APPENDICES

- Appendix A: Detailed consultation outcomes

Table 2 (below) presents a list of targets and indicators which attracted substantial attention from stakeholders over the course of the MHCA’s consultations. There was clear consensus on some, while others were the subject of discussion and debate. Table 2 provides commentary on the nature and level of support for each item.

Detailed wording for many of the items was developed at the CONGO forum, with feedback about the issues that each indicators relate to collected at prior consultations with consumers and carers, practitioners, policy makers and service providers. An indication of where support for each item came from is provided in **BOLD** in column number 2. Where the table indicates that views originate from the MHCA, this is based on feedback from the consultations as well as our subsequent analysis.

**Table 2: Full list of targets and indicators which attracted stakeholder discussion**

<table>
<thead>
<tr>
<th>Target</th>
<th>Related indicator(s)</th>
<th>MHCA Analysis of Consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reduce the gap in mortality rates between people with severe mental illness and the rest of the population by 30-40% within 5 years and 80% within 10 years</td>
<td>1a. Improvements in the physical health of people with mental illness in relation to comorbid health problems, alcohol misuse, metabolic syndrome and smoking rates <em>(CONGO)</em>&lt;br&gt;1b. Numbers of physical health care plans for people with mental illness using primary care services <em>(CONGO &amp; MHCA)</em></td>
<td>Across all levels of consultation there was widespread agreement that a key medium term goal of mental health reform must be to drive to improve physical health outcomes for people living with mental illness, in particular, severe and persistent mental illness. Both the target presented here and the associated indicators were endorsed by CONGO delegates. There was a high level of consensus around the need to adopt similar indicators and targets at the State and Territory consultations and the NMHCCF/Register consultation.</td>
</tr>
<tr>
<td>Target</td>
<td>Related indicator(s)</td>
<td>MHCA Analysis of Consensus</td>
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</tbody>
</table>
| 2. Reduce the number of people not accessing the services they need by 20% within 4 years and 50% within 10 years. | 2a. Proportion of consumers and carers who receive timely access to quality services that meet their self-assessed needs (MHCA/NMHCCF)  
2b. Service outcomes (CONGO)  
2c. Alignment between service outcomes and consumer and carer satisfaction (CONGO)  
2d. Levels of access to community mental health services linked to reductions in hospitalisations and ED presentations (CONGO)  
2e. Proportion of mental health services which document and implement an externally accredited, recovery-oriented, consumer/carer driven framework for the delivery of treatment and support (NHMCCF & Register)  
2f. Proportion of people who have exited the mental health system and have re-engaged in the community (MHCA)  
2g. Proportion of services participating in quality assurance and CQI processes that involve consumers and carers (MHCA)  
2h. Numbers of people with psychosocial disability receiving support under the NDIS (MHCA) | There was significant debate about the broader measurement of service access and whether or not we need to be measuring system capacity or both system capacity and service quality/satisfaction.  
In addition, there was debate about the importance of tracking system access across metro, regional, rural and remote areas.  
There was broad consensus around the need to improve system access but as the indicators in column two illustrate, there was a general view, particularly amongst consumer and carer representatives, need to track the extent to which services are guided by and facilitate a recovery focus.  
The key message is that both access and quality are important and consumers and carers need to be provided with alternative avenues to evaluate satisfaction with services including where possible subjective assessment. |
<table>
<thead>
<tr>
<th>Target</th>
<th>Related indicator(s)</th>
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</tr>
</thead>
</table>
| 3. Increase the employment participation rate for people with mental illness to 35% within 4 years. Within ten years, increase the employment participation rate for people with mental illness to 80% of the national rate | 3a. Year 12/VET completion rates *(CONGO)*  
3b. Number of working days lost per annum *(CONGO)*  
3c. NEETS (not in employment, education or training) *(CONGO & NMHCCF)* | There was broad consensus that increasing employment participation rates by people living with mental illness and their carers is an important target to set.  
Consumer and Carer representatives agreed that targets and indicators aimed at driving improved levels of participation in education, employment and training by people living with mental illness and their carers was important but stressed that the work needed to be meaningful and appropriately remunerated.  
