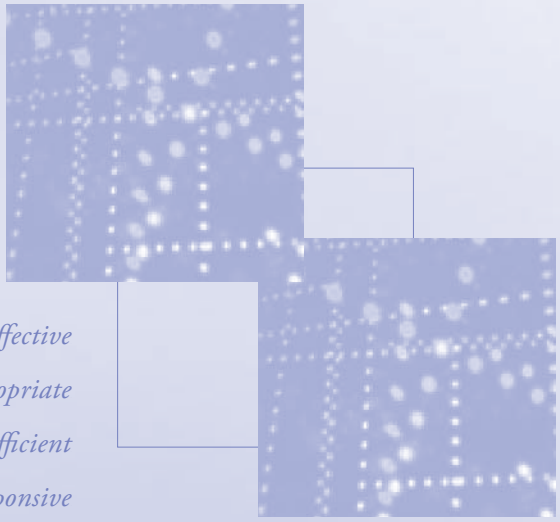
Key Performance Indicators for Australian Public Mental Health Services

SECOND EDITION 2011



effective
appropriate
efficient
responsive
accessible
safe
continuous
capable
sustainable

A REPORT BY THE NATIONAL MENTAL HEALTH PERFORMANCE SUBCOMMITTEE

MENTAL HEALTH INFORMATION STRATEGY SUBCOMMITTEE

AHMAC MENTAL HEALTH STANDING COMMITTEE

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Key Performance Indicators for Australian Public Mental Health Services - Second Edition, 2011

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

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Foreword.

Quality improvement is a driving force in health care and is an essential aspect of service delivery at all levels. Key Performance Indicators (KPIs) are essential tools for enabling this improvement to occur. The first edition of this document released in 2005 defined a mental health specific performance framework (the Framework) and a set of 'phase one' indicators. This represented the mental health sectors' first attempt to articulate a common framework and standardised set of indicators to support benchmarking and guide quality improvement at the level of the mental health service organisation. Ongoing refinement is required on a routine basis to ensure the Framework and indicators meet the requirements of the evolving reform agenda.

A range of activity has been initiated by states and territories over the past five years to utilise the Framework to support performance reporting, monitoring and management for quality improvement. The initial KPI set was also 'road-tested' from 2006–2008 through the National Mental Health Benchmarking Project. The establishment of demonstration benchmarking forums provided an opportunity for additional service level advice about the utility of the indicators for benchmarking.

Based primarily on learnings and advice from states and territories and the output of the Benchmarking Project, this document represents the culmination of work to date to refine and enhance the original set of indicators published in 2005. This document is being published at this time to put the most current information in the public domain whilst other data development is progressed. As such the focus of this second edition remains on the clinical services delivered by states and territories. The work planned over the next two years will consider the scope of the Framework and potential application to other components of the mental health system.

Despite the investment to date there is still considerable variation in the capacity and stage of implementation across states and territories. Whilst some have an embedded process for regular reporting and use of performance information, others are only commencing this process. As such there remains concern regarding the level of transparency and accountability across the mental health system in Australia. A key driver to address this concern is the commitment by governments through the Fourth National Mental Health Plan to improved accountability and transparency in mental health reform and service delivery. Significant investment will be required to ensure this occurs, however the National Mental Health Performance Framework and associated indicator set will facilitate the ability of all governments to meet this commitment.

I would like to thank everyone who participated and supported the development of this second edition, and look forward to your continued support as we work cooperatively towards our vision for mental health.

Dr Aaron Groves, *Chair*
Mental Health Information Strategy Subcommittee
Mental Health Standing Committee
May 2011

Contents.

Executive Summary.

The Fourth National Mental Health Plan (the Fourth Plan) commits governments to improved accountability and transparency in mental health reform and service delivery. To strengthen these aspects at the service delivery level, the Plan commits to building "... a service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders".[1]

A key strategy for facilitating a culture of continuous quality improvement in mental health service delivery, the National Mental Health Performance Framework ((the Framework) supports the Fourth Plan commitment to improving accountability and transparency at the Mental Health Service Organisation (MHSO) level.

This report outlines a performance framework and set of key performance indicators for use in Australia's public sector mental health services that aim to support benchmarking and guide quality improvement at the level of the mental health service organisation. Since the publication of the first edition of this document in 2005 a range of activity has been undertaken to implement and review the initial indicator set.

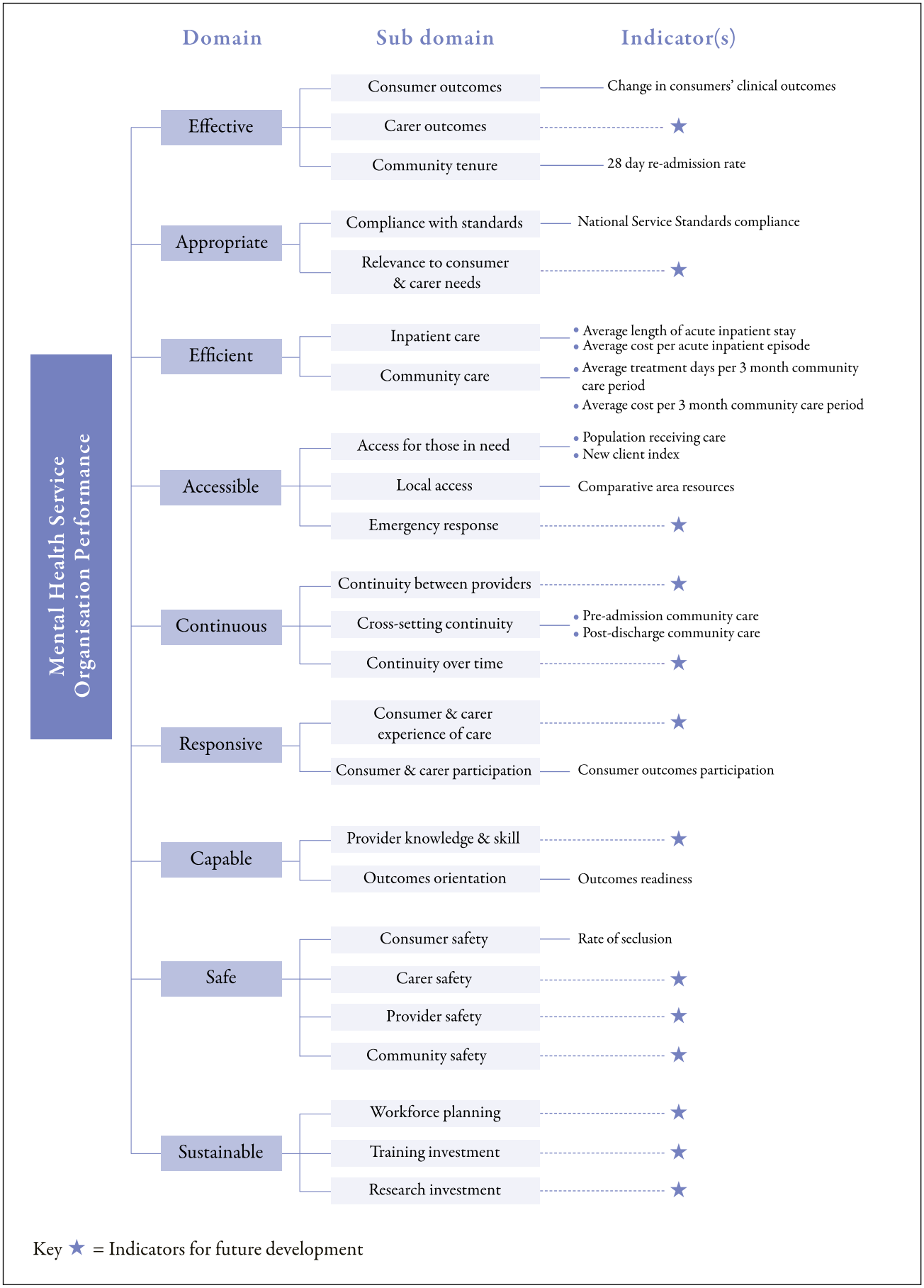
The results and learnings from this activity have informed the refinement and enhancement of the indicator set. This work has been led by the Mental Health Information Strategy Subcommittees' National Mental Health Performance Subcommittee (NMHPSC). The design issues and principles outlined in the 2005 document remain relevant to the current indicator set and were used by the NMHPSC to inform the production of the current indicator set.

In addition to technical changes and clarification, three new indicators have been proposed and one removed, bringing the number of indicators in the set to 15. The figure below summarises the proposed indicator set.

The focus remains on public sector mental health services, however continued data development will enable the Framework to be utilised in the broader mental health sector.

The National Mental Health Performance Subcommittee will continue to refine and develop the current indicator set considering all sectors involved in mental health care and the requirement to build a culture of continuous quality improvement. A full consultative review of the Framework and indicator set will be undertaken with the aim of releasing a third edition of the Framework in 2013. This review will fully consider the implications of the modification to the National Health Performance Framework and further incorporate learnings from the National Mental Health Benchmarking Project, states and territories, and the evolving reform context.

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


Domain
Sub domain
Indicator(s)
Mental Health Service Organisation Performance
Effective
Consumer outcomes
Change in consumers' clinical outcomes
Carer outcomes
★
Community tenure
28 day re-admission rate
Appropriate
Compliance with standards
National Service Standards compliance
Relevance to consumer & carer needs
★
Efficient
Inpatient care
Average length of acute inpatient stay
Average cost per acute inpatient episode
Community care
Average treatment days per 3 month community care period
Average cost per 3 month community care period
Accessible
Access for those in need
Population receiving care
New client index
Local access
Comparative area resources
Emergency response
★
Continuous
Continuity between providers
★
Cross-setting continuity
Pre-admission community care
Post-discharge community care
Continuity over time
★
Responsive
Consumer & carer experience of care
★
Consumer & carer participation
Consumer outcomes participation
Capable
Provider knowledge & skill
★
Outcomes orientation
Outcomes readiness
Safe
Consumer safety
Rate of seclusion
Carer safety
★
Provider safety
★
Community safety
★
Sustainable
Workforce planning
★
Training investment
★
Research investment
★
Key ★ = Indicators for future development

1. Introduction.

1.1 Purpose.

This document collates development and activity to date, delivering into the public domain the most current set of key performance indicators for use in Australia's public sector mental health services. Based on the National Health Performance Framework (NHPF) and linked to the strategic directions of the Fourth Plan, these fifteen key performance indicators have been endorsed for implementation by the Australian Health Ministers' Advisory Council Mental Health Standing Committee.

Since the endorsement and publication of the Framework and associated key performance indicator set in 2005, all states and territories have commenced a process of embedding performance management and monitoring within public sector mental health service delivery. Over this time, the mental health sector, led by the Mental Health Information Strategy Subcommittee's National Mental Health Performance Subcommittee (NMHPSC), has continued to refine and develop the indicator set.

The refined indicator set outlined in this document has been informed primarily by the experience of states and territories in implementing the initial indicator set, national data development activity and the advice of organisations participating in the National Mental Health Benchmarking Project.

1.2 Current context.

The Australian health system is evolving as fundamental changes to responsibilities of governments for the funding and delivery of health services are progressed and these changes to the broader health environment impact on the development of policy and the delivery of mental health care.

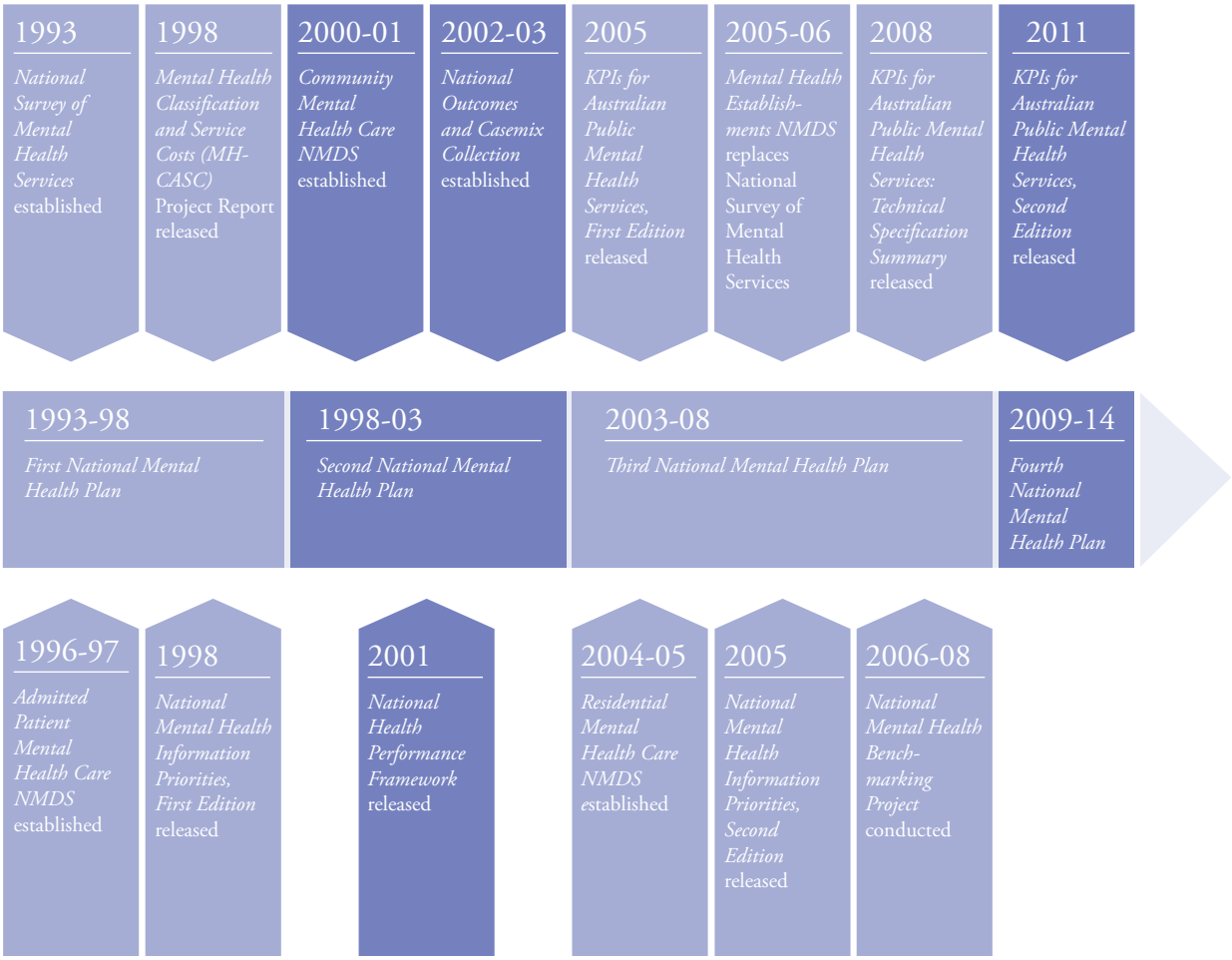
Following the release of the first edition of the Key Performance Indicators for Australian Public Mental Health Services in 2005, considerable work has been undertaken to progress and develop the mental health performance agenda and to shape a more accountable and transparent mental health system.

The current national health reform agenda, including the Fourth Plan and the reforms agreed by the Council of Australian Governments (COAG) in April 2010 and February 2011, emphasise the importance of performance monitoring and influence the need for embedding this activity within mental health service delivery and policy development.

The Framework domains of *safe, responsive* and *effective* were the major focus in relation to the development of new indicators. The NMHPSC has continued to refine the technical specifications and have developed three new indicators which have been endorsed for inclusion. A significant contributor to this work was the National Mental Health Benchmarking Project conducted between 2006–2008.

A summary of key activity contributing to the development of the current indicator set is shown in Figure 1.

Figure 1: Key activity contributing to current indicator development.



Fourth National Mental Health Plan.

The Fourth National Mental Health Plan (the Fourth Plan) follows on from the work of the previous three national mental health plans in collaboratively shaping mental health sector reform by identifying key priority areas for development and committing governments to a set of agreed actions. Recognising that factors outside the health system impact on mental health and mental illness, the Fourth Plan commits governments to reform beyond the mental health sector and from across portfolios outside of health. This whole-of-government approach articulates the collaboration required between agencies, and promotes greater awareness across human services at all levels of government and the community.

