Australian Government
Department of Health

New National Key Performance Indicator (nKPI) for primary health care – mental health

Consultation paper

Introduction

The Clinical and Technical Working Group for the Aboriginal and Torres Strait Islander Health Services Data Advisory Group (HS DAG) met on 18 May 2021 to consider the feasibility of a new nKPI for mental health.

The Working Group discussed applicable clinical considerations as well as the technical feasibility of implementing the indicator.

A number of options were considered by the Working Group and these are outlined in the *New nKPI Briefing Paper – mental health* (Attachment A). The options relate to the following broad considerations:

1. Viability of the indicator
2. Definition of mental health condition
3. Age range to include in the indicator
4. Review period for GP Mental Health Treatment Plan Review

Working Group Recommendations

The Working Group did not support consideration of a social and emotional wellbeing nKPI at this time.

The proposed mental health nKPI is based on the GP Mental Health Treatment Plan (MHTP). The Working Group recommended that further consultation with the health sector be undertaken to determine whether implementation of this indicator would be acceptable to health services.

The Working Group acknowledged that:

- mental health is an issue of high importance for Aboriginal and Torres Strait Islander people
- health services may not use MHTPs if onward referral services are not available in their area/region
- MHTPs provide an important pathway of care into Medicare-supported services such as psychology services
- MHTPs provide access to evidence-based treatment such as psychology services but there is a lack of evidence to confirm the efficacy of MHTPs in themselves for improving health outcomes
- the indicator would be useful to understand the proportion of clients who do not have a MHTP in place, as well as those whose MHTP has not been reviewed

- measuring completion of MHTPs could result in a focus on completion rather than quality
- there may be stigma associated with having a MHTP recorded in a clinical system and in a person's Medicare record, leading to reluctance from clients as well as clinicians to use this Medicare item
- if this indicator is acceptable to health services, it would be a good addition to the nKPI collection
- no other viable options are currently available for a mental health nKPI when taking into consideration the criteria for new nKPIs, which must:
    - relate to conditions that are routinely screened/checked for in primary healthcare
    - be routinely recorded in clinical information systems
    - be easily extractable from clinical information systems
    - align with current clinical best practice guidelines
    - not create additional reporting burden for health services.

Attachments

A. New nKPI Briefing Paper – mental health

B. New indicator template – mental health

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New nKPI – mental health (Attachment A)

This indicator is proposed as one indicator with two parts:

Part A. Proportion of Indigenous regular clients living with a mental health condition who have a GP Mental Health Treatment Plan.

Part B. Proportion of Indigenous regular clients living with a mental health condition who had their GP Mental Health Treatment Plan reviewed.

This process of care indicator is proposed as per the *AIHW's draft template for a mental health nKPI:*

Part A: GP Mental Health Treatment Plans

Numerator: Number of Indigenous regular clients with an active, mental health condition who had a GP Mental Health Treatment Plan (GP MHTP) claimed (as indicated by relevant VR/non-VR MBS items[1]). Categories defined as:

- no GP MHTP recorded
- GP MHTP recorded < 6 months prior to census date[2]
- GP MHTP recorded 6 to <12 months prior to census date[2]
- GP MHTP recorded 12 to < 24 months prior to census date[2]
- GP MHTP recorded >=24 months prior to census date[2].

Denominator: Number of Indigenous regular clients with an active mental health condition.

Part B: Review of GP Mental Health Treatment Plans

Option 1: Include all those with a GP MHTP 6 months or more prior to census date

Numerator: Proportion of regular Indigenous clients with an active, mental health condition and with a GP Mental Health Plan claimed 6 months or more prior to the census date[2] who have had at least one Review of the Plan.

Categories defined as:

- Documented Review of the GP MHTP
- No documented Review of the GP MHTP.

Denominator: Number of Indigenous regular clients with an active mental health condition who had a GP Mental Health Treatment Plan claimed (as indicated by relevant VR/non-VR MBS items[1]) 6 months or more prior to the census date[2].

Option 2: Include all those with a GP MHTP 12 months or more prior to census date

Numerator: Proportion of regular Indigenous clients with an active, mental health condition and with a GP Mental Health Plan claimed 12 months or more prior to the census date[2] who have had at least one Review of the Plan.

Categories defined as:

- Documented Review of the GP MHTP
- No documented Review of the GP MHTP.

Denominator: Number of Indigenous regular clients with an active mental health condition who had a GP Mental Health Treatment Plan claimed (as indicated by relevant VR/non-VR MBS items[1]) 12 months or more prior to the census date[2].

[1.] These include both face-to-face and non-face-to-face item numbers as well as VR/non-VR GP items
[2.] nKPI data collection census date.

Note. Option 1 would follow the recommendations by looking at whether Reviews had happened for those whose GP MHTP was completed six months prior to the census date, but would have no leeway. Option 2 would exclude those with more recent plans, but would allow a broader timeframe for the review to have occurred. Source: Draft indicator template (AIHW).

1. Rationale

An estimated 31% of Aboriginal and Torres Strait Islander adults reported high or very high levels of psychological distress in 2018–19, a rate which was 2.3 times that of non-Indigenous Australians. Nearly one quarter (24%) reported a mental health or behavioural condition, with anxiety the most commonly reported mental health condition (17%), followed by depression (13%). Indigenous Australians are also more likely to be hospitalised for mental and behavioural conditions and have higher rates of suicide.

Source: Australian Bureau of Statistics (ABS) 2019 National Aboriginal and Torres Strait Islander Health Survey (here) and *Aboriginal and Torres Strait Islander Health Performance Framework (here).*

There was widespread support in the Australian Institute of Health and Welfare's (AIHW) review of the National Key Performance Indicators (nKPIs) and Online Services Report (OSR) published in 2020, for a mental health or social and emotional wellbeing (SEWB) indicator. 76% of respondents said there was value in a national mental health or SEWB indicator.

After assessing the literature, potential data availability, previous work, and the *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people* (the National Guide), published by the National Aboriginal Community Controlled Health Organisation (NACCHO), and the Royal Australian College of General Practitioners (RACGP), two main options were identified by the AIHW for potential inclusion in the nKPIs; an indicator focusing on SEWB screening for young people and/or an indicator focusing on GP Mental Health Treatment Plans, and associated reviews, for those with a diagnosed mental health condition.

The Department is currently funding development of culturally validated SEWB / mental health measures. This includes the Australian Bureau of Statistics to undertake initial analysis to inform the development of a national Aboriginal and Torres Strait Islander Mental Health Survey. In recognition of the protective and strengthening impact that practising culture directly has on health, mental health and social and emotional wellbeing, the Department is working the Mayi Kuwayu Study team, led by Associate Professor Ray Lovett, to determine cultural wellbeing measures for the refreshed National Aboriginal & Torres Strait Islander Health Plan (Health Plan). This will include analysing the measures and providing the results for reporting over a three-year period.

There is currently only one jurisdiction, New South Wales (NSW) Ministry of Health, that collects a mental health indicator, and none that collect a SEWB indicator. The NSW Aboriginal mental health KPIs are collected under the Aboriginal Health Program Key Performance Indicators (here). The indicators are currently being updated and the *revised* information is not publicly available. The two indicators are outlined below.

Indigenous Australians living with a mental health condition may benefit from a structured, culturally appropriate approach to managing their condition. GP Mental Health Treatment Plans and regular reviews support a partnership approach between patients and clinicians for identifying and accessing appropriate services.

Measuring the proportion of clients living with a mental health condition who have a regularly reviewed Mental Health Treatment Plan in place will provide important information on coverage and access to services, as well as whether plans are kept up to date.

Source: AIHW - New Indicator template GP Mental Health Treatment Plan, section B Importance.

2. Analysis

Mental health and the SEWB of Indigenous individuals and communities are intertwined and hard to quantify for data capture.

Finding standalone, singular indicators which can be used within primary care to improve service delivery and outcomes for Indigenous clients has been challenging, particularly as there is no single clinical assessment tool which is recommended for all clients.

The proposed nKPI focuses on one aspect of care for those living with a mental health condition - the uptake of mental health treatment plans, and the review of these plans. This indicator can be viewed as an initial step while a future, more thorough and robust, SEWB indicator is developed.

Evidence Base

The National Mental Health Plan 2003–08 noted that mental health is an area where 'diverse views exist and ... terms are used in different ways.' The term 'social and emotional wellbeing' is often inaccurately considered synonymous with 'mental health'. SEWB implies a holistic, strengths-based approach, and is distinguished from a disease-oriented medical model (refer to box 1 below).

Box 1. Concepts of social and emotional wellbeing[2]

'In broad terms, social and emotional wellbeing is the foundation for physical and mental health for Aboriginal and Torres Strait Islander peoples. It is a holistic concept which results from a network of relationships between individuals, family, kin and community. It also recognises the importance of connection to land, culture, spirituality and ancestry, and how these interact and affect the individual.

Social and emotional wellbeing may change across the life course: what is important to a child's social and emotional wellbeing may be quite different to what is important to an Elder. However, across the life course a positive sense of social and emotional wellbeing is essential for Aboriginal and Torres Strait Islander people to lead successful and fulfilling lives.'

The *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people, 3rd-edition* (The National Guide Evidence Base, *here*), describes SEWB as a key component of the Aboriginal definition of health. It includes concepts of connection to country, kin and community and is applicable across the whole lifecycle. However, much of the research in this area is performed in settings outside Aboriginal and Torres Strait Islander communities, without Indigenous ownership, and is grounded within a more Western, individualistic, medical model of health. As such, inclusion criteria and outcomes are determined by Western-centric diagnostic categories, such as those in the Diagnostic and Statistical Manual of mental disorders, 5th edition (DSM-5, here), and do not incorporate Indigenous perspectives. There is increasing evidence that symptoms associated with depression are differently expressed across various cultures and by gender.

