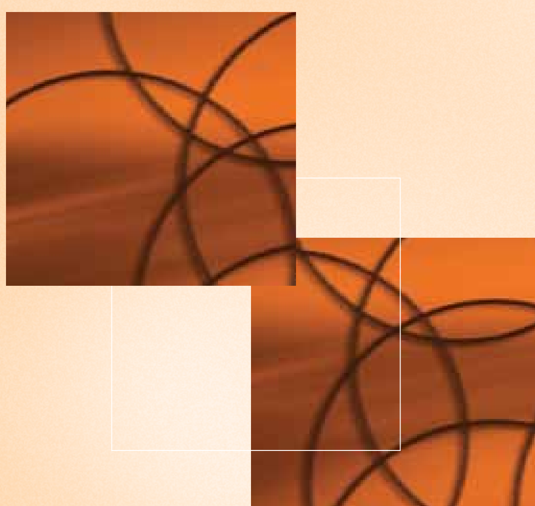
National Mental Health
Benchmarking Project
Evaluation Report July 2009



MENTAL HEALTH INFORMATION
STRATEGY SUBCOMMITTEE

AHMAC MENTAL HEALTH
STANDING COMMITTEE

Mental Health Information
Strategy Subcommittee
Discussion Paper No. 7

national
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Paper-based version

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Discussion Paper No. 3 – e-mental Health in Australia: Implications of the Internet and Related Technologies for Policy, (Christensen, H., Griffiths, K. & Evans, K.), 2002.

Discussion Paper No. 4 – Towards National Benchmarks for Australian Mental Health Services (Eager, K., Burgess, P. & Buckingham, B.), 2003.

Discussion Paper No. 5 – Key Performance Indicators for Australian Public Mental Health Services (Information Strategy Committee AHMAC National Mental Health Working Group), 2005.

Discussion Paper No. 6 – AHMAC NMHWG Information Strategy Committee, National Action to Improve the Quality of Australian Mental Health Services, 2005.

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Acknowledgments

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Foreword

The National Mental Health Benchmarking Project was a collaboration between the Australian Government and the states and territories to establish demonstration benchmarking forums within public sector mental health services. The aim was to promote the sharing of information and to identify benefits, barriers and issues associated with benchmarking.

The project provided the 23 participating organisations with an opportunity to share information on nationally agreed key performance indicators and identify similarities and differences on how they affect organisational performance. This information can then be used to support change and quality improvement activities.

This document outlines the results of the evaluation of the National Project and the extent to which the project met its core objectives. The information is primarily sourced from participants' experience of two years of benchmarking activity.

The evaluation shows that benchmarking is a useful tool to enhance understanding of initiatives to improve service delivery and support quality. It also highlights that sustainable benchmarking activity is a complex and evolutionary process, influenced by a range of factors, especially organisational capacity and commitment.

This evaluation provides a mental health service organisation with a perspective on benchmarking and performance information. This will be considered together with information from other stakeholders, including other service providers, policy makers and funders, to support future benchmarking activity and the development of indicators in the mental health sector. This will also contribute to further development of the performance indicators identified in the *Fourth National Mental Health Plan* and support review of information used in national publications.

I would like to thank everyone who participated and supported the *National Mental Health Benchmarking Project* and look forward to your continued support as we work towards our vision for mental health.

Dr Aaron Groves
Chair
Mental Health Standing Committee
February 2010

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PART 1. Introduction

This document outlines the results of the evaluation of the National Mental Health Benchmarking project following two years of benchmarking activity for participants. Participating services and the steering committee have made recommendations on how to continue and enhance participation of the sector in benchmarking.

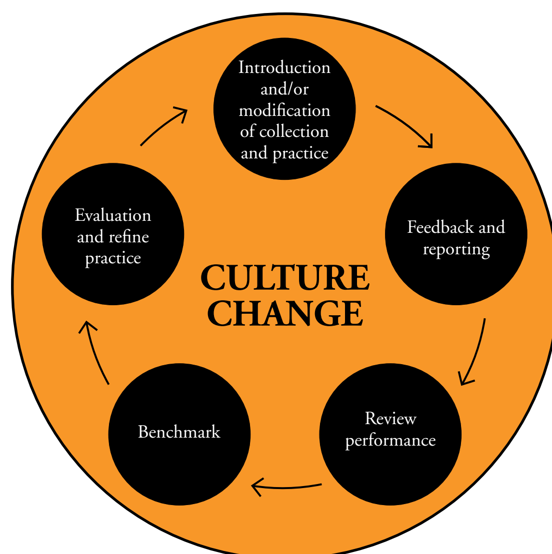
Improving service quality has been a theme of the National Mental Health Strategy since it began in 1993. Each of the National Mental Health Plans has supported this and there have been increasing demands for both funders and service providers to accelerate efforts to improve outcomes for people affected by mental illness.

The critical role of information systems and data as a foundation for quality improvement has been emphasised in all national work undertaken to date. Recently, major investments have been made to upgrade the quantity and quality of information available to support decisions at all levels of the mental health system. This includes the introduction of standardised measures for assessing consumer outcomes.

The achievements so far have primarily been in the collection aspects of information—putting systems in place, preparing documentation and training the clinical workforce. The second edition of the *Mental Health Information Development Priorities* (Department of Health and Ageing 2005) stated that the main challenge is to engage service providers in the measurement for quality improvement cycle (Figure 1). This builds a culture of information use where:

- data is used routinely to improve clinical practice, service management and policy development
- benchmarking is established as the norm with all services able to access regular reports on their performance relative to similar services and can then be used in a quality improvement cycle.

Figure 1: Measurement for quality improvement cycle



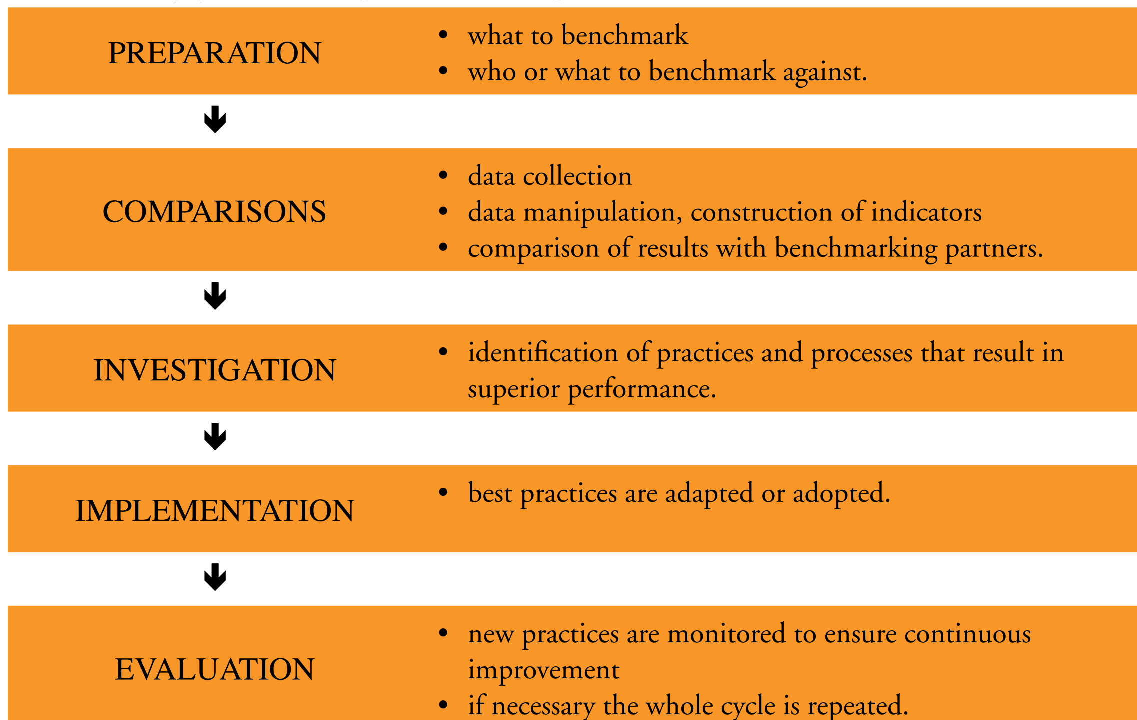
1.1 Benchmarking defined

There are a number of definitions of benchmarking in the relevant literature. The National Mental Health Plan 2003–2008 adopted the approach taken by Bullivant (1994) who defined benchmarking as concerned with:

> *…the systematic process of searching for and implementing a standard of best practice within an individual service or similar groups of services. Benchmarking activities focus on service excellence, customer/client needs, and concerns about changing organisational culture.*

Benchmarking is often seen as a passive process that involves simple publication of data comparing the performance of organisations against the benchmark 'standard'. In practice, benchmarking is an active process of participation and learning that involves bridging the gap between evidence and practice. This requires participants be reflective, measure performance (either as an organisation as a whole or for specific aspects of service delivery), and receive feedback in a way that allows learning through comparisons. Benchmarking may be internal, comparing performance of individual units within a single organisation, or a collaboration of independent organisations with a common interest in a particular industry.

Benchmarking generally comprises five basic phases:



Source: National Health Ministers Benchmarking Working Group (1996)

PART 2. National Mental Health Benchmarking Project

The National Mental Health Benchmarking Project established demonstration benchmarking forums within the four main target populations of public sector mental health services (general adult, child and adolescent, older persons and forensic).

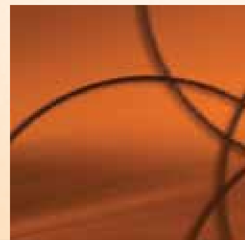
Four core objectives guided the development and implementation of the National Project.

1. Promote information sharing between organisations to increase understanding and acceptance of benchmarking as a key process to improve service quality.
2. Identify the benefits, barriers and issues for organisations in the mental health field engaging in benchmarking activities.
3. Understand what is required to promote such practices on a wider scale.
4. Evaluate the suitability of the National Mental Health Performance Framework (domains, sub domains and key performance indicators) as a basis for benchmarking and identify areas for future improvement of the framework and its implementation.

First conceptualised in the Second National Mental Health Plan, the National Project ran from May 2006 to November 2008. During this period a range of activities occurred, including:

- developing and disseminating resources such as:
  - the project manual
  - technical specifications for national indicators and indicators developed or used in the project
  - data-entry workbooks
  - research reports
  - presentations.
- construction, analysing and reporting indicators including:
  - 13 phase one national indicators
  - over 50 supplementary indicators included in the initial comparative indicator documents
  - varied additional indicators developed throughout the project.
- developing special projects in each of the forums, such as:
  - the good practice guide for readmission rates developed by the adult forum
  - the staff activity survey and community discharges projects in the child and adolescent forum
  - the seclusion project in forensic and length of stay activity in the older persons forum.