The Fourth Plan commits governments to improved accountability and transparency in mental health reform and service delivery. To strengthen these aspects at the service delivery level, the Plan commits to building "... a service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders"[2]. The Mental Health Information

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

Strategy Subcommittee is responsible for the development of a system of public reporting to enable jurisdictions and mental health service organisations (MHSOs) to meet this commitment. A key strategy for facilitating a culture of continuous quality improvement in mental health service delivery, the Framework supports the Fourth Plan commitment to improving accountability and transparency at the MHSO level.

1.3 Developments in performance monitoring and reporting.

Key achievements in the ongoing development of mental health performance monitoring are represented by the National Mental Health Report series, the Mental Health Services in Australia reports, the Report on Government Services, and the COAG National Action Plan for Mental Health Progress Reports. However, the primary focus of these reports has been on the overall system performance at the policy development and funder (state, territory and Australian governments) level and there has been limited reporting of service level performance.

The Fourth Plan commits governments to publicly report on service level performance and to the continued development and refinement of mental health information and performance measurement systems. Public state and territory services and the private hospital sector have contributed to the improved maturity and availability of data for service level reporting.

The performance indicators in the Framework provide a platform for measuring service level performance and enable services to benchmark against the performance of their peers, however some indicators are also linked to the strategic direction of the Fourth Plan. Figure 2 summarises the approach agreed in the Fourth Plan for strengthening accountability at both levels. Together, the two levels of reporting will provide coverage of the mental health sector and will place a wide range of performance information into the public domain.

Figure 2: Multi-level approach to building an accountable and transparent mental health.

	Required actions	Promoting accountability through…
POLICY LEVEL	• Appropriate resourcing of mental health services. • Appropriate legislative, governance and service-delivery frameworks. • Follow through on commitments to implementing agreed Fourth Plan actions.	• Measuring the effect of actions in progressing reform. • Development of a range of supports and incentives to assist service organisations to introduce local transparent reporting on mental health service delivery.
SERVICE DELIVERY LEVEL	• Implementation of quality improvement systems, including systems monitoring key aspects of service-performance. • Establishment of transparent reporting to local constituencies.	• Publicly report results and progress.

National Health Performance Authority.

The national health reforms agreed by COAG in April 2010 and February 2011 outline structural reform as well as additional investments in hospital, primary and aged care services, and preventive care in mental health and diabetes health care. This includes the establishment of a National Health Performance Authority to oversee a program of performance monitoring.

Under a Performance and Accountability Framework, the National Health Performance Authority will develop and produce performance reports which will help Australians make more informed choices about their health services, and help ensure the standard of care across hospital, general practice and primary health services continues to improve.

It is anticipated that the extensive work already undertaken by the mental health sector will contribute to the work of the National Performance Authority once it is established.

2. National Mental Health Performance Framework

The National Mental Health Performance Framework, at Figure 3, is based upon the initial National Health Performance Framework (NHPF) developed in 2001. The Framework includes three tiers which provide a comprehensive picture of population health and provides a structure through which key questions can be posed concerning how well the mental health system is performing. The tiers are not intended to be hierarchical in nature, rather they reflect that health status and health outcomes are influenced by health determinants and overall health system performance. While the NHPF was modified in 2010, the mental health sector continues to utilise its existing framework, focusing on the further development of tier three domains and mental health specific sub-domains (Figure 4).

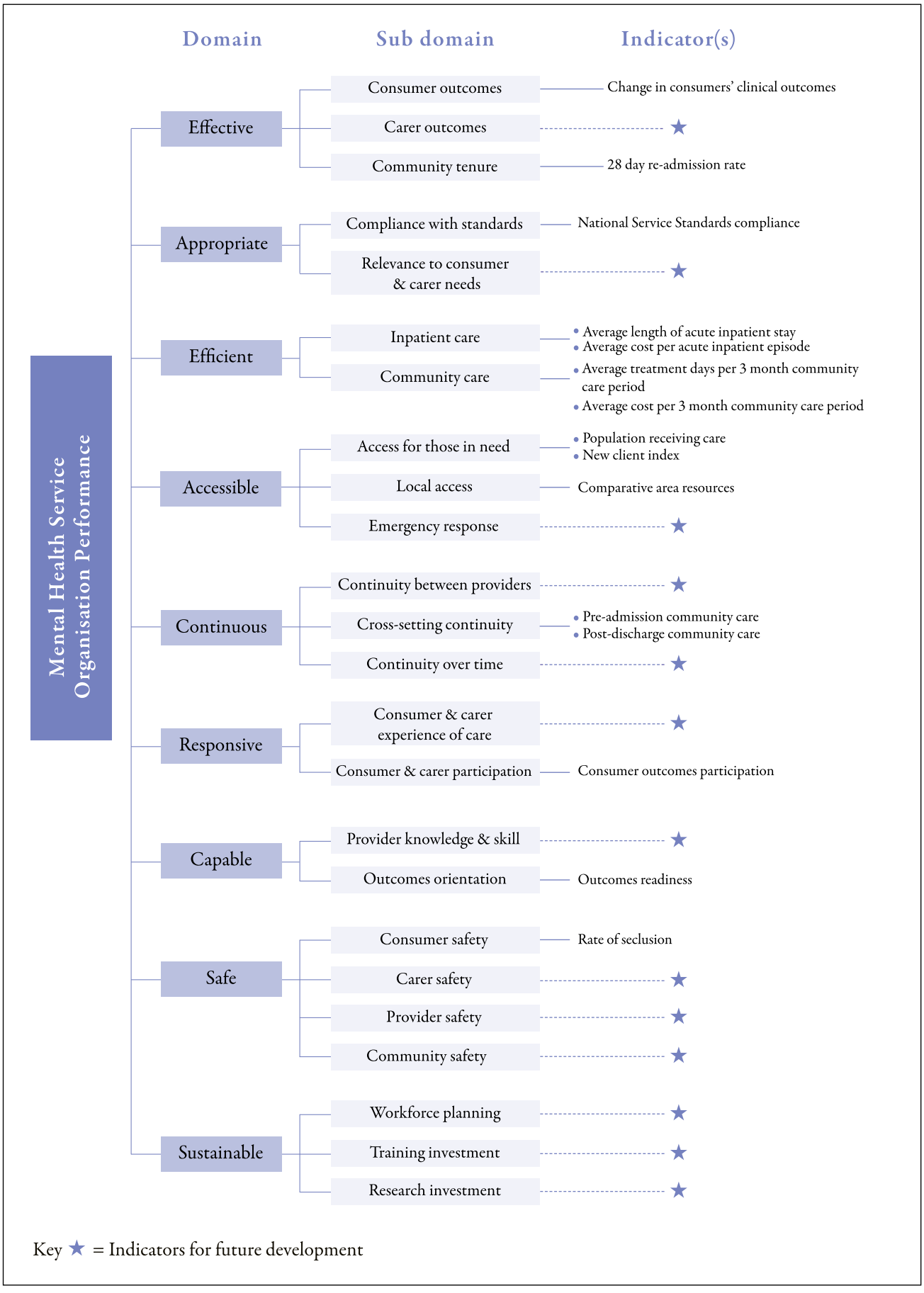
Figure 3: National Mental Health Performance Framework.

Health Status and Outcomes ('TIER 1')			*How healthy are Australians? Is it the same for everyone? Where is the most opportunity for improvement?*
Health Conditions	Human Function	Life Expectancy and Well-being	Deaths
Prevalence of disease, disorder, injury or trauma or other health-related states.	Alterations to body, structure or function (impairment), activities (activity limitation) and participation (restrictions in participation).	Broad measures of physical, mental, and social wellbeing of individuals and other derived indicators such as Disability Adjusted Life Expectancy (DALE).	Age or condition specific mortality rates.

Determinants of Health ('TIER 2')			*Are the factors determining health changing for the better? Is it the same for everyone? Where and for whom are they changing for the worse?*	
Environmental Factors	Socio-economic Factors	Community Capacity	Health Behaviours	Person-related Factors
Physical, chemical and biological factors such as air, water, food and soil quality resulting from chemical pollution and waste disposal.	Socio-economic factors such as education, employment per capita expenditure on health, and average weekly earnings.	Characteristics of communities and families such as population density, age distribution, health literacy, housing, community support services and transport.	Attitudes, beliefs knowledge and behaviours eg patterns of eating, physical activity, excess alcohol consumption and smoking.	Genetic related susceptibility to disease and other factors such as blood pressure, cholesterol levels and body weight.

Health System Performance ('TIER 3')		*How well is the health system performing in delivering quality health actions to improve the health of all Australians? Is it the same for everyone?*
Effective	Appropriate	Efficient
Care, intervention or action achieves desired outcome.	The care, intervention or action provided is relevant to the consumer's and/or carer's needs and based on established standards.	Achieving desired results with most cost effective use of resources.
Responsive	Accessible	Safe
Service provides respect for persons and is consumer and carer orientated: respect for dignity, confidential, participate in choices, prompt, quality of amenities, access to social support networks, and choice of provider.	Ability of people to obtain health care at the right place and right time irrespective of income, geography and cultural background.	Potential risks of an intervention or the environment are identified and avoided or minimised.
Continuous	Capable	Sustainable
Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time	An individual or service's capacity to provide a health service based on skills and knowledge	System or organisation's capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring)

Figure 4: Summary of 'Tier 3' of the National Mental Health Performance Framework and current indicator set



2.1 Indicator design issues.

The first edition of this document highlighted issues and concerns in relation to good data development practices and designing quality indicators for multiple purposes. The issues and criteria utilised in the development of the initial indicator set are still applicable and have been utilised in the refinement of the existing indicator set.

All indicators have been evaluated using the criteria outlined in the National Health Performance Framework, nine of which target the viability of each individual indicator, and five of which relate to the comprehensiveness of the proposed indicator set as a whole (Table 1). Indicators were also assessed against reliability and validity criteria that are implicit within the Framework but were considered of sufficient importance to warrant explicit assessment.

Table 1: Criteria used to evaluate candidate indicators.

Criteria applied to individual indicators.
• ***Be worth measuring:*** The indicators represent an important and salient aspect of the public's health or the performance of the health system.
• ***Be measurable for diverse populations:*** The indicators are valid and reliable for the general population and diverse populations (ie Aboriginal and Torres Strait Islander peoples, rural/urban, socioeconomic etc).
• ***Be understood by people who need to act:*** People who need to act on their own behalf or on that of others should be able to readily comprehend the indicators and what can be done to improve health.
• ***Galvanise action:*** The indicators are of such a nature that action can be taken at the national, state, local or community level by individuals, organised groups and public and private agencies.
• ***Be relevant to policy and practice:*** Actions that can lead to improvement are anticipated and feasible–they are plausible actions that can alter the course of an indicator when widely applied.
• ***Measurement over time will reflect results of actions:*** If action is taken, tangible results will be seen indicating improvements in various aspects of the nation's health.
• ***Be feasible to collect and report:*** The information required for the indicator can be obtained at reasonable cost in relation to its value and can be collected, analysed and reported on in an appropriate time frame.
• ***Comply with national processes of data definitions.***
• ***Be reliable and valid.***
Criteria applied to overall indicator set.
• Cover the spectrum of the health issue.
• Reflect a balance of indicators for all appropriate parts of the Framework.
• Identify and respond to new and emerging issues.
• Be capable of leading change.
• Provide feedback on where the system is working well, as well as areas for improvement.

2.2 Measuring mental health performance.

The National Mental Health Performance Framework (NMHPF) provides a comprehensive model for measuring and monitoring the performance of mental health services. The nine 'tier three' domains of performance identified in the original NHPF represent the broad areas of concern for health service performance and remain the basis for the NMHPF.

It is important to note that although focussed on different aspects of quality, there is considerable overlap between the nine domains. For example, the domain *appropriateness* includes elements relevant to *responsiveness* and *continuity*. The implication is that any one indicator may be relevant across multiple performance domains. For the purpose of simplicity, where an indicator can be mapped to more than one domain of the Framework, it has been assigned to a 'primary domain', however relevant secondary domains have also been identified. Table 2 provides a summary of the mapping of the current indicator set across the tier three domains, as well as the levels at which the indicators can be used for benchmarking.

The nine domains have been defined further into 24 sub-domains which have specific relevance to the delivery of mental health services. Each sub-domain can be regarded as describing a topic of concern, or the most salient aspects of organisation performance. It is important to recognise that sub-domains considered most relevant are likely to change over time in response to community expectations or specific challenges facing the service delivery system. Decisions regarding future development will be influenced by determination of aspects of service delivery considered most important in the current service delivery and policy climate.

While the indicators have been developed to measure MHSO performance, the NMHPF is intended for use at all levels of the mental health system to facilitate more detailed interpretation and understanding of performance. Consequently, there is more than one use for most indicators as some have capacity for aggregated reporting at state and territory levels and can be utilised for reporting or benchmarking purposes at service unit or team level (Table 2).

Table 2: National Mental Health Performance Framework domains, indicators and benchmarking usage.

Mental Health Services Key Performance Indicators		Effective	Appropriate	Efficient	Responsive	Accessible	Sustainable	Capable	Safe	Continuous	Level at which indicators can be used for benchmarking			
											State and Territory	Regional Group of Services	MHSOs	Service Units
MHS PI 1:	Change in consumers' clinical outcomes	▲									✓	✓	✓	✓
MHS PI 2:	28 day readmission rate	▲								■	✓	✓	✓	✓
MHS PI 3:	National Service Standards compliance		▲					■			✓	✓	✓	○
MHS PI 4:	Average length of acute inpatient stay		■	▲							✓	✓	✓	✓
MHS PI 5:	Average cost per acute inpatient episode			▲							✓	✓	✓	○
MHS PI 6:	Average treatment days per three month community care period		■	▲							✓	✓	✓	✓
MHS PI 7:	Average cost per three month community care period			▲							✓	✓	✓	○
MHS PI 8:	Population receiving care					▲					✓	✓	✓	×
MHS PI 9:	New client index					▲					✓	✓	✓	○
MHS PI 10:	Comparative area resources					▲	■				✓	✓	✓	×
MHS PI 11:	Pre-admission community care					■				▲	✓	✓	✓	✓
MHS PI 12:	Post-discharge community care					■			■	▲	✓	✓	✓	✓
MHS PI 13:	Consumer outcomes participation				▲			■			✓	✓	✓	✓
MHS PI 14:	Outcomes readiness	■						▲			✓	✓	✓	✓
MHS PI 15:	Rate of seclusion		■						▲		✓	✓	✓	✓

▲ = Primary domain

■ = Secondary domain

✓ = Valuable at this level

○ = Limited value at this level

× = Not useful at this level

2.3 Understanding domains and sub-domains.

This section defines the nine domains and sub-domains of tier three for interpretation within a mental health context and provides an overview of the strategic policy context that has influenced the development of the national key performance indicators.

2.3.1 EFFECTIVE: 'Care, intervention or action achieves desired outcome'

Strategic context.

The need to improve mental health service effectiveness has been a central goal of the National Mental Health Strategy (the Strategy) since its inception in 1992. Establishing a system for the routine monitoring of consumer outcomes has also been an objective of the Strategy since it was first agreed. The National Mental Health Policy included as one of its original objectives *"to institute regular review of client outcomes of services provided to persons with serious mental health problems and mental disorders as a central component of mental health service delivery."*[3] The revised National Standards for Mental Health Services also identified the need to be able to review services and outcomes at an individual consumer and mental health service level.

Over the past decade, states and territories have established an information infrastructure to embed the measurement of consumer outcomes as a routine part of service delivery. By June 2008, routine measurement of consumer outcomes was in place in an estimated 98% of public mental health services.[4] It is important to recognise that the embedding of routine outcome measurement into public sector mental health services is a 'work in progress'. The main tools being used describe the condition of the consumer from the clinician's perspective and do not address the 'lived experience' from the consumer's viewpoint. Although consumer rated measures are included in Australia's approach to outcome measurement, uptake by public sector services has been poor to date.

Interpretation of the domain.