The following information is sourced through the *Aboriginal and Torres Strait Islander Health Performance Framework - summary report 2020- 1.18 Social and emotional wellbeing (the Health Performance Framework, here).*

Depression is recognised to be a major health and wellbeing issue in Aboriginal and Torres Strait Islander communities. *The National Aboriginal and Torres Strait Islander Health Survey* (the Health Survey) of 2018–19 showed that 31% of Indigenous Australians aged 18 and over reported high/very high levels of psychological distress.

Indigenous adults were 2.4 times as likely as non-Indigenous adults to experience high levels of psychological distress in 2018–19 (31% compared with 13%). Indigenous females were more likely than Indigenous males to report high levels of psychological distress (35% compared with 26%).

Indigenous adults reporting high levels of psychological distress were more likely to:

- have lower income (44% compared with 18% of those with high income),
- be unemployed (42% compared with 22% for those who were employed),
- smoke (38% compared with 27% for non-smokers),
- have a disability (46% compared with 18% for those with no disability),
- have three or more long term health conditions (42% compared with 15% for those with no long term health conditions).

The 2014–15 National Aboriginal and Torres Strait Islander Social Survey showed that 68% of Indigenous Australians aged 15 and over had experienced one or more stressors in the last 12 months. The most reported stressors for Indigenous Australians were death of a family member or close friend (28%), inability to get a job (19%), serious illness (12%) and mental illness (10%).

In the 2018–19 Health Survey, 24% (187,500) of Indigenous Australians aged 18 years and over reported having a current, diagnosed long-term mental health condition (ABS 2019). The most commonly reported mental health conditions for Indigenous adults were depression or feeling depressed (78%), anxiety or feeling anxious or nervous (78%), behavioural or emotional problems (30%) and harmful use of drugs or alcohol.

In 2010–15, around 11% of all problems managed by general practitioners (GP) for Indigenous patients were mental health-related. Depression was the leading mental health problem managed by GPs for Indigenous and Other Australians (both 2.9% of all problems).

Indigenous Australians were hospitalised for mental health-related conditions (not including intentional self-harm) at 1.8 times the rate for non-Indigenous Australians. The most common mental health-related conditions leading to hospitalisation for Indigenous Australians were psychoactive substance use (40%), schizophrenia (23%), mood disorders (13%) and neurotic, stress-related disorders (12%). Between July 2015 and June 2017, 1.1% of all hospitalisations of Indigenous Australians were due to intentional self-harm.

In 2014–2018, Indigenous deaths from intentional self-harm (suicide) were reported at a rate of 24 per 100,000 deaths. Suicide accounted for approximately 5% of Indigenous deaths. Indigenous males accounted for 74% of suicides in the Indigenous population, this was similar to the rate for non-Indigenous males (76%). After adjusting for differences in the age structure between the two populations, the suicide rate for Indigenous Australians was 1.9 times the rate for non-Indigenous Australians. In 2018, the suicide rates for Indigenous Australians were highest for those aged 35–39, lower than the rate for non-Indigenous Australians aged 45–49.

The high prevalence of these stressors in adults also has effects on children. The 2005 *Western Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal children and young people* (the WA Survey, here) found that 70% of children were living in families that had experienced three or more significant life events in the previous 12 months. The WA survey also found 22% of Aboriginal children aged 4–17 years were living in families where 7 or more major life stress events had occurred over the preceding 12 months and that 38.9% of these children were at high risk of clinically significant emotional or behavioural difficulties compared to 13.9% in families that had experienced none, one or two stressful events.

Conversely, cultural, and social factors can have a profound protective effect on Aboriginal and Torres Strait Islander people's social and emotional wellbeing. Continuing connection to country and culture are, for example, protective, as are increasing income, increased level of education and participation in the labour force.

Fifth National Mental Health and Suicide Prevention Plan

The Department of Health's *Fifth National Mental Health and Suicide Prevention Plan: Implementation Plan*, 2017, (the Fifth Plan, here) commits to a nationally agreed set of priority areas and actions, that are designed to achieve an integrated mental health system and that will be used to build a stronger, more transparent, accountable, efficient and effective mental health system. The Fifth Plan sets out to achieve outcomes in eight priority areas that align with specific aims and policy directions in the National Mental Health Policy. This plan is the first to specifically outline an agreed set of actions to address social and emotional wellbeing, mental illness and suicide amongst Aboriginal and Torres Strait Islander people as a priority, under 'Priority 4, Improving Aboriginal and Torres Strait Islander mental health and suicide prevention'.

Statistics and evidence presented in the Fifth Plan align with the summary provided above. In addition the Fifth Plan highlights mental illness and substance use disorders are estimated to comprise 14 per cent of the overall health gap and 29 per cent of the health gap for 15–44 year-olds. The high rates of chronic disease experienced by Aboriginal and Torres Strait Islander people mean that many people are likely to experience coexisting physical and emotional health problems. Despite having greater need, Aboriginal and Torres Strait Islander people have lower than expected access to mental health services and professionals. In 2012–2013, the most common Closing the Gap service deficits reported by Aboriginal Community Controlled Health Services (ACCHSs) related to mental health and SEWB services.

The commitments in the Fifth Plan aim to result in better mental health and wellbeing for Aboriginal and Torres Strait Islander people, including reduced rates of psychological distress, drug use in people with mental health conditions, and suicide. In addition, wherever possible, all mental health indicators will be analysed and reported to show rates for Aboriginal and Torres Strait Islander people and to identify gaps in access, quality or outcomes when compared with other Australians.

Links to each state and territory's plan and commitments are on page 50 of the Fifth Plan (here).

Most recent data on SEWB and mental health for Indigenous Australians

The 2018–19 Health Survey collected information on a range of topics including those relevant to Indigenous social and emotional wellbeing. Respondents to the survey indicated that connection to country and culture were important:

- 66% identified with a tribal/language group or clan
- 74% recognised an area as homeland/traditional country
- 92% were proud of their culture/being and Indigenous Australian.

Similar results regarding country and culture were found in the 2014–15 *National Aboriginal and Torres Strait Islander Social Survey* (NATSISS, in AIHW 2018). Other responses highlighted the importance of family to Indigenous wellbeing.

National Agreement on Closing the Gap

SEWB has specifically been included in the refreshed *National Agreement on Closing the Gap* (the National Agreement, here) which was developed in partnership between Australian governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations in July 2020. Outcome 14 of the agreement is that Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing, with the associated target a significant and sustained reduction in suicide of Indigenous Australians towards zero.

The RACGP/NACCHO National Guide

The National Guide (here) focuses on depression and suicide. It recommends a risk-based approach to screening for depression as part of an annual health assessment. Screening for suicide prevention is not routinely recommended. Refer to boxes on next page for detail.

Recommendations: Prevention of depression			
Preventive intervention type	**Who is at risk?**	**What should be done?**	**How often?**
Screening	All people aged ≥15 years	Universal screening for depression is not recommended. Identify those people in whom the risk of depression is greater (Box 1)	As part of annual health assessment
	People in whom depression risk is greater (Box 1)	For those with a higher risk of depression, ask about symptoms of depression. Consider using one of the 'social and emotional wellbeing' or mental health assessment tools to guide the conversation. Options include the Kessler Psychological Distress Scale (K-5) (Box 2), the Here and Now Aboriginal Assessment (HANAA) tool, the Patient Health Questionnaire 9 (PHQ-9), PHQ-9 adapted (Box 3), and the PHQ-2 (refer to 'Resources')	

Box 1. People in whom depression risk is greater[24]

- Exposure to adverse psychosocial events, such as unemployment, divorce or poverty
- A previous history of depression or suicide attempts
- A history of physical or sexual abuse
- A history of substance misuse
- Presence of other chronic diseases, including chronic pain
- Multiple presentations to health services may also be an indicator of depression

Factors that make it more likely that depression will be missed include:

- Limited consultation time
- Presentations of mostly physical or atypical symptoms
- Health professional attitudes – for example, the belief that nothing can be done, or that depression is a normal response to stress
- Communication difficulties

Recommendations: Prevention of suicide			
Preventive intervention type	**Who is at risk?**	**What should be done?**	**How often?**
Screening	All people	Screening for suicide risk is not routinely recommended	
	People with any one of the following: • past history of intentional self-harm • history of mood disorders and other mental health problems • hazardous alcohol consumption or misuse of other drugs • close to someone who has recently died by suicide (postvention)	Consider asking about past and current suicidal ideation and intent as part of a comprehensive medical history (Box 4)	Opportunistic

The SEWB Framework

The *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023* (the SEWB framework, here), is one of the most comprehensive Indigenous mental health frameworks in Australia. The SEWB framework draws its

guiding principles from the 1995 *Ways Forward* report (here) and the original 2004 SEWB Framework, which emphasises the holistic and whole-of-life definition of health held by Indigenous Australians. The nine principles are:

1. Indigenous health is viewed in a holistic context, that encompasses mental health and physical, cultural and spiritual health. Land is central to wellbeing. Crucially, it must be understood that when the harmony of these interrelations is disrupted, ill health will persist.
2. Self-determination is central to the provision of health services.
3. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of health problems generally, and mental health problems, in particular.
4. It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continues to have inter-generational effects.
5. The human rights of Indigenous Australians must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health. Human rights relevant to mental illness must be specifically addressed.
6. Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Indigenous Australians' mental health and wellbeing.
7. The centrality of family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.
8. There is no single culture or group, but numerous groupings, languages, kinships, and tribes, as well as ways of living. Furthermore, Indigenous Australians may currently live in urban, rural or remote settings, in traditional or other lifestyles, and frequently move between these ways of living.
9. It must be recognised that Indigenous Australians have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.