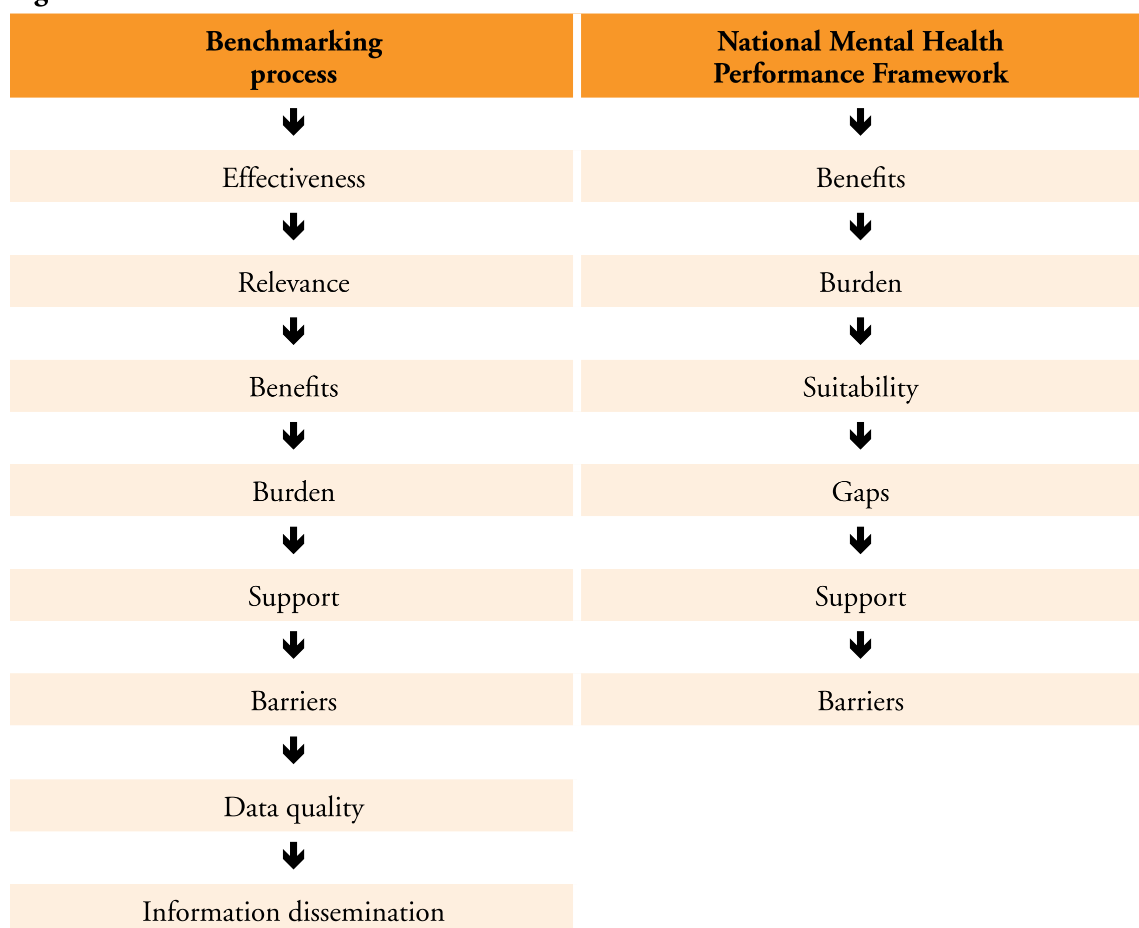
- supporting participants during and between forums on a range of issues including:
  - constructing and interpreting indicators
  - promoting support within organisations.
- disseminating information on outputs for participating organisations to facilitate information sharing and learning
- conducting two technical specifications workshops in May and June 2006
- holding two National Mental Health Benchmarking meetings in May 2006 and November 2008
- conducting 32 benchmarking forums (eight for each target population) between August 2006 and July 2008.



PART 3. Evaluation Framework

The evaluation of the National Mental Health Benchmarking Project assesses the extent to which the project met its four core objectives. This relates to both the process and the framework.

Figure 2: Evaluation framework



- **The benchmarking process**—an assessment of the effectiveness and use of the process used for the national benchmarking forums. This will provide information and ideas to inform future activity related to benchmarking of mental health services across Australia.
- **The National Mental Health Performance Framework**—a review of the suitability of the third tier of the National Mental Health Performance Framework as a basis for benchmarking mental health service organisations Australia.

The areas of focus within the framework are summarised in Figure 2. It is important to acknowledge that the purpose of the evaluation is **not** to assess the performance of participating services against the indicators, but rather to evaluate how the indicators assist services in identifying challenges and achievements in their performance.

The evaluation focuses on issues and advice from the **mental health service organisation perspective.** Outcomes from the evaluation were considered in conjunction with information from other stakeholders and sources, such as state health authorities, to guide the steering committee and other relevant authorities on future benchmarking activity and indicator development for the mental health sector.

3.1 Methodology

The evaluation was primarily qualitative, based on the experiences and opinions of the participating organisations and the organising group. The key components of the evaluation methodology are outlined in Table 1.

Table 1: Evaluation components

Activity	Purpose
• Collation of baseline information, such as expectations	• identify changes in expectations and previous experiences that may refine and support the benchmarking process.
• Attendance at forums and relevant national meetings	• monitor progress and record relevant discussion related to indicators and the process • identify issues, including those relevant across all forums.
• Forum-based surveys	• gauge progress against the objectives • identify issues and strategies for quality improvement activities • re-align process to expectations and needs of forums.
• Progress reports	• identify issues and strategies for use and dissemination of performance information.
• Review of the national key performance indicators	• determine the relevance, utility and appropriate specification of the national indicators • advise on contextual factors required to interpret indicators.
• Review of the supplementary indicators developed throughout the project	• determine the relevance, utility and appropriate specification of supplementary indicators • identify indicators that will be of use to services participating in service-level benchmarking • identify indicators that may be appropriate to include in the national framework.
• Final evaluation survey completed by participating organisations	• gather advice and recommendations from participants on the overall benchmarking process, the utility of the process and indicators, the impact of participation on services and issues of data quality and sustainability.
• Discussions with participants and the organisation group	• finalise advice and recommendations from participants on the overall benchmarking process, the utility of the process and indicators, the impact of participation on services and issues of data quality and sustainability.

3.2 Governance

The National Mental Health Performance Subcommittee (NMHPSC) was established to

- advise on the ongoing development of a national mental health performance framework
- support benchmarking in mental health services
- provide national information on mental health system performance.

The NMHPSC acted as the steering committee for the National Mental Health Benchmarking Project.

3.3 The participants

Services were invited to apply through state and territory central health authorities and the steering committee selected the final participants. The services selected (Appendix 8.2) included a range of metropolitan and regional services of differing sizes and included single and multiple service settings. Unfortunately, no organisations from the Northern Territory or Tasmania were able to participate in the project.

Approximately ten per cent of mental health service organisations in Australia had at least one service component participating in the project. The defining characteristic for inclusion in each forum was the *target population* served, rather than identical service models or mix of consumers. Participants in the Older Persons Mental Health Benchmarking Forum provided specialist older persons services. This is different from general mental health services that provide care to the older population (that is, persons aged 65 years and over).

Participants were generally nominated by jurisdictions as high performing services and this may have affected the results, discussion and recommendations made through the evaluation.

3.4 The organisation group

The Australian Mental Health Outcomes and Classification Network (AMHOCN) was funded to coordinate the National Project. The purpose of the role was to keep discussions focused and moving towards a consensus. The AMHOCN also supported participating organisations to deliver on the agreed activities, through collation and analysis of data, reminders, teleconferences and data entry mechanisms (spreadsheet and database).

The AMHOCN purchased additional expertise to enhance its facilitation and analysis capacity. Participating organisations led some of the special projects developed during the forums, but AMHOCN continued to play a pivotal role in the coordination of participants.

PART 4. Evaluation of the benchmarking process

4.1 Expectations of the National Project

Participants generally had the same expectations on the purpose and perceived benefits of the National Project, although some variation existed. Expectations were primarily related to:

- discussing the measurement of performance, learning from similar services and developing a national frame of reference for service performance
- identifying collaborative and individual quality improvement activities that would benefit and improve service and clinical practice
- learning about benchmarking, constructing and selecting performance indicators
- contributing to the national discussion of performance and the development of indicators relevant to each target population.

The project generally met these expectations, particularly in relation to the measurement of performance and learning about benchmarking. However, services felt that their capacity to identify and implement quality improvement activities was affected by the time required to understand the indicators. For some forums this resulted in less time being devoted to understanding clinical practices and identifying quality improvement activities than originally anticipated. Perceived and actual differences in service models also limited the capacity for some forums to engage in collaborative quality improvement activity. Services felt they had less influence than they had initially anticipated, particularly in selecting indicators specific to target populations.

A number of services had limited or low expectations at the start of the project as they were unclear of the intended process and purpose. These services suggested that the distributed documentation and preliminary national meetings could have been clearer about what the process was and what was expected of participants.

Most services also felt that their expectations generally changed throughout the course of the National Project as it moved from focusing on the technical aspects of indicators to comparing service performance and identifying quality improvement activities. These services stated that their expectations became more realistic about what could be achieved within time frames of the project, and they were clearer about the potential use of benchmarking.

Services felt that learning and collaboration were central to any benchmarking process.

4.2 Participating in the National Mental Health Benchmarking Project

4.2.1 Benefits of participation

Participants identified a number of benefits of participating in benchmarking, consistent with existing literature. These included the:

- *ability to nationally compare service performance and practices*

  Services had a greater understanding of their own performance than from internal assessment alone. Benchmarking also enabled the identification of similarities and differences between services. For some forums there were more similarities than initially anticipated, which facilitated collaborative activity. The discussion of differences also generated a range of investigations and quality improvement activities.

- *development of expertise in the techniques, tools and use of benchmarking indicators*
- *development and sustainability of quality leadership*

  The skills required to effectively participate are the same as those needed to provide leadership to a team or in the management of services.

- *identification of new peers and development of key relationships*

This will form the basis of collaboration for future research and quality improvement activities.

4.2.2 Supporting factors

The methodology and structure of the National Project supported service participation through:

- *allocating funding to enable services to dedicate resources to coordination and participation*

  Services used the funding in a variety of ways, although the majority of funding was used to employ project officers, back-fill existing staff and attend the forums. Some services invested additional resources to support information dissemination and engagement within their services.

  developing and providing of detailed technical specifications, data entry workbooks and convening workshops and web discussions to build knowledge and understanding about the construction of the indicators

  This minimised, but did not eliminate, confusion and different interpretation of terminology and specifications. Although the indicators were pre-determined, services could modify specifications to better reflect their own service structure. This encouraged engagement with the process.

- *providing a safe environment for sharing information through endorsing a clear code of conduct* (Figure 3).

  This alleviated apprehension about issues of privacy and misuse of information. Services also identified that the respect shown by other participants, the facilitator and organisers enhanced the environment and enabled healthy discussion.

- *providing planning and direction through the coordinating group*

  In the first year of the project additional resources were available to support the project coordination and this enabled more comprehensive follow-up and timely dissemination of materials. This resource was reduced in the second year of the project which affected the group's capacity to support participation by services.

Figure 3: Code of conduct

Conduct of organisations and participants in the National Project (including all persons who attend the forums and/or receive information about the forums) was based on the following core principles:

Principle of exchange

- Be willing to provide the same amount of information and level of detail that your organisation receives.

Principle of confidentiality

- Treat benchmarking activities as something confidential to the services involved.
- A service's participation in the benchmarking forums should not be disclosed without their permission. Information about the benchmarking forums and/or its participants must not be communicated outside the forums without prior consent from all relevant participants.

Principle of use

- Use benchmarking activities to inform and improve the quality of service provision.

Principle of preparation

- Demonstrate a commitment to the benchmarking process with adequate preparation for each step in the process.

- *controlling the frequency of meetings*

  This required a balance between the amount of activity conducted between forums, maintenance of momentum and the expectation of change. Face-to-face forums were held approximately every three months; however, the final three meetings were held over a five-month period, which increased the pressure to undertake a significant amount of activity within a compressed time-frame.