Furthermore consumers indicated they wanted to be given the opportunity to self-assess their level of community connectedness and social inclusion.  
There was less agreement on the specifics of these indicators at the consumer and carer consultation than there was at the CONGO meeting. |
<table>
<thead>
<tr>
<th>Target</th>
<th>Related indicator(s)</th>
<th>MHCA Analysis of Consensus</th>
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</thead>
</table>
| 4. Decrease the proportion of people who do not have access to affordable, appropriate, safe, secure and lasting accommodation (including people in hospital) by 20% within four years and 50% within 10 years | 4a. Proportion of people in mental health and justice settings who are in insecure or unstable housing *(MHCA & CONGO)*  
4b. Proportion of people experiencing mental illness who are afforded housing choices including flexible tenure arrangements and the ability to access step up, step down models of care *(MHCA)*  
4c. Rates of 7- and 28 and 180-day post-discharge follow-up by clinical mental health, community mental health, homelessness and forensic services, with mandatory reporting by all services *(MHCA, CONGO)*  
4d. Numbers of discharge plans including multidisciplinary involvement and input from family, friends and supporters *(NMHCCF)* | There was a high level of consensus on the importance of secure, stable and affordable housing as a pre-requisite for recovery.  
Housing was a leading concern identified by respondents to the surveys distributed at the MHCA consultations.  
Consumers and Carers also identified safe, stable and secure housing as well as community and personal safety (relevant to housing) as vitally important to assisting in the recovery process.  
It is clear from our consultations that targets to improve housing stability have the support of the broader mental health sector. |
| 5. Reduce rates of completed suicide among at risk groups by 25% with four years. | 5a. Rates of attempted suicide *(CONGO, MHCA, NMHCCF)*  
5b. Rates of use of suicide prevention services *(CONGO)*  
5c. Rates of follow up of people who have had a mental health emergency *(MHCA, CONGO)*  
5d. Rates of mental health assessment and screening in primary care settings *(CONGO)* | There was a high level of consensus around the need to reduce both the numbers and rates of attempted and completed suicides in Australia.  
Frustration was expressed at the long delays in the collection of suicide data and reporting on it and the capacity of the sector to respond beyond emerging crises.  
The lack of follow-up post attempts is an area that stakeholders raised as important at a range of consultation forums including the CONGO.  
This is reflected in the indicators in column 2. |
<table>
<thead>
<tr>
<th>Target</th>
<th>Related indicator(s)</th>
<th>MHCA Analysis of Consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Within the next four years, all services that work with people who</td>
<td>6a. Size and qualifications of the peer workforce <em>(NMHCCF, MHCA, CONGO)</em></td>
<td>There was a high level of consensus that increasing the size and qualifications of the peer workforce is vital to ensuring that service outcomes align with consumer and carer expectations. Consumers and carers strongly advocated the need for consumers and carers to be involved in the design of service delivery and planning processes. However, there was no firm agreement about the most appropriate way to measure improvement particularly within clinical and community settings.</td>
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<tr>
<td>have a mental health issue (including Centrelink) have a peer</td>
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<td>workforce strategy. Within the next ten years, all services that work</td>
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<td>with people who have a mental health issue have 20% - 40% of</td>
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<td>workforce as peers, or have implemented a strategy to provide access</td>
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<td>to peers.</td>
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<tr>
<td>7. Comparative increase in national wellbeing, as measured by either</td>
<td>7a. Population awareness of mental health issues <em>(CONGO, NMHCCF)</em></td>
<td>The indicators developed are illustrative of the key focus in all of our consultations on the importance of mental health promotion, early intervention, prevention and the importance of a positive environment to recovery. There was much discussion at the CONGO about the importance and political appeal of setting a target to be ranked in the top 5 OECD nations.</td>
</tr>
<tr>
<td>the OECD wellbeing index, or the Australian National Development</td>
<td>7b. Levels of stigma in the broader community <em>(NMHCCF, MHCA, CONGO)</em></td>
<td></td>
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<tr>
<td>index, within the next four years to be better than New Zealand,</td>