Effectiveness measures are generally regarded as the most important requirement for health service monitoring. They are also widely recognised as presenting the most complex area for indicator development. Within mental health, the complexity arises from several factors:

- ***Multiple levels at which outcome may be measured:*** Outcomes of mental health care can be described at the level of whole populations (for example, suicide rates), or for service systems (for example, percent of discharges to homeless shelters), or at the level of the individual consumer.
- ***Multiple outcome sub domains:*** The concept of outcome has multiple dimensions, each of which need to be considered independently. For example, outcomes at the level of the individual consumer may be measured by improvements in functioning (which in turn has multiple aspects covering social, occupational and activities of daily living functioning), clinical status, or quality of life. No single outcome measure can adequately assess all aspects.

[3] Australian Health Ministers (1992) *National Mental Health Policy*, Commonwealth of Australia, Canberra, p 13.

[4] Department of Health and Ageing (2010) *National Mental Health Report 2010*, Commonwealth of Australia, Canberra, p.57.

- ***Multiple perspectives on outcomes:*** Similarly, assessment of the outcomes of mental health care needs to ask the question 'according to whom?' Outcomes as assessed by clinicians may (and often are) different from those made by consumers and carers. The need to consider differing perspectives on health service performance applies across all domains but is particularly critical to the selection of effectiveness indicators.
- ***Multiple timeframes:*** An outcome may be initial, intermediate, or long-term. Selecting an appropriate timeframe for measurement is especially important for defining a 'good outcome' for people with recurrent or continuing mental disorders. Satisfactory results achieved in the short-term may be misleading when viewed from a longer-term perspective, or vice versa.

Sub-domains.

There are three sub-domains identified for monitoring the effectiveness of mental health services:

- ***Consumer outcomes:*** addresses the impact of health care on the consumer's clinical status and functioning.
- ***Carer outcomes:*** addresses the impact of mental disorders on the quality of life of family members and other carers as they support a person experiencing mental illness.
- ***Community tenure:*** addresses the extent to which mental health services are effective in maintaining consumers in the community, without unnecessary hospitalisation. The development of effective clinical community services as alternatives to hospital based care remains a key aim of the National Mental Health Strategy.

2.3.2 APPROPRIATE: 'The care, intervention or action provided is relevant to the consumer's and/or carer's needs and based on established standards'

Strategic context.

Concerns about the appropriateness of care remain a key driver of the reform agenda progressed through the National Mental Health Strategy. The primary focus of the reform effort in the early years of the Strategy was on structural reform to reduce Australia's historical reliance on separate psychiatric hospitals and to develop a better mix of clinical community-based and general hospital services. This structural change was complemented in 1996 by the introduction of the National Standards for Mental Health Services (the Standards) to assist in the development and implementation of appropriate practices and guide continuous quality improvement in mental health services.

Current reform emphasises the need for a range of inter-connected clinical and community service options to support the provision of the right care at the right time, including primary care, acute care and community support services.[5] To complement this requirement, a revised set of Standards, which can be applied to all mental health services (government, non-government and private sectors), were released in 2010. Demonstration of the delivery of services against these standards ensures that consumers, carers and the community can be confident of what to expect from mental health services[6].

[5] Australian Health Ministers Conference (2009) *National Mental Health Policy 2008*, Commonwealth of Australia, Canberra, p 24.

[6] Australian Health Ministers' (2010). *National Standards for Mental Health Services 2010*. Commonwealth of Australia, Canberra.

Interpretation of the domain.

Assessment of the appropriateness of mental health services is inherently about the processes of care, or the way in which care is provided. For consumers and carers, 'good process' is the critical ingredient in whether they have a successful outcome. For providers, good process is synonymous with 'best practice' and is usually based on evidence that such processes are more likely to achieve satisfactory results.

The *appropriate* domain overlaps with the domains of *responsive* and *continuous* because these are also intrinsically concerned with processes of service delivery. The distinguishing attribute in assigning indicators to appropriateness as the primary domain is that such indicators require assessment against some external standard.

Sub-domains.

The NMHPF defines two sub-domains for monitoring the appropriateness of health care:

- ***Compliance with established standards:*** addresses the question of whether the services provided by the organisation conform to guidelines that are evidence-based or derived from expert consensus on what constitutes 'best practice'.
- ***Relevance to consumer and carer needs:*** addresses the question of whether the organisation provides care that is tailored to the individual characteristics and requirements of the consumer.

2.3.3 EFFICIENT: 'Achieving desired results with the most cost effective use of resources'

Strategic context.

While many of the policy directions advocated by the Strategy can be construed from the perspective of allocative efficiency (achieving optimal outcomes using available resources), relatively little has been written at the national level about the technical efficiency of public mental health services (production of outputs for the least cost). This reflects the limited progress made to date on developing nationally agreed costing concepts and benchmarks in the mental health field, as well as highlighting the need for meaningful data to inform such developments.

In the context of significant pressures on health budgets and increased demands by government to ensure efficient use of resources, the introduction of Activity Based Funding (ABF), driven through the Council of Australian Governments (COAG) national health reforms, will inform future development and directions in relation to measuring efficiency.

Interpretation of the domain.

Measurement of health sector efficiency has historically focused on technical efficiency rather than allocative efficiency. Although some of the required developmental work is being progressed through the ABF program, it is not yet available. Until the work of ABF comes to fruition the indicators of mental health sector efficiency will remain concerned with technical efficiency issues, focusing on cost per unit of output. The unit of output for efficiency indicators is currently an episode of mental health care.

Sub-domains.

To ensure comparisons are based on similar service or care types, there are two sub-domains concerning efficiency of mental health services:

- Inpatient care: inpatient services account for approximately 47 percent of national expenditure on public sector mental health services, and have very different unit cost characteristics from community-based care.
- Community (ambulatory) care: ambulatory care services account for approximately 40 percent of mental health services expenditure.

2.3.4 ACCESSIBLE: 'Ability of people to obtain health care at the right place and right time irrespective of income, geography and cultural background'

Strategic context.

One in five Australians experienced mental illness[7] in 2007, but just over one third had received services for their mental health problems. Improving access to services has been a continuing priority theme throughout the history of the National Mental Health Strategy. National objectives to improve access to mental health care have been multifaceted and cover local access to specialist services through decentralisation of resources, increasing access to mainstream health and community support programs for people affected by mental illness, and improving service availability for special needs groups and specific populations (Aboriginal and Torres Strait Islanders, consumers with complex needs). The Fourth Plan maintains and enhances the focus on improving accessibility through the development of a national service planning framework and establishing regional partnerships with relevant stakeholders to facilitate local solutions for community mental health needs.

Interpretation of the domain.

Access is a multidimensional domain and encompasses the objective of equity. It is useful to consider three meanings of the concept from a mental health service delivery perspective:

Access implies that people in need of care in fact actually receive services. Despite increased funding for primary and specialist services, access to mental health services is still not considered adequate. The issue of unmet need continues to be a priority with evidence suggesting that just under two thirds of adults who are affected by mental illness do not receive any form of treatment[8].

Access also implies geographical proximity so that services are delivered in a way that minimises dislocation of the consumer from family and local supports.

Access also concerns timeliness, or responding to needs when they arise. Timely access to services is a major factor in ensuring that consumers receive needed services. It includes prompt attention to emergencies as well as reasonable wait times for other referrals.

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7 Slade, T., Johnston, A., Teeson, M., Whiteford, H., Burgess, P., Pirkis, J., Saw, S. (2009) *The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing*. Department of Health and Ageing, Canberra.

8 Ibid.

Sub-domains.

Three sub-domains cover the different aspects of access:

- ***Access for those in need:*** addresses the extent to which defined populations receive mental health care.
- ***Local access:*** addresses the issue of the availability of local services.
- ***Emergency response:*** addresses the degree to which services are provided when they are needed, with a particular focus on response to psychiatric crises.

2.3.5 CONTINUOUS: 'Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time'

Strategic context.

Continuity of care has special relevance for the mental health sector and features prominently in the National Mental Health Strategy as a priority area for improvement. Two factors underpin the emphasis given. Firstly, the ongoing nature of many mental illnesses often requires care to be provided on an ongoing basis or intermittently over a considerable period of an individual's life. Secondly, effective care typically requires the involvement of multiple service providers and coordination across service sectors.

The Fourth Plan promotes the need for better coordination between the range of service sectors providing treatment and care, to promote continuity and lessen the risk of people dropping out of services at periods of transition. For example, consumers moving from adult to aged persons' mental health services, or consumers in particular groups such as those in the justice system, children in protective services, and those with chronic physical illness or disability.

Interpretation of the domain.

Continuity of care embraces several concepts including the concept of care provided over time (during the course of an illness and across the lifespan), care and support provided by different services (the specialist mental health sector, primary health care, other areas of the health sector and community services), and across structural boundaries (between the public and private sectors and between the government and non-government sectors).

Sub-domains.

Three sub-domains cover aspects of continuity of care relevant to the mental health sector:

- ***Continuity between providers:*** concerns the integration of services delivered by multiple providers.
- ***Cross-setting continuity:*** focuses on coordination between inpatient and community services as consumers move between treatment settings.
- ***Continuity over time:*** focuses on continuity across the course of an illness, recognising that consumers will have different needs at different points in time.

2.3.6 RESPONSIVE: 'Service provides respect for persons and is consumer and carer orientated. It includes respect for dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks, and choice of provider'

Strategic context.

The concerns driving the Strategy have evolved over time, from protecting human rights abuses to advocating more contemporary concepts of consumer empowerment and participation. Underpinning this change has been the need to destigmatise mental illness and ultimately improve mental health outcomes by supporting recovery through service delivery, both as a process and as an outcome to promote hope, wellbeing and autonomy. While progress has been made in establishment and enhancing mechanisms for consumer and carer participation, the Fourth Plan reiterates the importance of continuing initiatives to build mental health service systems that are truly responsive.

Interpretation of the domain.

While linked closely to the *accessible* and *appropriate* domains, a distinguishing feature of the *responsive* domain is that it views service delivery from the perspective of consumer's, and their family's and carer's experience and expectations.

Sub-domains.

There are currently two sub-domains identified for monitoring the responsiveness of mental health services:

- ***Consumer and experience of care:*** focuses on the extent to which services meet consumer and carer expectations. In principle, indicators for this sub-domain can cover all domains of the Framework and include perceptions of access, continuity, effectiveness, and so forth.
- ***Consumer and carer experience:*** concerns the active involvement by consumers and carers in treatment planning, decision-making, and definition of treatment goals.

2.3.7 CAPABLE: 'An individual's or service's capacity to provide a health service based on skills and knowledge'

Strategic context.

The National Mental Health Policy emphasises that to achieve the desired outcomes for individual consumers as well as the overarching reform agenda, there must be ongoing development and support of a skilled workforce delivering quality services that are based on the best available evidence[9]. However, the recruitment, retainment and availability of suitably qualified staff across the diverse range needed in mental health service delivery is a challenge for all governments. The Fourth Plan acknowledges that having clear guidelines to determine roles, competencies, skill mix and professions required for a capable workforce will improve consistency of care and increase the effective and efficient use of the available

[9] Australian Health Ministers Conference (2009) *National Mental Health Policy 2008*, Commonwealth of Australia, Canberra.

workforce. The proposed development and implementation of a National Mental Health Workforce Strategy[10] will define standardised workforce competencies and roles in not only clinical, but community and peer support areas, consistent with the National Practice Standards for the Mental Health Workforce released in 2002.

Interpretation of the domain.

The primary focus of this domain relates to the training of health professionals. However it also concerns the overall ability of the organisation to deliver quality mental health care.

Sub-domains.

Two sub-domains examine aspects of capability relevant to the mental health sector:

- ***Provider knowledge and skill:*** concerns the extent to which the health professional workforce, employed by mental health service organisations, meets its core competency requirements.
- ***Outcomes orientation:*** reflects the work being undertaken by states and territories in implementing routine consumer outcome measurement. The logic underpinning the sub-domain is that a capable service is results oriented and has systems in place to regularly monitor consumer outcomes.

2.3.8 SAFE: 'Potential risks of an intervention or environment are identified and avoided or minimised'

Strategic context.

Safety is a core component of both the National Standards for Mental Health Services and the National Practices Standards for the Mental Health Workforce, with the expectation that a service will ensure the safety and wellbeing of its consumers, carers, staff and others. The National safety priorities in mental health[11] were endorsed in 2005 and identify four priority areas for initial action:

- reducing suicide and deliberate self-harm in mental health and related health care settings;
- reducing use of, and where possible eliminating, restraint and seclusion;
- reducing adverse drug events in mental health services; and
- safe transport of people experiencing mental disorders.

Interpretation of the domain.

Safety is a key component of quality and involves "the avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered."[12].The concept of safety in mental health services is diverse and complex, encompassing many different aspects, including the safety of the consumer, health service providers, carer and the community.

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[10] Australian Health Ministers Conference (2009) National Mental Health Policy 2008, Commonwealth of Australia,Canberra.

[11] National Mental Health Working Group 2005, *National safety priorities in mental health: a national plan for reducing harm*, Health Priorities and Suicide Prevention Branch, Department of Health and Ageing, Commonwealth of Australia, Canberra.

[12] Ibid, p. 34.

Sub-domains.

Four sub-domains cover the key areas of safety that are impacted on by mental health services:

- ***Consumer Safety:*** concerns the extent to which health care environment and/or service provided to and/or for consumers of mental health services is safe. A consumer is "a person who uses or has used a mental health service".[13]
- ***Carer Safety:*** concerns the extent to which a safe environment is supported for mental health carers, with a carer defined as a "person who has a caring role for a person with a mental health problem or mental illness. They could be family, friends or staff and be paid or unpaid. The role of the carer is not necessarily static or permanent, and may vary over time according to the needs of the consumer and carer."[14]
- ***Provider Safety:*** concerns the extent to which the working environment established and/or maintained for providers of mental health services is safe. A provider is defined as a paid or unpaid employee, contractor or volunteer of a mental health service.
- ***Community Safety:*** concerns the extent to which a safe environment is supported for the broader community. There is currently no standard or sufficient definition of community available to support data and/or indicator development.

2.3.9 SUSTAINABLE: 'System or organisation's capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring)'

Strategic context.

Workforce development is a crucial aspect of quality service delivery and reform and future workforce investments will be underpinned by the development and implementation of a *National Mental Health Workforce Strategy*.[15] The Fourth Plan also highlights the need to support the implementation of evidence-based and innovative service models and practices, underpinned by an active research agenda, including both quantitative and qualitative research led by or involving consumers.

Interpretation of the domain.

In contrast to the *capable* domain which concerns the ability of an organisation to provide services at the current level, the *sustainable* domain concerns the potential of the system to remain viable and meet future levels of demand. Sustainability of mental health services depends on their capacity to build an adequate resource base, attract and retain suitably qualified staff, and apply new knowledge to practice.

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

[14] Ibid, p. 84.

[15] Ibid.

Sub-domains.

Three sub-domains are identified for the mental health sector:

- ***Workforce planning:*** concerns how organisations plan for workforce change and turnover to meet anticipated future demands.
- ***Training investment:*** examines the extent to which the organisation invests in keeping its workforce up to date with current knowledge and in building new skills.
- ***Research investment:*** concerns the extent to which the organisation invests in research activities, both in terms of conducting research and in applying established research findings.

3. Performance indicators in everyday use

3.1 Implementation of national mental health Key Performance Indicators.

In endorsing the National Mental Health Performance Framework in 2005, each state and territory agreed to their implementation, however, not all have the capacity to proceed at an equal pace. The NMHPSC regularly surveys states and territories (the Implementation Survey) on the progress of implementing the NMHPF and the national KPIs to better support the implementation process and inform indicator development.

Since 2005, states and territories have embarked on a range of reforms to their mental health sectors that have had a subsequent impact on the collection and use of information. As at March 2010, there remained considerable variation in the status of implementation across jurisdictions, with some already having an embedded process for regular reporting of performance information to MHSOs, while others are only commencing this process. Whilst each state and territory had implemented a system of reporting mental health system performance information to a range of stakeholders, no two systems are the same.

States and territories have begun to utilise the national KPIs to regularly report performance results to MHSOs, while public reporting of performance information is generally still in its infancy. Two indicators, *28 day readmission rate* and *post-discharge community care*, are reported by all states and territories, albeit at different levels, with some constructed at the jurisdiction level only whilst others are at the MHSO level. No jurisdiction currently constructs and reports all national indicators.