Challenges related to measuring SEWB

There have been multiple previous attempts at developing a SEWB measure suitable for this population:

- The AIHW workshop in 2003 on a SEWB module for inclusion in the 2004-05 National Aboriginal and Torres Strait Islander Health Survey.
- Dr Ray Lovett's review of available SEWB related measures for consideration as a SEWB nKPI in 2016.
- The work of the SEWB Clinical Working Group under the Health Services Data Advisory Group (HS DAG) in considering the development of a SEWB nKPI in 2017.

The most recent attempt at SEWB nKPI development, by the HS DAG Clinical Working Group in 2017, again found it challenging to balance conflicting considerations in developing recommendations for a SEWB nKPI. In particular, there was no single screening tool that captured all aspects of SEWB as defined in the SEWB Framework, was validated for Aboriginal and Torres Strait Islander populations and appropriate for clinical use with all clients. As noted in the national guide, clinicians should select the tool that's most appropriate for each situation.

HS DAG noted at their August 2018 meeting, that a SEWB measure developed and validated specifically for the Aboriginal and Torres Strait Islander population does not exist yet. SEWB is a highly complex area, where the risk of using an imperfect measure is greater than the benefit from implementing one. The Health Performance Framework, Medicare Benefits Schedule data, and OSR data include measures related to SEWB, and these can be used to monitor SEWB among Indigenous people until a more specific and appropriate measure of SEWB is available. The SEWB module has since been removed from the OSR and national policy for SEWB sits with the National Indigenous Australians' Agency whose relevant programs include data collection.

Instruments used to assess social and emotional wellbeing

A number of instruments can be used to assess the psychological distress affecting Aboriginal and Torres Strait Islander people. Most have been used to assess non-Indigenous populations and may not adequately cover Indigenous concepts of social and emotional wellbeing. This lack of validation of these tools for use with Aboriginal and Torres Strait Islander Australians means their widespread use is not recommended. To quote the Australian Psychological Association, 'Particular caution should be exercised where tests have not been extensively tried with Indigenous people and where test norms for those Indigenous populations are non-existent'. Moreover, Aboriginal and Torres Strait Islander communities are very diverse, and use of any instrument will require clinical discretion to account for this diversity.

One of the most widely used tools in Australia for monitoring and assessing psychological distress is the Kessler Psychological Distress Scale (K-10). This tool has not been validated as a screening tool for depression. Moreover, there are concerns from Aboriginal and Torres Strait Islander people that the K-10 is not culturally appropriate for use within their communities. For this reason, the K-10 was adapted, in an ABS stakeholder workshop, which included representatives from NACCHO, to make it more appropriate for use in Aboriginal and Torres Strait Islander communities. The resulting reduced questionnaire has only five questions and is known as the K-5, which has been culturally validated for use in Aboriginal and Torres Strait Islander communities.

Other non-Indigenous questionnaires have been adapted for use with Aboriginal and Torres Strait Islander people:

The Pearlin Mastery Scale

Adapted for use in Arnhem Land with extensive involvement of the Yolgnu community.

Patient Health Questionnaire 9 (PHQ-9)

Brown and colleagues adapted the PHQ-9, involving the expertise of focus groups of men from primary language groups in central Australia. Given that the PHQ-9 is one of the most validated tools for screening for depression, this adaptation may prove to be very useful once it has been further validated.

Additional tools developed specifically by and for Aboriginal and Torres Strait Islander people that take a strengths-based approach to assessing wellbeing:

The Growth and Empowerment Measure (GEM)

GEM takes a positive wellbeing perspective and includes concepts of connectedness to family and cultural identity. It is currently the only tool to include these.

The Here and Now Aboriginal Assessment (HANAA)

HANAA takes the form of a yarning circle, promoting a conversation in a range of areas relating to social and emotional wellbeing, rather than a series of rated questions. It takes a broad approach to SEWB but is still oriented toward mental health diagnosis and treatment in mental health settings. The tool has been designed for use by those working in health and mental health services and community-based services.

A recent study of users of the HANAA demonstrated positive experiences of the tool, especially the semi-structured, narrative style of administration and simple rating system. The HANAA assessment domains showed a high level of utility and cultural applicability. Users recommended to include a domain addressing personality and to develop a child and adolescent version.

The National Guide evidence base suggests that these tools require further validation.

Source: The National Guide Evidence Base (here).

SEWB related measures from the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention website (here) and other mental health researchers:

What Matters (WM) 2 Adults Wellbeing Measure

What Matters is a research project that is developing a tool to measure wellbeing for Aboriginal and Torres Strait Islander people. The lead researchers are Professor Gail Garvey of the Menzies School of Health Research and Professor Kirsten Howard of the University of Sydney and it is a 5-year NHMRC funded project running from 2017-21. The aim is to develop a nationally relevant tool to measure the wellbeing of Aboriginal and Torres Strait Islander adults. Over 1000 people have participated to date. When complete, this will be a multidimensional measure of wellbeing validated for use with Aboriginal and Torres Strait Islander population groups.

Aboriginal Resilience and Recovery Questionnaire (ARRQ)

ARRQ was developed by Dr. Graham Gee, an Aboriginal psychologist at the Victorian Aboriginal Health Service (VAHS) in 2016. It includes 60 items designed to assess a range of personal, relationship, community and cultural strengths, as well as resources associated with resilience, healing and recovery from trauma. Dr Gee found that among Aboriginal help-seeking clients, many of the strengths from the ARRQ were correlated with greater empowerment and healing, lower drug and alcohol use, and lower posttraumatic stress and depression related symptoms of distress. Dr Gee and VAHS also recently evaluated two community-designed programs and found that the ARRQ was able to detect significant changes in strengths and resilience among both male and female participants.

Aboriginal and Islander Mental Health Initiative (AIMhi) NT

AIMhi was conducted by the Menzies School of Health Research and the Remote Alcohol and Other Drugs Workforce Program with Aboriginal people to address complex needs. It has developed resources including mental health assessment and brief wellbeing screening tools, and training to support a culturally adapted strengths-based approach to assessment and early intervention. These are used in mental health, alcohol and other drug and chronic disease settings.

Strong Souls: SEWB Assessment Tool

Strong Souls is a 25-item screening and research tool of SEWB, specifically problems related to depression, anxiety, suicide risk and levels of resilience. There is also an 8-item version.

The tool has been used and validated in an Aboriginal Birth Cohort Study, research in substance misuse rehabilitation, and prison settings. Factor analysis of the 25-item version found support for a 4-factor model which demonstrated sound construct validity and reliability. Factor structure was consistent with the epidemiological literature, identifying constructs of anxiety, resilience, depression and suicide risk. While these align with observations in mainstream populations, different relationships between distinct factors and differences in symptomatology were found in this population. For example, two key findings were: feelings of sadness and low mood were linked with anxiety and not depression; and the expression of anger was verified as a unique symptom of depression for Indigenous people. Strong Souls demonstrated validity, reliability and cultural appropriateness as a tool for screening for SEWB among Indigenous young people in the Northern Territory.

Strong Souls is currently recommended only for research or screening purposes as the tool has not yet been validated in a clinical setting and there are currently no guidelines or manual available for its use or scoring.

Words for Feeling Map

The Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women’s Council has developed a culturally sensitive guide to help Aboriginal children and young people talk about mental health. The Words for Feelings Map depicts characters experiencing a range of adverse feelings and links English and Aboriginal words to express them. It has been developed in both Ngaanyatjarra and Pitjantjatjara languages. This guide is intended to encourage children and young people to talk about their feelings and seek help when they need to. The Words for Feelings Map is an illustrated poster that is designed to help people find the right words to express different feelings and is available for a fee.

Risks posed by COVID-19 on SEWB and mental health

The COVID-19 pandemic has posed, and continues to pose, a high risk to Indigenous Australians' physical and social and emotional wellbeing. The Mental Health and Wellbeing Pandemic Response Plan identifies many of the potential concerns Indigenous Australians have, and may continue, to face.

Some of the concerns included:

- Lack of accessible, culturally appropriate and culturally safe mental health services
- Challenges faced by the Indigenous Australian allied health workforce, including those living with high-risk individuals
- Inequalities within the health system that may affect access to care, particularly in the move to digital and telehealth
- Potential loss of access to care with border closures (such as loss of fly in fly out mental health related care services).
- Implications of the restrictions on freedom of movement for cultural practices and connectedness.

To address these concerns, the response plan reinforces the importance of Indigenous leadership in decision-making about mental health supports.

Existing indicators

NSW have two mental health Aboriginal KPIs (here). Although not yet publicly available, the revised draft indicators have been provided by NSW Health. They have indicated they are keen to align with any future nKPI.

Note. NSW KPI 9a was previously *KPI 26: GP Mental Health Plan;* NSW KPI 9b was previously *KPI 27: GP Mental Health Plan Review*.

NSW KPI 9a Mental Health – GP Mental Health Treatment Plan	
Short Name	GP Mental Health Treatment Plan
Description	Proportion of regular Aboriginal Clients with an identified mental illness/es who have had a GP Mental Health Treatment Plan (MBS Item 2700, 92112, 92124, 2701, 92113, 92125, 2715, 92116, 92128, 2717, 92117 or 92129) claimed within the previous 24 months
Measure Type	Percentage
Numerator	The number of regular Aboriginal Clients with a diagnosis matching the mental illness definition, with a GP Mental Health Treatment Plan (MBS Item 2700, 92112, 92124, 2701, 92113, 92125, 2715, 92116, 92128, 2717, 92117 or 92129) claimed within the previous 24 months
Denominator	The number of regular Aboriginal Clients with a diagnosis matching the mental illness definition in the previous 24 months
Disaggregation	None.