<td>7c. Levels of connectedness with family, friends, culture and community, with</td>
<td></td>
</tr>
<tr>
<td>and within the next ten years to be in the top 5 in the OECD.</td>
<td>reference to parenting support, loneliness and access to support in crisis <em>(CONGO, NMHCCF)</em></td>
<td></td>
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<tr>
<td>7d. Workplace take-up of mental health strategies, including training</td>
<td>7e. Mental health literacy in the broader workforce <em>(MHCA)</em></td>
<td></td>
</tr>
<tr>
<td><em>(CONGO &amp; MHCA)</em></td>
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</tr>
<tr>
<td>Target</td>
<td>Related indicator(s)</td>
<td>MHCA Analysis of Consensus</td>
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<tr>
<td>8. Eliminate all instances of seclusion and physical and chemical restraint in mental health and justice settings</td>
<td>8a. Reporting of seclusion and restraint by every jurisdiction</td>
<td>This is a critically important issue for consumers and carers and the Mental Health sector broadly.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consumer and carer representatives identified the need to set clear targets for ending instances of chemical, emotional and physical restraint and seclusion in all care and support settings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>At the MHCA State and Territory workshops there was widespread agreement about the need to adopt targets for progressively reducing ‘inappropriate’ use of restraint and seclusion with a view to working towards ending the practices.</td>
</tr>
<tr>
<td></td>
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<td>This was challenged by some clinicians who felt that there were some circumstances in which chemical restraint was unavoidable in order to ensure patient and staff safety during acute episodes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regardless, there was strong support for mandatory, consistent reporting on all instances of emotional, physical and chemical restraint and seclusion in both clinical and community settings in every jurisdiction and for setting targets to progressively reduce such practices.</td>
</tr>
<tr>
<td>9. Growth in national spending on community based mental health services exceeds growth in the national health budget</td>
<td>All stakeholder groups agreed on the need for greater government investment in mental health and in particular, increased investment in community based mental health services.</td>
<td></td>
</tr>
<tr>
<td>Target</td>
<td>Related indicator(s)</td>
<td>MHCA Analysis of Consensus</td>
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<tr>
<td>10. Halve the proportion of people with a mental health diagnosis in the criminal justice system and increase the proportion of these people who receive ongoing voluntary treatment within 10 years</td>
<td></td>
<td>There was lively debate about the broader issue of mental illness in forensic settings and interactions with the criminal justice system by people with mental illness as victims of crime, alleged perpetrators and prisoners. Consumer and carer representatives expressed concern about further stigmatisation by limiting the forensic focus purely to rates of involvement in the prison system. Stakeholders also highlighted the issue of people living with mental illness being more likely to be victims of crime than the general population. Nonetheless there was a strong desire for people living with mental illness who are in the corrections system (prisons and juvenile justice) to receive treatment for mental illness voluntarily. The issue of involuntary treatment including the use of restraint and seclusion within forensic systems was also a concern raised both at the NMHCCF and in the State and Territory consultations.</td>
</tr>
<tr>
<td>11. No clear target</td>
<td>11a. Experiences of discrimination against people with mental illness in the general population and among health professionals (NMHCCF)</td>
<td>There was a strong desire on the part of consumers and carers for this indicator to be adopted.</td>
</tr>
<tr>
<td>Target</td>
<td>Related indicator(s)</td>
<td>MHCA Analysis of Consensus</td>
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<tr>
<td>12. No clear target</td>
<td>12a. People experiencing mental illness and their carers report ‘having a voice’ and being able to participate in community life and social activities as desired (MHCA &amp; NMHCCF)</td>
<td>This is a critical issue for consumers and carers and by extension the MHCA. Many stakeholders the need to acknowledge that consumers and carers are best placed to self-assess what is an appropriate level of community participation and social inclusion.</td>
</tr>
<tr>
<td>13. No clear target</td>
<td>13a. Prevalence rates for each mental illness (MHCA)</td>
<td>There is disagreement about whether governments should hope that prevalence rates of specific mental illnesses (as a result of prevention measures) or rise (as a result of increased awareness and help-seeking behaviours).</td>
</tr>
</tbody>
</table>