In the 2010 Implementation Survey states and territories identified a range of issues that impact on their implementation of the NMHPF and national KPIs. Some issues are unique to a single jurisdiction whilst others are common across many or all jurisdictions. These included:

- ***Information Systems:*** Each state and territory has their own mental health information system to support the collection of the data required to construct the national KPIs. As such, the capacity and functionality varies between jurisdictions. For example, not all states and territories' mental health information systems generate unique consumer identifiers that enable the capacity to match data between settings or across MHSOs.
- ***Business Practices:*** Every state and territory identified issues with compliance with data entry requirements and business processes. Additionally, states and territories employ different business rules governing data collection practices, and modify some national KPI specifications to fit local requirements. This results in increased utility within the jurisdiction, however, a subsequent decrease in comparability nationally. A program of work is being progressed, both nationally and within individual states and territories, to address these issues.

- ***Access to required expertise:*** The majority of states and territories identified that they can access the expertise to construct indicators, however, the capacity of these resources to conduct all required analyses is limited. States and territories are required to focus their specialist resources on a broad range of activity for both operational and strategic purposes. Generally, there is greater capacity within central mental health administrations than within MHSOs to construct indicators and analyse results.
- ***KPI Specifications:*** All states and territories identified a requirement for more detailed technical specifications to enable appropriate comparisons. Specification and definitional issues and concerns were most commonly associated with indicators requiring access to expenditure and National Outcomes and Casemix Collection (NOCC) data. Another concern relates to the use of the same or a similar title to describe indicators in acute healthcare settings, yet the mental health specification may measure factors that are not directly comparable.
- ***Information Literacy:*** Although there are examples of excellence, and champions exist, each state and territory identified an overall deficit in data and indicator literacy amongst clinical managers, clinicians and other stakeholders. Computer literacy and access may be an issue for a number of individuals and services.

Considerable work has been undertaken to progress and develop the mental health performance agenda, to provide a platform for nationally comparable information for mental health services to utilise in benchmarking activity to inform quality improvement, and shape a more accountable and transparent mental health system.

3.2 National Mental Health Benchmarking Project.

Improving service quality has been a theme of the National Mental Health Strategy since it began in 1992. Each of the National Mental Health Plans has supported this objective and there have been increasing demands for both funders and service providers to accelerate efforts to improve outcomes for people affected by mental illness. The National Mental Health Benchmarking Project (the Project) was developed as a collaborative initiative between the Australian and state and territory governments. During 2006–2008 the Project convened demonstration benchmarking forums in each of the main mental health target populations: general adult, child and adolescents, older persons and forensic mental health services. There were four core objectives of the Project:

- promote the sharing of information between organisations to better understand variations in data and promote acceptance of the process of comparison as a fundamental concept/principle;
- identify the benefits, barriers and issues arising for organisations in the mental health field engaging in benchmarking activities;
- learn what is required to promote such practices on a wider scale; and
- evaluate the suitability of the Framework (domains, sub domains and mental health key performance indicators) as a basis for benchmarking and identifying areas for future improvement of the Framework and its implementation.

The Project was an opportunity for the participating organisations to deconstruct the complex process of making data and indicators relevant to service and clinical practice, to explore and analyse differences in performance through peer comparisons, and to test how benchmarking concepts can be utilised within mental health services.

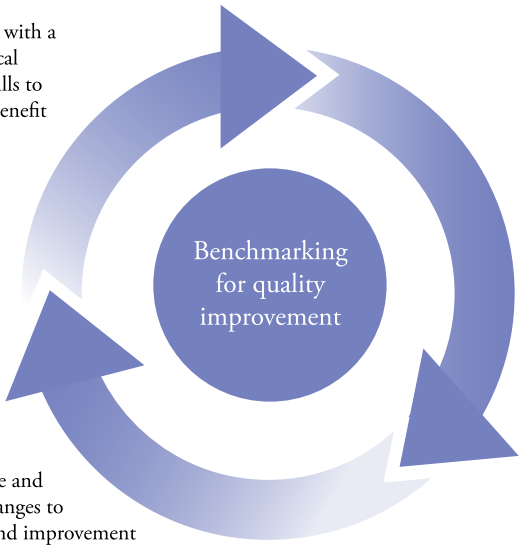
To illustrate how benchmarking can support service improvement through identifying, measuring and evaluating performance issues two case studies from the Project are outlined in Boxes 1 and 2. As the case study in Box 1 demonstrates, understanding and improving performance requires a significant investment. It generally takes collaborative effort over an extended period of time before the impact of incremental improvements become evident in the data, identifying that changes in outcomes have occurred.

The case study in Box 2 highlights the importance of exploring the source or cause of differences in performance. The Project utilised the 13 KPIs which were then included in the national indicator set, however, each forum required access to significantly more data to help them analyse performance and understand the source of variation.

The Project met its four core objectives to varying extents. It was resource intensive and expensive and it is not a model that can be replicated on an ongoing basis. However, through this Project much has been learnt about benchmarking mental health services in Australia. Participating services and the project steering committee identified actions and associated roles and responsibilities at two levels of the sector—the mental health service organisation and the health authority as policy developers and funder. The project recommendations, outlined in Figure 5, were formed on the basis that contributions from the different levels should complement and enhance benchmarking activity.

Figure 5: National Mental Health Benchmarking Project key recommendations.

Recommendation One:
Workforce development with a focus on technical, clinical utility and leadership skills to enable services to fully benefit from participation in benchmarking activity.

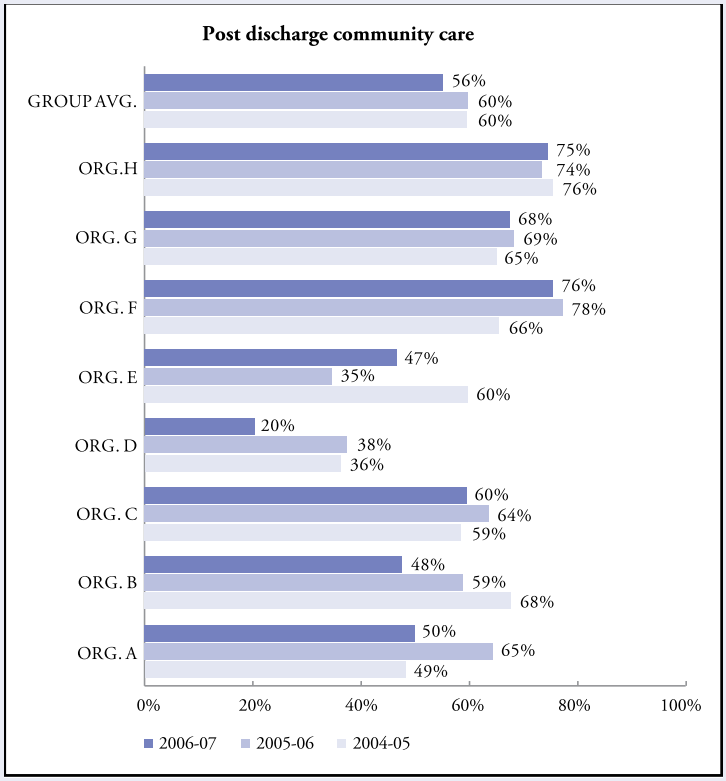


Recommendation Two:
Development, enhancement and support for the technological infrastructure required to enable efficient and appropriate use of quality information for benchmarking.

Recommendation Three:
Foster leadership, culture and process management changes to enhance collaboration and improvement of communication and information dissemination in alignment with the National Mental Health Performance Framework.

The evaluation findings of the Project highlight that sustainable benchmarking processes are complex and influenced by a range of factors including data quality and service models. Nevertheless, the advice and outputs from the Project provide a mental health service organisation perspective that informs future discussion and activity by stakeholders, including both service providers and funders. Clearly benchmarking is an evolutionary process and as identified by the Project there are benefits from integrating this type of activity into a quality improvement cycle for mental health services.

Box 1: Change is possible… but it takes time.



Participating organisations undertook a range of activity to interrogate the data, identify potential explanations of performance, and implement action targeted at improving their performance. In the adult mental health services forum, participants focused on their performance in relation to community contact within 1–7 days following discharge from an acute inpatient unit. Whilst there were mixed views regarding what constitutes good performance measured by this indicator, participants agreed that in general a higher level of follow-up was desirable. The 2004–2005 baseline data showed considerable variation between organisations (see figure right), from 20–75 percent, and a group average of 56 percent. In 2006–2007, the variation between services had reduced and the group average rose slightly to 60 percent.

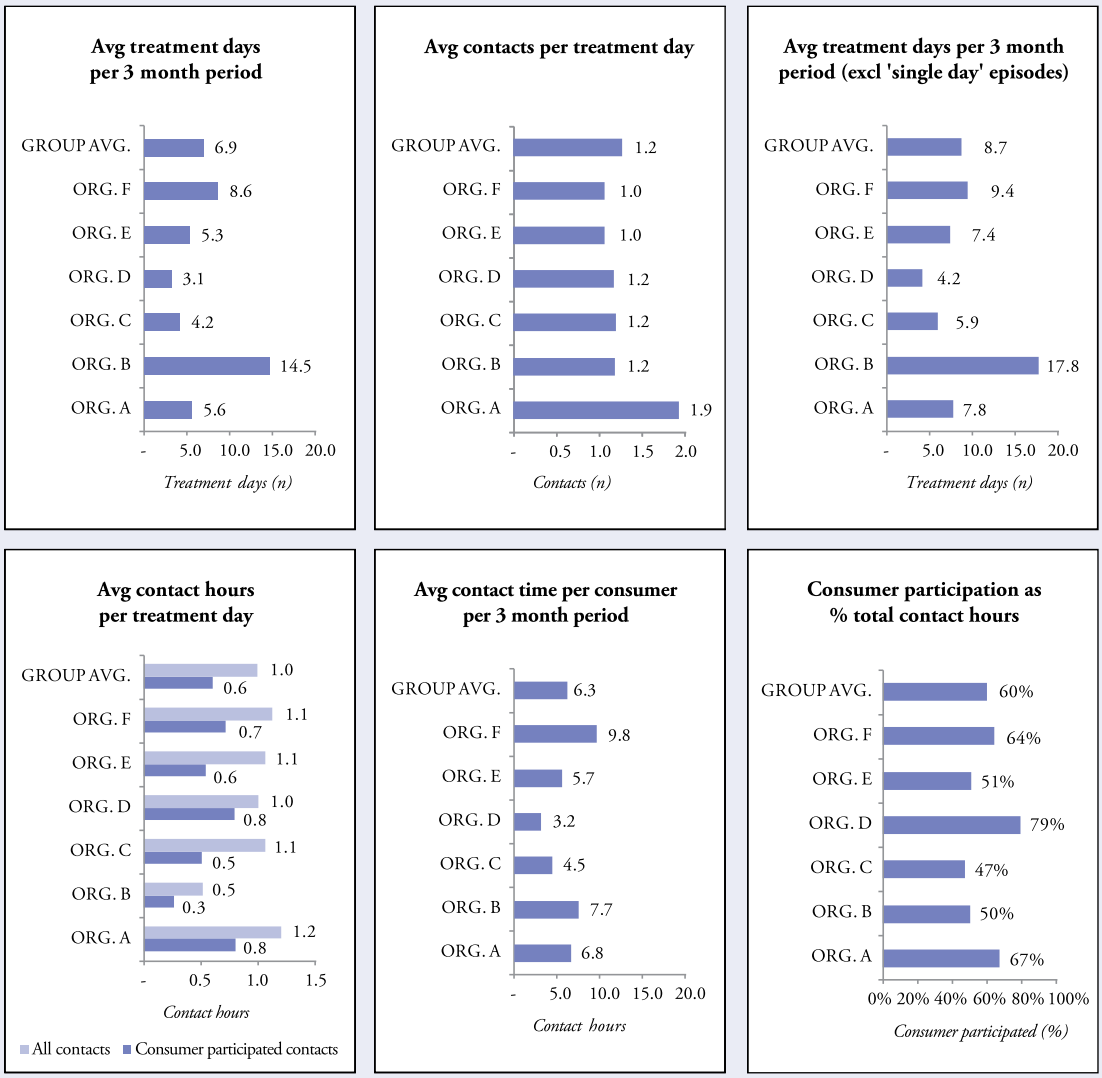
Over the three years of data, it was evident that performance did change, albeit it was varied across organisations. Organisation B undertook a range of activity aimed at improving their understanding of local business practices, and implementing strategies to improve the quality of data, such as standardised business processes and clearer definitions for data entry. This service identified an enhancement to its existing business process which impacted on the improvement in their performance.

Data availability and quality remained a significant issue which impacted on some services' ability to direct activity and monitor change, however, it was recognised that improvement must start somewhere and can only be achieved by analysing gaps between desired results and actual results and by developing a strategic and integrated approach to increasing performance effectiveness. The activity implemented by most organisations was not a significant overhaul of clinical practice, rather most organisations focused on manageable sized actions such as refining business process.

The work undertaken in relation to this example highlights that sustainable change takes time. Over the past two decades the foundation of Australia's mental health services performance management has been laid through the ongoing development of cost, quality and outcome information collection systems. However, we are only beginning to see the potential impact of benchmarking and significant continued effort is needed to utilise information to meaningfully evaluate performance.

Box 2: More than 13 indicators… exploring complexity and organisational differences.

The core data set utilised in the Project was the initial 13 KPIs included in the national indicator set. However, to support appropriate analysis and understanding, each forum was presented with more than 40 supplementary indicators covering a range of different themes, including: productivity and activity of ambulatory services; continuity of care; access to ambulatory care; casemix; and safety. The child and adolescent mental health services forum further investigated measures of ambulatory care by modifying the specifications of the national indicator (such as removing single treatment day episodes), as well as considering the differences in duration and client participation across participants. The following figures show the indicators and output investigated for 2006–2007.



These analyses provided insight into the variation in service models and practice that was not evident from the single indicator. The addition of supplementary and contextual indicators enabled more accurate comparisons across organisations, and supported target discussion and investigation into performance issues.

4. Next steps

The Fourth Plan articulates that developing a clear performance and benchmarking framework across the mental health service system will enable comparison between services and within services over time, and is a key tool for promoting quality improvement in health care.

Whilst the initial focus has been on clinical services provided by public sector state and territory services, the current policy context acknowledges that coordinating care between the health system and other areas of government service delivery are required to provide effective services to support consumers and their families towards recovery. Future initiatives will aim to increase the ability of people with a mental illness to participate in the community, employment, education and training, and their access to stable accommodation.

The National Mental Health Performance Framework has been designed to incorporate these determinants and recognises the critical role these community and non-clinical services play in complementing the role of specialised health services. However, the primary focus to date has been in the public mental health sector and continued work is required to broaden the indicators to enable performance reporting of the entire mental health system.

The National Mental Health Performance Subcommittee will continue to refine and develop the current indicator set considering all sectors involved in mental health care and the requirement to build a culture of continuous quality improvement. A full consultative review of the Framework and indicator set will be undertaken with the aim of releasing a third edition of the Framework in 2013. This review will fully consider the implications of the modification to the National Health Performance Framework and further incorporate learnings from the National Mental Health Benchmarking Project, state and territory implementation and jurisdictions and evolving reform context.

5. Appendices

5.1 Technical specifications.

MHS PI 1: Change in consumers' clinical outcomes.	
Strategic issue.	Mental health services provide a range of services and interventions for consumers that aim to improve clinical outcomes.
Rationale.	• Improvement in clinical outcomes, measured by a reduction in the severity of symptoms and improvements in functioning, is a core objective of mental health services. • The implementation of routine mental health outcome measurement in Australia provides the opportunity to monitor the effectiveness of mental health services across services and jurisdictions. • Identifying the comparative effectiveness of mental health services informs benchmarking between services and related service quality improvement activities.
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.
Date last updated.	24 March 2011.
Indicator details.	
Description.	The proportion of episodes of care, or partial episodes, where either: • significant improvement. • significant deterioration. • no significant change. was identified between baseline and follow-up of completed outcome measures.
Numerator.	Number of episodes or partial episodes with completed outcome measures, partitioned by mental health setting, where either significant change/significant deterioration/no significant change was identified between *baseline* and *follow-up* within the reference period.
Denominator.	Number of episodes or partial episodes of care with completed outcome measures, partitioned by mental health setting within the reference period.
Computation.	(Numerator ÷ Denominator) x 100 . Calculated separately for each group.