In addition to the resources and structure provided by the National Project, services identified a range of internal factors that supported their participation, including:

- the level of support from and involvement of *senior management*. Services that received support from senior management generally identified that participating in the forums was simpler and that they had more success in initiating quality improvement activities.
- the *integration* of the project in existing quality processes and structures (such as establishing benchmarking as standing items at quality and management meetings). This enabled services to engage a range of stakeholders and limited the process being seen as an ad hoc or isolated activity.
- *overcoming the defensiveness* that is often associated with the sharing and comparison of information. Services identified being open-minded, actively participating, and taking ownership of the process and their own data as the key supporting factors.
- relatively *consistent involvement* of staff in forums and the overarching project facilitated the capacity of services to effectively participate as the knowledge-base consistently grew over the course of the project. However, services also identified that the strategic involvement of additional staff in the forums would have been beneficial in promoting dissemination and understanding within the service.

4.2.3 Barriers and challenges

The project identified a number of barriers and challenges to participation. The main barriers to the benchmarking process were issues related to data quality, comparability of service models, service capacity and literacy, leadership, and resources.

Data quality

Data quality was an issue for all participating services with variable confidence in the data drawn from the electronic information systems used in each jurisdiction. There were two data sources which were of particular concern:

1. **Community activity data:** There was uncertainty as to how accurate and representative this data was due to (i) variation in the completeness of the data due to differing compliance with data entry; and (ii) how comparable the data was due to variable protocols, processes and definitions (for example when to commence a service episode).
2. **Costing data:** There were highly variable costing practices, both between and within jurisdictions, which limited both the accuracy of the output and the capacity to compare performance on measures which used expenditure data. All participants highlighted the need for a national process to address issues of costing methodology, but acknowledged the issue was broader than the mental health sector.

The capacity of services to access accurate data efficiently was varied and presented a range of challenges to participants. Some services were relatively self-sufficient, others depended entirely on the central health authority to provide and interrogate the data. This added a layer of complexity as services had to explain specifications to an external body. This reduced confidence and ownership of the indicators and limited their ability to identify data quality issues.

A number of services identified significant data quality issues and implemented strategies to address this. This included developing standardised processes for recording, cleansing and auditing data. Other services identified improvements in quality through utilisation of data rather than specific intervention.

Comparability and representativeness of participating services

The services selected to participate in the National Project included a range of different sized metropolitan and regional services and multiple and single service settings. These differences influenced the comparability of indicators and limited the capacity for some forums to engage in collaborative activity in quality improvement.

However, most services saw value in investigating the source of variation. This generally involved identifying data quality issues before looking at other factors such as availability of resources, service models and casemix profiles. If these factors were not the sole source of variation, the participants looked at clinical practices and processes.

The discussion within forums clearly highlighted that models of service are critical to interpreting indicators and perceived variation in performance. It was noted that the advice provided though the National Project was limited by the service models used by participating services. For example, participants in the Older Persons Forum all provided specialist older persons services. The issues identified for these services may not necessarily be applicable to general mental health services, which also provide care to the older population.

Participant literacy and capacity

At the start of the project the capacity of services to consistently translate national definitions and specifications was highly variable. A number of services lacked or could not access expertise in this area.

In order to interpret and use the data appropriately it is important to understand the technical specifications, construction and applicability of the indicators. Those attending the forums did not always have an understanding of the technical aspects of indicator construction and this affected the pace and momentum of discussions during forums. This presented a range of challenges to the project.

The project provided technical documentation, workshops and discussions on how data could contribute to improve clinical practice and service management. Despite this, there were still difficulties in constructing the indicators uniformly and services felt they had underestimated the skills required to participate in the benchmarking process.

Leadership

Services highlighted the need to engage management, clinical leadership and the workforce in the project. The general view was that without engaging these stakeholders the benchmarking process would be seen as a special or time-limited project with little relevance to service delivery. It was felt that leaders should be involved both in the forums and within the organisation, acknowledging that this takes significant time and resources.

Services used a range of strategies to convey information to those not attending the forums. These included presentations at meetings, newsletters, posters, and workshops. Participants stated that the ability to simply explain the indicators and the impact they would have on the service was very important in successfully engaging leaders.

The level of support of senior management directly affected participation in the project, as did the capacity of staff to understand the technical and clinical aspects of the process. The forums which continued to focus on issues associated with the differences between the services showed the least engagement with the process.

In the final evaluation survey a number of services suggested that the project would have benefited from greater capacity to assist services who struggled, or being able to remove or replace a non-involved organisation. They felt that guidelines outlining processes and the potential impact of these options would have been beneficial.

Resources

Benchmarking is a resource intensive process. The Department of Health and Ageing provided additional resources to facilitate organisational participation, however there were significant additional unfunded resources required to effectively participate. This placed additional strain on existing resources and affected the efficiency and effectiveness of participation. For example, the involvement of senior management was critical but limited by the busy schedules of these staff.

4.2.4 Making it relevant

The different forums of the project concentrated on different indicators and domains of the performance framework. However, all forums discussed the relevance of benchmarking at various levels and its potential impact on delivery of services.

The process for making data and indicators relevant to service and clinical practice was complex. A significant amount of energy was invested in finding relevance in the indicators for all forums. This may have been at the expense of other more useful information or indicators, particularly for sub-specialist services like the forensic. Discussions did, however, enable the forums to provide informed advice about the suitability of the individual indicators to their target population.

As with many aspects of benchmarking what is relevant depends on the purpose of the activity and the different levels and roles of participants (e.g. Executive Director is likely to have a broader focus than that of a clinician). Relevance is also impacted on by the need to ensure that the expected outcome or change is tenable and feasible, for example, a clinical practice change identified as necessary through the process may not impact or change performance on the actual indicator, especially within the short-term.

4.2.5 Developing an understanding of data and performance indicators

Understanding data and performance indicators and applying them to practice was critical to the success of the project. Not all organisations had the same level of expertise or understanding of the data and performance indicators.

Participants in the benchmarking project required time to understand data and performance indicators at two broad levels:

- **Technical:** understanding of definitions, specifications and construction enables discussion to move beyond data quality and specification to interpretation and use.
- **Utilisation:** understanding the potential use of data and indicators to identify and describe performance is the second element that is necessary for effective participation.

4.2.6 Coordination and facilitation

A significant amount of support is required to support benchmarking activities, both during discussions and in the data collation and preparation phase. Overall, services were positive about the professional contribution of the facilitation and coordination group, which was seen as essential for making progress both within and between forums. The facilitator was able to guide discussion, take advice from and challenge participants and draw wisdom from the discussion. This was seen as integral to the success of the project.

4.3 Information dissemination

Sharing of information is essential for successful benchmarking and although participants were happy to share information within forums, there was some hesitancy to do so outside the formal benchmarking forums. The main concern was that the highly contextual nature of the material could lead to inaccurate interpretation, inappropriate action and setting of unrealistic benchmarks (particularly in relation to cost indicators). The key risk identified was the creation of a punitive rather than collaborative benchmarking environment.

Both participants and the organising group found it complicated to present the breadth of information in a meaningful way to a range of stakeholders. Dissemination strategies used or identified included:

- presentation of the results of the benchmarking projects at special forums within their own services

- regular presentations and updates in the organisation, often focusing on a small sub-set of indicators rather than presenting all information
- regular discussion as a standing item at a range of quality and management meetings
- use of the data to inform planning and service development
- development of benchmarking forums within their own jurisdictions using the results of the national benchmarking project to stimulate participation
- national and international conference presentations.

4.4 The impact of benchmarking

Benchmarking helped identify issues in business and clinical processes for mental health organisations. Identified improvements included:

- identifying data quality issues and implementing strategies to improve quality, such as standardised business processes and clearer definitions for data entry
- using indicators to guide and evaluate service improvement activities
- improving understanding of local business practices and how to more effectively link data to practice, enabling services to develop and use indicators for specific quality improvement activities
- improving a service's accountability and transparency both internally to staff and externally to consumers, carers and other stakeholders
- shifting organisational culture towards less resistance for using information and indicators to identify and monitor service performance
- developing a knowledge-base and experience that services are able to access, which provides them with a greater capacity to influence and advocate in the wider organisational and political environment.

The complexity of the mental health system and the time-frames of the project made it difficult to identify the impact on individual consumers. The wider impact of benchmarking is also difficult to measure, with services stating that success was most often seen through discrete, targeted activity rather than significant change or restructure.

4.5 Sustainability

The National Mental Health Benchmarking Project was resource-intensive and expensive and although much has been learnt about benchmarking mental health services it is not a model that can be sustainably replicated.

Services and the organising group suggested that the following key factors would contribute to sustainable benchmarking within the sector:

- **The right resources**

  Services need to dedicate extra resources for benchmarking. It cannot be 'added-on' to an already overburdened workload. A range of stakeholders need to be involved for the service to benefit from the process. The level of resources determines the feasibility and level of participation within any benchmarking process. There needs to be an understanding of many aspects of the service (including structural and financial), as well as an understanding of how to interpret and use data and indicators and how results translate to business processes.

- **Commitment**

  To succeed, organisations have to support and participate in the process. This includes ensuring that staff involved in the project are supported by all levels of the organisation and there is sufficient investment in building the capacity of the organisation and its staff to use and apply data, performance indicators and results for service improvement activity.

- **Leadership**

  Benchmarking is a confronting experience for many participants and without sufficient leadership the benefits will be limited and the exercise has the potential to be passive and uninformative. Changes to leadership during the course of the project for some services had a significant impact on their capacity and willingness to collaborate and participate.

- **Integrity, transparency and accountability**

  These three principles are fundamental to benchmarking as they:
  - enable a safe environment to be established for discussion
  - ensure participants are clear on purpose and direction
  - facilitate engagement with staff as they can see that promises are kept and action is taken
  - facilitate ownership of the process.

- **Making it normal**

  Benchmarking is traditionally seen as outside the norm and, as identified by one participating organisation, the technical skills have not historically been developed within the mental health sector. To be sustainable, the process needs to be integrated into normal service structures rather than being seen as a special initiative. This is linked to available resources, the level of commitment and the strength of leadership.

- **Differences and similarities**

  Mental health service organisations are generally complex organisations with many differences in models of service, casemix profiles and legislative frameworks. Peer groups need to be similar enough to make benchmarking a useful quality improvement activity. It is important for services to learn from both the similarities and differences between organisations.

- **Facilitation, coordination and support**

  Any benchmarking process needs to be coordinated and facilitated. How that happens will depend on the process being used. There is growing expertise in Australian Government and private organisations for providing this coordination and facilitation.

  Current options include:
  - providing or funding an activity through the central health authority (such as InforMH in New South Wales and Mental Health Clinical Collaborative in Queensland)
  - purchasing expertise from the general health sector (such as the Health Round Table)
  - the AMHOCN which continues to coordinate benchmarking activities for the forensic sector.

Although services learnt a great deal through their participation, they acknowledged that there is still much to be learnt about indicators and benchmarking mental health services that can only be enhanced through participation by a greater proportion of the sector.

Part 5. Evaluation of the National Mental Health Performance Framework

The following section outlines advice about the benefits and suitability of the *National Mental Health Performance Framework* as a basis for benchmarking, from the perspective of the mental health service organisation.

This advice should be considered in the context of the issues identified in Section 4.2.3 which are critical to interpreting performance and setting targets. Issues include variable data quality and the differing service models of participating organisations.

Stakeholders, including service providers and funders, need to discuss the implications of this advice and resolve the issues. These include interpreting the variable advice from participating services and understanding the differences between service-level and jurisdiction-wide targets.

5.1 Benefits of the National Framework

Services agreed that the key benefit of the National Framework was the common starting point it provided by identifying what data to collect, so the process could begin with limited debate. Although not all indicators were relevant to all target populations, the framework facilitated informed discussion.