- **Appendix B - Background paper for the consultation workshops**

**Consultation on national indicators and targets for mental health**

Thank you for participating in the Mental Health Council of Australia’s consultations. 2013 is a federal election year, so it’s more important than ever that mental health is high on the policy agenda. Your feedback is critical to ensuring that the MHCA understands the priorities of consumers, carers, workers and service providers, and that we can convey these to policy-makers at the national level.

One of the key agenda items for today’s workshop is a discussion about what aspirational and achievable national indicators and targets should be used to guide mental health reform over the long term. The MHCA is collecting your feedback in partnership with the National Mental Health Commission, which will develop recommendations about indicators and targets for COAG’s consideration.

We understand that you may not have expertise in data or performance indicators. That’s completely fine – we won’t be asking you for technical information. Instead, we want to know your views about what areas Australia should report on and measure that will show – from a whole of life perspective – whether the lives of people and families affected by mental health difficulties are getting better. For example, what things are most important to you and your recovery? What in your experience has worked or made the biggest difference?

**Why are we talking about targets and indicators now?**

In November 2012, ‘A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention was released. The Report Card is the first of its kind to take a national, ‘whole of life’ approach that was built on the personal perspectives of people with a lived experience of mental health issues, their families and supporters.
In December, an open letter to the Council of Australian Governments (COAG) was co-signed by 70 leading non-government organisations across Australia, urging governments to develop effective targets and indicators to guide Australia’s mental health response. The open letter was based in part on priority areas identified at the CONGO meeting in October.

On 7 December 2012 COAG welcomed the release of the Report Card, reaffirmed its commitment to mental health reform and released the *Roadmap for National Mental Health Reform 2012-2022*.

Of particular note was COAG’s announcement of two new consultative structures to achieve the aspirations of COAG for ongoing mental health reform, including the development of national indicators and targets. This announcement reflected the call in the 2012 Report Card for COAG to agree on the right indicators and targets at the national level that will bind all governments to work co-operatively and drive results.

This work will be oversighted by a Working Group on Mental Health Reform, which is a national high level, inter-jurisdictional, cross-portfolio body tasked with ensuring that mental health reform remains a priority across governments. An Expert Reference Group (ERG) will provide advice to the Working Group on the most appropriate set of national, whole-of-life, outcome-based indicators and targets for mental health. Importantly, the ERG has been established to provide advice that reflects a broader community perspective, especially taking into account the views of those with lived experience of mental health issues, their families and support people.

The time is now right for the non-government mental health and social services sectors to take advantage of these new consultative mechanisms, and to play a leading role in the development of appropriate and meaningful indicators and targets.

The MHCA is working in partnership with the Commission to gather the views of consumers, carers and NGOs on the most appropriate mix of indicators and targets. The MHCA and the Commission are particularly concerned that government deliberations regarding indicators and targets are made with the input of non-government stakeholders, including consumers, carers, health professionals, community workers and service providers.

**The rationale for good indicators and targets in mental health**

Accessible and reliable indicators provide a powerful way of communicating the collective experiences of mental health consumers and carers and for conveying the state of the ‘mental health system’. The right set of national indicators and targets, which are reported regularly, will provide a clear picture to the community of how we are doing as a nation to support people and families affected by mental health problems. They will also provide a way to hold governments at state and federal levels accountable for progress.

In order to maintain a broad focus on all aspects of the lived experience of mental illness – not just on clinical issues – indicators should reflect the Commission’s ‘contributing life’ approach and focus on different issues including (but not limited to) education, employment, support networks, a safe and quality home, and social connectedness.

Indicators should focus on outcomes rather than inputs. Organisations currently collect a lot of activity data around mental illness and it is tempting to use this data as the basis for indicators. However, much existing data focuses on inputs and does not tell us whether those inputs are helping people with mental illness lead a ‘contributing life’.
Targets set for each indicator should stretch Australian governments to achieve mental health reform. This may require multiple short term targets that fit together to achieve longer term targets (such as, for example, halving rates of suicide over the course of a decade).

To tell the whole story about mental health and mental illness, indicators might reflect how mental health reform affects outcomes at the level of the individual, at the program and service level, and at the national level. For example, indicators might cover the following:

- **Individual level**: e.g. Meaningful employment, progress towards recovery, experiences of stigma and discrimination
- **Program and service level**: e.g. Timely access to services, Respectful and healing service environment, Consumer satisfaction with services
- **National level**: e.g. workforce participation rates, life expectancy, community awareness of signs and symptoms

Please note that these are examples, and you might have different ideas about what kinds of indicators would best reflect whether governments and service providers are making a difference in the lives of people affected by mental illness. We would love to hear about these ideas in today’s discussion.

**Next steps**

As well as taking part in today’s consultation, we would be grateful if you could complete a short survey. Please give your completed survey to someone from the MHCA. If you don’t have a survey form to complete, just ask for one. The MHCA and Commission will use your responses and insights to guide our thinking about which areas need to be covered through a comprehensive set of indicators and targets.

In addition to workshops in each state and territory (including today’s session), the MHCA and the Commission are convening two special workshops in May: one with consumers and carers and one with members of Council of Non-Government Organisations on Mental Health (CONGO). Your feedback today will inform discussions at these later events.

If you have any questions or would like to talk to someone at the MHCA about these issues, please contact Josh Fear on (02) 6285 3100 or at josh.fear@mhca.org.au.

**APPENDIX C – Survey questionnaire for State and Territory workshops**

**Survey on national indicators and targets for mental health**

The Mental Health Council of Australia and the National Mental Health Commission would value your input into our consultations on national targets and indicators for mental health. We would be grateful if you could fill out this short survey and give it to a staff member from the MHCA before you leave today.