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

MHS PI 1: Change in consumers' clinical outcomes.	
Definitions.	• Health of the Nation Outcome Scales (HoNOS) family includes HoNOS, HoNOS 65+ and HoNOS Children and Adolescents (HoNOSCA). • As defined by the National Outcomes and Casemix Collection (NOCC) Specifications Version 1.6, an *Episode of Care* is defined as a more or less continuous period of contact between a consumer and a *Mental Health Service Organisation* that occurs within the one *Mental Health Service Setting*. • Episodes of Care may be brief or prolonged, and may be provided in three settings – inpatient, ambulatory or residential. Under the NOCC protocol, a consumer may be in only one episode of mental health care at any one time. • The term 'partial episode' is used here to refer to the period between baseline and follow-up measurement for those consumers who are in ongoing ambulatory episodes (See Group C). • Effect size is a statistic used to assess the magnitude of a treatment effect. It is based on the ratio of the difference between the baseline and follow-up scores to the standard deviation of the baseline score. As a rule of thumb, effect sizes of 0.2 are considered small, 0.5 considered medium and 0.8 considered large. Based on this rule, a medium effect size of 0.5 is used to assign outcome scores to the three outcome categories. Thus individual episodes are classified as either: 'significant improvement' if the Effect Size index is greater than or equal to positive 0.5; 'significant deterioration' if the Effect Size index is less than or equal to negative 0.5; or 'no change' if the index is between -0.5 and 0.
Presentation.	Percentage by group by setting.
Disaggregation.	• Target population. • Diagnosis.
Notes .	• A specific issue in the interpretation of 'change' scores is how they relate to 'expectations of change' for a given consumer within a given mental health service setting. For consumers who have episodes of care in acute inpatient settings, it is generally accepted that there may be positive significant change as measured by the HoNOS family. In ambulatory settings, the outcome for some people would be improvement, but the outcome for others might be prevention of relapse (ie, no change). The thresholds for change need to be specific to mental health service settings and programs. • This indicator is only indicative of a single type of effectiveness and outcome for mental health consumers. Where possible, NOCC-based consumer outcome measures should be complemented by one or more other measures of consumer outcomes (eg, social outcomes – housing tenure, employment etc) that demonstrate the different perspectives on, and dimensions of, mental health consumer outcomes. • This indicator addresses the sub-domain of consumer outcomes, and assesses severity of symptoms from the clinician's perspective. Improvements on other measures that assess other dimensions from both clinician and consumer perspectives should be considered for future development of performance indicators. • The national data set does not currently allow episodes of care to be connected across financial years. This limitation does not exist for states and territories own data sets. • This indicator was designed as a measure of aggregate group change.
Is specification interim or long-term?	Long-term.
Reported in.	COAG National Action Plan Progress Report (Indicator 6 Mental health outcomes for people who receive treatment from state and Territory services and the private hospital system).

MHS PI 1: Change in consumers' clinical outcomes.				
National Mental Health Performance Framework.				
Tier.	Tier 3 – Health System Performance.			
Primary domain.	Effective.			
Secondary domains.	-			
Mental health sub-domain.	Consumer outcomes.			
Type of measure.	Outcome.			
Level at which indicator can be useful for benchmarking.	Service unit.	☑	Mental Health Service Organisation.	☑
	Regional group of services.	☑	State/Territory.	☑
Related performance indicators and performance benchmarks.	-			
Data collection details				
Data source(s).	Numerator:	National Outcomes and Casemix Collection.		
	Denominator:	National Outcomes and Casemix Collection.		
Data source(s) type.	Numerator:	Clinical outcome measure.		
	Denominator:	Clinical outcome measure.		
Frequency of data source(s) collection.	Numerator:	Annually.		
	Denominator:	Annually.		
Data development.	Short-term:	-		
	Medium-term:	-		
	Long-term:	-		

MHS PI 2: 28 day readmission rate.		
Strategic issue.	High levels of readmissions within a short time frame are widely regarded as reflecting deficiencies in inpatient treatment and/or follow-up care and potentially points to inadequacies in the functioning of the overall system.	
Rationale.	• Mental health inpatient services aim to provide treatment that enables individuals to return to the community as soon as possible. Readmissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital. In this sense, they potentially point to deficiencies in the functioning of the overall care system. • Avoidable rapid readmissions place pressure on finite beds. • International literature identifies the concept of one month as an appropriate defined time period for the measurement of unplanned readmissions following separation from an acute inpatient mental health service.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	Proportion of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient units that are followed by readmission to the same or to another public sector acute psychiatric inpatient unit within 28 days of discharge.	
Numerator.	Number of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) occurring within the reference period, that are followed by a readmission to the same or another acute psychiatric inpatient unit within 28 days.	
Denominator.	Number of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) occurring within the reference period.	
Computation.	(Numerator ÷ Denominator) x 100.	
Calculation conditions.	Coverage/ Scope:	All public mental health service organisations acute psychiatric inpatient units. The following separations are excluded: • Same day separations, including index separation and subsequent readmission. • Statistical and change of care type separations. • Separations that end by transfer to another acute or psychiatric hospital. • Separations that end by death, left against medical advice/discharge at own risk. • Separations where length of stay is one night only and procedure code for ECT is recorded.
	Methodology:	• Readmission is considered to have occurred if the person has been admitted to any public sector mental health acute inpatient unit within the state/territory. As such a state-wide unique patient identifier is required for full implementation of this indicator. • Where a mental health service organisation has more than one unit of a particular service type for the purpose of this indicator those units should be combined. • Procedure code for ECT identified from the ACHI 7th edition: Electroconvulsive therapy Block 1907.
Definitions.	• Same day separations are defined as inpatient episodes where the admission and separation dates are the same. • 'Same or another public acute psychiatric inpatient unit': for the purposes of this indicator 'another' means within the same jurisdiction.	
Presentation.	Percentage.	

MHS PI 2: 28 day readmission rate.				
Disaggregation.	• Target population. • Remoteness. • Diagnosis groupings. • Involuntary status.			
Notes .	• Due to limitations of the data, the indicator cannot differentiate between planned and unplanned readmissions. • This indicator will not track readmissions across state/territory boundaries or track movement between public and private hospitals.			
Is specification interim or long-term?	Long-term.			
Reported in.	• Council of Australian Governments (COAG) National Action Plan on Mental Health Progress Reports. • Report on Government Services.			
National Mental Health Performance Framework				
Tier.	Tier 3 – Health Service Performance.			
Primary domain.	Effective .			
Secondary domain(s).	Continuous.			
Mental health sub-domain.	Community tenure.			
Type of measure .	Outcome.			
Level at which indicator can be useful for benchmarking.	Service unit.	☑	Mental Health Service Organisation.	☑
	Regional group of services.	☑	State/Territory.	☑
Related performance indicators and performance benchmarks.	• Pre-admission community care. • Post-discharge community care. • Average length of acute inpatient stay.			
Data collection details				
Data source(s).	Numerator:	National Minimum Data Set Admitted Patient Mental Health Care or state/territory equivalents.		
	Denominator:	National Minimum Data Set Admitted Patient Mental Health Care or state/territory equivalents.		
Data source(s) type.	Numerator:	Administrative by-product.		
	Denominator:	Administrative by-product.		
Frequency of data source(s) collection.	Numerator:	Annually.		
	Denominator:	Annually.		
Data development.	Short-term:	-		
	Medium-term:	-		
	Long-term:	• Future development of this indicator should consider the impact of the evolving and growing sub-acute mental health sector • Development of unique state-wide patient identifiers in all jurisdictions.		

MHS PI 3: National Service Standards compliance.		
Strategic issue.	National standards are one way in which concerns regarding quality of mental health service delivery may be addressed.	
Rationale.	• Implementation of the National Standards for Mental Health Services has been agreed by all jurisdictions. • Service quality has been a driving force for the National Mental Health Strategy.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	Proportion of the mental health service organisation's services (weighted by expenditure) that have been reviewed against the National Standards for Mental Health Services. The indicator grades services into four categories: • Level 1: Services have been reviewed by an external accreditation agency and judged to have met all national standards. • Level 2: Services have been reviewed by an external accreditation agency and judged to have met some but not all National Standards. • Level 3: Services: (i) are in the process of being reviewed by an external accreditation agency but the outcomes are not known; or (ii) are booked for review by an external accreditation agency. • Level 4: Mental health services that do not meet criteria detailed under Levels 1 to 3.	
Numerator.	Total expenditure by mental health service organisations on mental health services that meet the definition of Level X where X is the level at which the indicator is being measured (either Level 1, Level 2, Level 3 or Level 4).	
Denominator.	Total mental health service organisation expenditure on mental health services.	
Computation.	(Numerator ÷ Denominator) x 100. By level calculated.	
Calculation conditions.	Coverage/Scope:	All public mental health service organisations, with the following exceptions: • Older Persons Mental Health Community Residential Services approved under or working towards the accreditation standards gazetted as part of the Australian Government *Aged Care Act 1997.*
	Methodology:	• Weighted by expenditure within various levels of aggregation above service unit/team.
Definitions.	Mapping of levels to National Minimum Data Set Mental Health Establishments (MHE) codes as follows: *Level 1*: MHE code 1; *Level 2*: MHE codes 2; *Level 3*: MHE codes 3-4; *Level 4*: MHE codes 5-8.	
Presentation.	Percentage.	
Disaggregation.	-	
Notes .	• External review is a process of negotiation between mental health service organisations and the accrediting agency. Accordingly, variations may exist in the extent to which all or some Standards are deemed to be applicable to individual service units. • A review may apply to the service units within a mental health service organisation, not the mental health service organisation as an entity in itself. • External accreditation agencies such as ACHS and QIC use differing review methodologies.	

MHS PI 3: National Service Standards compliance.				
Is specification interim or long-term?	Interim.			
Reported in.	• National Mental Health Report. • Report on Government Services. • Mental Health Services in Australia.			
National Mental Health Performance Framework.				
Tier.	Tier 3 – Health Service Performance			
Primary domain.	Appropriate.			
Secondary domain(s).	Capable.			
Mental health sub-domain.	Community tenure.			
Type of measure .	Process.			
Level at which indicator can be useful for benchmarking.	Service unit.	☐	Mental Health Service Organisation.	☑
	Regional group of services.	☑	State/Territory.	☑
Related performance indicators and performance benchmarks.	Outcomes readiness.			
Data collection details				
Data source(s).	Numerator:	National Minimum Data Set Mental Health Establishments or state/territory equivalent.		
	Denominator:	National Minimum Data Set Mental Health Establishments or state/territory equivalent.		
Data source(s) type.	Numerator:	Administrative by-product.		
	Denominator:	Administrative by-product.		
Frequency of data source(s) collection.	Numerator:	Annually.		
	Denominator:	Annually.		
Data development.	Short-term:	New National Standards have been developed, and work is underway to establish a method of measuring compliance, this indicator will be revised accordingly.		
	Medium-term:	-		
	Long-term:	-		

MHS PI 4: Average length of acute inpatient stay.		
Strategic issue.	To better understand the factors underlying variation in inpatient episode costs.	
Rationale.	• Length of stay is the main driver of variation in inpatient episode cost and reflects differences between mental health service organisations in practice, casemix or both. Inclusion of this indicator promotes a fuller understanding of an organisation's episode costs as well as providing a basis for utilisation review. For example, it allows services provided to particular patient groups to be assessed against any clinical protocols developed for those groups. • This measure enables average bed day costs to be derived when used in conjunction with a measure of average cost per overnight acute inpatient episode.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	Average length of stay of in-scope overnight separations from acute psychiatric inpatient units managed by the mental health service organisation.	
Numerator.	Number of patient days in the mental health service organisation's acute psychiatric inpatient unit(s) accounted for by in-scope overnight separations during the reference period.	
Denominator.	Number of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) occurring within the reference period.	
Computation.	Numerator ÷ Denominator.	
Calculation conditions.	Coverage/Scope:	All public mental health service organisations acute psychiatric inpatient units. The following separation and associated patient days are excluded: • Same day separations. For jurisdictional level reporting the following separation and associated patient days are excluded: • Forensic services.
	Methodology:	• Length of stay is measured in patient days. • Length of stay of an overnight stay patient is calculated by subtracting the admission date from the date of separation and deducting total leave days.
Definitions.	• Episodes are defined as 'acute' on the basis of the classification of the inpatient unit according to the definitions used in the National Minimum Data Set Mental Health Establishments. • Same day separations are defined as inpatient episodes where the admission and separation dates are the same.	
Presentation.	Number.	
Disaggregation.	• Target population. • Disorder specific services.	
Notes.	• Casemix adjustment is needed to interpret variation between organisations – to distinguish patient and provider factors. • Same day admissions are a confounding issue that require the identification of intent of admission (that is, day care or overnight stay). • Leave presents special complexities in the mental health area and further work is required to ensure that it does not distort this indicator.	

MHS PI 4: Average length of acute inpatient stay.					
Is specification interim or long-term?	Long-term.				
Reported in.	-				
National Mental Health Performance Framework.					
Tier.	Tier 3 – Health Service Performance.				
Primary domain.	Efficient.				
Secondary domain(s).	Appropriate.				
Mental health sub-domain.	Inpatient.				
Type of measure .	Process.				
Level at which indicator can be useful for benchmarking.	Service unit.	☑	Mental Health Service Organisation.	☑	
	Regional group of services.	☑	State/Territory.	☑	
Related performance indicators and performance benchmarks.	• 28-day readmission rate. • Average cost per acute inpatient episode.				
Data collection details.					
Data source(s).	Numerator:	National Minimum Data Set Admitted Patient Mental Health Care or state/territory equivalent.			
	Denominator:	National Minimum Data Set Admitted Patient Mental Health Care or state/territory equivalent.			
Data source(s) type.	Numerator:	Administrative by-product.			
	Denominator:	Administrative by-product.			
Frequency of data source(s) collection.	Numerator:	Annually.			
	Denominator:	Annually.			
Data development.	Short-term:	-			
	Medium-term:	• Standardised definitions and methodology to identify acute units that provide particular functions, such as disorder specific services, within jurisdictions. • Appropriate methodology for casemix adjustment required.			
	Long-term:	Comparable efficiency indicators for admitted patient programs other than acute (eg: rehabilitation or extended care) and residential facilities need to be developed.			

MHS PI 5: Average cost per acute inpatient episode.		
Strategic issue.	Efficient functioning of public mental health acute inpatient units is critical to ensuring that finite funds are used effectively to deliver maximum community benefit.	
Rationale.	• Unit costs are a core feature of management-level indicators in all industries and are necessary to understand how well an organisation uses its resources in producing services. They are fundamental to value for money judgements. • Acute mental health inpatient units account for 70 percent of the total costs of specialised mental health inpatient care and 36 percent of overall delivery costs. • This indicator is based on the concept of the episode as the patient care product that should be the focus for indicator development, and is designed to give more direct estimates of technical efficiency.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	Average cost of in-scope overnight separations from acute psychiatric inpatient units managed by the mental health service organisation.	
Numerator.	Total recurrent expenditure occurring within the mental health service organisation's acute inpatient unit(s) during the reference period.	
Denominator.	Number of in-scope acute inpatient episodes occurring within the mental health service organisation's acute psychiatric inpatient unit(s) during the reference period.	
Computation.	Numerator ÷ Denominator.	
Calculation conditions.	Coverage/Scope:	All public mental health service organisations acute psychiatric inpatient units. The following activity and associated expenditure are excluded: • Same day separations. For jurisdictional level reporting the following activity and associated expenditure are excluded: • Forensic services.
	Methodology:	• Episode cost is calculated as (total patient days) x (average patient day cost) where (average patient day cost) = (total recurrent expenditure)/(total patient days). • The proportion of patient days attributable to excluded episodes should be removed from both *total patient days* and *total recurrent expenditure.*
Definitions.	• Episodes are defined as 'acute' on the basis of the classification of the inpatient unit according to the definitions used in the National Minimum Data Set Mental Health Establishments. • Recurrent costs include costs directly attributable to the unit(s) plus a proportional share of indirect costs. Cost data for this indicator is based on gross recurrent expenditure as compiled by Health Departments according to the specifications of the National Minimum Data Set (NMDS) Mental Health Establishments. As such, it is subject to the concepts, definitions and costing methodology developed for the NMDS. • Same day separations are defined as inpatient episodes where the admission and separation dates are the same.	
Presentation.	Currency.	
Disaggregation.	• Target population. • Disorder specific services.	