Additional benefits included:

- *an overall framework* which encouraged consideration of different domains of performance
- *technical specifications* and the use of existing collections with relatively consistent data definitions (noting that the accuracy and comparability of data was limited for some collections.)

5.2 Limitations of the National Framework

The major limitation identified was the high-level and generic nature of the national indicator set. This did not adequately capture the complexity of individual services.

Additional limitations included the:

- *focus on inpatient and adult models of service*

  This limited the application of all indicators to all forums. However, there were relevant indicators within the framework which guided discussion and helped with identifying quality improvement activities.

- *breadth and complexity of the complete comparative indicator set*

  This required considerable energy to interpret and took away from the consideration or development of alternate indicators that may be more suitable to different target populations.

- *quality of, and access to, data*

  Although the data should have been readily available, it became evident during the project that access to quality and comparable data varied significantly between participating organisations.

5.3 Suitability of the National Framework and indicator set

There was general agreement by participants that the overall National Mental Health Performance Framework was suitable as a basis for benchmarking, primarily as it encouraged consideration of different domains of performance and helped identify related issues. A formal review (Table 2) was conducted of the 13 national indicators to determine their suitability for benchmarking, from the perspective of the mental health service organisation.

Table 2: Indicator review criteria

1. Is the indicator **relevant** to the target population? Is the underlying concept and intent of the indicator relevant to the target population? Does it provide information about an aspect of performance that is important to the target population?
2. Does the indicator **measure what is intended** within the target population? Is it an appropriate indicator for the nominated performance domain and sub-domain? Is it better mapped to another primary domain? Does it inform about an organisation's performance on the domain?
3. Is the national indicator **definition** appropriate to the target population? Is the current national definition suitable? Or is some variation needed to better define the underlying concept so that it is more appropriate to your target population?
4. Are the **national data specifications** for the indicator appropriate to your target population? Is the way in which the technical data inclusions and exclusions are specified meaningful to the target population? Are there specific technical issues that need to be better reflected in the way data is manipulated to produce the indicator?
5. Can **uniform targets** be set for this indicator? Can performance be meaningfully compared using the same 'benchmark' or target? What might be the appropriate targets to define 'good practice' standards in your target population? What might be appropriate targets that set an 'alert threshold' for further investigation? Are targets set in the basis of relativities or absolutes (based on some standard such as evidence, expert opinion or stakeholder consensus)?
6. Can the indicator be **interpreted and understood** by people who need to act? Does it give an unambiguous signal or can it be interpreted in multiple ways? (e.g. Are higher scores indicative of better or worse performance?) Does interpretation of performance depend on the domain being considered?
7. Can performance on the indicator be **influenced by local decisions** by people who have the power to act? Is performance on the indicator under the control of people with power to act? Or is it mainly the result of factors outside the control of the organisation?
8. Is it **feasible** to collect the required data and report at an organisational level, on a regular basis? Can the indicator be produced regularly, in a timely way, and within current resources?
9. What **contextual information** is critical to the interpretation of an organisation's performance on this indicator? What other important information or indicators are needed to make sense of an organisation's performance on this indicator?
10. Is the indicator relevant at the **service unit** and **individual clinician** levels? The service unit generally refers to individual wards of an inpatient service or teams of the ambulatory service within an overarching mental health service organisation. For some services the service unit is equivalent to the mental health service organisation (e.g. where an organisation only has one inpatient ward).

Table 3 provides an overview of recommendations and areas of concern from the perspective of each forum. It is important to reiterate that the information provided below represents the views of participating services from a local perspective and identification of targets should not be considered as their endorsement for national implementation. Further work is required to resolve issues identified by the forums at jurisdictional and national levels.

Table 3: Overview of forum review of key performance indicators

	Adult	Older persons	Child and adolescent	Forensic
Indicator: 28 day readmission rate				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target	**GPT:** ≤ 10% **AT:** ≥ 20%	**GPT:** ≤ 7.0% **AT:** ≥ 10.0%		
Indicator: National Service Standards compliance				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target			**GPT**: 100% Level 1	
Indicator: Average length of acute inpatient stay				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target	**GPT:** ≤ 12 days	**AT:** ≤ 35 days **AT:** ≥ 50 days	**AT:** ≥ 15 days	
Indicator: Average cost per acute inpatient episode				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target				

Table 3: **Overview of forum review of key performance indicators**

	Adult	Older persons	Child and adolescent	Forensic
Indicator: Average treatment days per 3-month community care period				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target	**AT**: ≤ 6 days **AT**: ≥ 18 days	**AT**: ≤ 8 days	**AT**: ≤ 3 days	
Indicator: Average cost per 3-month community care period				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target				
Indicator: Population receiving care: *ambulatory*				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target	**GPT**: ≥ 2.0%		**GPT**: ≥1.9% - 2.4%	
Indicator: Population receiving care: *acute inpatient*				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target				

Table 3: Overview of forum review of key performance indicators

	Adult	Older persons	Child and adolescent	Forensic
Indicator: Population receiving care: *residential*				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target				
Indicator: Local access to acute inpatient care				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target				
Indicator: New client index				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target		**AT**: ≤ 50.0% **AT**: ≥ 80.0%	**AT**: ≤ 50.0%	
Indicator: Comparative area resources: *ambulatory*				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target				

Table 3: **Overview of forum review of key performance indicators**

	Adult	Older persons	Child and adolescent	Forensic
Indicator: Comparative area resources: *acute inpatient*				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target				
Indicator: Comparative area resources: *residential*				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target				
Indicator: Pre-admission community contact				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target	**GPT**: ≥ 75.0% **AT**: ≤ 50.0%	**GPT**: ≥ 80.0%	**AT**: ≤ 70.0%	**GPT**: 100.0%
Indicator: Post-discharge community contact				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target	**GPT**: ≥ 75.0% **AT**: ≤ 50.0%	**GPT**: ≥ 80.0%	**AT**: ≤ 70.0%	**GPT**: 100.0%

Table 3: Overview of forum review of key performance indicators

	Adult	Older persons	Child and adolescent	Forensic
Indicator: Outcomes readiness				
Concept is relevant				
Specification is **appropriate**				
Sufficient **data quality** (numerator)				
Sufficient **data quality** (denominator)				
Forum identified target			**GPT**: ≥ 85.0%	**GPT**: ≥ 85.0%

NOTES

I. Targets are the views of participating services from a local perspective.

II. Identification of targets should not be considered as their endorsement for national implementation.

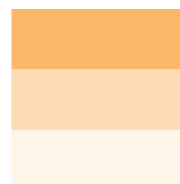
III. Further work is required to resolve issues at jurisdictional and national levels.

LEGEND

Substantial issues and disagreement with proposition

Minor, but fixable issues, with proposition

No or few issues with proposition



Good practice target GPT

Alert target1* AT

5.3.1 Gaps in the national indicator set

There was limited opportunity for participants to reflect on gaps within the current framework and indicator set. The following gaps were identified through the course of the forums and through the evaluation process:

- *a lack of measures of consumer outcome*
- Services felt that different aspects of mental health consumer outcomes need to be included in a comprehensive performance measurement framework.
- *limited focus on community-based indicators*
- Despite the majority of service activity in non-admitted services, there is limited focus on these indicators.
- lack of alternative indicators to represent varying service models

Although many participants were able to identify with at least a sub-set of the indicators relevant to their target population, alternatives are necessary to more appropriately represent issues specific to the different target populations.

In addition to the 13 national indicators, each forum reviewed supplementary performance and contextual indicators. The review was loosely based on the criteria outlined in Table 2; however, given the number of indicators the review was not as comprehensive. Further detail on the issues and recommendations from participating organisations on supplementary indicators is summarised in Appendix 8.5.

Table 4 highlights the indicators that forums identified as potentially appropriate for inclusion (either as a supplement or replacement) within the national indicator set. The proposals include a mixture of contextual and performance based indicators.

Table 4: Key recommendations of the review of supplementary indicators

Domain	Indicator title	Rationale	Appropriate for:
Efficient	**Community ambulatory mental health services direct care FTE per 100 000 population**	FTE information is more comparable than financial data as it is less susceptible to different accounting practices and overcomes many of the issues that arise with comparisons of financial data.	Older persons Adult
	Acute beds per 100 000 population	Bed information is more comparable than financial data as it is less susceptible to different accounting practices. Additionally, the concept of beds has more operational meaning and provides a better basis for jurisdictional comparisons.	Older persons Forensic Adult
	Community residential beds per 100 000 population	Community residential services often have broad catchments and a mental health service organisation may not be responsible for its functioning but is considered part of its catchment.	Older persons
	Proportion of expenditure on salaries and wages	The proportion of expenditure on salaries and wages provides information on how services are expending their funds. This allows some comparison and understanding of resource availability and allocation.	Adult Child & adolescent
	Average cost per acute inpatient bed day	This indicator limits the influence of length of stay, has more operational meaning and provides a better basis for jurisdictional comparisons. There was variable advice from the forums as to whether this indicator should replace or be used to complement the indicator of average cost per acute inpatient episode.	Older persons Adult Child & adolescent

Domain	Indicator title	Rationale	Appropriate for:
Efficient	**Average cost per community treatment day**	This indicator limits the influence of number of episodes, has more operational meaning and provides a better basis for jurisdictional comparisons. This information can also be used to identify issues of under-reporting of ambulatory collections. There was variable advice from the forums as to whether this indicator should replace or be used to complement the indicator average cost per 3-month community care period.	Older persons Adult Child & adolescent
Safe **Efficient**	**Bed occupancy**	Bed occupancy is important in understanding a range of indicators and can have a significant impact on a service's performance on those indicators, such as readmission rates. Although there was some divergent views the Adult Forum generally considered that action could be taken to influence performance on bed occupancy, although resource availability was a significant influence.	Adult Child & adolescent Forensic (context)
Responsive	**Consumer outcomes participation**	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. 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.	Adult
	Average days from referral to assessment	Wait time is an important measure and can be expressed as referral to assessment or referral to treatment. This indicator is about the responsiveness of the service to see a client.	Child & adolescent
	Average days assessment to discharge	The length of time a consumer accesses a mental health service is an important measure of the capacity and responsiveness of services to meet the needs of consumers.	Child & adolescent

PART 6. Conclusions

The National Mental Health Benchmarking Project met its four core objectives to varying extents. The participating organisations were very positive about the experience and eager to contribute to the national discourse on the future of benchmarking.

Core objective 1

Promote information sharing between organisations to increase understanding and acceptance of benchmarking

Participants were generally engaged with the process and despite initial reservations there was increased understanding and acceptance of benchmarking as an important means of improving service quality. Extensive discussion enabled participants to challenge and be challenged on appropriate outputs, models and strategies. The opportunity for collaboration with peers facilitated acceptance of the process.

Core objective 2

Identify the benefits, barriers and issues for organisations in the mental health field engaging in benchmarking activities

The major benefits and challenges that were identified included:

Benefits	Challenges
• the establishment of a national frame of reference • a greater understanding of models of service, local processes and their impact on overall performance • the development of expertise in the techniques, tools and utility of benchmarking and indicators • collaboration with peers.	• data (both access and quality, particularly in relation to costing and community mental health) • overcoming limitations due to differences in models of service, such as ability to appropriately compare performance and applicability of what has been learnt to the whole sector • the intensity of resources required (particularly unfunded components such as involvement of senior management) • the varying capacity, commitment and engagement of participating services.

Core objective 3

Understand what is required to promote such practices on a wider scale

Services and the organising group identified the following as important for achieving sustainable benchmarking within the sector.

