		
Data source(s) type.	Numerator.	Face-to-face survey (Computer Assisted Personal Interview).		
	Denominator.	Face-to-face survey (Computer Assisted Personal Interview).		
Frequency of data source(s) collection.	Numerator.	Triennially.		
	Denominator.	Triennially.		
Data development.	Short-term.	-		
	Medium-term.	-		
	Long-term.	-		

NMHP PI 4 – Percentage of mental health consumers living in stable housing.		
Strategic issue.	Social Inclusion and Recovery.	
Rationale.	People with mental illness are at greater risk of being or becoming homeless than the general population. Having unstable housing is also a significant destabilising factor and may contribute to the risk of developing or exacerbating mental illness. Evidence suggests that collaboration and coordination between mental health services, housing providers, and accommodation support services contribute to better outcomes for consumers, and their carers and families.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.	
Date last updated.	January 2011.	
Indicator details.		
Description.	Percentage of public mental health service consumers who are considered, at baseline rating, to have no significant problems with their accommodation as rated on Scale 11 ('Problems with living conditions') of the HONOS/65+.	
Numerator.	Number of baseline collection occasions with a HONOS/65+ score of 0 or 1.	
Denominator.	Number of baseline collection ratings with a valid HoNOS/65+.	
Computation.	(Numerator ÷ Denominator) x 100.	
Calculation conditions.	Coverage/Scope.	All public inpatient or ambulatory mental health services.
	Methodology.	A valid clinical rating for 10 of the 12 HONOS/65+ items is required to be included.
Definitions.	• HoNOS/65+ Item 11: Problems with living conditions. • Baseline: first collection occasion for a service episode within the reference period that is either an admission or review.	
Presentation.	Percentage.	
Disaggregation.	State/Territory and age, subject to sample size.	
Notes.	Use of HoNOS/65+ data provides a proxy for this indicator until required data development occurs.	
Is specification interim or long-term?	Interim.	
Reported in.	-	
National Mental Health Performance Framework.		
Tier.	Not applicable.	
Primary domain.	-	
Secondary domain(s).	-	
Mental health sub-domain.	-	
Type of measure.	Outcome.	

NMHP PI 4 – Percentage of mental health consumers living in stable housing.				
Level at which indicator can be useful for benchmarking.	Service Unit.	☐	Mental Health Service Organisation.	☐
	Regional group of services.	☐	State/Territory.	☑
Related performance indicators and performance benchmarks.	-			
Data collection details.				
Data source(s).	Numerator.	National Outcomes and Casemix Collection.		
	Denominator.	National Outcomes and Casemix Collection.		
Data source(s) type.	Numerator.	Outcome data.		
	Denominator.	Outcome data.		
Frequency of data source(s) collection.	Numerator.	Annually.		
	Denominator.	Annually.		
Data development.	Short-term:	-		
	Medium-term:	-		
	Long-term:	Specific details on housing are not contained in national data sets covering state and territory mental health services. Work has commenced to fill this gap through development of a survey instrument that will cover the range of *social inclusion* indicators targeted in the Fourth Plan that do not currently have suitable data sources.		

NMHP PI 6a – Proportion of secondary schools with mental health literacy component included in curriculum.				
Strategic issue.	Prevention and Early Intervention.			
Rationale.	Evidence suggests that mental health literacy programs in schools enhances resilience in young people, promotes early detection and intervention, whilst decreasing stigma. Substantial investment has been made in Australia to implement school-based mental health literacy programs.			
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.			
Date last updated.	January 2011.			
Indicator details.				
Description.	Proportion of secondary schools using MindMatters within their curriculum.			
Numerator.	Number of secondary schools using one of more aspects of MindMatters in their curriculum.			
Denominator.	Number of secondary schools.			
Computation.	(Numerator ÷ Denominator) x 100.			
Calculation conditions.	Coverage/Scope. Australian secondary schools.			
	Methodology.			
Definitions.	• Mental health literacy included in curriculum: use of MindMatters.			
Presentation.	Percentage.			
Disaggregation.	State/Territory, subject to sample size.			
Notes.	-			
Is specification interim or long-term?	Long-term.			
Reported in.	Results of secondary school surveys are at www.mindmatters.edu.au/about/acer_evaluation_2010.html.			
National Mental Health Performance Framework.				
Tier.	Tier II – Determinants of Health.			
Primary domain.	Community capacity.			
Secondary domain(s).	-			
Mental health sub-domain.	-			
Type of measure .	Output.			
Level at which indicator can be useful for benchmarking.	Service Unit.	☐	Mental Health Service Organisation.	☐
	Regional group of services.	☐	State/Territory.	☑
Related performance indicators and performance benchmarks.	-			

NMHP PI 6a – Proportion of secondary schools with mental health literacy component included in curriculum.		
Data collection details.		
Data source(s).	Numerator.	Principals Australia–surveys conducted by Australian Council for Educational research (ACER).
	Denominator.	Principals Australia–surveys conducted by ACER.
Data source(s) type.	Numerator.	Survey.
	Denominator.	Survey.
Frequency of data source(s) collection.	Numerator.	Periodic. Secondary school surveys conducted to date: 2006 and 2010.
	Denominator.	As per Numerator.
Data development.	Short-term:	-
	Medium-term:	-
	Long-term:	-

NMHP PI 7 – Rates of contact with primary mental health care by children and young people.		
Strategic issue.	Prevention and Early Intervention.	
Rationale.	Early identification and intervention of mental illnesses results in better outcomes, however young people have low rates of help seeking for mental health problems.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.	
Date last updated.	January 2011.	
Indicator details.		
Description.	Proportion of the population <25 years who have contact with primary mental health care services subsidised through the Medicare Benefits Schedule.	
Numerator.	Number of individual consumers aged <25 years seen by in-scope primary mental health care services subsidised through the Medicare Benefits Schedule.	
Denominator.	Estimated residential population aged <25 years.	
Computation.	(Numerator ÷ Denominator) x 100.	
Calculation conditions.	Coverage/Scope.	Initially this indicator will be reported for the following MBS-subsidised primary mental health care services. GP and other services include MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2721, 2723, 2725, 2727. Also includes Item 2702, with effect from 1 January 2010. Clinical psychologist services include MBS items 80000, 80005, 80010, 80015, 80020. Other allied health services include MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 81325, 81355, 82000, 82015.
	Methodology.	
Definitions.	• Children and young people defined as persons aged <25 years. • Primary mental health care defined as specified MBS-subsidised mental health services.	
Presentation.	Percentage.	
Disaggregation.	State/Territory and age, subject to sample size.	
Notes.	It is acknowledged that primary mental health care for children and young people extends beyond MBS-subsidised services, and that other providers should be included in estimates for this indicator, including community health centres, school counsellors and school health nurses, university and TAFE counselling services. Lack of available data relating to the mental health activity of these service streams prevents their inclusion. Additionally, a component of the work carried out by state and territory specialised public mental health services can be construed as primary mental health care but this cannot be reliably differentiated from other service provision.	