NSW KPI 9b Mental Health – GP Mental Health Treatment Plan Review	
Short Name	GP Mental Health Treatment Plan Review
Description	Proportion of regular Aboriginal Clients with an identified mental illness/es who have had a GP Mental Health Treatment Plan (MBS Item 2700, 92112, 92124, 2701, 92113, 92125, 2715, 92116, 92128, 2717, 92117 or 92129) claimed within the previous 24 months, but not in the last 12 months, where a review (MBS Item 2712, 92114, 92126) has been conducted
Measure Type	Percentage
Numerator	The number of regular Aboriginal Clients with a diagnosis matching the mental illness definition, with a GP Mental Health Treatment Plan (MBS Item 2700, 92112, 92124, 2701, 92113, 92125, 2715, 92116, 92128, 2717, 92117 **OR** 92129) claimed - within the previous 24 months, AND - not within the previous 12 months, Where reviews (MBS Item 2712, 92114, 92126) were claimed after the GP Mental Health Plan (MBS Item 2700, 92112, 92124, 2701, 92113, 92125, 2715, 92116, 92128, 2717, 92117 or 92129) was claimed.
Denominator	The number of regular Aboriginal Clients with a diagnosis matching the mental illness definition, with a GP Mental Health Plan (MBS Item 2700, 92112, 92124, 2701, 92113, 92125, 2715, 92116, 92128, 2717, 92117 or 92129)) claimed - within the previous 24 months, AND - not within the previous 12 months.
Disaggregation	*None.*

A measure of client engagement

Through external specialist consultation to contribute to this paper, an alternate measure for ‘clients that did not attend’ was raised as a potential indication of client engagement with the health service. For example, the number/proportion of clients who did not attend, attended and where this data was not complete/not available.

As this measure doesn’t directly address the desire for a mental health or SEWB indicator it is unlikely to be a viable option for an nKPI.

3. Clinical considerations

An nKPI that is focussed on SEWB is preferable but is much more complex. Identifying appropriate measures has proved challenging. A mental health indicator is proposed as an interim indicator until such time as a SEWB indicator can be agreed, developed and is measurable.

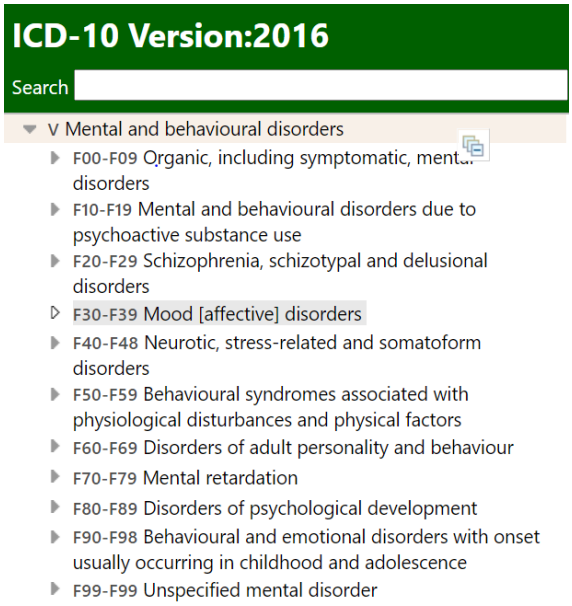
To report against the proposed mental health indicator the following are required:

Definition of mental health condition

MBS definition

In the MBS, mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (more information here). MBS references the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: International Classification of Diseases, 10th revision (ICD-10) Chapter V Primary Care Version (here) for further information. Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of the GP Mental Health Treatment items.

ICD-10 Version:2016 chapter 5 categories are listed in the image below:



Mental health skills training definition

General Practice Mental Health Standards Collaboration's (GPMHSC) Mental Health Skills Training defines the mental illnesses applicable under Better Access (here) as:

Acute psychotic disorders	Enuresis
Adjustment illness	Generalised anxiety
Alcohol-use disorders	Hyperkinetic (attention deficit) illness
Bereavement disorders	Mental illness, not otherwise specified
Bipolar illness	Mixed anxiety and depression
Chronic psychotic disorders	Neurasthenia
Conduct illness	Panic illness
Depression	Phobic disorders
Dissociative (conversion) illness	Sexual disorders
Drug-use disorders	Sleep problems
Eating disorders	Unexplained somatic complaints

Mental illnesses not applicable under Better Access are Dementia, Delirium, Mental retardation, Tobacco-use illness, unless presentation with mental illness comorbidity.

GPMHSC refers to ICD-10 for up-to-date information.

None of the CIS (Best Practice, Communicare, Medical Director, MMEx) use ICD-10.

NSW Health definition

The NSW Aboriginal KPIs have moved away from categorising mental health conditions as high-impact mental illness and low-impact mental illness and now specify inclusion by International Classification of Primary Care, 2nd Edition (ICPC-2) plus codes.

Not all CIS use ICPC-2 plus so some translation would be required by vendors. Based on the work to date on the nKPI Condition Coding Framework the inclusion of whole ICPC-2 plus codes may be too broad and potentially over inclusive. This may be the reason NSW Health have cited differences between CIS. NSW Health have expressed an interest to align their definition with a future mental health nKPI, if one is supported.

Rigorously defined mental health in a condition coding framework to a lower level than specified by NSW Health would minimise disparity between vendors due to misinterpretation, under or over inclusion.

CIS capability

Each of the CIS use different coding terminologies, some are proprietary, and most are tailored to primary health care, eg, Docle, Pyefinch and ICPC-2 plus. MMEx uses a different inclusion methodology by including relevant plans with nKPI tags in their specifications. As a result, the range of coding options will differ by CIS. This level of specification is defined in the new nKPI Condition Coding Framework, which includes conditions relevant to existing nKPIs.

To ensure consistency across vendors and to align with the approach for the existing nKPIs, the mental health cohort may best be defined by including mental health in the nKPI Condition Coding Framework using the same methodology and rigour as was applied for existing conditions. Consideration will need to be given to the scope of the indicator, claiming rules/existing definitions as well as inclusion and exclusion of specific terms.

Mental health subgroups are a well utilised way of defining the inclusion criteria for a diagnosed mental health condition appropriate for this indicator. Sample subgroups already utilised by primary health care data programs include: depression and anxiety, schizophrenia and bipolar, ADHA, autism, dementia, obsessive compulsive disorder, post-traumatic stress disorder, phobias, panic disorders, post-natal depression and others.

Based on other primary health care datasets, and to give a sense of the volume of terms to consider, for each subgroup of depression and anxiety there are approximately 25-30 terms. Noting these are only coded terms because free text conditions are not included in the nKPI Condition Coding Framework.

Active condition

A current condition is primarily referred to as an active condition. In most cases this equates to a condition/diagnosis that is marked as active in the CIS. Not all CIS have this capability. It is common practice for primary care data programs to determine when use of an active condition is appropriate and when it's not.

Medical Director and Best Practice both have capability enabling a condition to be marked as either active or inactive. This is a simple process and the status can be changed as needed, for example when a patient's depression has been treated and no longer considered a current condition.

Communicare doesn't have an active / inactive condition flag but has an equivalent method. When entering a condition/diagnosis, the CIS user chooses whether to add the condition to the 'Active Problem/ Significant History' by selecting the 'Display on Main Summary' checkbox. This can be checked and unchecked as the condition status changes over time, just like the active/inactive example above.

Communicare also has an optional 'episode' dropdown that allows the clinician to further define the diagnosis as a 'First', 'Ongoing' or 'New' diagnosis where there are previous diagnoses. It was created for sites that wanted to add a diagnosis as a 'reason for encounter'. Not many sites use this and Communicare do not recommend this utility for the nKPIs.

MMEx condition coding is managed differently. This relies on the user selecting a current relevant plan marked with an nKPI tag. Plans can be marked as inactive. Some consultation with MMEx would be essential to ensure accurate interpretation. This could then be documented in the clinical coding framework as per other conditions.

Confidential conditions

Conditions can be marked as 'confidential' in CIS in some CIS (Best Practice and Medical Director). This feature was introduced primarily to support the My Health Record (MyHR) ie, a condition flagged as confidential is not shared with the MyHR. Communicare and MMEx have different systems.

It may be worth considering, for a sensitive topic such as mental health, whether it is appropriate to include a confidential condition in nKPI counting rules. Should this be perceived as sensitive and worthy of exclusion this could be defined in the condition specifications of the nKPI Condition Coding Framework.

A note about diagnosis date

This detail is included to address any considerations of recent diagnosis in part sparked by some ambiguity in the NSW Aboriginal mental health KPI. Although recency of diagnosis is not a requirement in the NSW Aboriginal mental health KPI, the denominator definition (as listed above on page 10) has caused some confusion.

Reporting against a mental health condition diagnosed within a specific period of time is challenging in some CIS. There are known existing issues in CIS regarding the reliability of the recorded date matching the actual diagnosis date; this is a known data limitation. For example, the clinician may become aware of a pre-existing diagnosis but when this is entered into some CIS the default date stamp relates to the date of data entry, ie, the date they are made aware, rather than the diagnosis date. The clinician may choose to include the date of diagnosis where known but anecdotally this doesn't always happen.

Recent diagnosis is NOT a requirement in the proposed nKPI and is NOT a requirement for relevant MBS items. Instead, for the reasons outlined here, a current/active diagnosis is proposed.

Relevant MBS items

The MBS defines the GP Mental Health Treatment item services for which Medicare rebates are payable where GPs undertake early intervention, assessment, and management of patients with mental disorders. They include referral pathways for treatment by psychiatrists, clinical psychologists and other allied mental health workers.

The GP Mental Health Treatment items incorporate a model for best practice primary health treatment of patients with mental disorders, including patients with both chronic or non-chronic disorders, that comprises:

- assess and plan
- provide and/or refer for appropriate treatment and services
- review and ongoing management as required.

All consultations conducted as part of the GP Mental Health Treatment items must be rendered by the GP. A specialist mental health nurse, other allied health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health treatment where the GP considers that they have skills appropriate to the assistance required.

All GPs can access the GP Mental Health Treatment items. GPs that have completed the Mental Health Skills Training can access the higher schedule fee items 2715 or 2717 (information for GPs from the GPMHSC, here). Those that haven't access MBS items 2700 or 2701.