- There needs to be a commitment to identify appropriate resources for organisation and facilitation.
- Participants need to be committed and active.
- There needs to be strong leadership, both within collaborative activities and organisations. Without sufficient leadership the benefits will be limited and the exercise has the potential to be passive and uninformative.
- Integrity, transparency and accountability are required to enable a safe environment for discussion and to ensure participants are clear on purpose and direction. Participants also need the opportunity to see that promises are kept and action is taken.
- Benchmarking needs to be incorporated and embedded as part of service practice (making it normal).
- Organisations need to identify appropriate peers who are similar enough to make benchmarking a useful quality improvement activity. Service models are critical to the interpretation of performance information. Services can learn from both the similarities and differences between organisations.
- Any benchmarking process needs to be coordinated and facilitated. There is no single model for benchmarking and the level of facilitation and coordination required will vary according to the model used.
- Quality data is needed to support and guide the correct interpretation and use of benchmarking information.

Regardless of the benchmarking model used, participation requires significant organisational capacity. This includes understanding clinical, structural and financial aspects of the service; understanding data and indicators; effective liaison with information personnel; and time to effectively participate and consider the results of the constructed indicators and how they may be explained in terms of local business processes.

The National Project had limited success in promoting benchmarking outside participating organisations. Promoting benchmarking on a wider scale is complex, particularly as the capacity of services to participate is variable.

Disseminating information from the project is an important first step but responsibility for developing the capacity of services to participate, support and perpetuate is primarily located at local, area and state levels. Participants publishing papers about specific aspects of their forums will help to promote benchmarking.

Core objective 4

Evaluate the suitability of the National Mental Health Performance Framework as a basis for benchmarking

The *National Mental Health Performance Framework* provided a relatively suitable basis for benchmarking; however, different domains did not always engage all participants and the relevance of individual indicators varied across the target populations. For example, the forensic forum identified that although some indicators were relevant, they would not be the first choice for investigating the performance of forensic mental health services. The child and adolescent forum identified the focus on admitted patient services was of limited use for community-oriented models.

The *National Mental Health Benchmarking Project* was resource intensive and expensive and it is not a model that can be replicated on an ongoing basis. Despite its limitations much has been learnt about benchmarking mental health services in Australia. The evaluation highlights that benchmarking is an evolutionary process and there are benefits from integrating this type of activity into a quality improvement cycle for mental health services.

A sustainable benchmarking process is complex and influenced by a range of factors including data quality and service models. The advice and outputs from the project will provide a mental health service organisation perspective that will inform future discussion and activity by stakeholders, including both service providers and funders.

PART 7. Recommendations

7.1 Supporting benchmarking

The outcomes of the project support benchmarking as a mechanism to promote quality improvement, accountability and transparency within the mental health sector. Although there are benefits to national benchmarking, the next stage should be within jurisdictions where there is greater capacity to implement a sustainable process.

Recommendations from participating services and the steering committee identify actions and the associated roles and responsibilities at two levels of the sector—the mental health service organisation and the health authority as policy developers and funders.

These recommendations are made on the basis that contribution from different levels should complement and enhance, not constrain or interfere with benchmarking activity.

7.1.1 Workforce development

These recommendations relate to activities to develop the technical, clinical utility and leadership skills of the workforce to enable services to fully benefit from participating in benchmarking activity.

Roles, responsibilities and actions

Mental health service organisation	Health authority
Technical	
• Formal recognition of technical tasks and required skill set, including the need for data analysis skills and capacity to understand data in a clinical context, and ensuring tasks are matched to appropriate roles. • Developing and distributing skill base among appropriate staff.	• Workforce development strategies, such as development of resources (manuals, training programs) and provision of support (such as an internet-based help desk). • Workforce investment in core technical skills (such as data analysis).
Leadership	
• Clear communication of expectations and benefits of benchmarking activity and findings. • Recognition of leadership responsibility in benchmarking. • Clarification of clinical and corporate governance responsibilities for benchmarking.	
• Development of a leadership culture that supports the use of information to guide service improvement. • Promotion of clinical and managerial ownership and collaboration. • Communication of organisational vision about benchmarking.	• Leadership development strategies and opportunities to incorporate benchmarking concepts. • Facilitator development strategies to ensure broad resources to facilitate benchmarking activity.

7.1.2 Technological infrastructure

These recommendations relate to the development, enhancement and support of the technological infrastructure required to enable efficient and appropriate use of quality information for benchmarking.

Roles, responsibilities and actions

<table>
<tr><th>Mental health service organisation</th><th>Health authority</th></tr>
<tr><td colspan="2">Data quality</td></tr>
<tr><td colspan="2">• Support for the development and implementation of standardised processes for data collection, such as costing methodology.</td></tr>
<tr><td>• Implementation of performance management systems to support data quality, including investment in processes such as audits and compliance monitoring.
• Promotion of innovation in the use and feedback of information to improve understanding and identification of data quality issues.
• Support for implementation of standardised processes to control data integrity in source systems.</td><td>• Development and dissemination of technical specifications and documentation.
• Provision of a clearing house role to support resolution and communication of data quality issues.
• Development and review of standardised processes to control data integrity in source systems.</td></tr>
<tr><td colspan="2">Access</td></tr>
<tr><td>• Development of strategies to address or compensate for systems limitations (e.g. increase number of computers, development of centralised data extraction and process for distributing information to relevant staff).
• Investment in supporting systems for data access and use in benchmarking, such as broadband and web-based resources.</td><td>• Development and support of electronic information systems and other technology, such as web-based technologies to support indicator construction.
• Scoping and mapping of system limitations and development of appropriate resolutions, such as enhancement of systems functionality to enable timely access and analysis of data.
• Provision of system support, including training strategies.
• Building capacity regarding data extraction and collation to support jurisdiction and service-level activity.</td></tr>
<tr><td colspan="2">Reporting</td></tr>
<tr><td colspan="2">• Development and enhancement of reporting capacity, including investment in relevant and user-friendly routine reports to support benchmarking activity.</td></tr>
<tr><td></td><td>• Provision of central (jurisdiction-wide) capacity for reporting/dissemination to minimise unnecessary duplication, including alignment with related state-wide reporting functions.</td></tr>
</table>

7.1.3 Leadership, culture and process management

The following recommendations are for activities related to culture, leadership and processes that will facilitate the uptake and proliferation of benchmarking to support quality improvement.

Roles, responsibilities and actions

<table>
<tr><th>Mental health service organisation</th><th>Health authority</th></tr>
<tr><td colspan="2">Leadership and culture change</td></tr>
<tr><td colspan="2">• Prioritisation and support for benchmarking activity within quality improvement cycle.
• Clarification of clinical and corporate governance responsibilities and expectations for benchmarking processes and findings.
• Allocation and investment of appropriate resources to support service-level understanding and use of benchmarking information.</td></tr>
<tr><td>• Fostering of excellence and good practice, harnessing pride and healthy competitiveness within staff.
• Integration of benchmarking activity into existing infrastructure, e.g. quality management frameworks and processes, and training initiatives and programs.
• Development and support for appropriate literacy and education activity to ensure appropriate understanding and utilisation of performance information.
• Utilising benchmarking findings to improve service infrastructure, delivery and outcomes.
• Set realistic expectations and goals in the context of timelines and resources.</td><td>• Review of approach and identification of potential improvements in the ongoing implementation of benchmarking (e.g. setting process indicators for benchmarking activity).
• Set realistic expectations and goals for timelines and resources.
• Supporting infrastructure changes in response to benchmarking findings, e.g. service redesign.</td></tr>
<tr><td colspan="2">Collaboration</td></tr>
<tr><td>• Identification and selection of appropriate peer groups.
• Identification and support for mechanisms to enable interactions between peers, including face-to-face, teleconference, video conference, and web-based technologies.
• Support and adherence for rules for collaboration, participation, information sharing and release.</td><td>• Creation and facilitation of opportunities for peer group formation.
• Trial and development of alternate mechanisms for interaction, such as web-based forums.
• Formulation of rules for collaboration, participation, information sharing and release, e.g. code of conduct.</td></tr>
</table>

Roles, responsibilities and actions

Mental health service organisation	Health authority
Communication and information dissemination	
• Identification of appropriate and sustainable mechanisms to disseminate information to clinicians and managers, such as intranet-based resources.	
• Use of communication vehicles to support literacy and education activity to ensure appropriate understanding and use of performance information. • Provision of clear and consistent messages regarding benefits and limitations of the use of performance information.	• Provision of clear and consistent messages regarding benefits and limitations of the use of performance information. • Identification of vehicles for disseminating information about the process and findings, including conferences (both mental health specific and general health), additional journal articles, and publication of resource documents.
Performance framework	
• Ensure processes to enable regular review of relevance and utility of performance information, including identification strategies to combine universal measures with more local or specific measures.	• Manage an evolving *National Mental Health Performance Framework* to move with the reform agenda, including replacement of irrelevant indicators and development of new indicators to meet emerging priorities.

7.2 Refinement of national key performance indicators

Each forum devoted a significant amount of time and energy to discussing the suitability, relevance and use of the national indicators at the mental health service organisation level. This advice should contribute to the national debate and activity related to:

- how applicable the current indicator set is for different levels of the mental health sector
- future research and development of indicators (particularly in relation to identified gaps and supplementary indicators)
- identifying national and/or state targets where appropriate.

PART 8. Appendices

Appendix 8.1

References

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Appendix 8.2

Participating services

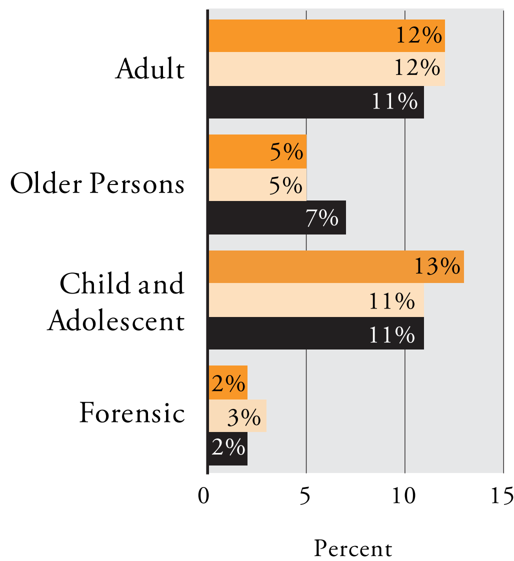
Adult services	Child and adolescent services	Older persons services	Forensic services
• Western Sydney Area Health Services—Blacktown Adult Mental Health Services (NSW) • South Eastern Sydney Illawarra Area Health Service—St George Hospital and Community Services (NSW) • Barwon Health (VIC) • Bayside Health (VIC) • Central Queensland Mental Health Services (QLD) • South Metro Area Health Services—Fremantle (WA) • Noarlunga Health Services (SA) • ACT Adult Mental Health Services (ACT)	• Eastern Health Child and Adolescent Mental Health Service (VIC) • Northern Sydney and Central Coast Area Health Service—Child and Adolescent Mental Health Service (NSW) • Mater Child and Youth Mental Health Service (QLD) • South Metro Area Health Service—Bentley (WA) • Southern Child and Adolescent Mental Health Services—Flinders Medical Centre (SA) • ACT Child and Adolescent Mental Health Services (ACT)	• Sydney South West Area Health Service—Braeside Hospital Aged Care (NSW) • North western Health—Melbourne Health Aged Mental Health (VIC) • Princess Alexandra Health Service District—Aged Care Mental Health Service (QLD) • South Metro Area Health Service—Bentley Elderly Mental Health Service (WA) • Repatriation General Hospital (SA)	• Justice Health (NSW) • Forensicare (VIC) • Integrated Forensic Mental Health (QLD) • State Forensic Mental Health Service (WA)