NMHP PI 7 – Rates of contact with primary mental health care by children and young people.				
Is specification interim or long-term?	Interim.			
Reported in.	-			
National Mental Health Performance Framework.				
Tier.	Tier III – Health System Performance.			
Primary domain.	Accessible.			
Secondary domain(s).	-			
Mental health sub-domain.	-			
Type of measure.	Outcome.			
Level at which indicator can be useful for benchmarking.	Service Unit.	☐	Mental Health Service Organisation.	☐
	Regional group of services.	☐	State/Territory.	☑
Related performance indicators and performance benchmarks.	-			
Data collection details.				
Data source(s).	Numerator.	Medicare Benefits Schedule (Medicare).		
	Denominator.	Estimated resident population.		
Data source(s) type.	Numerator.	Administrative by-product.		
	Denominator.	Census.		
Frequency of data source(s) collection.	Numerator.	Annually.		
	Denominator.	Annually.		
Data development.	Short-term:	-		
	Medium-term:	Investigations into data sources and methodologies to populate the additional activity have commenced.		
	Long-term:	-		

NMHP PI 8 – Rates of use of licit and illicit drugs that contribute to mental illness in young people.				
Strategic issue.	Prevention and Early Intervention.			
Rationale.	Evidence suggests that high rates of substance use and abuse in young people contributes to the onset of, and poor recovery from, mental illness.			
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.			
Date last updated.	January 2011.			
Indicator details.				
Description.	Proportion of the population aged 14 or over that use specific licit and illicit drugs in the preceding 12 months.			
Numerator.	People aged 14 and over who have used specific drugs.			
Denominator.	Estimated Resident Population aged 14 or over.			
Computation.	(Numerator ÷ Denominator) x 100.			
Calculation conditions.	Coverage/Scope.	The following substances are included: alcohol, marijuana, ecstasy, meth/amphetamine, cocaine, hallucinogens, GHB, inhalants, and heroin.		
	Methodology.			
Definitions.	-			
Presentation.	Percentage.			
Disaggregation.	State/Territory and age, subject to sample size.			
Notes.	The National Drug Strategy Household Survey participants are aged 14 or over.			
Is specification interim or long-term?	Long-term.			
Reported in.	A similar indicator is reported in the COAG NAP Annual Progress Reports (Indicator 3 'Rates of use of illicit drugs that contribute to mental illness in young people')			
National Mental Health Performance Framework.				
Tier.	Tier II – Determinants of Health.			
Primary domain.	Health behaviours.			
Secondary domain(s).	-			
Mental health sub-domain.	-			
Type of measure.	Outcome.			
Level at which indicator can be useful for benchmarking.	Service Unit.	☐	Mental Health Service Organisation.	☐
	Regional group of services.	☐	State/Territory.	☑

NMHP PI 8 – Rates of use of licit and illicit drugs that contribute to mental illness in young people.		
Related performance indicators and performance benchmarks.	COAG National Action Plan Progress Report (Indicator 3 'Rates of use of illicit drugs that contribute to mental illness in young people').	
Data collection details.		
Data source(s).	Numerator.	National Drug Strategy Household Survey.
	Denominator.	Estimated resident population.
Data source(s) type.	Numerator.	Survey.
	Denominator.	Census.
Frequency of data source(s) collection.	Numerator.	Triennially.
	Denominator.	Annually.
Data development.	Short-term:	-
	Medium-term:	-
	Long-term:	-

NMHP PI 9 – Rates of suicide in the community.				
Strategic issue.	Prevention and Early Intervention.			
Rationale.	Suicide is a leading cause of death among the general population, and people with mental illness are at even greater risk. Suicide rates are a commonly used global indicator of the mental health of the community.			
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.			
Date last updated.	January 2011.			
Indicator details.				
Description.	Proportion of the population for whom suicide was the cause of death.			
Numerator.	Number of people who have died by suicide over five year period.			
Denominator.	Estimated residential population.			
Computation.	(Numerator ÷ Denominator).			
Calculation conditions.	Coverage/Scope.	All deaths registered as suicide.		
	Methodology.			
Definitions.				
Presentation.	Rate per 100,000 population.			
Disaggregation.	State/Territory, age, sex and indigenous status, subject to sample size.			
Notes.				
Is specification interim or long-term?	Long-term.			
Reported in.	Similar indicators are reported in the Report on Government Services, and the COAG National Acton Plan Progress Reports (Indicator 4 'The rate of suicide in the community').			
National Mental Health Performance Framework.				
Tier.	Tier 1 – Health Status and Outcomes			
Primary domain.	Deaths.			
Secondary domain(s).	-			
Mental health sub-domain.	-			
Type of measure.	Outcome.			
Level at which indicator can be useful for benchmarking.	Service Unit.	☐	Mental Health Service Organisation.	☐
	Regional group of services.	☐	State/Territory.	☑
Related performance indicators and performance benchmarks.	-			

NMHP PI 9 – Rates of suicide in the community.		
Data collection details.		
Data source(s).	Numerator.	ABS Causes of Death.
	Denominator.	ABS Estimated Residential Population.
Data source(s) type.	Numerator.	Register.
	Denominator.	Census.
Frequency of data source(s) collection.	Numerator.	Annually.
	Denominator.	Annually.
Data development.	Short-term:	-
	Medium-term:	-
	Long-term:	-

NMHP PI 12 – Prevalence of mental illness.				
Strategic issue.	Prevention and Early Intervention.			
Rationale.	Monitoring the overall prevalence rates provides a global indication of the mental health of Australians.			
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.			
Date last updated.	January 2011.			
Indicator details.				
Description.	Percentage of the population who meet the criteria for a diagnosis of a mental illness in the past 12 month.			
Numerator.	Population aged 16–85 years with a diagnosable mental illness.			
Denominator.	Estimated resident population aged 16–85 years.			
Computation.	(Numerator ÷ Denominator) x 100.			
Calculation conditions.	Coverage/Scope.	-		
	Methodology.	-		
Definitions.	Mental illness is defined as a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities, generally according to the classification systems Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).			
Presentation.	Percentage.			
Disaggregation.	Age, subject to sample size.			
Notes.	-			
Is specification interim or long-term?	Long-term.			
Reported in.	-			
National Mental Health Performance Framework.				
Tier.	Tier 1 – Health Status and Outcomes.			
Primary domain.	Health conditions.			
Secondary domain(s).	-			
Mental health sub-domain.	-			
Type of measure.	Outcome.			
Level at which indicator can be useful for benchmarking.	Service Unit.	☐	Mental Health Service Organisation.	☐
	Regional group of services.	☐	State/Territory.	☑
Related performance indicators and performance benchmarks.	-			

NMHP PI 12 – Prevalence of mental illness.		
Data collection details.		
Data source(s).	Numerator.	National Survey of Mental Health and Wellbeing 2007.
	Denominator.	Estimated resident population 2007.
Data source(s) type.	Numerator.	Survey.
	Denominator.	Census.
Frequency of data source(s) collection.	Numerator.	Ten-yearly.
	Denominator.	2007.
Data development.	Short-term:	-
	Medium-term:	-
	Long-term:	-