MHS PI 5: Average cost per acute inpatient episode.				
Notes.	• Casemix adjustment is needed to interpret variation between organisations – to distinguish patient and provider factors. • Leave presents special complexities in the mental health area and further work is required to ensure that it does not distort this indicator. • Episode costs may be affected by provider factors beyond management control (for example, high fixed costs in institutions during downsizing, structural or design problems with units that need to be countered through higher rostering levels, etc). • There is a need for considerable development of episode costing within mental health (for example, the inclusion/exclusion of teaching and research expenditure, costing according to actual service use, etc). • Variations in costing methodologies may occur between mental health service organisations.			
Is specification interim or long-term?	Interim.			
Reported in.	-			
National Mental Health Performance Framework.				
Tier.	Tier 3 – Health Service Performance.			
Primary domain.	Efficient.			
Secondary domain(s).	-			
Mental health sub-domain.	Inpatient.			
Type of measure.	Process.			
Level at which indicator can be useful for benchmarking.	Service unit.	☐	Mental Health Service Organisation.	☑
	Regional group of services.	☑	State/Territory.	☑
Related performance indicators and performance benchmarks.	Average length of acute inpatient stay.			
Data collection details				
Data source(s).	Numerator:	National Minimum Data Set Mental Health Establishments or state/territory equivalent.		
	Denominator:	National Minimum Data Set Admitted Patient Mental Health Care or state/territory equivalent.		
Data source(s) type.	Numerator:	Administrative by-product.		
	Denominator:	Administrative by-product.		
Frequency of data source(s) collection.	Numerator:	Annually.		
	Denominator:	Annually.		
Data development.	Short-term:	Consideration of developments in Activity Based Funding will inform future modifications of this indicator.		
	Medium-term:	• Standardised definitions and methodology to identify acute units that provide particular functions, such as disorder specific services, within jurisdictions. • Methodology for casemix adjustment is required.		
	Long-term:	Comparable efficiency indicators for extended care and residential facilities need to be developed.		

MHS PI 6: Average treatment days per three-month community care period.		
Strategic issue.	To better understand the factors underlying variation in community care costs.	
Rationale.	• The number of treatment days is the community counterpart of length of stay and provides an indication of the relative volume of care provided to people seen in ambulatory care. • Frequency of servicing is the main driver of variation in community care costs and may reflect differences between health service organisation practices. Inclusion of this indicator promotes a fuller understanding of an organisation's community care costs as well as providing a basis for utilisation review. For example, it allows the frequency of servicing of particular patient groups in the community to be assessed against any clinical protocols developed for those groups. • When combined with average costs per three month community care period, it allows average treatment day costs to be derived should this be required. • May also demonstrate degrees of accessibility to public sector community mental health services.	
Endorsement status.	Endorsed by Australian Health Ministers Advisory Council.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	Average number of community treatment days per three month period of ambulatory care provided by the mental health service organisation's community mental health services.	
Numerator.	Number of community treatment days provided by the mental health service organisation's community mental health services within the reference period.	
Denominator.	Number of ambulatory care statistical episodes (three month periods) treated by the mental health service organisation's community services within the reference period.	
Computation.	Numerator ÷ Denominator.	
Calculation conditions.	Coverage/Scope:	All public mental health service organisations community mental health services. The following services are excluded: • Community residential mental health services. The following activity of community mental health services are excluded: • All activity (treatment days and statistical episodes) associated with non-uniquely identified consumers.
	Methodology:	• Episode based datasets to be constructed from contact data at analysis rather than collected as discrete variable. • For the purposes of this measure, ambulatory community care statistical episodes will consist of the following fixed three monthly periods; January–March, April–June, July–September, and October–December.
Definitions.	• A statistically derived community episode is defined as each three month period of ambulatory care of an individual registered patient where the patient was under 'active care', defined as one or more treatment days in the period. Each patient is counted uniquely at the mental health service organisation level, regardless of the number of teams or community programs involved in his/her care. • Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode. • 'Non-uniquely identifiable consumers' refers to service contacts for which a unique person identifier was not recorded.	
Presentation.	Number.	
Disaggregation.	Target population.	

MHS PI 6: Average treatment days per three-month community care period.					
Notes.	• Casemix adjustment is needed to interpret variation between organisations to distinguish patient and provider factors. • Further development of national funding models, including episode-based or casemix models will enable more meaningful measurement than the arbitrary three month period used in this indicator.				
Is specification interim or long-term?	Interim.				
Reported in.	• Mental Health Services in Australia. • Report on Government Services.				
National Mental Health Performance Framework.					
Tier.	Tier 3 – Health Service Performance.				
Primary domain.	Efficient.				
Secondary domain(s).	Appropriate.				
Mental health sub-domain.	Community.				
Type of measure.	Process.				
Level at which indicator can be useful for benchmarking.	Service unit.	☑	Mental Health Service Organisation.	☑	
	Regional group of services.	☑	State/Territory.	☑	
Related performance indicators and performance benchmarks.	Average cost per three-month community care period.				
Data collection details					
Data source(s).	Numerator:	National Minimum Data Set Community Mental Health Care or state/territory equivalent.			
	Denominator:	National Minimum Data Set Community Mental Health Care or state/territory equivalent.			
Data source(s) type.	Numerator:	Administrative by-product.			
	Denominator:	Administrative by-product.			
Frequency of data source(s) collection.	Numerator:	Annually.			
	Denominator:	Annually.			
Data development.	Short-term:	-			
	Medium-term:	• 'One treatment day' episodes are defined as an episode with less than two treatment days. These episodes are a potentially confounding factor and require segregation to ensure like-with-like comparisons. A consistent methodology for accounting for 'one treatment day' ambulatory episodes is required. • Methodology to collect multifaceted levels of service usage, such as intensity and complexity issues and the impact on contact duration, is needed in order to improve cost modelling and efficiency measurement in general. • Methodology for casemix adjustment is required. • Accurate reporting at levels above that of mental health service organisation requires unique state-wide patient identifiers which are not currently available in all jurisdictions.			
	Long-term:	-			

MHS PI 7: Average cost per three-month community care period.		
Strategic issue.	Efficient functioning of public community mental health services is critical to ensure that finite funds are used effectively to deliver maximum community benefit.	
Rationale.	• Unit costs are a core feature of management-level indicators in all industries and are necessary to understand how well an organisation uses its resources in producing services. They can be fundamental to value for money judgements. • Previous estimates of unit costs in community care have been compromised by inadequate product definition. Most commonly, estimates have been based on average cost per occasion of service, and provide little indication of the overall costs of care. • This indicator is based on the concept of a statistically derived episode as the patient care product that should be the focus for indicator development for community mental health services.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	Average cost per three month period of ambulatory care provided by the mental health service organisation's community mental health services.	
Numerator.	Total mental health service organisation recurrent expenditure on community mental health ambulatory care services within the reference period.	
Denominator.	Total number of ambulatory care statistical episodes (three month periods) treated by the mental health service organisation within the reference period.	
Computation.	Numerator ÷ Denominator.	
Calculation conditions.	Coverage/ Scope:	All public mental health service organisations community mental health services . The following services are excluded: • Community residential mental health services. The following activity and associated expenditure of community mental health services are excluded: • All activity (treatment days and statistical episodes) associated with non-uniquely identified consumers.
	Methodology:	• Episode based datasets to be constructed from contact data at analysis rather than collected as discrete variable. • For the purposes of this measure, ambulatory statistical episodes will consist of the following fixed three monthly periods; January–March, April–June, July–September, and October–December.
Definitions.	• A statistically derived community episode is defined as each three month period of ambulatory care of an individual registered patient where the patient was under 'active care', defined as one or more treatment days in the period. Each patient is counted uniquely at the mental health service organisation level, regardless of the number of teams or community programs involved in his/her care. • There is no national definition for 'unregistered clients', as such until an NMDS outcome is reached the most appropriate alternative to 'dummy' or 'unregistered' client is 'non-uniquely identifiable consumers'. For the purposes of this indicator this term refers to service contacts for which a unique person identifier was not recorded. • Recurrent costs include costs directly attributable to the unit(s) plus a proportional share of indirect costs. Cost data for this indicator is based on gross recurrent expenditure as compiled by Health Departments according to the specifications of the National Minimum Data Set – Mental Health Establishments. As such, it is subject to the concepts, definitions and costing methodology developed for the NMDS.	
Presentation.	Number.	
Disaggregation.	Target population.	

MHS PI 7: Average cost per three-month community care period.					
Notes.	• Constructing this indicator using the mental health NMDS data has limitations. • Casemix adjustment is needed to interpret variation between organisations to distinguish patient and provider factors. • Further development of national funding models, including episode-based or casemix models will enable more meaningful measurement than the arbitrary three month period used in this indicator.				
Is specification interim or long term?	Interim.				
Reported in.	-				
National Mental Health Performance Framework.					
Tier.	Tier 3 – Health Service Performance.				
Primary domain.	Efficient.				
Secondary domain(s).	-				
Mental health sub-domain.	Community.				
Type of measure .	Process.				
Level at which indicator can be useful for benchmarking.	Service unit.	☐	Mental Health Service Organisation.	☑	
	Regional group of services.	☑	State/Territory.	☑	
Related performance indicators and performance benchmarks.	Average cost per three-month community care period.				
Data collection details.					
Data source(s).	Numerator:	National Minimum Data Set Mental Health Establishments or state/territory equivalent.			
	Denominator:	National Minimum Data Set Community Mental Health Care or state/territory equivalent.			
Data source(s) type.	Numerator:	Administrative by-product.			
	Denominator:	Administrative by-product.			
Frequency of data source(s) collection.	Numerator:	Annually.			
	Denominator:	Annually.			
Data development.	Short-term:	-			
	Medium-term:	• 'One treatment day' episodes are defined as an episode with less than two treatment days. These episodes are a potentially confounding factor and require segregation to ensure like-with-like comparisons. A consistent methodology for accounting for 'one treatment day' ambulatory episodes is required. • Contact duration data is needed for a more sophisticated cost modelling methodology. • Methodology for casemix adjustment is required, • Accurate reporting at levels above that of mental health service organisation requires unique state-wide patient identifiers which are not currently available in all jurisdictions.			
	Long-term:	-			

MHS PI 8: Population receiving care.		
Strategic issue	Access to public sector mental health services is an issue of significant public concern.	
Rationale.	• The issue of unmet need has become prominent since the National Survey of Mental Health and Wellbeing indicated that a majority of adults and younger persons affected by a mental disorder do not receive treatment . • The implication for performance indicators is that a measure is required to monitor population treatment rates and assess these against what is known about the distribution of mental disorders in the community. • Access issues figure prominently in concerns expressed by consumers and carers about the mental health care they receive. More recently, these concerns are being echoed in the wider community. • Most jurisdictions have organised their mental health services to serve defined catchment populations, allowing comparisons of relative population coverage to be made between organisations.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	Percentage of persons resident in the mental health service organisation's defined catchment area who received care from a public sector ambulatory mental health service.	
Numerator.	Number of persons resident in the defined MHSO catchment area who are recorded as receiving one or more ambulatory service contact from a public sector mental health service organisation in the reference period.	
Denominator.	Number of persons resident in the defined MHSO catchment area within the reference period.	
Computation.	(Numerator ÷ Denominator) x 100.	
Calculation conditions.	Coverage/ Scope:	All public mental health service organisations.
	Methodology:	• Requires a non-duplicated person count, using a unique state-wide identifier. • Statistical local area codes or postcodes recorded at time of community contact need to be mapped to mental health service organisation catchment population boundaries.
Definitions.	An ambulatory service contact is the provision of a clinically significant service by a specialised mental health service provider(s) for patients/clients, other than those patients/ clients admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24 hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.	
Presentation.	Percentage.	
Disaggregation.	• Age. • Remoteness. • Indigenous status. • Diagnosis groupings.	

MHS PI 8: Population receiving care.				
Notes.	• As defined populations may receive services from organisations other than their catchment provider, this measure is not a 'pure' indicator of mental health service organisation performance but more about service utilisation by the population they serve. However, it is regarded as an important indicator to understand the overall relationship of the mental health service organisation in relation to its catchment population needs. • Resource allocation based on psychiatric epidemiology, associated morbidity and disability, mortality and socio-demographic factors is generally regarded as resulting in more equitable distribution of resources in relation to local need than funding strategies based on service-utilisation and population size alone. This indicator advances these concepts by creating scope in the future to compare expected treatment rates to actuals. • This measure does not consider the roles of primary mental health care or the specialist private mental health sector. While people who received care from specialist non-government organisations are not counted, it is expected that these people will be captured by the activities of clinical services. • This measure may under report levels of service access in areas where persons are able to access public sector mental health services across jurisdictional boundaries.			
Is specification interim or long-term?	Interim.			
Reported in.	NHA (National Healthcare Agreement).			
National Mental Health Performance Framework.				
Tier.	Tier 3 – Health Service Performance.			
Primary domain.	Accessible.			
Secondary domain(s).	-			
Mental health sub-domain.	Access for those in need.			
Type of measure.	Process.			
Level at which indicator can be useful for benchmarking.	Service unit.	☐	Mental Health Service Organisation.	☑
	Regional group of services.	☑	State/Territory.	☑
Related performance indicators and performance benchmarks.	• New client index. • Comparative area resources.			
Data collection details				
Data source(s).	Numerator:	National Minimum Data Set Community Mental Health Care or state/territory equivalent.		
	Denominator:	Australian Bureau of Statistics Estimated Resident Population (or equivalent).		
Data source(s) type.	Numerator:	Administrative by-product.		
	Denominator:	Census-based.		
Frequency of data source(s) collection.	Numerator:	Annually.		
	Denominator:	Annually.		
Data development.	Short-term:	-		
	Medium-term:	-		
	Long-term:	Development of unique state-wide patient identifiers in all jurisdictions.		

MHS PI 9: New client index.		
Strategic issue.	Access to services by persons requiring care is a key issue. There is significant concern that the public sector mental health service system is inadequately responding to new people requiring care.	
Rationale.	• Existing population treatment rates (generally less than one percent) are relatively low • There is concern that public sector mental health services invest a disproportionate level of resources in dealing with existing clients and too little in responding to the needs of new clients as they present.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	New clients as a proportion of total clients under the care of the mental health service organisation's mental health services.	
Numerator.	Number of new clients who received services from the mental health service organisation's specialised mental health services within the reference period.	
Denominator.	Number of clients who received services from the mental health service organisation's specialised mental health services within the reference period.	
Computation.	(Numerator ÷ Denominator) x 100.	
Calculation conditions.	Coverage/ Scope:	All public mental health service organisations.
	Methodology:	-
Definitions.	• Clients in receipt of services include all persons who received one or more community service contacts or had one or more days of inpatient or residential care in the reference period. • Client counts should be unique at the organisation level. • A new client is defined as a consumer who has not been seen in the five years preceding the first contact with the mental health service organisation in the reference period. • The reference period should be calculated on the five year preceding the date of first contact rather than on a calendar year.	
Presentation.	Percentage.	
Disaggregation.	• Setting. • Target population.	
Notes.	• This indicator presents some complexity at the analysis stage and will need to be developed over time. • There are several approaches to defining 'new client' that depend on how the following issues are resolved: – Level of the mental health system at which 'newness' is defined: Clients new to a particular organisation may be existing clients of other organisations. Counts of new clients at the state/territory level would certainly yield lower estimates than those derived from organisation-level counts. – Diagnosis criteria for defining 'newness': A client may present with a new condition, although they have received previous treatment for a different condition. • The approach here is to specify an initial measure for implementation with a view to further refinement following detailed work to address the complexities associated with the definition of a new client, and the possible implementation of unique state-wide patient identifiers within all jurisdictions. • Does not take into account the activities of private mental health services or of primary mental health care or the specialist private mental health sector.	