Appendix 8.3

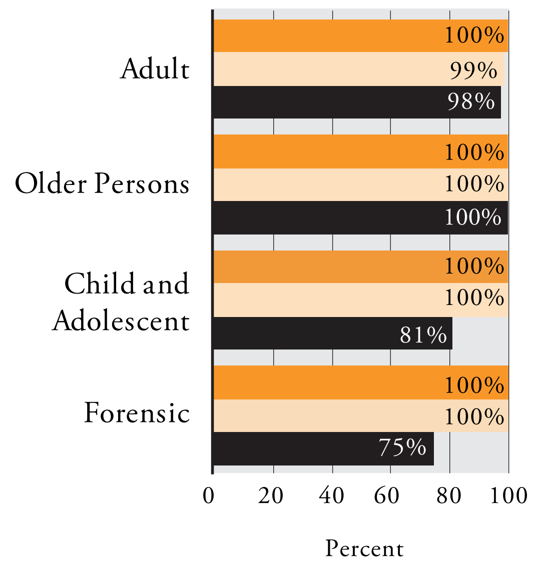
Key performance indicator output

Effective | **Appropriate**

28 day readmission rate

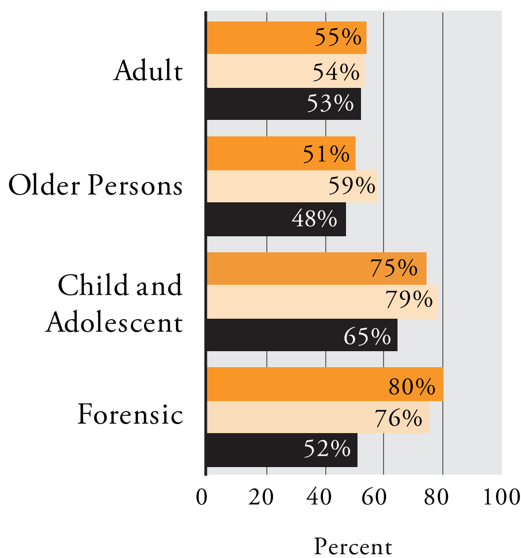


National Service Standards compliance

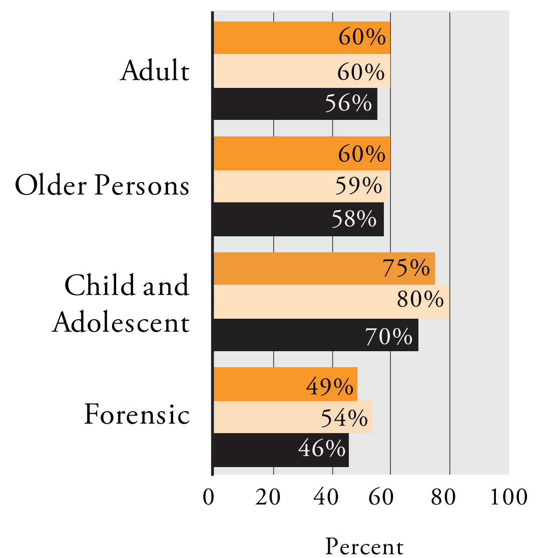


Continuous

Pre-admission community contact



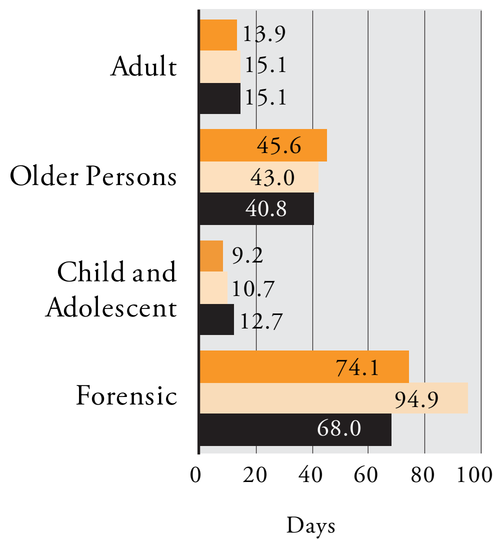
Post-discharge community contact



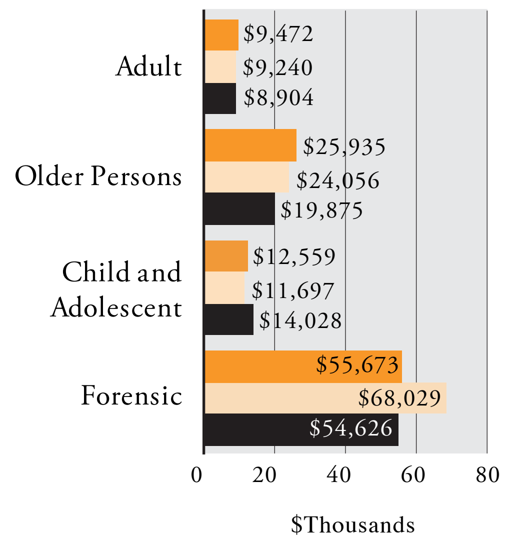
2004-05 2005-06 2006-07

Efficient

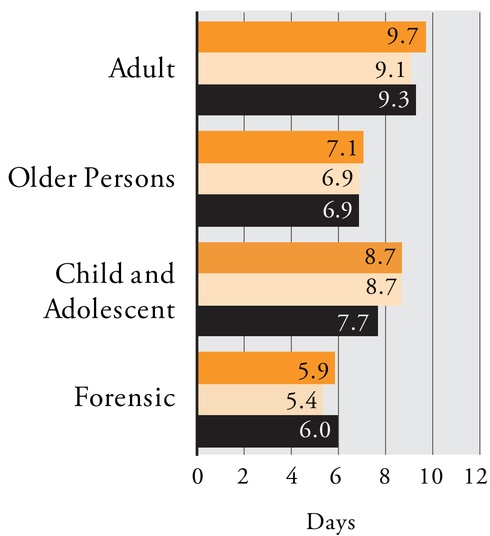
Average length of acute inpatient stay



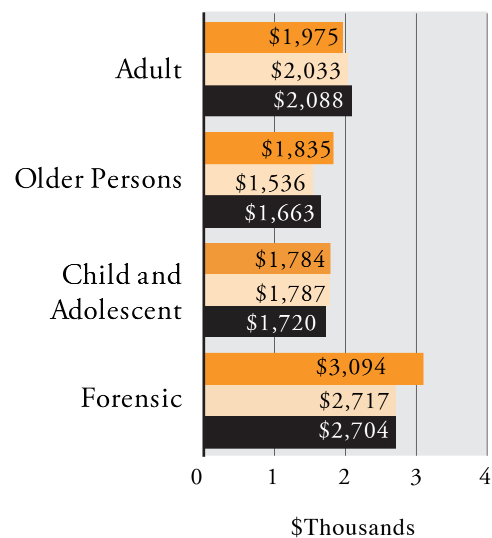
Average cost per acute inpatient episode



Average treatment days per 3-month community care period



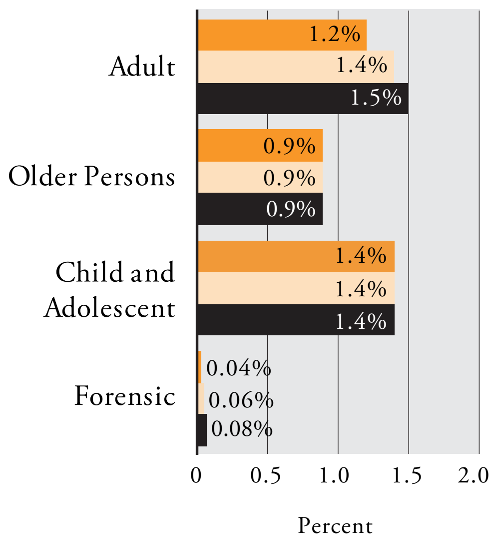
Average cost per 3-month community care period