The term 'GP' is used as a generic reference to general practitioners able to claim these items. This term is also used in the explanatory notes for equivalent medical practitioner item numbers.

Other medical practitioners (OMP) providing GP Mental Health Treatment Plans have access to Medical Practitioner Mental Health Treatment items, ie, for non-VR practitioners. Medical practitioners that have completed mental health skills training can access items 281 and 282, those that haven't access items 272 and 276. MBS items for both GPs and medical practitioners (excluding specialists or consultant physicians) are included below.

MBS Item Note AN.0.56 (here) and AN.7.22 (here) confirm requirements are similar across both GP and medical practitioner item numbers. Item numbers for the GP Mental Health Treatment Plan and Review that follow are from MBS Group A20 - GP Mental Health Treatment, Subgroup1 - GP Mental Health Treatment Plans and Group A7 - Acupuncture and Non-Specialist Practitioner Items, Subgroup 9 - Non-Specialist Practitioner mental health care.

GP Mental Health Treatment Plan

MBS Items 2700, 2701, 2715, 2717, 272*, 276*, 281* and 282*:

Professional attendance by a general practitioner (including a general practitioner who has not undertaken mental health skills training) or a medical practitioner (who has undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP Mental Health Treatment Plan for a patient.

Review of a GP Mental Health Treatment Plan

MBS Items 2712 and 277*:

Professional attendance by a general practitioner or medical practitioner to review a GP Mental Health Treatment Plan which he or she, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan.

**Items relating to attendances rendered by a medical practitioner who is not a general practitioner, specialist or consultant physician.*

Temporary items

Group A40 - COVID-19 services

- Subgroup 20 - COVID-19 GP Mental Health Treatment Plan – Phone Service
- Subgroup 19 - COVID-19 GP Mental Health Treatment Plan – Telehealth Service

Temporary MBS items were introduced in response to the COVID-19 pandemic to accommodate services provided by telehealth or phone attendance.

From time to time the list of relevant MBS items may change to accommodate new items that are considered to appropriately reflect preparation of a Chronic Disease Management Plan. Where such new items are identified, the Department will seek advice from the HS DAG as to whether they are suitable for immediate inclusion in this indicator. Once confirmed as suitable, software providers and health services will be notified.

GP Mental Health Treatment Plan – temporary items

MBS Items: 92124, 92125, 92128, 92129 *AND* 92130*, 92131*, 92134*, 92135*

MBS Items: 92112, 92113, 92116, 92117 AND 92118*, 92119*, 92122*, 92123*

Phone attendance/telehealth services, by a general practitioner who has OR has not undertaken mental health skills training (and not including a specialist or consultant physician), of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP Mental Health Treatment Plan for a patient.

Note. It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 here for the definition of 'patient's usual medical practitioner' as some exemptions do apply).

Review of a GP Mental Health Treatment Plan – temporary items

MBS Items: 92114, 92126 AND 92120*, 92132*:

Phone attendance/telehealth services by a general practitioner to review a GP Mental Health Treatment Plan which the general practitioner, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan.

Note. It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply).

**Items relating to attendances rendered by a medical practitioner who is not a general practitioner, specialist, or consultant physician.*

Co-claiming mental health treatment plan items with CDM items

Inclusion of CDM items should not be required to capture patients with co-morbidity.

MBS Item Note *AN.0.56 GP Mental Health Treatment Items (Items 2700 to 2717)* here confirms that GP Mental Health Treatment items can be claimed WITH chronic disease management (CDM) items. Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a GP Management Plan (GPMP), and to manage their mental health condition through a GP Mental Health Treatment Plan. In this case, or where a patient has a mental health condition as well as significant co-morbidities and complex needs requiring team-based care, the GP is able to use both the CDM items (for team-based care) AND the GP Mental Health Treatment items.

The Department's *GP Mental Health Treatment Medicare Items, Frequently Asked Questions* (here) guide provides further interpretive information for healthcare providers.

Summary of relevant MBS Items		
Item type	**Practitioner type**	**MBS Items**
GP Mental Health Treatment Plan	GP – not mental health (MH) skills trained	2700, 2701
	GP – MH skills trained	2715, 2717
	Other Medical practitioner (OMP) – not MH skills trained	272, 276
	OMP – MH skills trained	281, 282
GP Mental Health Treatment Plan Review	GP	2712
	OMP	277
Temporary items - telehealth: GP Mental Health Treatment Plan	GP – not MH skills trained	92112, 92113
	GP – MH skills trained	92116, 92117
	OMP – not MH skills trained	92118, 92119
	OMP – MH skills trained	92122, 92123
Temporary items - telehealth: GP Mental Health Treatment Plan Review	GP	92114
	OMP	92120
Temporary items - phone: GP Mental Health Treatment Plan	GP – not MH skills trained	92124, 92125
	GP – MH skills trained	92128, 92129
	OMP – not MH skills trained	92130, 92131
	OMP – MH skills trained	92134, 92135
Temporary items – phone: GP Mental Health Treatment Plan Review	GP	92126
	OMP	92132

Definition of a GP Mental Health Treatment Plan / Review

Completion of a GP Mental Health Treatment Plan and review of a GP Mental Health Treatment Plan are most reliably captured through health services claims for the relevant MBS item numbers (as outlined above).

Where a healthcare practitioner undertakes preparation of a GP Mental Health Treatment Plan but does not make an MBS claim (for preparation of a GP Mental Health Treatment Plan), this may be considered an 'equivalent GP Mental Health Treatment Plan'.

Similar to the approach outlined in the review of nKPI PI07 *Proportion of regular clients with a chronic disease for whom a GP Management Plan was claimed (MBS Item 721),* preparation of an 'equivalent' GP Mental Health Treatment Plan / Review could be identified from the details recorded in the CIS. However, there is no 'standard' method across CISs for capturing preparation of a GP Mental Health Treatment Plan / Review other than via MBS item numbers. For example, the CISs may use terminology relating to the GP Mental Health Treatment Plan / Review in the reason for encounter/visit, system codes (Communicare) and forms (particularly in MMEx) that could identify an 'equivalent' GP Mental Health Treatment Plan / Review. Acceptable criteria would need to be determined with each vendor based on their system capability.

Preparation of an 'equivalent' GP Mental Health Treatment Plan / Review doesn't equate to a confirmed MBS item claim but may be considered as an appropriate measure for this indicator, particularly in health services where an MBS item was not claimed or claiming the MBS item is not possible or where the GP Mental Health Treatment Plan / Review was completed in a non-face-to-face consult.

Limitations for a GP Mental Health Treatment Plan / Review indicator are similar to that of nKPI PI07, ie, not everyone with a diagnosed condition may want a GP Mental Health Treatment Plan and completion of some plans may not be possible because of a lack of services to refer clients to. It's possible that patients with chronic conditions and mental health may have their mental health managed under a GPMP and not under a separate GP Mental Health Treatment Plan. The continued support of telehealth items that began during the pandemic may increase access to and the availability of services. The indicator only measures what was done/reviewed - there is no way to capture what services were used or the impact on the client.

Age range inclusion

The National Guide SEWB recommendations are that all young people aged 12-24 years should be screened at least annually.

Recommendations: Social emotional wellbeing

Preventive intervention type	Who is at risk?	What should be done?	How often?	Level/ strength of evidence
Screening	All young people aged 12–24 years	Conduct a Social Emotional Wellbeing (SEW) assessment using a strengths-based approach, to obtain a holistic assessment of health and to determine risk factors affecting wellbeing Useful tools include a table of adolescent development stages (Appendix 1); the HEEADSSS assessment tool (Appendix 2); and the Aboriginal and Torres Strait Islander Youth SEW assessment (modified HEEADSSS; Appendix 3a) with its question guide (Appendix 3b)	Opportunistic and as part of an annual health check	GPP

The National Guide recommends screening starts at age 15 for clients at risk of depression.

The NSW Aboriginal KPIs start age is poorly articulated and appears to start at 15 years of age (as per vendor technical specifications). Detailed specifications are not publicly available and to date have not been supplied. Given this indicator is going through review this may change. NSW Health have yet to confirm the revised age.

There is no minimum age specified by Medicare for eligibility for a GP Mental Health Treatment Plan. The proposed mental health indicator follows this advice with age categories starting at <=14 years.

Disaggregation, for the agreed indicator age range, should where possible align with the age bands as per the majority of nKPIs.

Other considerations

Cultural acceptance of an indicator reporting uptake of plans and reviews for patients with diagnosed mental illness should be carefully considered through the consultation phase.

4. Technical feasibility

Implementation of a SEWB indicator

Implementing a SEWB indicator will be technically difficult and perhaps even impossible until SEWB measures are clearly defined, agreed and validated.

If consensus was agreed to use an existing assessment tool, for example K-5, and the agreed tool was already built into/integrated within the CIS, it would be technically straightforward to measure utility of the assessment tool. As this consensus has not been reached and no single clinical assessment tool is recommended for all clients this is not an option. Any future agreed SEWB assessment tool will need to be built into and integrated with the CIS before utility could be measured.

At this stage proceeding with a SEWB indicator is not feasible without further consultation, agreement and development.

Implementation of a mental health indicator

Implementation of the mental health indicator as proposed:

Mental health condition coding

- Adding mental health to the nKPI Condition Coding Framework will be complex to define but is straightforward.

  Given the interest from other programs such as NSW Health, consideration could be given to a multi-jurisdictional group could be convened to align across indicator sets.

Active conditions

- Defining the active and inactive condition by vendor is reasonably straightforward and could be documented in the nKPI Condition Coding Framework. Some clarification with MMEx to specify acceptance criteria may be warranted.

Defining the GP Mental Health Treatment Plan / Review

- Measuring by defined MBS items is straightforward.
- Defining the equivalent GP Mental Health Treatment Plan / Review in the CIS in absence of MBS items will require consideration of CIS capability and variation across vendor. This is reasonably straightforward.