NMHP PI 13 – Percentage of population receiving mental health care.		
Strategic issue.	Service Access, Coordination and Continuity of Care.	
Rationale.	The issue of unmet need has become prominent since the National Survey of Mental Health and Wellbeing indicated that a majority of adults and younger persons affected by a mental disorder do not receive treatment. Access issues figure prominently in concerns expressed by consumers and carers about the mental health care they receive. More recently, these concerns are being echoed in the wider community.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.	
Date last updated.	January 2011.	
Indicator details.		
Description.	Proportion of population receiving clinical mental health services.	
Numerator.	Number of people receiving clinical mental health services.	
Denominator.	Estimated residential population.	
Computation.	(Numerator ÷ Denominator) x 100. Calculated separately for public, private and MBS-funded services.	
Calculation conditions.	Coverage/Scope.	Rates directly age-standardised. Inclusive of all mental-health related MBS items and includes some ambulatory-equivalent admitted patient mental health service contacts. Consultant psychiatrist services include MBS items 134, 136,138, 140, 142, 289,291, 293, 296, 297, 299, 300, 302, 304,306, 308, 310, 312, 314, 316, 318, 319, 320, 322, 324, 326, 328, 330, 332, 334, 336, 338, 342, 344, 346, 348, 350, 352, 353, 355, 356, 357, 358, 359, 361, 364, 366, 367, 369, 370, 855, 857, 858, 861, 864, 866, 14224. GP and other services include MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2721, 2723, 2725, 2727. Also includes Item 2702, with effect from 1 January 2010. Clinical psychologist services include MBS items 80000, 80005, 80010, 80015, 80020. Other allied health services include MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 81325, 81355, 82000, 82015.
	Methodology.	Requires a non-duplicated person count separately for public, private and MBS-funded services.

NMHP PI 13 – Percentage of population receiving mental health care.	
Definitions.	'Receiving mental health care': • State and territory mental health services: receiving one or more community contacts provided by mental health services. All service contacts are counted in defining whether a person receives a service, including those delivered 'on behalf' of the consumer. • Private psychiatric care: receiving specialist psychiatric care within the private hospital service stream, including both overnight and same day admitted patient care. • MBS: receiving one or more of the services provided under any of the Medicare-funded services streams specified in the Calculation conditions above.
Presentation.	Percentage.
Disaggregation.	State/Territory, age, and service stream.
Notes.	• State and territory disaggregation of Medicare data is based on patient residence, whereas state and territory disaggregation of community mental health care data and Private Mental Health Alliance data is based on location of service. • There is likely to be considerable overlap between the Medicare data and the private hospital data, as most patients accessing private hospital services would access MBS items in association with the private hospital service. • There is also likely to be some double counting of consumers receiving public and MBS funded services.
Is specification interim or long-term?	Interim.
Reported in.	• National Healthcare Agreement performance reports. • COAG National Action Plan Progress Report (Indicator 5 Percentage of people with a mental illness receiving mental health care).
National Mental Health Performance Framework.	
Tier.	Tier III – Health System Performance.
Primary domain.	Accessible.
Secondary domain(s).	-
Mental health sub-domain.	-
Type of measure.	Outcome.
Level at which indicator can be useful for benchmarking.	Service Unit. ☐ Mental Health Service Organisation. ☐ Regional group of services. ☐ State/Territory. ☑

NMHP PI 13 – Percentage of population receiving mental health care.		
Related performance indicators and performance benchmarks.	-	
Data collection details.		
Data source(s).	Numerator.	• State and Territory community mental health care data. • Private Mental Health Alliance (PMHA) Centralised Data Management System (CDMS). • Medicare (MBS) data.
	Denominator.	• ABS Estimated Resident Population. • ABS Indigenous Experimental Estimates and Projections (Indigenous population).
Data source(s) type.	Numerator.	Administrative by-product data.
	Denominator.	Census.
Frequency of data source(s) collection.	Numerator.	Annually.
	Denominator.	Annually.
Data development.	Short-term:	Inclusion of DVA counts in MBS-funded services.
	Medium-term:	Resolve definitional issues regarding what constitutes 'receiving mental health care' to enable national consistency in reporting.
	Long-term:	Develop capacity in the national datasets to uniquely count individuals.

NMHP PI 14 – Readmission to hospital within 28 days of discharge.		
Strategic issue.	Service Access, Coordination and Continuity of Care.	
Rationale.	Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall care system. Admissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.	
Date last updated.	January 2011.	
Indicator details.		
Description.	Percentage of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient units that are followed by a readmission to the same or to another public sector psychiatric inpatient unit within 28 days of discharge.	
Numerator.	Number of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) occurring within the reference period, that are followed by a readmission to the same or another acute psychiatric inpatient unit within 28 days.	
Denominator.	Number of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) occurring within the reference period.	
Computation.	(Numerator ÷ Denominator) x 100.	
Calculation conditions.	Coverage/ Scope.	All public mental health service organisations acute psychiatric inpatient units. The following separations are excluded: • Same day separations, including index separation and subsequent readmission. • Statistical and change of care type separations. • Separations that end by transfer to another acute or psychiatric inpatient hospital. • Separations that end by death, left against medical advice/ discharge at own risk. Separations, where purpose of admission was for maintenance ECT and length of stay is one night only.
	Methodology.	• Readmission is considered to have occurred if the person has been admitted to any public sector mental health acute inpatient unit within the state/territory. As such a state-wide unique patient identifier is required for full implementation of this indicator. • Where a mental health service organisation has more than one unit of a particular service type for the purpose of this indicator those units should be combined.

NMHP PI 14 – Readmission to hospital within 28 days of discharge.					
Definitions.	• 'Same day separations' are inpatient episodes where the admission and separation dates are the same. • 'Same or another acute psychiatric inpatient unit' for the purposes of this indicator 'another' means within the same jurisdiction.				
Presentation.	Percentage.				
Disaggregation.	State/Territory and age.				
Notes.	• This indicator cannot differentiate between 'planned' and 'unplanned' readmissions. • This indicator will not track readmissions across state/territory boundaries or track movement between public and private hospitals.				
Is specification interim or long-term?	Long-term.				
Reported in.	• COAG National Action Plan Progress Report (Indicator 8 Readmission to hospital within 28 days of discharge). • Report on Government Services.				
National Mental Health Performance Framework.					
Tier.	Tier III – Health System Performance.				
Primary domain.	Effective.				
Secondary domain(s).	Continuous.				
Mental health sub-domain.	Community tenure.				
Type of measure.	Outcome.				
Level at which indicator can be useful for benchmarking.	Service Unit.	☑	Mental Health Service Organisation.	☑	
	Regional group of services.	☑	State/Territory.	☑	
Related performance indicators and performance benchmarks.	• Rates of pre-admission community care. • Rates of post-discharge community care.				
Data collection details.					
Data source(s).	Numerator.	State/territory admitted patient data.			
	Denominator.	State/territory admitted patient data			
Data source(s) type..	Numerator.	Administrative.			
	Denominator.	Administrative.			
Frequency of data source(s) collection.	Numerator.	Annually.			
	Denominator.	Annually.			