Further details about why these consultations are taking place can be found in a background paper prepared by the MHCA. If you would like a copy of the background paper, or if you have any questions or comments about targets and indicators, please contact Josh Fear on (02) 6285 0812 or at josh.fear@mhca.org.au.
About you...

Are you a...?

☐ Mental health consumer  
☐ Mental health carer  
☐ Policy officer/manager  
☐ Frontline worker/clinician  
☐ Other (please specify)

__________________________________________

__________________________________________

__________________________________________

__________________________________________

Organisation (if applicable) (optional)

__________________________________________

Your thoughts on targets and indicators...

Q1. In your view, what kinds of indicators would best help us to determine **whether the lives of people affected by mental illness are getting better**?

__________________________________________

__________________________________________

__________________________________________

Q2. In your view, what kinds of indicators would best help us to determine **whether programs and services are making a positive difference for people affected by mental illness**?

__________________________________________

__________________________________________

__________________________________________

Q3. In your view, what kinds of indicators would best help us to determine **whether we are succeeding at a national level in meeting the needs of people affected by mental illness**?

__________________________________________

__________________________________________

__________________________________________

Q4. Are there **any other areas or domains** that you think it is important to collect information on?

__________________________________________

__________________________________________

__________________________________________

Are you happy for us to contact you at a later date to discuss your feedback?

☐ Prefer not  
☐ Yes (please provide contact details)

Name *(optional)*

________________________________________________________________________

Contact details *(optional)*

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Q5. What do you think will be the most important characteristic that will determine whether indicators are useful when advocating for mental health reform? (Please tick one box)

- Understandable to a range of people
- Evidence-based link to outcomes
- Based on quality data
- Political acceptability
- Specificity/broadness
- Link to recovery principles
- Other (please specify)

Q6. Are there any national targets that you hope governments will adopt to drive mental health reform?

________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

Some possible outcome areas for indicators...

Q7. In the list below, please tick up to 5 areas that you think are most important in indicating whether the lives of people affected by mental illness are getting better.

- Meaningful employment
- Progress towards recovery
- Experiences of stigma and discrimination
- Social participation
- Self-assessed wellbeing
- Physical health
- Participation in education
- Economic participation
- Having a stable and safe home
- Independence
- Ability to self-manage illness
- Co-morbidity
- Social/family support networks
- Connections to culture
- Any other area (please specify)

Q8. In the list below, please tick up to 5 areas that you think are most important in indicating whether programs and services are making a positive difference for people affected by mental illness.

- Timely access to services
- Respectful and healing service environment
- Consumer satisfaction with services
- Carer satisfaction with services
- Experiences of stigma in a service context
- Focus on at-risk populations
- Focus on early intervention
- Focus on recovery
- Inclusion of families and carers in decision-making
- Responsiveness to consumers’ choice of service
- Access by consumers and carers to disability support
- Access by carers to carer support and respite
- Access by consumers and carers to the welfare system
- Access by consumers to housing
- Geographical coverage of services
- Appropriate referral and discharge
- Other (please specify)
Q9. In the list below, please **tick up to 5 areas** that you think are most important in indicating **whether we are succeeding at a national level** in meeting the needs of people affected by mental illness

- [ ] Workforce participation rates for mental health consumers
- [ ] Workforce participation rates for mental health carers
- [ ] Life expectancy
- [ ] Community awareness of signs and symptoms
- [ ] Supportive workplace practices
- [ ] Rates of homelessness
- [ ] Rates of suicide and self-harm
- [ ] Coverage of mental illness in the NDIS
- [ ] Community attitudes towards mental illness
- [ ] Other (please specify)

Q10. Do you have **any ideas for specific indicators**, based on the areas or domains mentioned above?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Q11. Are you aware of **any data** (collected within or outside your organisation) that might contribute to national indicators and targets?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Thank you for taking the time to complete the survey.**
### Appendix D - MHCA Proposed Interim Candidate Indicators for the CONGO Workshop

The matrix of possible targets and indicators that the MHCA presented to CONGO delegates