Age range

- Age ranges are straightforward to apply.

5. Options

The following table outlines considerations and options.

Note. Multiple options could be implemented in number 3.

	Consideration *Select one or more*	Options	Implications/ Pros and Cons *Discussion points*
1	**Viability of indicator**	a) Implement mental health indicator as proposed until a SEWB indicator has been developed, is measurable and therefore more viable. OR b) Do not implement mental health at this time, wait until SEWB is more feasible.	SEWB is not currently sufficiently developed to be measurable and may be some time away given existing challenges to agree measures. Desire for an indicator is high. Is something now better than nothing? Is a mental health indicator acceptable to community? Funding for two indicators (ie both SEWB and mental health) may not be realistic. If mental health is implemented may be hard to retire. Would a future SEWB indicator need to replace a mental health indicator?
If 1a is selected, the following considerations/options are also relevant:			
2	**Definition of a mental health condition** ***(and an active condition)***	a) Include mental health in the nKPI Condition Coding Framework. *Note. This should include definition of active condition. Consideration of confidential condition inclusion also suggested.* OR b) Allow vendors to implement their best interpretation and accept CIS variation and/or possible errors. *Note. This is not acceptable to the Department.*	CIS terminology differs. Existing examples of significant variation across vendors. Clear definitions avoid implementation variation across CIS and provides consistency of data and interpretation. Including mental health in the coding framework ensures consistent approach for all conditions.
3	**Definition of a GP Mental Health Treatment Plan / Review**	a) Inclusion of GP Mental Health Treatment Plan / Review MBS items for GPs and OMP (as above). b) Inclusion of related temporary Covid-19 items for both telehealth and phone	How inclusive should this be? Consistency with other indicators, ie, to include temporary MBS items.

		consult for both GP and OMP (as above). c) Inclusion of equivalent GP Mental Health Treatment Plan / Review, ie, where no MBS item is claimed	
4	**Age range**	a) Age <= 14 as per the AIHW indicator template. OR b) Age 15+ as per the National Guide.	Which age range is most relevant for a National indicator? Are there any cultural sensitivities in younger age groups? Consistency with other indicators that align with the National Guide
5	**GP Mental Health Treatment Plan Review – review period**	For Part B of the proposed indicator: a) Include Option 1 b) Include Option 2	

6. Recommendation

The following actions are recommended based on the clinical feedback, and evidence base:

a) Implement mental health indicator, until such time as SEWB is more measurable and revisit at that time, Option 1a.

Note. If 1b is selected the following recommendations are no longer applicable.

b) Define mental health conditions via addition of mental health to the nKPI Condition Coding Framework, Option 2a, and include definition of an active condition.

c) Include GP Mental Health Treatment Plan / Review MBS items, Option 3a, and the temporary Covid-19 items, Option 3b as per the summary table.

Note. When nKPI PI07 (Care Plans) was revised it was agreed that inclusion of temporary items may need to be modified at HS DAG discretion should additional temporary items be introduced. For consistency its suggested that acceptance of 3b should be managed in the same way.

d) To maintain consistency with Working Group decisions for nKPI PI07 (GPMPs), include the equivalent GP Mental Health Treatment Plan / Review (ie, where no MBS Item is claimed), Option 3c.

e) Implement age 15+ (align with the National Guide), Option 4b.

f) Working group to determine whether Part B of the proposed indicator is implemented with Option 1 and/or Option 2 as per page 1, (Options 5a and 5b in the options table).

g) Note data limitation outlined in the document above:

- Not everyone with a diagnosed condition may want a GP Mental Health Treatment Plan and
- Potential lack of services to refer clients to.

This report was funded by the Australian Government Department of Health. For further information please contact info@nps.org.au

June 2021

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Australian Government
Australian Institute of Health and Welfare

AIHW

Proposal template—new nKPI (Attachment B)

This template supports the process outlined in the *Indicator selection and maintenance framework for the nKPI collection* (the Framework). It is used to:

- submit a proposal to add a new indicator to the nKPIs
- record associated discussion and decisions in a consistent format
- enhance transparency around the decision-making process.

A description of each section of the template is provided in the table below, with further instructions provided in the template itself.

Section	Description
Submitter information	Captures the details of the submitting organisation. Completed by submitter.
A. Proposal indicator specification	Outlines the proposed indicator specifications. Completed by submitter.
B. Assessment against individual criteria	Records the submitter response to each review criteria and the committee's* assessment. Completed by submitter and the committee.
C. Committee* assessment and recommendations	Records a summary of the committee's* assessment along with their decision and any follow-up actions required.
D. Department of Health decision and follow-up actions	Records the decision made by the Department of Health and any follow-up actions required.
Appendix A: additional information	Records additional information to support the proposal, for example, evidence of any preliminary analyses/implementation/pre-testing. Completed by submitter.

**Note that initial consideration of the proposal is made by the Health Services Data Advisory Group (HSDAG). HSDAG may decide to convene the Specialist Working Group (SWG) to seek additional advice on the proposal. If the SWG is consulted, that should be noted in the template.*

To be completed by submitter

Submitter information	
Contact name	
Contact email	
Contact phone number	
Submitting committee/agency/organisation	Australian Government Department of Health

To be completed by submitter

Section A: Proposed indicator specifications	
Proposed indicator name	This indicator is proposed as one indicator with two parts: **Part A.** Proportion of Indigenous regular clients living with a mental health condition[1] who have a GP Mental Health Treatment Plan **Part B.** Proportion of Indigenous regular clients living with a mental health condition who had their GP Mental Health Treatment Plan reviewed
Type of indicator	☑ Process-of-care ☐ Health-outcome
Reason for proposed inclusion	An estimated 31% of Aboriginal and Torres Strait Islander adults reported high or very high levels of psychological distress in 2018–19, a rate which was 2.3 times that of non-Indigenous Australians. Nearly one quarter (24%) reported a mental health or behavioural condition, with anxiety the most commonly reported mental health condition (17%), followed by depression (13%).[2] Indigenous Australians are also more likely to be hospitalised for mental and behavioural conditions and have higher rates of suicide.[3] MBS-rebated GP Mental Health Treatment Plans (GP MHTPs) are designed to help ensure that those with a mental health condition have a documented and structured approach to accessing services that can assist them to manage their condition and improve recovery. The plans do not expire, but an initial review between four weeks and six months after the completion of the GP Mental Health Treatment Plan is recommended, and, if required, a further review at least three months after the first review can be conducted.[4]

[1] Mental health conditions are equivalent to mental disorders as per Medicare Guidelines: "*Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (Refer to the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version). Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of the GP Mental Health Treatment items*."

[2] ABS 2018–19 National Aboriginal and Torres Strait Islander Health Survey data reported in the AIHW's Australia's health 2020: Indigenous health and wellbeing.

[3] AIHW/NIAA. 2020. Section 1.18 Social and Emotional Wellbeing in the Aboriginal and Torres Strait Islander Health Performance Framework https://indigenoushpf.gov.au/measures/1-18-social-emotional-wellbeing

[4] MBS online—GP Mental Health Treatment Items (Items 2700 to 2717).

Section A: Proposed indicator specifications	
	The indicators would provide useful information on the uptake of the plans, whether reviews are being conducted, and help organisations identify gaps (noting that the plans are voluntary and can only be done in partnership with clients). At a higher level, it would support the priority area of Improving Aboriginal and Torres Strait Islander mental health in the Fifth National Mental Health and Suicide Prevention Plan and Outcome 14 (that Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing) of the National Agreement on Closing the Gap.
Rationale for indicator *Outline why the indicator is important. Include relevance to services and policy makers.*	Indigenous Australians living with a mental health condition may benefit from a structured, culturally appropriate approach to managing their condition. GP Mental Health Treatment Plans and regular reviews support a partnership approach between patients and clinicians for identifying and accessing appropriate services. Measuring the proportion of clients living with a mental health condition who have a regularly reviewed Mental Health Treatment Plan in place is a proxy for active management, and will provide important information on coverage and access to services, as well as on whether plans are kept up to date.
Proposed definition	This indicator is proposed as one indicator with two parts: **Part A.** Proportion of Indigenous regular clients living with an active mental health condition who have a GP Mental Health Treatment Plan. **Part B**. Proportion of Indigenous regular clients living with an active mental health condition who had their GP Mental Health Treatment Plan reviewed.
Proposed calculation *Include computation, and specify numerator and denominator.*	**Computation:** (Numerator ÷ Denominator) x 100 **Part A: GP Mental Health Treatment Plans** Numerator: Number of Indigenous regular clients with an active mental health condition who had a GP Mental Health Treatment Plan (GP MHTP) claimed (as indicated by relevant VR/non-VR MBS items)[5]. Categories defined as: • no GP MHTP recorded • GP MHTP recorded < 6 months prior to census date • GP MHTP recorded 6 to <12 months prior to census date • GP MHTP recorded 12 to < 24 months prior to census date • GP MHTP recorded >=24 months prior to census date Denominator: Number of Indigenous regular clients with an active mental health condition. **Part B: Review of GP Mental Health Treatment Plans**

[5] These include both face-to-face and non-face-to-face item numbers as well as VR/non-VR GP items.