MHS PI 9: New client index.					
Is specification interim or long-term?	Interim.				
Reported in.	-				
National Mental Health Performance Framework.					
Tier.	Tier 3 – Health Service Performance.				
Primary domain.	Accessible.				
Secondary domain(s).	-				
Mental health sub-domain.	Access for those in need.				
Type of measure.	Process.				
Level at which indicator can be useful for benchmarking.	Service unit.	☐	Mental Health Service Organisation.	☑	
	Regional group of services.	☑	State/Territory.	☑	
Related performance indicators and performance benchmarks.	Population receiving care.				
Data collection details.					
Data source(s).	Numerator:	National Minimum Data Set Community Mental Health Care, National Minimum Data Set Admitted Patient Mental Health Care and National Minimum Data Set Residential Mental Health Care or state/territory equivalent.			
	Denominator:	National Minimum Data Set Community Mental Health Care, National Minimum Data Set Admitted Patient Mental Health Care and National Minimum Data Set Residential Mental Health Care or state/territory equivalent.			
Data source(s) type.	Numerator:	Administrative by-product.			
	Denominator:	Administrative by-product.			
Frequency of data source(s) collection.	Numerator:	Annually.			
	Denominator:	Annually.			
Data development.	Short-term:	-			
	Medium-term:	State-wide reporting requires unique patient identifiers not currently available in most jurisdictions.			
	Long-term:	-			

MHS PI 10: Comparative area resources.		
Strategic issue.	Equity of access to mental health services is, in part, a function of differential level of resources allocated to area populations.	
Rationale.	• Review of comparative resource levels is essential for interpreting overall performance data, for example, an organisation may achieve relatively lower treatment rates because it has relatively less resources available rather than because it uses those resources inefficiently. • When used with measures of population under care this indicator may illustrate relative resourcing in terms local mental health service delivery and therefore accessibility by proxy.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	Per capita recurrent expenditure by the organisation on mental health services (stratified by ambulatory, inpatient and community residential) for the target population within the organisation's defined catchment area.	
Numerator.	Recurrent expenditure on mental health services partitioned by ambulatory, inpatient and community residential services.	
Denominator.	Total number of persons who were resident in the defined catchment area for the mental health service organisation's services, partitioned by ambulatory, inpatient and community residential services.	
Computation.	Numerator ÷ Denominator.	
Calculation conditions.	Coverage/ Scope:	All public mental health service organisations. The following services are excluded: • Public sector mental health services that provide a cross regional or a state-wide specialist function.
	Methodology:	• Estimates of expenditure for defined populations are based on expenditure reported by the mental health service organisation with specific catchment responsibility for the population, adjusted to remove any cross-regional and state-wide services included in the organisation's expenditure. • Defined populations should match with catchment areas of the mental health service organisations.
Definitions.	Recurrent costs include costs directly attributable to the unit(s) plus a proportional share of indirect costs. Cost data for this indicator is based on gross recurrent expenditure as compiled by Health Departments according to the specifications of the National Minimum Data Set – Mental Health Establishments. As such, it is subject to the concepts, definitions and costing methodology developed for the NMDS.	
Presentation.	Number.	
Disaggregation.	• Target population. • Remoteness.	
Notes .	This indicator assumes that the expenditure reported by the local mental health service organisation is directed to its catchment population and does not take account of cross border flows. The alternative approach of basing estimates on actual service utilisation by populations is desirable and needs to be explored in the future. Such an approach will require reliable utilisation data and development of cost modelling methodologies.	
Is specification interim or long-term?	Long-term.	
Reported in.	-	

MHS PI 10: Comparative area resources.					
National Mental Health Performance Framework.					
Tier.	Tier 3 – Health Service Performance.				
Primary domain.	Accessible.				
Secondary domain(s).	Sustainable.				
Mental health sub-domain.	Local access.				
Type of measure .	Process.				
Level at which indicator can be useful for benchmarking.	Service unit.	☐	Mental Health Service Organisation.	☑	
	Regional group of services.	☑	State/Territory.	☑	
Related performance indicators and performance benchmarks.	Population receiving care.				
Data collection details.					
Data source(s).	Numerator:	National Minimum Data Set Mental Health Establishments or state/territory equivalent.			
	Denominator:	Australian Bureau of Statistics Estimated Resident Population (or equivalent).			
Data source(s) type.	Numerator:	Administrative by-product.			
	Denominator:	Census-based.			
Frequency of data source(s) collection.	Numerator:	Annually.			
	Denominator:	Annually.			
Data development.	Short -term:	Population catchments for public sector mental health services to be defined.			
	Medium-term:	-			
	Long-term:	-			

MHS PI 11: Pre-admission community care.		
Strategic issue.	Access to community based mental health services may alleviate the need for, or assist with improving the management of, admissions to inpatient care.	
Rationale.	• To monitor the continuity/accessibility of care via the extent to which public sector community mental health services are involved with patients prior to:. – To support and alleviate distress during a period of great turmoil. – To relieve carer burden. – To avert hospital admission where possible. – To ensure that admission is the most appropriate patient option. – To commence treatment of the patient as soon possible where admission may not be averted. • The majority of clients admitted to public sector mental health acute inpatient units are known to public sector community mental health services and it is reasonable to expect community teams should be involved in pre-admission care.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	Proportion of admissions to the mental health service organisation's acute psychiatric inpatient unit(s) for which a community ambulatory service contact was recorded in the seven days immediately preceding that admission.	
Numerator.	Number of admissions to the mental health service organisation's acute psychiatric inpatient unit(s) for which a public sector community mental health service contact was recorded in the seven days immediately preceding that admission.	
Denominator.	Number of admissions to the mental health service organisation's acute psychiatric inpatient unit(s).	
Computation.	(Numerator ÷ Denominator) x 100.	
Calculation conditions.	Coverage/ Scope:	All public mental health service organisations acute psychiatric inpatient units. The following admissions are excluded: • Same day admissions. • Admissions by inter-hospital transfer or between programs. The following community service contacts are excluded: • Community service contacts on day of admission.
	Methodology:	• Implementation of this indicator requires the capacity to track service use across inpatient and community boundaries and is dependent on the capacity to link patient identifiers. • Where a mental health service organisation has more than one unit of a particular service type for the purpose of this indicator those units should be combined.
Definitions.	• Same day admissions are defined as inpatient episodes where the admission and separation dates are the same. • An ambulatory service contact is the provision of a clinically significant service by a specialised mental health service provider(s) for patients/clients, other than those patients/clients admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24 hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.	

MHS PI 11: Pre-admission community care.				
Presentation.	Percentage.			
Disaggregation.	• Target population. • Remoteness.			
Notes.	• The reliability of cross-jurisdictional comparisons on this indicator is dependent on the implementation of state-wide unique patient identifiers as the community services may not necessarily be delivered by the same mental health service organisation that admits the patient. • This measure does not consider variations in intensity or frequency of contacts prior to admission. Additionally, it does not distinguish differences between phone and face-to-face community contacts, or whether or not the consumer participated in the service contact.			
Is specification interim or long-term?	Long-term.			
Reported in.	-			
National Mental Health Performance Framework.				
Tier.	Tier 3 – Health System Performance.			
Primary domain.	Continuous.			
Secondary domain(s).	Accessible.			
Mental health sub-domain.	Cross-setting continuity.			
Type of measure .	Process.			
Level at which indicator can be useful for benchmarking.	Service unit.	☑	Mental Health Service Organisation.	☑
	Regional group of services.	☑	State/Territory.	☑
Related performance indicators and performance benchmarks.	• Post-discharge community care. • 28-day readmission rate. • Average length of acute inpatient stay.			
Data collection details.				
Data source(s).	Numerator:	National Minimum Data Set Admitted Patient and Community Mental Health Care or state/territory equivalents.		
	Denominator:	National Minimum Data Set Admitted Patient Mental Health Care or state/territory equivalents.		
Data source(s) type.	Numerator:	Administrative by-product.		
	Denominator:	Administrative by-product.		
Frequency of data source(s) collection.	Numerator:	Annually.		
	Denominator:	Annually.		
Data development.	Short-term:	-		
	Medium-term:	-		
	Long-term:	Full implementation of this measure requires unique state-wide patient identifiers not currently available in all jurisdictions.		

MHS PI 12: Post-discharge community care.		
Strategic issue.	Continuity of care and support following discharge from a mental health inpatient service.	
Rationale.	• A responsive community support system for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission. • Patients leaving hospital after a psychiatric admission with a formal discharge plan, involving linkages with community services and supports, are less likely to need early readmission. • Research indicates that patients have increased vulnerability immediately following discharge, including higher risk for suicide.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	Proportion of separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated, was recorded in the seven days immediately following that separation.	
Numerator.	Number of in-scope separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a public sector ambulatory service contact in which the consumer participated, was recorded in the seven days immediately following that separation.	
Denominator.	Number of in-scope separations for the mental health service organisation's acute psychiatric inpatient unit(s).	
Computation.	(Numerator ÷ Denominator) x 100.	
Calculation conditions.	Coverage/ Scope:	• All public mental health service organisations acute psychiatric inpatient units. • Community service contacts on day of separation are not included. The following separations are excluded: • Same day separations. • Statistical and change of care type separations. • Separations that end by transfer to another acute or psychiatric inpatient hospital. • Separations that end by death, left against medical advice/discharge at own risk.
	Methodology:	• Implementation of this indicator requires the capacity to track service use across inpatient and community boundaries and is dependent on the capacity to link patient identifiers. • Where a mental health service organisation has more than one unit of a particular service type for the purpose of this indicator those units should be combined.
Definitions.	• Same day separations are defined as inpatient episodes where the admission and separation dates are the same. • An ambulatory service contact is the provision of a clinically significant service by a specialised mental health service provider(s) for patients/clients, other than those patients/clients admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24 hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.	
Presentation.	Percentage.	

MHS PI 12: Post-discharge community care.					
Disaggregation.	• Target Population. • Remoteness.				
Notes.	• The reliability of cross-jurisdictional comparisons on this indicator is dependent on the implementation of state-wide unique patient identifiers as the community services may not necessarily be delivered by the same mental health service organisation that admits the patient. Consideration should be given to confining counts of post-discharge community care to only those services managed by the mental health service organisation responsible for the inpatient admission. • This measure does not consider variations in intensity or frequency of service contacts following discharge from hospital. • This measure does not distinguish qualitative differences between phone and face-to-face community contacts.				
Is specification interim or long-term?	Long-term.				
Reported in.	• Council of Australian Governments National Action Plan on Mental Health Progress Reports. • Report on Government Services.				
National Mental Health Performance Framework.					
Tier.	Tier 3 – Health System Performance.				
Primary domain.	Continuous.				
Secondary domain(s).	Accessible and Safe.				
Mental health sub-domain.	Cross-setting continuity.				
Type of measure .	Process.				
Level at which indicator can be useful for benchmarking.	Service unit.	☑	Mental Health Service Organisation.	☑	
	Regional group of services.	☑	State/Territory.	☑	
Related performance indicators and performance benchmarks.	• Pre-admission community care. • 28-day readmission rate. • Average length of acute inpatient stay.				
Data collection details.					
Data source(s).	Numerator:	National Minimum Data Set Admitted Patient and Community Mental Health Care or state/territory equivalents.			
	Denominator:	National Minimum Data Set Admitted Patient Mental Health Care or state/territory equivalents.			
Data source(s) type.	Numerator:	Administrative by-product.			
	Denominator:	Administrative by-product.			
Frequency of data source(s) collection.	Numerator:	Annually.			
	Denominator:	Annually.			
Data development.	Short-term:	-			
	Medium-term:	-			
	Long-term:	Full implementation of this measure requires unique state-wide patient identifiers not currently available in all jurisdictions.			

MHS PI 13: Consumer outcomes participation.		
Strategic issue.	The active involvement by consumers and carers in treatment planning, decision-making, and definition of treatment goals is a key goal of the National Mental Health Strategy.	
Rationale.	• Consumer self-assessment outcome measures are one mechanism through which consumers and carers can be actively involved in treatment planning, and decision-making and definition of treatment goals. • The self-assessment measures provide useful information about the way clients feel and how well they are able to cope with their usual activities and are an opportunity for consumers, carers and clinicians to track progress through comparison of ratings over time. • Offering a self-assessment measure can be useful for engagement as well as collaboration between consumers, carers and clinicians and can enrich treatment and care planning. • Obtaining a consumer self-assessment measure requires mental health services to have an adequate degree of engagement (both clinically and organisationally) with consumers to facilitate this process.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	Proportion of ambulatory episodes of mental health care with completed consumer self-assessment outcome measures.	
Numerator.	Number of ambulatory episodes of mental health care reported with completed consumer self-assessment outcome measures.	
Denominator.	Number of episodes of ambulatory mental health care in the reference period where an episode is counted for each person seen with two or more treatment days within each of the three month calendar periods.	
Computation.	(Numerator ÷ Denominator) x 100.	
Calculation conditions.	Coverage/Scope:	All public community mental health service organisations. The following episodes are excluded: • Episodes that end in death. • Consultation and liaison. • One treatment day episode.
	Methodology:	• The appropriate consumer self-assessment measure utilised within each jurisdiction should be considered in the construction of this indicator, that is, Mental Health Inventory (MHI), Behaviour and System Identification Scale (BASIS-32) and Kessler-10-Plus (K10+). • Only the following versions of the Strengths and Difficulties Questionnaire (SDQ) are to be considered in the construction of this indicator: – The parent-rated version for children aged 4–10 years. – Either the parent-rated version and/or the self-report version for adolescents aged 11–17 years. • Non-mandated measures (such as the teacher-version of the SDQ) should not be considered in the construction of this indicator. • All completed returns (of mandated measures) are to be considered in the construction of the numerator. For example, if both a parent-rated version and self-report version of the SDQ is received this would count as two completed outcome measures.
Definitions.	The National Outcomes and Casemix Collection protocol requires that consumer self-assessment outcome measures be offered at the commencement of care and at maximum intervals of 91 days thereafter until completion of care, at which point an exit measure is offered.	

MHS PI 13: Consumer outcomes participation.					
Definitions.	• A completed consumer self-assessment outcome measure is defined as a consumer self-assessment outcome measure where at least one of the required items is entered. Note that measures that are offered to consumers and/or parents/carers but not returned are not considered completed. • Treatment day episode refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode.				
Presentation.	Percentage.				
Disaggregation.	• Target population. • Collection occasion.				
Notes.	• Given the different protocol requirements across service settings the national indicator is only constructed for the ambulatory setting. This is not to diminish the importance of the use of the measures within acute inpatient (for child and adolescent) and residential settings. Australian Government funded aged residential services should be excluded from the construction of this indicator. • Exploratory work is required to resolve methodological issues in relation to the denominator, ie estimates of the total number of episodes requiring outcomes assessment. This is not provided directly by the NOCC data but can be estimated from the National Minimum Data Sets (Community Mental Health Care, Admitted Patient Mental Health Care and Residential Mental Health Care). • The work of the Australian Mental Health Outcomes and Classification Network (AMHOCN) will contribute to the further refinement of this indicator.				
Is specification interim or long-term?	Long-term.				
Reported in.	-				
National Mental Health Performance Framework.					
Tier.	Tier 3 – Health System Performance.				
Primary domain.	Responsive.				
Secondary domain(s).	Capable.				
Mental health sub-domain.	Consumer and carer participation.				
Type of measure.	Process.				
Level at which indicator can be useful for benchmarking.	Service unit.	☑	Mental Health Service Organisation.	☑	
	Regional group of services.	☑	State/Territory.	☑	
Related performance indicators and performance benchmarks.	Outcomes readiness.				
Data collection details.					
Data source(s).	Numerator:	National Outcomes and Casemix Collection.			
	Denominator:	National Minimum Data Set Community Mental Health Care or state/territory equivalent.			
Data source(s) type.	Numerator:	Clinical outcome measures.			
	Denominator:	Administrative by-product.			
Frequency of data source(s) collection.	Numerator:	Annually.			
	Denominator:	Annually.			
Data development.	Short-term:	-			
	Medium-term:	-			
	Long-term:	-			

MHS PI 14: Outcomes readiness.		
Strategic issue.	A capable service is results-oriented and has systems in place to regularly monitor client outcomes.	
Rationale.	• All States and Territories have committed to implementing routine outcome measurement in public sector mental health services. • This indicator is an interim measure to monitor the uptake of the National Outcomes Casemix Collection (NOCC). • Indicators derived from outcome assessments should form an integral component of the next stage of key performance indicator development.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	Proportion of mental health episodes with clinical outcome assessments completed.	
Numerator.	Number of episodes of care reported with completed outcome assessments.	
Denominator.	Total number of episodes of mental health care.	
Computation.	(Numerator ÷ Denominator) x 100.	
Calculation conditions.	Coverage/ Scope:	All public mental health service organisations. The following episodes are excluded: • Episodes that end in death. • Consultation and liaison. • Assessment only episodes. The following measures are excluded: • Consumer self assessment measures. The following services are excluded: • Australian Government funded aged residential services. • Community residential mental health services.
	Methodology:	Implementation of this indicator requires the capacity to track service use across inpatient and community boundaries and is dependent on the capacity to link patient identifiers.
Definitions.	• For purposes of this indicator, completed clinical assessment is defined as one where the number of items completed is consistent with that provided in 95 percent of assessments. Translated to individual rating scales this would mean: – For the HoNOS/65+, a minimum of 10 of the 12 items. – For the HoNOSCA, a minimum of 11 of the first 13 items. – For the LSP, a minimum of 13 of the 16 items. • One treatment day episodes seen by community teams excluded – defined as community episodes where the consumer is seen on less than two treatment days within each three month period. • Outcome assessments occur at commencement of care and at maximum intervals of 91 days thereafter until completion of care, at which point an exit assessment is made. • Total number of episodes of mental health care defined as the sum of total separations in the reference period from the mental health service organisation's acute inpatient unit(s) where length of stay is greater than three days, plus, total number of ambulatory episodes in the reference period where an episode is counted for each person seen with two or more treatment days within each of the three month calendar periods.	
Presentation.	Percentage.	
Disaggregation.	Collection occasion.	