NMHP PI 14 – Readmission to hospital within 28 days of discharge.		
Data development.	Short-term:	-
	Medium-term:	-
	Long-term:	Data linkage may allow identification of readmission between jurisdictions, and between public and private hospitals.

NMHP PI 15 – Rates of pre-admission community care.		
Strategic Issue.	Service Access, Coordination and Continuity of Care.	
Rationale.	The majority of clients admitted to public sector mental health acute inpatient units are known to public sector community mental health services and it is reasonable to expect community teams should be involved in pre-admission care.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.	
Date last updated.	January 2011.	
Indicator details.		
Description.	Percentage of admissions to the mental health service organisation's acute psychiatric inpatient unit(s) for which a community ambulatory service contact was recorded in the seven days immediately preceding that admission.	
Numerator.	Number of admissions to the mental health service organisation's acute psychiatric inpatient unit(s) for which a public sector community ambulatory service contact was recorded in the seven days immediately preceding that admission.	
Denominator.	Number of admissions to the mental health service organisation's acute psychiatric inpatient unit(s).	
Computation.	(Numerator ÷ Denominator) x 100.	
Calculation conditions.	Coverage/Scope.	All public sector mental health acute psychiatric inpatient units. The following admissions are excluded from the calculation: . • Same day admissions. • Admissions by inter-hospital transfer or between programs (for example, acute to rehabilitation). The following community ambulatory service contacts are excluded from the calculation: • Community ambulatory service contacts occurring on the day of admission.
	Methodology.	Requires capacity to track service use across inpatient and community boundaries and is dependent on the capacity to link patient identifiers.
Definitions.	• Same day admissions are defined as inpatient episodes where the admission and separation dates are the same. • An ambulatory service contact is the provision of a clinically significant service by a specialised mental health service provider(s) for patients/clients, other than those patients/clients admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24 hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.	

NMHP PI 15 – Rates of pre-admission community care.					
Presentation.	Percentage.				
Disaggregation.	State/Territory and age.				
Notes.	• The reliability of cross-jurisdictional comparisons on this indicator is dependent on the implementation of statewide unique patient identifiers as the community services may not necessarily be delivered by the same mental health service organisation that admits the patient. • This measure does not consider variations in intensity or frequency of contacts prior to admission. Additionally, it does not distinguish differences between phone and face-to-face community contacts.				
Is specification interim or long-term?	Long-term.				
Reported in.	-				
National Mental Health Performance Framework.					
Tier.	Tier III – Health System Performance.				
Primary domain.	Continuous.				
Secondary domain(s).	Accessible.				
Mental health sub-domain.	Cross-setting continuity.				
Type of measure.	Process.				
Level at which indicator can be useful for benchmarking.	Service Unit.	☑	Mental Health Service Organisation.	☑	
	Regional group of services.	☑	State/Territory.	☑	
Related performance indicators and performance benchmarks.	• 28 day readmission rate. • Average length of acute inpatient stay. • Post-discharge community care.				
Data collection details.					
Data source(s).	Numerator.	State/territory admitted patient and community mental health care data.			
	Denominator.	State/territory admitted patient mental health care data.			
Data source(s) type.	Numerator.	Administrative.			
	Denominator.	Administrative.			
Frequency of data source(s) collection.	Numerator.	Annually.			
	Denominator.	Annually.			

NMHP PI 15 – Rates of pre-admission community care.		
Data development.	Short-term:	-
	Medium-erm:	-
	Long-term:	Full implementation of this measure requires unique statewide patient identifiers not currently available in all jurisdictions.

NMHP PI 16 – Rates of post-discharge community care.		
Strategic issue.	Service Access, Coordination and Continuity of Care.	
Rationale.	Transition in care from hospital to the community is identified as a critical time in the treatment continuum. Evidence suggests that immediately following discharge is a period of increased vulnerability, and that timely follow-up mitigates the risk of relapse. A responsive community support system for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.	
Date last updated.	January 2011.	
Indicator details.		
Description.	Percentage of separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a community ambulatory service contact was recorded in the seven days immediately following that separation.	
Numerator.	Number of in-scope separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a community ambulatory service contact in which the consumer participated, was recorded in the seven days immediately following that separation.	
Denominator.	Number of in-scope separations for the mental health service organisation's acute psychiatric inpatient unit(s).	
Computation.	(Numerator ÷ Denominator) x 100.	
Calculation conditions.	Coverage/Scope.	All public mental health service organisations acute psychiatric inpatient units. The following separations are excluded: • Same day separations. • Statistical and change of care type separations. • Separations that end by transfer to another acute or psychiatric inpatient hospital. • Separations that end by death, left against medical advice/discharge at own risk. The following community ambulatory service contacts are excluded from the calculation: • Community ambulatory service contacts occurring on the day of separation.
	Methodology.	• Implementation of this indicator requires the capacity to track service use across inpatient and community boundaries and is dependent on the capacity to link patient identifiers. • Where a mental health service organisation has more than one unit of a particular service type for the purpose of this indicator those units should be combined.

NMHP PI 16 – Rates of post-discharge community care.				
Definitions.	• Same day separations are defined as inpatient episodes where the admission and separation dates are the same. • An community ambulatory service contact is the provision of a clinically significant service by a specialised mental health service provider(s) for patients/clients, other than those patients/clients admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24 hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.			
Presentation.	Percentage.			
Disaggregation.	State/Territory and age.			
Notes.	• The reliability of cross-jurisdictional comparisons on this indicator is dependent on the implementation of statewide unique patient identifiers as the community services may not necessarily be delivered by the same mental health service organisation that admits the patient. • This measure does not consider variations in intensity or frequency of service contacts following discharge from hospital. • This measure does not distinguish qualitative differences between phone and face-to-face community contacts.			
Is specification interim or long-term?	Long-term.			
Reported in.	• COAG National Action Plan Progress Report. • Report on Government Services.			
National Mental Health Performance Framework.				
Tier.	Tier III – Health System Performance.			
Primary domain.	Continuous.			
Secondary domain(s).	Accessible and safe.			
Mental health sub-domain.	Cross-setting continuity.			
Type of measure.	Process.			
Level at which indicator can be useful for benchmarking.	Service Unit.	☑	Mental Health Service Organisation.	☑
	Regional group of services.	☑	State/Territory.	☑
Related performance indicators and performance benchmark.s	• 28 day readmission rate. • Average length of acute inpatient stay. • Pre-admission community care.			