Section A: Proposed indicator specifications	
	Option 1: ***Include all those with a GP MHTP 6 months or more prior to census date*** Numerator: Proportion of Indigenous regular clients with an active mental health condition and with a GP Mental Health Plan claimed 6 months or more prior to the census date who have had at least one Review of the Plan.[6] Categories defined as: • Documented Review of the GP MHTP • No documented Review of the GP MHTP Denominator: Number of Indigenous regular clients with an active mental health condition who had a GP Mental Health Treatment Plan claimed (as indicated by relevant VR/non-VR MBS items) 6 months or more prior to the census date. ***Option 2***: ***Include all those with a GP MHTP 12 months or more prior to census date*** Numerator: Proportion of Indigenous regular clients with an active mental health condition and with a GP Mental Health Plan claimed 12 months or more prior to the census date who have had at least one Review of the Plan. Categories defined as: • Documented Review of the GP MHTP • No documented Review of the GP MHTP Denominator: Number of Indigenous regular clients with an active mental health condition who had a GP Mental Health Treatment Plan claimed (as indicated by relevant VR/non-VR MBS items) 12 months or more prior to the census date. Note: Option 1 would follow the recommendations by looking at whether Reviews had happened for those whose GP MHTP was completed six months prior to the census date, but would have no leeway. Option 2 would exclude those with more recent plans, but would allow a broader timeframe for the review to have occurred.
Proposed disaggregation *Be specific, for example, if disaggregation is by age group specify the age groups.*	**1. Age group:** [Note: 5-year age groups are proposed, however there will need to be some testing to see if the numbers are large enough to support this or whether 10-year age groups may be necessary.] a) <= 14 b) 15–19 c) 20–24 d) 25–29 e) 30–39 f) 40–49

[6] It is recommended that GP Mental Health Treatment Plans be reviewed between 4 weeks or 6 months after completion or 3 months after the first review.

Section A: Proposed indicator specifications	
	g) 50–59 h) 60 and over. **2. Sex:** a) male b) female.

Submitter—*complete 'Submitter—response to criteria' ensuring to provide responses to all criteria.*

Committee facilitator—*complete 'Committee—record of discussion. Use the information provided by the submitter as a starting point and record the key points from the discussion, including if the submitter's assessment against the criterion is not agreed with. Record the assessment (not met at all, partially met, fully met) for the criterion and provide an explanation for the assessment. While separate questions may be included within each criterion, only an overall assessment for the criterion is required to be recorded.*

Section B. Assessment against individual criteria

Date discussed by committee: 18/05/2021

B1. Importance

Importance can be judged on a number of dimensions, including community priorities, gap between evidence and practice, relationship to morbidity and/or mortality, national priorities etc.

Criteria	Submitter—response to criteria	Committee—record of discussion
For process-of-care indicators—indicator captures an aspect of primary care delivery that is important for Aboriginal and Torres Strait Islander clients. ***For health-outcome indicators***—indicator captures a health status or level of risk that has important implications for the health and wellbeing of Aboriginal and Torres Strait Islander clients.	Strengths-based approaches to improving physical, mental, emotional and social health are core components of comprehensive and holistic primary care services among Indigenous-specific primary health care organisations. GP Mental Health Treatment Plans and their subsequent reviews provide clients who need them with input into setting their own goals and a pathway for accessing additional services to improve their well-being.	• The Working Group agreed that mental health is an important health issue amongst Aboriginal and Torres Strait Islander people. • The Working Group discussed the importance of mental health plans. It was noted that GP mental health plans provide an important pathway of care into MBS billed services, such as psychology services. • It was noted that there is limited evidence to show the efficacy of mental health plans in improving health outcomes for people with mental illness.

Committee—assessment of extent criterion met *Select one option only*	Assessment	Reason
	☐ Not met at all ☒ Partially met ☐ Fully met	**The Working Group noted that mental health is an important health issue, however there is limited evidence to suggest that mental health care plans are important in improvement mental health outcomes.**

B2. Acceptability		
Criteria	**Submitter—response to criteria**	**Committee—record of discussion**
Indicator is widely accepted	The proposed indicator is currently collected in the NSW Aboriginal Health KPIs for organisations receiving funding for mental health services. There was widespread support in the AIHW's *Review of the OSR and nKPI collections* (the AIHW review): 76% of survey respondents said there was value in a national mental health and/or SEWB indicator (16% did not know if there would be value and 8% said there would not be value in a national indicator).	The Working Group noted that some GPs and clients are opposed to mental health plans due to concerns about the way in which this information could be shared or used. For example, it was suggested that information from mental health plans may be used when accessing insurance policies.
Indicator and process of collecting is culturally safe	The data would be drawn from MBS-items within each CIS. The process is similar to that for PI07 in the current nKPI collection (GP Management Plans for those with a chronic disease).	• The Working Group discussed that mental health diagnoses and care plans often do not consider underlying factors which contribute to mental ill health for Aboriginal and Torres Strait Islander peoples, such as trauma. • The Working Group agreed that there is insufficient information to make a decision on the cultural safety and acceptability of the indicator. It was suggested that further consultation is required.
Collection of indicator is ethical	The denominator of Part A would identify the number of Indigenous regular clients with an active mental health condition. There would be no disaggregation by type of condition or any way of identifying individuals.	The Working Group noted that some health services are ethically and morally opposed to mental health plans due to concerns about the way in which this information is shared or used.
Health services are prepared to implement the indicator	There was support for a mental health/SEWB indicator in the AIHW Review (see above).	It was noted that some health services do not use mental health plans due to a lack of available onward referral services. It was noted that this is particularly prevalent in rural and remote jurisdictions where the availability of psychology and other mental health specific services is limited.
Inclusion in nKPIs provides more value than alternative sources of data	Using the national MBS data collection alone is problematic as the items are not Indigenous-specific, nor are they able to capture the population who would be eligible for the items.	The HS DAG Working Group did not specifically discuss this criterion.

<table>
<tr><th colspan="4">B2. Acceptability</th></tr>
<tr><th>Criteria</th><th>Submitter—response to criteria</th><th colspan="2">Committee—record of discussion</th></tr>
<tr><td>Describe why collecting in the nKPIs is better than collecting via another data source. Applies to where a similar, or related, indicator exists in another data collection, and to completely new measures.</td><td></td><td colspan="2"></td></tr>
<tr><td colspan="2" rowspan="2">Committee—assessment of extent criterion met
Select one option only</td><td>Assessment</td><td>Reason</td></tr>
<tr><td>☐ Not met at all
☐ Partially met
☐ Fully met</td><td>The HS DAG Working Group did not reach a consensus on whether the indicator meets the acceptability criterion. It was agreed that further consultation is needed with the sector.</td></tr>
</table>

B3. Evidence base		
Criteria	**Submitter—response to criteria**	**Committee—record of discussion**
Indicator is derived from a high quality evidence base *For example, it is based on clinical/best practice guidelines.* *Provide details on the strength of the evidence supporting the indicator—for example, NHMRC grading if available.*	According to the General Practice Mental Health Standards Collaboration (GPMHSC), the benefits of a GP MH Treatment Plans are that they: • provide a 'cycle of care' for people with a mental illness • provide a structured framework for GPs to undertake early intervention, assessment and management of patients with mental health disorders • assist with coordination of care and provides a referral pathway to clinical psychologists and allied mental health service providers • allow the GP to actively involve the patient and carer, where possible, in their care. Reviews of the plan were seen as essential for continuity of care and best outcomes.	• The Working Group discussed the evidence base for Part A: Proportion of Indigenous regular clients living with a mental health condition who have a GP Mental Health Treatment Plan. It was noted that there is limited evidence to show the efficacy of mental health care plans in improving health outcomes for people with mental illness. • The Working Group noted that mental health care plans can facilitate access to evidence-based treatment, such as psychology services. • The Working Group raised concerns about the availability of evidence-based services, such as psychologists, in remote jurisdictions. It was noted that there is no evidence for the health benefit of mental health plans if the plan does not facilitate access to an evidence-based service. • The Working Group discussed the evidence base for Part B: Proportion of Indigenous regular clients living with a mental health condition who had their GP Mental Health Treatment Plan reviewed. It was noted that there is a lack of evidence to support the review and follow up of mental health plans.
Indicator aligns with evidence base	Part A would focus on the preparation of the GP mental Health Treatment Plans and Part B would capture whether the plan has had a Review.	Please see response to "Indicator s derived from a high-quality evidence base" above.
There is limited variation in the evidence base *Describe any variation in the evidence base. For example, is variation uniform across Australia or is there regional variation which affects acceptability and appropriateness of indicator.*	The recommendations are national and apply across Australia.	The HS DAG Working Group did not specifically discuss this criterion.

B3. Evidence base			
Criteria	**Submitter—response to criteria**	**Committee—record of discussion**	
Committee—assessment of extent criterion met Select one option only		**Assessment** ☒ Not met at all ☐ Partially met ☐ Fully met	**Reason** **The HS DAG Working Group agreed that there is no evidence base which directly relates to the efficacy of mental health plans and their review in improving health outcomes for people with mental illness.**

B4. Actionable			
Criteria	**Submitter—response to criteria**	**Committee—record of discussion**	
For process-of-care indicators: • Results can be used to improve practice (that is, are actionable and within control of the organisation), which can contribute to improved health and wellbeing of clients in the future. ***For health-outcome indicators***: • The outcome itself (for example, the result) is amenable to change or improvement for individual clients. OR • Indicator provides information that the organisation can use for planning and resourcing purposes.	Organisations can use the indicators for CQI. Increasing the proportion of those eligible who have a plan and review should improve the wellbeing of clients with a diagnosed mental health condition.	• The Working Group agreed that the indicator is actionable when used as a process of care indicator. • It was noted that the indicator would be useful to understand the proportion of clients who do not have a mental health plan and those whose mental health plans have not been reviewed. • The Working Group raised concerns about data quality. It was noted that a diagnosis is not always recorded on a mental health plan. • The Working Group agreed that Part A: Proportion of Indigenous regular clients living with a mental health condition who have a GP Mental Health Treatment Plan is actionable. • The Working Group agreed that Part B: Proportion of Indigenous regular clients living with a mental health condition who had their GP Mental Health Treatment Plan reviewed is partially actionable.	
Committee—assessment of extent criterion met *Select one option only*		**Assessment** ☐ Not met at all ☒ Partially met	**Reason** • **The Working Group agreed that Part A: Proportion of Indigenous regular clients**