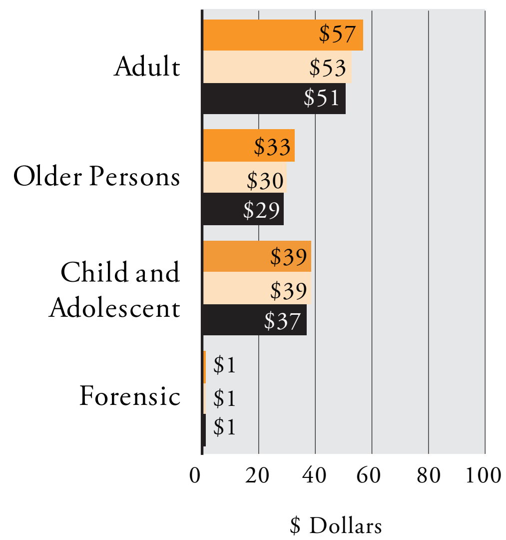
2004-05 2005-06 2006-07

Access

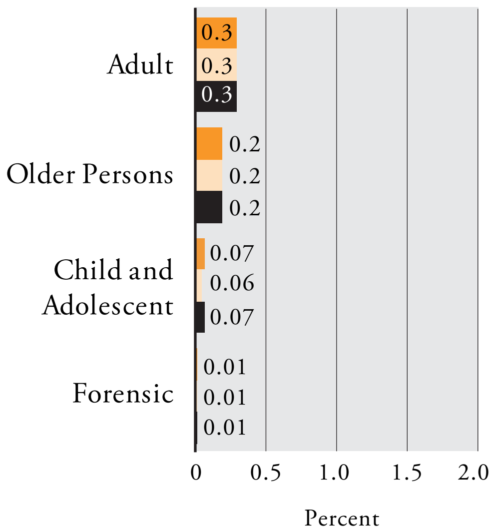
Population receiving care
Ambulatory



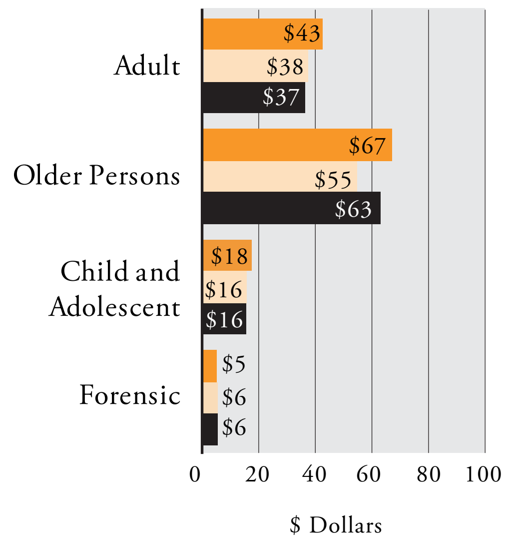
Comparative area resources
Ambulatory



Population receiving care
Inpatient



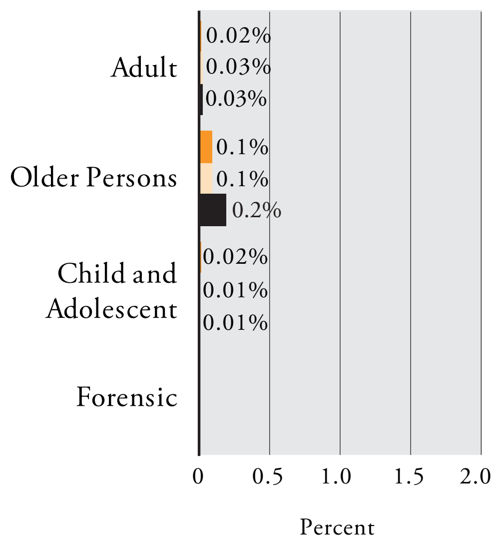
Comparative area resources
Inpatient



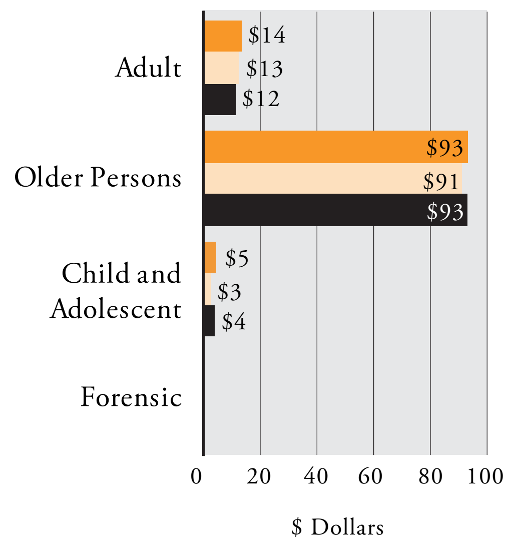
2004-05 2005-06 2006-07

Access

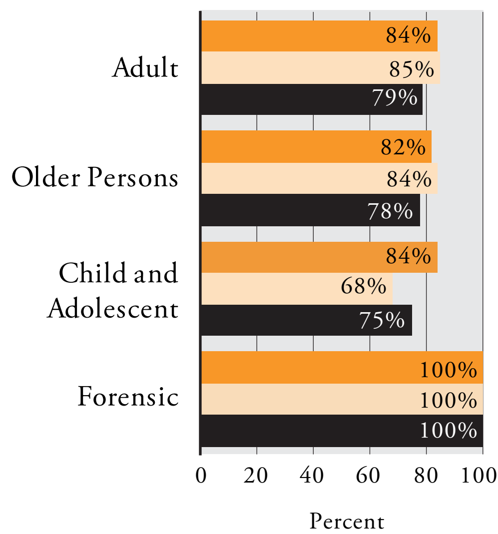
Population receiving care
Residential



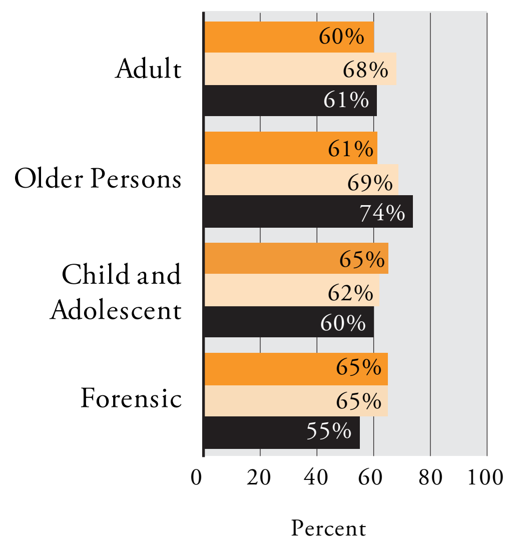
Comparative area resources
Residential



Local access to acute inpatient care

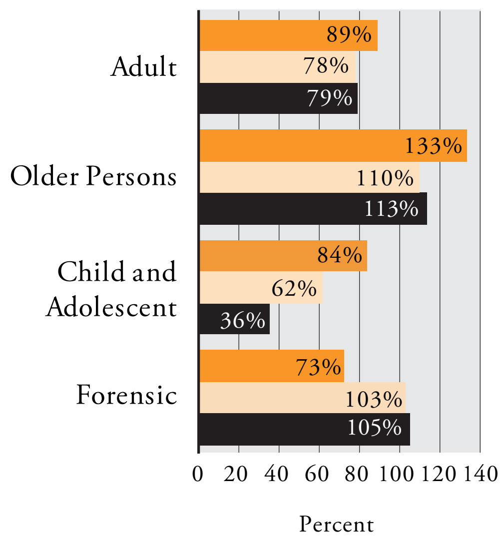


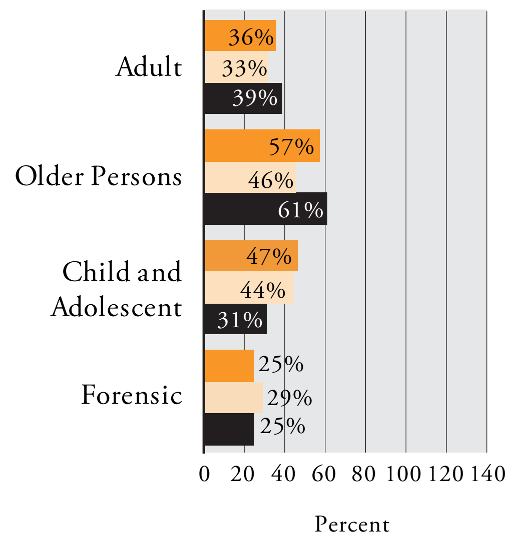
New client index



2004-05 2005-06 2006-07

Capable





2004-05 2005-06 2006-07

Appendix 8.4

Review of national indicators

The following information presents a high-level summary of the discussion and findings from each of the four forums. It is based on the views and expert opinions of participants, which in some cases was supported by existing literature, from a local perspective. The inclusion of recommendations in relation to each indicator, particularly in relation to targets, should not be considered as endorsement for national implementation. Work is being progressed to address a number of the issues identified by the forums at jurisdictional and national levels.

Notes

The following information applies across all indicators unless otherwise specified:

- **Specifications**
  Age was used as a parameter (child and adolescent < 18 years, adult 18–65 years, older persons 65+ years and forensic 18+ years).
- **Proposed targets**
  Unless otherwise indicated, targets are based on expert opinion and consensus of participants in the National Project. Proposed targets should be considered preliminary and may change as more evidence becomes available.

  Any targets proposed by the older persons forum only apply to sub-specialist services and may not be applicable for the 65+ population receiving inpatient care in general adult mental health services.
- **Good practice performance targets** identify the expected level of performance based on the premise that adequate resources are available and the mental health service organisation uses good practice.
- **Alert targets** identify a threshold that should trigger an investigation of the performance to ensure appropriateness of service models, clinical care and consumer outcomes. They do not identify poor practice.

Table 5

28 day readmission rate	
Percentage of separations from the mental health service organisation's acute psychiatric inpatient unit(s) that result in unplanned readmission to the organisation's acute psychiatric inpatient services 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 in the reference period that were followed by a readmission to the organisation's acute psychiatric inpatient services within 28 days.
Denominator	Number of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) occurring in the reference period.

- Same day separations and separations due to transfer, statistical discharge, leaving against medical advice (including absconding) and death were excluded.
- The national specifications count any readmission regardless of the organisation that manages the inpatient unit. The specifications for the project limited the count to readmissions to the same mental health service organisation.

Forum output

Adult			Older persons			Child and adolescent			Forensic		
2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07
11%	12%	12%	7%	5%	5%	11%	11%	13%	2%	3%	2%

Findings

Utility

- The concept of readmission is clinically valid as a measure of overall service effectiveness (both inpatient and community) that warrants monitoring and investigation. It is not diagnostic of a particular problem but identifies issues that suggest further investigation of some component of the system may be necessary, without necessarily directing the investigation.
- The utilisation of planned readmissions varies across target populations, with child and adolescent services using readmissions regularly, whereas the adult forum identified use as infrequent. The inability to distinguish planned and unplanned readmissions affects the interpretation and utility of the indicator.
- There are significant differences in the practices and models of service used by the different target population groups which will affect the likelihood of readmission. For example, inpatient care is rarely the preferred treatment for children and adolescents, and forensic consumers undergo an intensive step-down discharge process.

Table 5 (continued)

Specification

- Lengths of time between discharge and readmission vary. Further analysis is required to interpret the effect of varying reference periods.
- Evolving models of service, such as Psychiatric Emergency Care Centres (PECCs) and Prevention and Recovery Care (PARC) will affect the interpretation of readmission rates. The inclusion or exclusion of these services needs to be transparent to ensure that the readmissions are not being hidden.

Interpretation

- Factors influencing readmission include: bed availability; experience and skill mix of staff (inpatient and community); bed demand; degree of social integration; service practices, such as use and reporting of leave; discharge planning; service context such as structural issues and resources.
- Not all readmissions to inpatient mental health units are failures of care. Analysis and identification of allied indicators (such as average length of stay and post-discharge community care) and contextual factors (such as clinical outcomes, casemix, model of care) is essential to accurately interpret the output.
- The same output may have different causes across organisations. For example, a low readmission rate may be a factor of lack of access to beds, poor community resources, or the geographic location of discharge destination in one organisation; but due to concerted action to lower admission rates or improved staff skill base in another organisation.
- Specialist child and adolescent, older persons and forensic beds are scarce commodities and the capacity to readmit and re-refer consumers within a short period of time is limited. A lower readmission rate may indicate effectiveness but may alternatively indicate specific service models and resource limitations. Identifying psychiatric admissions to non-specialised units, such as paediatric units or general medical wards, would further enhance the utility of the indicator.
- The small number of separations and readmissions in some units affects the stability of the indicator (one or two additional readmissions can significantly increase the readmission rate). Additionally, the indicator can be driven by a small number of consumers who are regularly admitted to inpatient care. The number of consumers contributing to the result should be considered in any analysis of this indicator.
- The Adult Forum researched current literature and investigated factors that may affect readmission rates. Further details can be found within the 'Good Practice Guidelines' developed by the forum.

Table 5 (continued)

Contextual information		
National indicators	Supplementary indicators	Contextual information
• Average length of acute inpatient stay. • Post-discharge community contact.	• Bed occupancy. • Number of persons contributing to readmissions. • Waiting lists. • Discharge destination or source of readmission. • Legal status (*forensic*). • Readmission to acute medical unit (*older persons*).	• Community and inpatient service structures, practices (such as leave and discharge) and resources (such as Fulltime equivalent). • Case mix factors (including Health of the Nation Outcome Scales (HoNOS) and diagnosis profiles). • Availability of non-mental health community support (*older persons*).

Recommendations

- The indicator **28 day readmission rate** can be used for benchmarking *adult, older persons, forensic* and *child and adolescent* mental health services as nationally defined and specified.
- Further work is required to address and fix the current technical limitations for distinguishing between planned and unplanned readmissions.
- Research into the most appropriate length of time (such as 91 days or 180 days) for which to calculate readmission rates for different target populations should be considered.
- Research into the utility of additional indicators using variable lengths of time between discharge and readmission should be considered.
- The capacity to identify psychiatric admissions to non specialised units, such as pediatric units or general medical wards, would further enhance the appropriateness and utility of the indicator.

Forum Recommended Targets			
Adult	Older persons	Child and adolescent	Forensic
• Good practice target: *10 per cent or below.* • Alert target: *20 per cent or above.*	• Good practice target: *7 per cent or below.* • Alert target: *10 per cent or above.*	• No target identified.	• No target identified.

Table 6

National Service Standards compliance

Percentage of the mental health service organisation's services (weighted by expenditure) that have been reviewed against the *National Standards for Mental Health Services* categorised in four levels:

- Level 1—Services that have been reviewed by an external accreditation agency and judged to have met all national standards.
- Level 2—Services that have been reviewed by an external accreditation agency and judged to have met some but not all national standards.
- Level 3—Services that are (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known; or (ii) booked for review by an external accreditation agency.
- Level 4—Mental health services that do not meet criteria detailed under Level 1 or 3.

Numerator	Total mental health service organisation expenditure, during the reference period, 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 as detailed above).
Denominator	Total mental health service organisation expenditure on services during the reference period.