NMHP PI 16 – Rates of post-discharge community care.		
Data collection details.		
Data source(s).	Numerator.	State/territory admitted patient and community mental health care data.
	Denominator.	State/territory admitted patient mental health care data.
Data source(s) type.	Numerator.	Administrative by-product.
	Denominator.	Administrative by-product.
Frequency of data source(s) collection.	Numerator.	Annually.
	Denominator.	Annually.
Data development.	Short-term:	Nil.
	Medium-term:	Nil.
	Long-term:	Full implementation of this measure requires unique statewide patient identifiers not currently available in all jurisdictions.

NMHP PI 20 – Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities.				
Strategic issue.	Service Access, Coordination and Continuity of Care.			
Rationale.	Prison populations have higher rates of mental illness than the general population, and are highlighted as a risk group. An over-representation of people in mental illness may indicate failure to deliver appropriate intervention services to people with mental illness who are at risk of offending.			
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.			
Date last updated.	January 2011.			
Indicator details.				
Description.	The proportion of prisoners who self report they have been told by a doctor or mental health professional that they have a mental illness.			
Numerator.	Number of prison entrants who report that they have been told by a doctor or mental health professional that they have a mental illness.			
Denominator.	Total number of prison entrants.			
Computation.	(Numerator ÷ Denominator) x 100.			
Calculation conditions.	Coverage/Scop.e -			
	Methodology. -			
Definitions.	• Doctor or mental health professional: for the purpose of this indicator includes a medical practitioner, psychiatrist, psychologist, nurse. • Mental illness: a mental health disorder including drug and alcohol abuse.			
Presentation.	Percentage.			
Disaggregation.	Age, sex, and Indigenous status.			
Notes.	-			
Is specification interim or long-term?	Interim.			
Reported in.	Health of Australia's Prisoners 2009.			
National Mental Health Performance Framework.				
Tier.	Tier 1 – Health Status and Outcomes.			
Primary domain.	Health conditions.			
Secondary domain(s).	-			
Mental health sub-domain.	-			
Type of measure.	Outcome.			
Level at which indicator can be useful for benchmarking.	Service Unit.	☐	Mental Health Service Organisation.	☐
	Regional group of services.	☐	State/Territory.	☑

NMHP PI 20 – Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities.		
Related performance indicators and performance benchmarks.	-	
Data collection details.		
Data source(s).	Numerator.	National Prisoner Health Data Collection.
	Denominator.	National Prisoner Health Data Collection.
Data source(s) type.	Numerator.	Prisoner Census.
	Denominator	Prison Establishment Census.
Frequency of data source(s) collection.	Numerator.	Proposed as an annual collection.
	Denominator.	Proposed as an annual collection.
Data development.	Short-term:	-
	Medium-term:	Alternative data sources to provide proxy data for juvenile detainees are being investigated with Juvenile Justice departments. Data linkage between mental health and juvenile justice National Minimum Data Sets is being investigated.
	Long-term:	

NMHP PI 21 – Proportion of total mental health workforce accounted for by consumer and carer workers.		
Strategic issue.	Quality Improvement and Innovation.	
Rationale.	Consumer and carer involvement in the planning and delivery of mental health services is considered essential to adequately represent the views of consumers and carers, advocate on their behalf and promote the development of consumer responsive services.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.	
Date last updated.	January 2011.	
Indicator details.		
Description.	Proportion of the state and territory mental health workforce who are consumer and carer workers.	
Numerator.	Number of full time equivalent consumer and carer worker positions within Australian state and territory public mental health services.	
Denominator.	Number of full time equivalent clinical positions and customer and carer worker positions within Australian state and territory mental health services.	
Computation.	(Numerator ÷ Denominator) x 100.	
Calculation conditions.	Coverage/Scope.	Australian state and territory-provided public mental health services.
	Methodology.	-
Definitions.	Clinical positions are described in the National Minimum Dataset—Mental Health Establishments and include the labour force categories of *Consultant psychiatrists and psychiatrists*, *Psychiatry registrars and trainees*, *Other medical officers*, *Registered nurses*, *Enrolled nurses*, *Occupational therapists*, *Social workers*, *Psychologists*, *Other diagnostic and health professionals* and *Other personal care* staff.	
Presentation.	Percentage.	
Disaggregation.	State/Territory by consumer and carer workers.	
Notes.	Current data collections do not cover mental health services managed by government-funded NGOs.	
Is specification interim or long-term?	Long-term.	
Reported in.	• Mental Health Services in Australia. • National Mental Health Report. • Report on Government Services.	
National Mental Health Performance Framework.		
Tier.	Tier III – Health System Performance.	
Primary domain.	Capable.	
Secondary domain(s).	-	

NMHP PI 21 – Proportion of total mental health workforce accounted for by consumer and carer workers.				
Mental health sub-domain.	-			
Type of measure.	Input.			
Level at which indicator can be useful for benchmarking.	Service Unit.	☐	Mental Health Service Organisation.	☑
	Regional group of services.	☑	State/Territory.	☑
Related performance indicators and performance benchmarks.	-			
Data collection details.				
Data source(s).	Numerator.	National Minimum Dataset – Mental Health Establishments.		
	Denominator.	National Minimum Dataset – Mental Health Establishments.		
Data source(s) type.	Numerator.	Administrative.		
	Denominato.r	Administrative.		
Frequency of data source(s) collection.	Numerator.	Annually.		
	Denominator.	Annually.		
Data development.	Short-term:.	Definitional development for *Consumer consultant* and *Carer consultant* is currently underway to ensure definitions reflect the various arrangements that may exist between organisations and consumer/carer consultants.		
	Medium-term:	-		
	Long-term:	The development of a Mental Health Non-Government Organisation National Minimum Dataset (MH NGO NMDS) is currently in the scoping phase. This indicator has been noted as being desirable in any new Mental Health NGO collection.		

NMHP PI 22 – Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards.	
Strategic issue.	Quality Improvement and Innovation.
Rationale.	• Implementation of the National Standards for Mental Health Services has been agreed by all jurisdictions. • Service quality has been a driving force for the National Mental Health Strategy.
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.
Date last updated.	January 2011.
Indicator details.	
Description.	Percentage of the mental health service organisation's services (weighted by expenditure) that have been reviewed against the National Standards for Mental Health Services. The indicator grades services into four categories. • Level 1 – Services have been reviewed by an external accreditation agency and judged to have met all National Standards. • Level 2 – Services have been reviewed by an external accreditation agency and judged to have met some but not all National Standards. • Level 3 – Services: (i) are in the process of being reviewed by an external accreditation agency but the outcomes are not known; or (ii) are booked for review by an external accreditation agency. • Level 4 – Mental health services that do not meet criteria detailed under Levels 1 to 3.
Numerator.	Total expenditure by mental health service organisations on mental heath services that meet the definition of Level X where X is the level at which the indicator is being measured (either Level 1, Level 2, Level 3 or Level 4 as detailed above).
Denominator.	Total mental health service organisation expenditure on mental health services.
Computation.	(Numerator ÷ Denominator) x 100 calculated for each level.

