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.