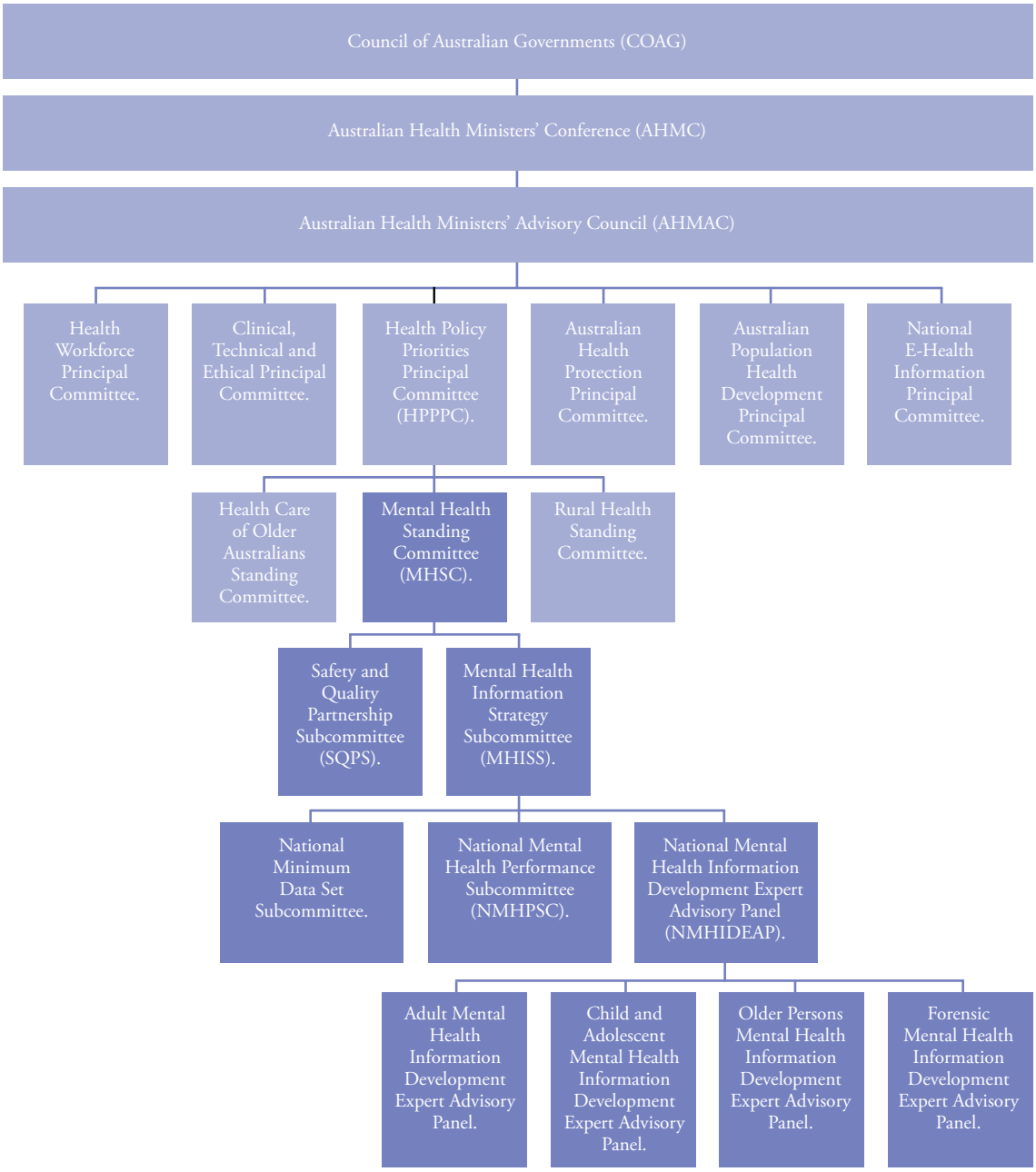
MHS PI 14: Outcomes readiness.					
Notes.	For the purposes of this measurement: • Exploratory work is required to resolve methodological issues in relation to the denominator, that is, estimates of the total number of episodes requiring outcomes assessment. This is not provided directly by the NOCC data but can be estimated from the National Minimum Data Sets for Admitted Patient Mental Health Care and Community Mental Health Care. • Further definition of a 'completed clinical outcome assessment' to resolve whether tolerance levels will be set to accept some degree of missing data also needs to be developed.				
Is specification interim or long-term?	Interim.				
Reported in.	-				
National Mental Health Performance Framework.					
Tier.	Tier 3 – Health System Performance.				
Primary domain.	Capable.				
Secondary domain(s).	-				
Mental health sub-domain.	Outcomes orientation.				
Type of measure	Process.				
Level at which indicator can be useful for benchmarking.	Service unit.	☑	Mental Health Service Organisation.	☑	
	Regional group of services.	☑	State/Territory.	☑	
Related performance indicators and performance benchmarks.	Consumer outcomes participation.				
Data collection details.					
Data source(s).	Numerator:	National Outcomes and Casemix Collection.			
	Denominator:	National Minimum Data Set Community Mental Health Care and National Minimum Data Set Admitted Patient Mental Health Care or state/territory equivalents.			
Data source(s) type.	Numerator:	Clinical outcome measures.			
	Denominator:	Administrative by-product.			
Frequency of data source(s) collection.	Numerator:	Annually.			
	Denominator:	Annually.			
Data development.	Short-term:	-			
	Medium-term:	-			
	Long-term:	-			

MHS PI 15: Rate of seclusion.		
Strategic issue.	The reduction, and where possible, elimination of seclusion in mental health services has been identified as a priority in the document National safety priorities in mental health: a national plan for reducing harm.	
Rationale.	• High levels of seclusion are widely regarded as inappropriate treatment, and may point to inadequacies in the functioning of the overall systems and risks to the safety of consumers receiving mental health care. • The use of seclusion in public sector mental health service organisations is regulated under legislation and/or policy of each jurisdiction.	
Endorsement status.	Endorsed by AHMAC Mental Health Standing Committee.	
Date last updated.	24 March 2011.	
Indicator details.		
Description.	Number of seclusion events per 1,000 patient days within a mental health service organisation.	
Numerator.	Number of seclusion events occurring in the mental health service organisation inpatient unit(s) during the reference period, partitioned by acute and non-acute inpatient mental health services.	
Denominator.	Number of accrued patient days within the mental health service organisation's inpatient unit(s) during the reference period, partitioned by acute and non-acute inpatient mental health services.	
Computation.	(Numerator ÷ Denominator) x 1,000.	
Calculation conditions.	Coverage/Scope:	• All public mental health service organisations admitted patient services. • Services where seclusion is not an authorised practice under relevant mental health legislation and/or policy (such as ambulatory mental health services) should be excluded (from numerator and denominator).
	Methodology:	• This indicator is to be partitioned by the service type (ie acute and non-acute inpatient). Consequently, there would be two potential scores for this indicator. This partitioning will enable appropriate interpretation of the indicator and concept and facilitate accurate and targeted action to reduce the use of seclusion in mental health services. • Leave days should be excluded from the construction of the denominator. • Where a mental health service organisation has more than one unit of a particular program type for the purpose of this indicator those units should be combined.

MHS PI 15: Rate of seclusion.	
Definitions.	• This indicator uses the national seclusion definition as developed and agreed by Safety and Quality Partnership Subcommittee (SQPS): *The confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented.* ***Key elements:*** 1. *The consumer is alone.* 2. *The seclusion applies at any time of the day or night.* 3. *Duration is not relevant in determining what is or is not seclusion.* 4. *The consumer cannot leave of their own accord.* ***Implications:*** 1. *The intended purpose of the confinement is not relevant in determining what is or is not seclusion.* 2. *Seclusion applies even if the consumer agrees or requests the confinement.* 3. *The awareness of the consumer that they are confined alone and denied exit is not relevant in determining what is or is not seclusion.* 4. *The structure and dimensions of the area to which the consumer is confined is not relevant in determining what is or is not seclusion. The area may be an open area eg courtyard.* 5. *"Seclusion does not include confinement of consumers to High Dependency sections of gazetted mental health units, unless it meets the local legislative definition".* ***Exceptions:*** *Any exceptions that are specified in relevant jurisdictional legislation.* • Regardless of duration, a 'seclusion event' commences when a consumer enters seclusion and ends when there is a clinical decision to cease seclusion. Following the clinical decision to cease seclusion, if a consumer re-enters seclusion within a short period of time this would be considered a new seclusion event. The term 'seclusion event' is utilised to differentiate it from the different definitions of 'seclusion episode' used across jurisdictions.
Presentation.	Rate.
Disaggregation.	• Target population. • Sex.
Notes.	• The use of seclusion is governed by either the legislation (a Mental Health Act or equivalent) or mandatory policy within each state and Territory. The definitions utilised within the legislation and policies vary slightly between jurisdictions. These variations should be recognised in the interpretation of the indicator. • SQPS have developed definitions, principles and protocols relating to the use of seclusion in mental health services and details are available from www.health.gov.au/internet/mhsc. This work will further support the collation and comparison of information relating to seclusion. • The duration of seclusion is an essential piece of information to align with an indicator of the rate or frequency of seclusion as it provides a better understanding of a services performance in relation to seclusion use and management. However, the capacity to collect information regarding duration of seclusion episodes varies substantially across jurisdictions. Work continues as a national level that will facilitate the development of a meaningful indicator of duration as it is likely to be easily skewed by outliers.
Is specification interim or long-term?	Long-term.
Reported in.	-

MHS PI 15: Rate of seclusion.				
National Mental Health Performance Framework.				
Tier.	Tier 3 – Health system Performance.			
Primary domain.	Safety.			
Secondary domain(s).	Appropriateness.			
Mental health sub-domain.	Consumer.			
Type of measure.	Outcome.			
Level at which indicator can be useful for benchmarking.	Service unit.	☑	Mental Health Service Organisation.	☑
	Regional group of services.	☑	State/Territory.	☑
Related performance indicators and performance benchmarks.	-			
Data collection details.				
Data source(s).	Numerator:	State/territory seclusion registers or relevant information systems.		
	Denominator:	National Minimum Data Set Admitted Patient Mental Health Care or State/territory equivalent.		
Data source(s) type.	Numerator:	Register.		
	Denominator:	Administrative by-product.		
Frequency of data source(s) collection.	Numerator:	Annually.		
	Denominator:	Annually.		
Data development.	Short-term:	• Work is required to improve the quality of reporting in seclusion registers and/or relevant information systems to facilitate reporting. • Work is required to scope the actual legislative and/or policy differences in jurisdictional definitions of seclusion.		
	Medium-term:	-		
	Long-term:	-		

5.2 Australian national mental health committee structure.



5.3 National Mental Health Performance Subcommittee – Membership as at May 2011.

Ms Ruth Catchpoole *(Chair)*	Director, Mental Health Information Unit, Mental Health Alcohol and Other Drugs Directorate, Queensland Health.
Dr Grant Sara	Director, InforMH, Mental Health and Drug and Alcohol Office, NSW Health Chair, National Mental Health Information Development Expert Advisory Panel.
Ms Tracey Burgess	Manager, Mental Health and Drugs Division, Department of Health, Victoria.
Ms Kristen Breed	Manager, Performance, Evaluation and Analysis Team, Mental Health Information Unit, Mental Health Alcohol and Other Drugs Directorate, Queensland Health.
Ms Danuta Pawelek	Director, Performance and Reporting, Mental Health Commission, Western Australia.
Ms Diane du Toit	Assistant Director, Monitoring and Evaluation Section, Mental Health Reform Branch, Department of Health and Ageing.
Mr Gary Hanson	Unit Head, Mental Health Services Unit, Australian Institute of Health and Welfare.
Mr Lei Ning	Consumer representative.
Ms Jackie Crowe	Carer representative
Dr Ruth Vine	Chair, Safety and Quality Partnership Subcommittee.
Mr Neville Board	Australian Commission of Safety and Quality in Health Care.
Dr Darren Neillie	Chair, Forensic Mental Health Information Development Expert Advisory Panel.
Dr Peter Brann	Chair, Child and Adolescent Mental Health Information Development Expert Advisory Panel.
Dr Rod McKay	Chair, Older Persons Mental Health Information Development Expert Advisory Panel.
Ms Liz Prowse	Chair, Adult Mental Health Information Development Expert Advisory Panel.
Professor Philip Burgess	Analysis and Reporting, Australian Mental Health Outcomes and Classification Network.
Mr Tim Coombs	Training and Service Development, Australian Mental Health Outcomes and Classification Network.
Mr Bill Buckingham	Director, Buckingham and Associates Pty Ltd, Consultant to Department of Health and Ageing.
Mr Rick Bastida (Secretariat)	Principal Project Officer, Performance, Evaluation and Analysis Team, Mental Health Information Unit, Mental Health Alcohol and Other Drugs Directorate, Queensland Health.
Ms Toni Ellis (Secretariat)	Senior Project Officer, Performance, Evaluation and Analysis Team, Mental Health Information Unit, Mental Health Alcohol and Other Drugs Directorate, Queensland Health.

5.4 Glossary of abbreviations.

ABF	Activity Based Funding.
AHMAC	Australian Health Ministers' Advisory Council.
AHMC	Australian Health Ministers' Conference.
COAG	Council of Australian Governments.
DALE	Disability Adjusted Life Expectancy.
HoNOS	Health of the Nation Outcome Scales.
HoNOS 65+	HoNOS 65 years and over.
HoNOS family of measures	Includes the HoNOS, HoNOSCA and HoNOS 65+.
HoNOSCA	HoNOS Child and Adolescents.
HPPPC	Health Policy Priorities Principal Committee.
KPI	Key Performance Indicators.
MHE	Mental Health Establishments.
MHISS	Mental Health Information Strategy Subcommittee.
MHSC	Mental Health Standing Committee.
MHSO	Mental Health Service Organisation.
NHA	National Healthcare Agreement.
NHPF	National Health Performance Framework.
NMHIDEAP	National Mental Health Information Development Expert Advisory Panel.
NMHPF	National Mental Health Performance Framework.
NMHPSC	National Mental Health Performance Subcommittee.
NMDS	National Minimum Data Set.
NOCC	National Outcomes and Casemix Collection.
SQPS	Safety and Quality Partnership Subcommittee.

www.health.gov.au/MHSC

All information in this publication is correct as of May 2011.

D0321 May 2011