NMHP PI 22 – Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards.		
Calculation conditions.	Coverage/Scope.	All public mental health service organisations, with the following exclusion. • Older Persons Mental Health Community Residential Services approved under or working towards the accreditation standards gazetted as part of the Australian Government Aged Care Act 1997.
	Methodology.	Weighted by expenditure within various levels of aggregation above service unit/team.
Definitions.	Mapping of levels to National Minimum Data Set – Mental Health Establishments (MHE) codes as follows: *Level 1:* MHE code 1; *Level 2:* MHE code 2; *Level 3:* MHE codes 3-4; *Level 4:* MHE codes 5-8.	
Presentation.	Percentage.	
Disaggregation.	State/Territory.	
Notes.	• External review is a process of negotiation between mental health service organisations and the accrediting agency. Accordingly, variations may exist in the extent to which all or some Standards are deemed to be applicable to individual service units. • A review may apply to the service units within a mental health service organisation, not the mental health service organisation as an entity in itself. • External accreditation agencies such as ACHS and QIC use differing review methodologies.	
Is specification interim or long-term?	Interim.	
Reported in.	A similar indicator is reported in the Report on Government Services.	
National Mental Health Performance Framework.		
Tier.	Tier III – Health Service Performance.	
Primary domain.	Appropriate.	
Secondary domain(s).	Capable.	
Mental health sub-domain.	Compliance with standards.	
Type of measure.	Process.	

NMHP PI 22 – Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards.				
Level at which indicator can be useful for benchmarking.	Service Unit.	☑	Mental Health Service Organisation.	☑
	Regional group of services.	☑	State/Territory.	☑
Related performance indicators and performance benchmarks.	National Mental Health Key Performance Indicator 'National Service Standards compliance'.			
Data collection details.				
Data source(s).	Numerator.	National Minimum Data Set – Mental Health Establishments or State/Territory central health administration.		
	Denominator.	National Minimum Data Set – Mental Health Establishments or State/Territory central health administration.		
Data source(s) type.	Numerator.	Administrative.		
	Denominator.	Administrative.		
Frequency of data source(s) collection.	Numerator.	Annually.		
	Denominator.	Annually.		
Data development.	Short-term:	-		
	Medium-term:	New National Standards have been developed, and work is underway to establish a method of measuring compliance. This indicator is based on the current National indicator National Service Standards Compliance, which will be reviewed in 2011 Subsequently, this indicator will be revised accordingly.		
	Long-term:	Mental Health NGO coverage is not included and will require new data collection.		

NMHP PI 23 – Mental health outcomes for people who receive treatment from State and Territory services and the private hospital system.	
Strategic issue.	Quality Improvement and Innovation.
Rationale.	• Improvement in clinical outcomes, measured by a reduction in the severity of symptoms and improvements in functioning, is a core objective of mental health services. • The implementation of routine mental health outcome measurement in Australia provides the opportunity to monitor the effectiveness of mental health services across services and jurisdictions. • Identifying the comparative effectiveness of mental health services informs benchmarking between services and related service quality improvement activities.
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee, February 2011.
Date last updated.	January 2011.
Indicator details.	
Description.	The proportion of episodes of care, or partial episodes, where either:. • significant improvement. • significant deterioration. • no significant change. was identified between baseline and follow-up of completed outcome measures.
Numerator.	Number of episodes or partial episodes with completed outcome measures, partitioned by mental health setting, where either significant change/significant deterioration/no significant change was identified between *baseline* and *follow-up* within the reference period.
Denominator.	Number of episodes or partial episodes of care with completed outcome measures, partitioned by mental health setting within the reference period.
Computation.	(Numerator ÷ Denominator) x 100. Calculated separately for each group.

NMHP PI 23 – Mental health outcomes for people who receive treatment from State and Territory services and the private hospital system.		
Calculation conditions.	Coverage/ Scope.	All public mental health services organisations, and private psychiatric hospitals, with the following exclusion. Public community residential mental health services.
	Methodology.	• Only the HoNOS family of measures is considered in the calculation of this indicator. • Outcomes are to be calculated for the following three cohorts of consumers. – **Group A: Consumers discharged from hospital** All people who were discharged from an acute psychiatric inpatient unit within the reference period. Scores should be calculated as the difference between the total score recorded at admission (the 'baseline') and discharge (the 'follow-up'). – **Group B: Consumers discharged from ambulatory care.** All people who were discharged from an ambulatory care episode within the reference period. Scores should be calculated as the difference between the total score recorded at admission to the episode (the 'baseline'), and discharge from the episode (the 'follow-up'). Ambulatory episodes that are completed because the consumer was admitted to hospital must be excluded from the analysis (that is, where the National Outcomes Casemix Collection (NOCC) 'reason for collection' equals change of setting). – **Group C: Consumers in ongoing ambulatory care.** All people who have an 'open' ambulatory episode of care at the end of reference period – that is, the person commenced the ambulatory episode some time either during or prior to the reference period and has not been discharged from that episode at the end of the reference period. Outcome scores should be calculated as the difference between the total score recorded on the first occasion rated which will be either admission or review, (the 'baseline') and the last occasion rated which will be a review (the 'follow-up') in the reference period. • Group change analyses can only be determined for episodes of care where both baseline and follow-up ratings are present. This excludes specific episodes defined by the NOCC data collection protocol as not requiring follow-up as well as episodes or partial episodes where either the baseline or follow-up measure is not available. • The total score is determined for each individual baseline and follow-up score. This is the sum total of the 12 HoNOS/65+ scales or the first 13 scales of the 15 HoNOSCA. Where one or more of the HoNOS/65+ or HoNOSCA scales has not been completed correctly, the collection occasion should only be regarded as valid and complete if • For the HoNOS and HoNOS65+: A minimum of 10 of the 12 scales have a valid severity rating (ie a rating of either 0, 1, 2, 3 or 4). • the HoNOSCA: A minimum of 11 of the first 13 items have a valid severity rating. • Outcome scores are classified as either 'significant improvement', 'significant deterioration or 'no significant change', based on Effect Size. • The group 'baseline' standard deviation score is calculated separately on the reference period for each age group and service setting stratification using the national data set. The group baseline standard deviation includes all valid clinical ratings (ie any valid baseline rating even although at an individual episode of care level it may not form a matched pair), and will be recalibrated periodically. • The reference period for this indicator (including calculation of the effect size) is typically a single financial year, and the result of modifying the reference period is unknown.