Matrix 1: Possible domains, targets and indicators

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Possible Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health</td>
<td>Morbidity and mortality rates due to cardiovascular disease and metabolic syndrome among people with severe and persistent mental illness</td>
<td>Increase the life-expectancy of people living with severe and persistent mental illness by 10 years by 2017 and equal to the Australian population by 2023.</td>
</tr>
<tr>
<td>Feeling safe, stable and secure – seclusion &amp; restraint</td>
<td>Instances of seclusion and (physical and chemical) restraint in clinical mental health, community, aged care and forensic settings, with mandatory reporting by all services</td>
<td>Reduce instances of chemical and physical restraint by 50% by 2017 with a view to eliminating these by 2023.</td>
</tr>
<tr>
<td>Suicide prevention and reduction</td>
<td>Rates of completed and attempted suicide</td>
<td>The rates of completed and attempted suicide are reduced by 20% by 2017 and by 50% by 2023.</td>
</tr>
<tr>
<td>Something meaningful to do, something to look forward to - Participation</td>
<td>Proportion of people with a diagnosed mental illness who are not involved in employment, education or training (for those of working age) and rates of non-participation in community activities (for all ages)</td>
<td>The proportion of people experiencing moderate-severe mental illness who are engaged in education, employment and training increases by 20% by 2017 and 50% by 2023.</td>
</tr>
<tr>
<td>Connections with family, friends, culture and</td>
<td>Levels of stigma and discrimination against people</td>
<td>People experiencing mental illness report a 20%</td>
</tr>
<tr>
<td>community - <strong>Stigma</strong></td>
<td>with mental illness in the general population and among health professionals</td>
<td>reduction in experiences of discrimination/stigma by 2017 and 50% by 2023.</td>
</tr>
<tr>
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<tr>
<td>Feeling safe, stable and secure (housing stability) - <strong>Housing</strong></td>
<td>Proportion of people with severe and persistent mental illness who do not have access to safe, secure and lasting accommodation, including people currently in hospital</td>
<td>The proportion of people achieving affordable, safe and sustainable housing increases by 10% by 2017 and 50% by 2023.</td>
</tr>
<tr>
<td>Ensuring effective support, care and treatment (supporting recovery through after-care) – <strong>Discharge planning</strong></td>
<td>Rates of 7- and 28- and 180-day post-discharge follow-up by clinical mental health, community mental health, homelessness and forensic services, with mandatory reporting by all services</td>
<td>Through mandatory surveying, the proportion of people who report post-discharge follow-up at these intervals increases by 20% by 2017 and 50% by 2023.</td>
</tr>
<tr>
<td>Feeling safe, stable and secure - <strong>Forensic</strong></td>
<td>Rates of mental illness and rates of mandatory/voluntary treatment in the criminal justice system</td>
<td>The proportion of people with a mental health diagnosis in the criminal justice system is halved by 2023. Of those in correctional facilities, the proportion receiving treatment increases by 50% by 2017.</td>
</tr>
<tr>
<td>Ensuring effective support, care and treatment (recovery) – <strong>Consumer/carer involvement in design and delivery</strong></td>
<td>Availability of and access to recovery-oriented services which are designed, delivered and/or evaluated by consumers and carers</td>
<td>70% of services document and implement their recovery oriented consumer/carer driven support framework by 2017 and all by 2023.</td>
</tr>
<tr>
<td>Ensuring effective support, care and treatment – <strong>Government spending</strong></td>
<td>Proportion of national health budget spent on community-based mental health services</td>
<td>The proportion of the national health budget spent on community based mental health services increases by 10% by 2017 and 50% by 2023 (over inflation).</td>
</tr>
<tr>
<td>Other - <strong>Peer workforce</strong></td>
<td>Numbers of employed peer workers with peer worker qualifications</td>
<td>All states and territories adopt a target for the proportion of the mental health workforce that will be consumers/carers by 2017 (in consultation with the NMHCCF).</td>
</tr>
<tr>
<td>Ensuring effective support, care and treatment - <strong>Consumer satisfaction</strong></td>
<td>Consumers’ satisfaction with clinical and community mental health services</td>
<td>All States and Territories implement reporting mechanisms for consumer satisfaction by 2017. Through these mechanisms, consumer satisfaction increases by 50% by 2023.</td>
</tr>
</tbody>
</table>
Ensuring effective support care and treatment - Carer satisfaction

| Carers’ satisfaction with services & supports for themselves & consumers | All States and Territories implement reporting mechanisms for carer satisfaction by 2017. Through these mechanisms, carer satisfaction increases by 50% by 2023. |

- Appendix E - Discussion Paper Targets & Indicators Nous Group

Please refer to e-mail attachment three, the Discussion Paper on Targets and Indicators prepared for the MHCA CONGO meeting by the Nous consulting group.