B4. Actionable			
Criteria	**Submitter—response to criteria**	**Committee—record of discussion**	
		☐ Fully met	**living with a mental health condition who have a GP Mental Health Treatment Plan is actionable.** • **The Working Group agreed that Part B: Proportion of Indigenous regular clients living with a mental health condition who had their GP Mental Health Treatment Plan reviewed is partially actionable.**

B5. Technical considerations and data quality		
Criteria	**Submitter—response to criteria**	**Committee—record of discussion**
Indicator has clearly defined counting and calculation rules *For example, numerator, denominator, exclusions.*	The counting rules are clear (see Section A). However, specifications may need to be updated whenever additional MBS items are added or deleted. [Note: equivalent plans are not included as clients will not be eligible for rebated services without the plan being claimed.]	The HS DAG Working Group did not specifically discuss this criterion.
Data are currently available in the right format to populate the indicator	MBS items are available in all 4 of the major CIS. However, NSW identified that there were differences in the coding of mental health conditions between vendors. It is currently unknown the extent to which the diagnoses of mental health conditions according to ICD-10 codes are comparable. The CIS would also be required to identify whether a client's mental health condition is active or inactive.	
Technical specifications match the intent of the indicator	The intent of Part A is to capture the proportion of those with active mental health conditions who have had a GP Mental Health Treatment Plan, and Part B is to capture those with an active mental health condition and a GP MHTP who have had a Review of that plan, and the specifications match that intent.	The Working Group discussed the most appropriate terminology classification system for mental health conditions. It was noted that SNOMED has more relevant terminology for the CIS. It was suggested that CIS vendors map CIS terminology to SNOMED.
Indicator is unambiguous in its interpretation	The results may reflect organisations' workforce capacity (e.g. GPs with training/confidence to develop GP MHTPs) as well as the acceptability of developing the plan among clients.	NPS MedicineWise noted issues with the NSW KPI with respect to data definitions.

B5. Technical considerations and data quality			
Criteria	**Submitter—response to criteria**	**Committee—record of discussion**	
Results are robust enough for use at the individual service level and for national reporting	Unable to be assessed[7]	The HS DAG Working Group did not specifically discuss this criterion.	
Results are valid and reliable across subgroups and geographic regions	Unable to be assessed.	The HS DAG Working Group noted that there is a lack of available onward referral services in some jurisdictions, meaning that mental health plans may not be common practice.	
There are no known data quality issues in related data collections *If a similar, or related, indicator exists in another data collection, outline any known data quality issues. For example, in a jurisdictional KPI collection such as the NT AHKPIs.*	NSW have indicated that there are inconsistencies in the coding of mental health conditions across vendors.	The Working Group noted that issues exist with coding of mental health conditions.	
The indicator reflects real change and is not masking other factors	The indicator may initially reflect changes in data capture (e.g. such as improvements in recording diagnoses in an extractable format) but this should improve over time.	• The Working Group discussed that there are a range of potential activities that can be measured to improve mental health outcomes for Aboriginal and Torres Strait Islander people. It was suggested that further discussion is needed to agree the most appropriate measure to understand quality of care. • The Working Group noted that GP consults are not always the most appropriate forum to deliver mental health services.	
Committee—assessment of extent criterion met *Select one option only*		**Assessment**	**Reason**
		☐ Not met at all ☒ Partially met ☐ Fully met	**The HS DAG Working Group agreed that the indicator partially meets this criterion due to the reasons outlined above.**

[7] Because of the Act surrounding the NSW Aboriginal Health KPIs, NSW are unable to provide any details on the results or the distribution of results between organisations. They did not identify any problematic issues, however, they noted that there are differences in the coding of mental health conditions between vendors.

<table>
<tr><th colspan="4">B6. Comparability</th></tr>
<tr><th>Criteria</th><th colspan="2">Submitter—response to criteria</th><th>Committee—record of discussion</th></tr>
<tr><td>Results can be compared across organisations and/or over time within the organisation</td><td colspan="2">Unable to be assessed.
Until the coding of mental health conditions is standardised across vendors the results will only be truly comparable within CIS groups.</td><td>The Working Group agreed that Criteria B6: Comparability cannot be assessed.</td></tr>
<tr><td colspan="2" rowspan="2">Committee—assessment of extent criterion met
Select one option only</td><td>Assessment</td><td>Reason</td></tr>
<tr><td>☒ Not met at all
☐ Partially met
☐ Fully met</td><td>The Working Group agreed that Criteria B6: Comparability cannot be assessed.</td></tr>
</table>

<table>
<tr><th colspan="4">B7. Variation</th></tr>
<tr><th>Criteria</th><th>Submitter—response to criteria</th><th colspan="2">Committee—record of discussion</th></tr>
<tr><td>There is enough variation in the results to be useful
For example, the indicator is responsive enough that when something changes it is meaningfully reflected</td><td>Unable to be assessed.</td><td colspan="2">The Working Group agreed that Criteria B7: Variation cannot be assessed.</td></tr>
<tr><td colspan="2" rowspan="2">Committee—assessment of extent criterion met
Select one option only</td><td>Assessment</td><td>Reason</td></tr>
<tr><td>☒ Not met at all
☐ Partially met
☐ Fully met</td><td>The Working Group agreed that Criteria B7: Variation cannot be assessed.</td></tr>
</table>

B8. Risk			
Criteria	**Submitter—response to criteria**	**Committee—record of discussion**	
The known or potential risks or unintended consequences of collecting and reporting are either minimal or can be managed	A potential risk is an increase in GP Mental Health Treatment Plans that are not performed well or in a culturally appropriate way.	• The Working Group raised concerns that measuring the completion of mental health plans may result in a focus on completion rather than quality. • The Working Group noted the risks associated with reporting at the service level, stating that data could be interpreted negatively. • It was discussed that measuring the completion and delivery of mental health plans may prompt referral to activities that are not suitable for all clients. It was noted that there is potential for pathways of care to be interrupted, rather than enhancing quality of care.	
The benefits of collecting the indicator outweigh the burden of reporting for services	The burden on reporting organisations should be relatively low—it's likely to lie in ensuring mental health conditions are recorded in an extractable format.	Please refer to criterion directly above.	
The associated resource implications and costs are either minimal or can be managed	An assessment will need to be carried out looking at the comparability between CIS in the recording/coding of mental health conditions. Resources will be required for training, changes to the Health Data Portal, and changes to the CIS.	The HS DAG Working Group did not specifically discuss this criterion.	
		Assessment	**Reason**
		☐ Not met at all ☒ Partially met ☐ Fully met	**The HS DAG Working Group noted that there are a number of risks associated with this indicator. It was noted that some risks, but not all, outweigh the burden of reporting.**

***Committee facilitator**—record the key points from the discussion and summarise the advantages/disadvantages of adding the indicator. Record the final group recommendation and assessment of priority, noting any dissenting opinions.*

Section C. Assessment and recommendations

Summary of discussion *Record an overview of the assessment noting key advantages and disadvantages of the proposal*	**Advantages** • The HS DAG Working Group agreed that mental health is an important issue for Aboriginal and Torres Strait Islander people. • The Working Group noted that a mental health related indicator would be beneficial to be included as a new indicator in the nKPI collection. **Disadvantages** • The HS DAG Working Group noted that there is insufficient evidence to show the efficacy of mental health plans in improving health outcomes for people with mental illness. • It was noted that there is a lack of available onward referral services in some jurisdictions. • The Working Group noted that there are concerns across the sector regarding how information provided in mental health plans is used more broadly. **Recommendations** • The HS DAG Working Group recommended that further consultation is needed to understand the acceptability of the proposed new mental health indicator. • The HS DAG Working Group did not reach a consensus on whether the indicator should be included as a new indicator in the nKPI collection, noting that further consultation is required to enable a more informed recommendation.	
Feasibility *Consider the proposal and any briefing papers accompanying the proposal and document advice against the specified areas on the feasibility of including the indicator*	Service data collection/recording processes	Please refer to the information provided in the briefing paper.
	Client Information Systems (CIS)	Please refer to the information provided in the briefing paper.
	National reporting	Please refer to the information provided in the briefing paper.
Recommendation *Select one option only*	☐ Supported for inclusion	*Provide modifications to specifications, if applicable* The HS DAG Working Group did not reach a consensus on whether the indicator should be included as a new indicator in the nKPI collection, noting that further consultation is required to enable a more informed recommendation.

Section C. Assessment and recommendations		
	☐ Not supported for inclusion	*Provide reason(s)* • The HS DAG Working Group recommended that further consultation is needed to understand the acceptability of the proposed new mental health indicator. • The Working Group agreed that broader consultation with the sector is required on the proposed new indicator, namely Part A: Proportion of Indigenous regular clients living with a mental health condition who have a GP Mental Health Treatment Plan; and Part B: Proportion of Indigenous regular clients living with a mental health condition who had their GP Mental Health Treatment Plan reviewed.
Assessment of priority *Reflects how important is it in practice for the change to be made.* *Select one option only.* *Provide reason(s) if applicable.*	☐ High	
	☐ Medium	
	☐ Low	

Follow up actions required *(add additional rows as required)*		
Action 1:	Responsible party:	Timeframe:
Action 2:	Responsible party:	Timeframe:

Section D. Department of Health decision and follow-up actions		
Decision *Select one option only*	☐ HS DAG recommendations accepted	
	☐ HS DAG recommendations not accepted	*Provide reason(s)*
Assessment of priority *Reflects how important is it in practice for the change to be made* *Select one option only*	☐ High	
	☐ Medium	
	☐ Low	
Follow up actions required *(add additional rows as required)*		
Action 1:	Responsible party:	Timeframe:
Action 2:	Responsible party:	Timeframe:

Appendix A. Additional information

For example, evidence of any preliminary analyses/implementation/pre-testing