NMHP PI 23 – Mental health outcomes for people who receive treatment from State and Territory services and the private hospital system.	
Definitions.	• HoNOS family includes HoNOS, HoNOS 65+ and HoNOSCA. • As defined by the NOCC Specifications Version 1.6, an *Episode of Care* is defined as a more or less continuous period of contact between a consumer and a *Mental Health Service Organisation* that occurs within the one *Mental Health Service Setting*. • Episodes of Care may be brief or prolonged, and may be provided in three settings – inpatient, ambulatory or residential. Under the NOCC protocol, a consumer may be in only one episode of mental health care at any one time. • The term 'partial episode' is used here to refer to the period between baseline and follow-up measurement for those consumers who are in ongoing ambulatory episodes, as discussed above (See Group C). • Effect size is a statistic used to assess the magnitude of a treatment effect. It is based on the ratio of the difference between the baseline and follow-up scores to the standard deviation of the baseline score. As a rule of thumb, effect sizes of 0.2 are considered small, 0.5 considered medium and 0.8 considered large. Based on this rule, a medium effect size of 0.5 is used to assign outcome scores to the three outcome categories. Thus individual episodes are classified as either: 'significant improvement' if the Effect Size index is greater than or equal to positive 0.5; 'significant deterioration' if the Effect Size index is less than or equal to negative 0.5; or 'no change' if the index is between -0.5 and 0.
Presentation.	Percentage by group.
Disaggregation.	State/Territory (for public mental health services), by HoNOS measure.
Notes.	• A specific issue in the interpretation of 'change' scores is how they relate to 'expectations of change' for a given consumer within a given mental health service setting. For consumers who have episodes of care in acute inpatient settings, it is generally accepted that there would be positive significant change as measured by the HoNOS family. In ambulatory settings, the expected outcome for some people may be improvement, but for others might be prevention of relapse (ie no statistical change. The thresholds for change need to be specific to mental health service settings and programs. • This indicator is only indicative of a single type of effectiveness and outcome for mental health consumers. Where possible, NOCC-based consumer outcome measures should be complemented by one or more other measures of consumer outcomes (eg social outcomes – housing tenure, employment etc) that demonstrate the different perspectives on, and dimensions of, mental health consumer outcomes. • This indicator addresses the sub-domain of consumer outcomes, and assesses severity of symptoms from the clinician's perspective. Improvements on other measures that assess other dimensions from both clinician and consumer perspectives should be considered for future development of performance indicators. • The national data set does note currently allow episodes of care to be connected across financial years. This limitation does not exist for states and territories own data sets. • This indicator was designed as a measure of aggregate group change.
Is specification interim or long-term?	Long-term.

NMHP PI 23 – Mental health outcomes for people who receive treatment from State and Territory services and the private hospital system.				
Reported in.	COAG National Action Plan Progress Report (Indicator 6 Mental health outcomes for people who receive treatment from State and Territory services and the private hospital system).			
National Mental Health Performance Framework.				
Tier.	Tier III – Health Service Performance.			
Primary domain.	Effective.			
Secondary domain(s).	-			
Mental health sub-domain.	Consumer outcomes.			
Type of measure.	Outcome.			
Level at which indicator can be useful for benchmarking.	Service Unit.	☑	Mental Health Service Organisation.	☑
	Regional group of services.	☑	State/Territory.	☑
Related performance indicators and performance benchmarks.	-			
Data collection details.				
Data source(s).	Numerator.	National Outcomes and Casemix Collection.		
	Denominator.	National Outcomes and Casemix Collection.		
Data source(s) type.	Numerator.	Outcome data.		
	Denominator.	Outcome data.		
Frequency of data source(s) collection.	Numerator.	Annually.		
	Denominator.	Annually.		
Data development.	Short-term:	-		
	Medium-term:	-		
	Long-term:	-		

4.2 Appendix 2: Australian national mental health committee roles and structure.

In 1991 the Australian Health Ministers' Advisory Council (AHMAC) established the MHSC (initially known as the National Mental Health Working Group) to oversee the implementation of the National Mental Health Strategy (NMHS), and to provide a forum for cross-jurisdictional information exchange to encourage a consistent approach to the implementation of the NMHS, and provide advice to the Commonwealth Minister for Health on expenditure of mental health national project funding.

The key roles of the MHSC are to oversee and monitor the implementation of the Fourth Plan and the COAG National Action Plan on Mental Health, and to support cross-jurisdictional communication and information exchange to improve both consistency and outcomes from national mental health reform.

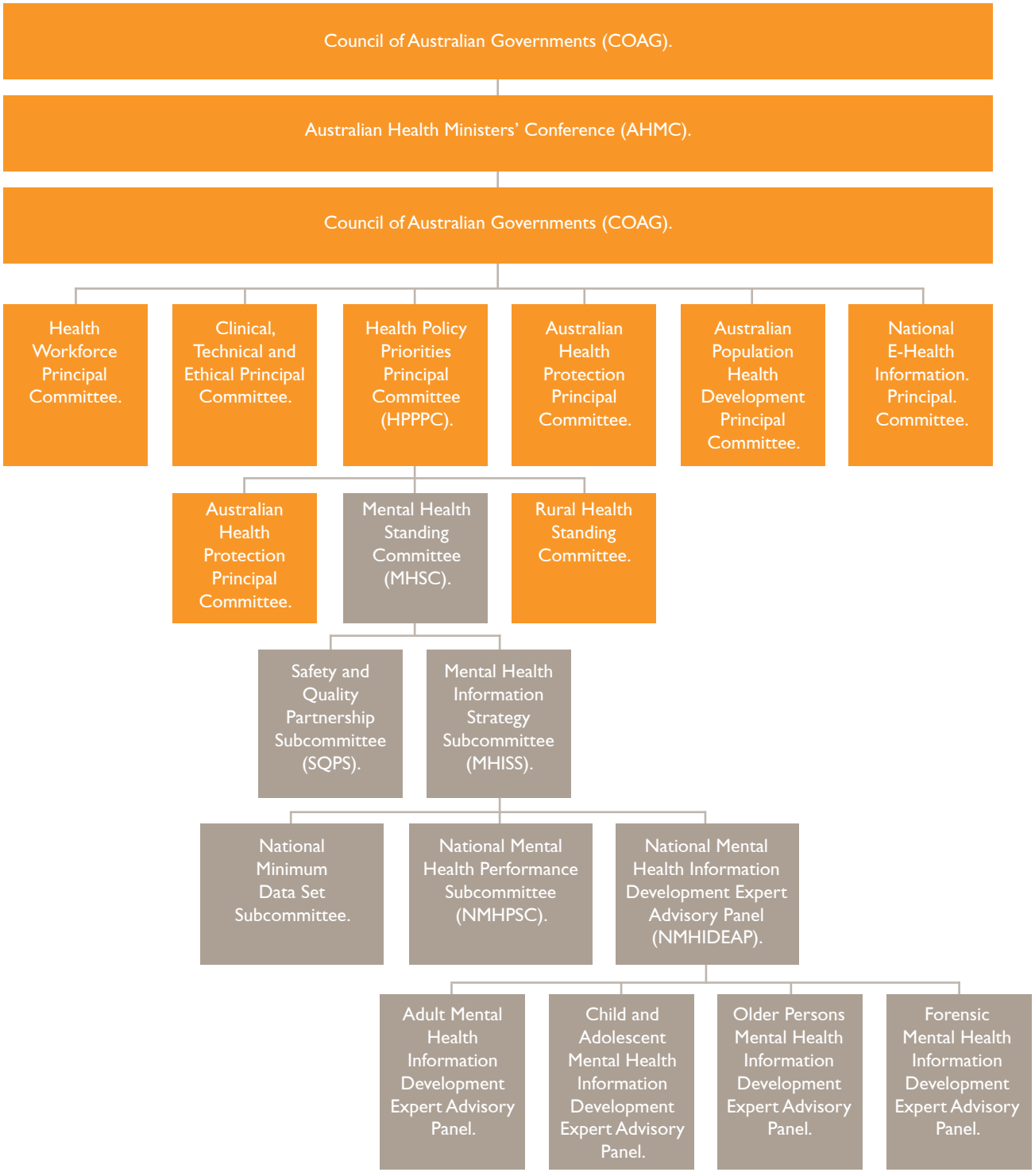
The MHSC reports to AHMAC through the Health Policy Priorities Principal Committee (HPPPC). The reporting structure is shown at Figure 4.1.

The work of the MHSC is supported by four subcommittees – the Safety and Quality Partnership Subcommittee (SQPS), the Mental Health Information Strategy Subcommittee (MHISS) the National Mental Health Performance Subcommittee (NMHPSC), and the National Minimum Data Set Subcommittee (NMDS Subcommittee). The NMHPSC and NMDS Subcommittee report to the MHSC through the MHISS. The subcommittees work together to progress the national reform agenda under the auspices of the National Mental Health Strategy.

The committees' members are from a wide range of stakeholder, including senior representatives from jurisdictions' mental health departments, a number of Australian Government agencies, the private and non-government sectors, consumers and carers, and clinical experts. The full representations can be found on the MHSC website www.health.gov.au/mhsc.

The MHISS was delegated responsibility to develop the measurement and reporting strategy for the Fourth Plan indicators. MHISS has taken an overall lead in indicator development and agreeing on approaches to be followed, and initiated investigations into potential sources of data for indicators identified in the plan as requiring data development. The NMHPSC was delegated work on those indicators where data was considered available, and with writing the Measurement Strategy.

Figure 4.1 National mental health committee structure.



4.3 Appendix 3: Selection criteria for national health performance indicators.

The following table lists the selection criteria from the National Mental Health Performance Framework, adopted from the National Health Performance Committee (now part of the AHMAC National Health Information Standards and Statistics Committee).

Selection Criteria for Individual Health Performance Indicators.

Be worth measuring.

The indicators represent an important and salient aspect of the public's health or the performance of the health system.

Be measurable for diverse populations.

The indicators are valid and reliable for the general population and diverse populations (i.e. Aboriginal and Torres Strait Islander peoples, rural/urban, socioeconomic etc).

Be understood by people who need to act.

People who need to act on their own behalf or on that of others should be able to readily comprehend the indicators and what can be done to improve health.

Galvanise action.

The indicators are of such a nature that action can be taken at the national, state, local or community level by individuals, organised groups and public and private agencies.

Be relevant to policy and practice.

Actions that can lead to improvement are anticipated and feasible – they are plausible actions that can alter the course of an indicator when widely applied.

Measurement over time will reflect results of actions.

If action is taken, tangible results will be seen indicating improvements in various aspects of the nation's health.

Be feasible to collect and report.

The information required for the indicator can be obtained at reasonable cost in relation to its value and can be collected, analysed and reported on in an appropriate time frame.

Comply with national processes of data definitions.

Selection Criteria Related to Sets of Indicators.

- Cover the spectrum of the health issue.
- Reflect a balance of indicators for all appropriate parts of the framework.
- Identify and respond to new and emerging issues.
- Be capable of leading change.
- Provide feedback on where the system is working well, as well as areas for improvement.

Additional Selection Criteria.

In addition to the general criteria for health performance indicators outlined above, indicators should:

- Facilitate the use of data at the health industry service unit level for benchmarking purposes.
- Be consistent and use established and existing indicators where possible.

4.4 Appendix 4: Glossary of abbreviations.

ABS	Australian Bureau of Statistics.
AHMAC	Australian Health Ministers Advisory Council.
AHMC	Australian Health Ministers Council.
AIHW	Australian Institute of Health and Welfare.
CAPI	Computer Assisted Personal Interview.
CATI	Computer Assisted Telephone Interview.
CMHC	Community Mental Health Care.
COAG	Council of Australian Governments.
DoHA	Australian Government Department of Health and Ageing.
DSM	Diagnostic and Statistical Manual of Mental Disorders.
DVA	Department of Veterans Affairs.
FaHCSIA	Families, Housing, Community Services and Indigenous Affairs.
GPs	General Practitioners.
GSS	General Social Survey.
HILDA	Household, Income and Labour Dynamics in Australia survey.
HoNOS	Health of the Nation Outcome Scale.
HoNOS 65+	HoNOS 65 years and over.
HoNOS family of measures	HoNOS, HoNOSCA and HoNOS 65+.
HoNOSCA	HoNOS Child and Adolescent.
ICD	International Classification of Diseases.
MBS	Medical Benefits Scheme (Medicare).
MHSC	Mental Health Standing Committee.
MHISS	Mental Health Information Strategy Subcommittee.
MHSiA	The annual AIHW Mental Health Services in Australia publication.
NAP	COAG National Action Plan on mental health (2006–2011).
NGOs	Non Government Organisations.
NHS	National Health Survey.
NMDS	National Minimum Data Set.
NMHP	National Mental Health Plan Performance Indicator.
NMHPSC	National Mental Health Performance Subcommittee.
NPA	National Performance Authority.
NSMHWB	National Survey of Mental Health and Wellbeing.
PMHA	Private Mental Health Alliance.
RoGS	Steering Committee for the Review of Government Service Provision Report on Government Services.
SMART	Specific, Measurable, Achievable, Realistic, Timely.

4.5 Appendix 5: Technical conventions.

The detailed specifications include proposed disaggregation to be utilised when reporting the indicators. Further work is required to clarify technical issues to ensure the consistent construction of the indicators. It should be noted that all proposed desegregations are subject to the limitations of each data source and available sample size.

Age.

When age is identified as a disaggregation the following calculation method applies (subject to limitations of the data and sample size):

- Calculating age: *Age at first contact within the reporting period.*
- Age groups:
  - pre-school (0–<5 years).
  - primary school (5–<12 years).
  - secondary school (12–<18 years).
  - youth/young adult (18–<25 years).
  - adult by 10 year bands (25–<35, 35–<45, 45–<55, and 55–<65 years).
  - older persons (65–<75, 75–<85, and 85 years and over).

Estimated Residential Population(ERP).

The Australian Bureau of Statistics bases ERP on the most recent census, updated by migration, birth and death data, as it becomes available. Updates are released at the end of June and December each year.

Three of the Fourth Plan indicators (PI 7, 9 and 13) utilise ERP as the denominator and will utilise the June released information.

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All information in this publication is correct as of May 2011

D0334 May 2011