Forum Output

Adult			Older persons			Child and adolescent			Forensic		
2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07
98%	99%	100%	100%	100%	100%	81%	100%	100%	75%	100%	100%

Findings

Utility

- Compliance with the *National Standards for Mental Health Services* is relevant and important for all mental health services. However, compliance as shown through this indicator does not necessarily equal appropriate service delivery.
- There are differences in the way that organisations are accredited against the Standards, e.g. some organisations are accredited as part of a larger organisation (such as an Area or District) and results may depend on other units or services within the organisation. Additionally, the review process is not necessarily consistent across surveyors or accreditation agencies.

Specification

- The use of expenditure to distribute compliance across the mental health service organisation complicates understanding of the indicator and the increasing trend for components of services to be accredited as a 'whole' rather than as individual units or settings further diminishes the utility of the indicator at the organisational level.
- The *adult forum* briefly discussed options for revising the definition and specifications such as number of recommendations and length of time accreditation was granted. It was noted that factors other than service appropriateness potentially influenced results.

Table 6 (Continued)

Interpretation

- At the organisational level this indicator has a tendency to produce a 'Yes' or 'No' output and so does not describe incremental improvement by an organisation.

Recommendations

- The indicator **National Service Standards Compliance** should not be used to benchmark the appropriateness of *adult, older persons* or *forensic* mental health services. However, it can be utilised to benchmark the appropriateness of *child and adolescent* mental health services.
- Research into an alternate indicator of service appropriateness should be considered.

Forum Recommended Targets

Adult	Older persons	Child and adolescent	Forensic
• No target identified.	• No target identified.	• Good practice target: *100% at Level 1*.	• No target identified.

Table 7

Average length of acute inpatient stay

Average length of stay of in-scope overnight separations from acute psychiatric inpatient units managed by the mental health service organisation.

Numerator	Total number of patient days in the mental health service organisation's acute psychiatric inpatient unit(s) accounted for by in-scope overnight separations in the reference period.
Denominator	Number of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) in the reference period.

- Same day separations and separations due to transfer, statistical discharge, leaving against medical advice (including absconding) and death were excluded.
- The National Project used age as a parameter (child and adolescent < 18 years, adult 18 < 65 years, older persons 65+ years and forensic 18+ years).

Forum Output

Adult			Older persons			Child and adolescent			Forensic		
2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07
15.1	15.1	13.9	40.8	43.0	45.6	12.7	10.7	9.2	68.0	94.9	74.1

Findings

- Performance on this indicator may reflect resources and model of service rather than the failure of any service to perform appropriately or to provide efficient services. This indicator must be carefully interpreted as it is influenced by a range of clinical and non-clinical factors such as changes in medical and nursing leadership and practice, discharge practices, bed occupancy, access to alternative admitted patient services and community resources.
  Additionally, there are a number of factors unique to each target population which affects length of stay. Factors include the profile of consumers (for example consumers with dementia and behavioural issues cannot be adequately cared for at home or in a nursing home), different models of service and prevalence of physical co-morbidities.
- The mean is affected by extreme outliers, for example consumers needing extended treatment care receiving care within acute units because no other beds are available. The greater the difference between the mean and median, the more the average length of stay is affected by outliers. Subsequently, the median and mode will provide additional contextual information to enable more accurate description of the typical length of stay of consumers.
- Small numbers of 'in-scope' discharges from smaller acute units affects the stability of the indicator.
- The average length of stay is influenced by factors including demographics, casemix, clinical processes, region, and service philosophies such as discharging as soon as risk is minimised. A range of activities can be undertaken to influence performance, such as patient flow practices. Ideally, measures of consumer outcomes should be considered in the interpretation of average length of acute inpatient stay.

Table 7 (Continued)

Forensic mental health services

- Average length of acute inpatient stay is less useful within services that provide extended treatment with few discharges over the reference period.
- Efficiency, if measured through average length of stay, is misleading in a forensic environment where length of stay is often affected by legal status and procedures rather than a need for high-level clinical care.

Contextual information

National indicators	Supplementary indicators	Contextual information
• Post-discharge community contact. • Length of stay (stratified by diagnostic groups). • 28 day readmission rate.	• Proportion of consumers awaiting placement or length of stay of acute inpatients. • Median, mode and range of length of stay. • Bed occupancy.	• Case mix factors (including HoNOS and diagnosis profiles). • Available resources (such as beds per 100 000, availability of alternate accommodation options).

Recommendations

- The indicator **average length of acute inpatient stay** can be used to benchmark the efficiency of *adult, older persons* and *child and adolescent* mental health services as nationally defined and specified. However, it cannot be used to benchmark the efficiency of *forensic* mental health services.
- Research to develop an appropriate indicator of length of stay or tenure for services providing extended treatment services should be considered.

Forum Recommended Targets

Adult	Older persons	Child and adolescent	Forensic
• Good practice target: *12 days or less.*	• Alert target: *50 days or more.* • Alert target: 35 days or less.	• Alert target: *15 days or more.*	• No target identified.

Table 8

Average cost per acute inpatient episode

Average cost of in-scope overnight separations from acute psychiatric inpatient units managed by the mental health service organisation.

Numerator	Total recurrent expenditure accounted for by in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) in the reference period.
Denominator	Number of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) in the reference period.

- Same day separations and separations due to transfer, statistical discharge, leaving against medical advice (including absconding) and death were excluded.

Forum Output

Adult			Older persons			Child and adolescent			Forensic		
2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07
$8 904	$9 240	$9 472	$19 875	$24 056	$25 935	$14 028	$11 697	$12 559	$54 626	$68 029	$55 673

Findings

- Inpatient episode costs are largely driven by the number of episodes and length of stay. Therefore the influences on length of stay also have an impact on the costs. For example, legal status has a significant impact on length of stay in forensic settings, and therefore will have an impact on costs.
- The concept of efficiency should only be viewed in context of the factors that influence an indicator.
- At the organisational level there is a need to break down costs and identify associated issues (such as staff hours per day) to enable understanding of efficiency.

Table 8 (Continued)

Cost methodology and data

- The reliability of the indicator is dependent on good quality, accurate and consistent financial reporting (especially on organisational overheads).
- There are significant concerns about the accuracy and consistency of mental health expenditure data, particularly differences in apportioning indirect costs (for example costs associated with stand-alone hospitals versus units aligned to general hospitals). There is potential for the indicator to skew analysis of an organisation's efficiency and performance.
- Changing of accounting practices, costing methodologies and other financial rules within organisations limits the use of trend analysis. There is significant difficulty in determining causes of differences with financial data. For example, a single organisation with three units was unable to accurately determine the causes of the differences in results on this indicator.
- A range of factors outside the control of individual organisations (or for which the organisations have limited capacity to influence), such as staffing mix, wage rates, organisational changes and restructures, accounting practices, recruitment practices (for example number of overseas trained staff) will have an impact on the output of this indicator and limit the comparability and trend analysis.
- Considerable work is required to develop consistent costing methodology across mental health services, both within and across jurisdictions.

Specifications

- As statistical discharges (such as transfer from acute to rehabilitation areas within the same organisation) are out-of-scope for the construction of the indicator of the cost of acute episodes, costs are inflated for some service models, particularly older person and forensic services.
- The indicator is skewed for services that have a greater proportion of out-of-scope separations. The link to the separated episode limits comparability and is misleading as an indicator of inpatient efficiency. For this indicator to be an accurate measure of efficiency, consideration should be given to modifying the specifications to enable costs for activity that is currently out-of-scope, such as transfers to sub-acute units or consumers admitted for the entire reference.

Table 8 (Continued)

Contextual information		
National indicators	**Supplementary indicators**	**Contextual information**
• Average length of acute inpatient stay.	• Bed occupancy. • Cost per bed day. • Annual average cost per bed. • Clinical hours per bed day.	• Staffing profile.

Recommendations

- The indicator **average cost per acute inpatient episode** can be used for benchmarking *child and adolescent* mental health services as currently nationally defined and specified. However, including the **average cost per acute bed day** as a supplementary indicator should be considered when benchmarking *child and adolescent* mental health services.
- The indicator **average cost per acute inpatient episode** is not appropriate for benchmarking *forensic*, *older persons or adult* mental health services as currently nationally defined and specified.
- **Average cost per bed day** should be included in benchmarking *older persons* and *adult* mental health services.
- More appropriate indicators for the efficiency of costs of inpatient care are required for benchmarking *forensic* mental health services.

Forum Recommended Targets			
Adult	**Older persons**	**Child and adolescent**	**Forensic**
• No target identified.	• No target identified.	• No target identified.	• No target identified.

Table 9

Average treatment days per three-month community care period	
Average number of treatment days per three-month period of ambulatory care provided by the mental health service organisation's community mental health services.	
Numerator	Total number of community treatment days provided by the mental health service organisation's community mental health services within the reference period.
Denominator	The total number of ambulatory care statistical episodes (three-month periods) treated by the mental health service organisation's community services within the reference period.

Forum Output

Adult			Older persons			Child and adolescent			Forensic		
2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07
9.3	9.1	9.7	6.9	6.9	7.1	7.7	8.7	8.7	6.0	5.4	5.9

Findings

Interpretation

- The concept of treatment days is complex and requires education and training to both interpret and use the information. Interpretation is further complicated by a lack of standardised definitions of what an episode of ambulatory mental health care actually entails. Subsequently, the same number of treatment days does not imply that the same type or level of care was provided to consumers.
- The indicator is useful for identifying issues at the overall service level but is not a measure of the quality of the treatment provided. Further information, such as outcomes-based information and detailed contact data (such as contacts per treatment day or duration of contacts), is required to understand issues related to intensity and quality of services.
- The indicator is not a measure of FTE productivity and is not intended to account for how clinicians spend their time. However, the indicator has the potential to highlight issues the team or individual clinician.
- The indicator needs to be interpreted within the service context as it is influenced by the model of service adopted (e.g. case management versus assessment or acute treatment), staff experience, location, access to inpatient services and access to NGO services. Additionally, the average can be affected by extreme outliers, particularly in smaller services.
- The indicator provides an average and should not be considered as a guide for each individual consumer (ideally clinical judgment on the intensity of treatment should dictate the care provided to consumers). The average can be affected by extreme outliers, particularly in smaller services.
- An exceedingly high number of average treatment days and a low average number of treatment days are both of concern and may warrant investigation by organisations.
- Under-reporting of ambulatory contacts continues to be a significant issue affecting the reliability of the indicator.

Table 9 (Continued)

Specification

- The inclusion of all types of service contacts in the construction of a treatment day was deemed acceptable as the purpose of the measure is to be a high-level indicator.
- Ideally each episode should be counted from the time it commences for each individual consumer, rather than based on arbitrary three-month periods. Current systems and technology limit the capacity of most jurisdictions to accurately provide this information.
- The aggregation of the indicator for all ambulatory services within an organisation limits the use of the indicator at the organisational level, particularly for services with a number of different service models, such as forensic services which provide court liaison, prison mental health, consultation liaison and case-management. It may be more useful to split the indicator into the different forensic community service types.

Contextual information

National indicators	Supplementary indicators	Contextual information
• Comparative area resources. • Population under care. • New client index.	• Average contacts per treatment day. • Average duration of contacts. • Proportion of direct contacts. • Proportion of assessment only contacts. • Average treatment hours per 3-month community care period.	• Model of service. • Staffing profile. • Case mix factors (including HoNOS and diagnosis profiles). • Available resources (e.g. FTE per 100 000, collaboration with other service providers). • Geographic size of catchment. • Ambulatory data coverage and data collection protocols.

Recommendations

- The indicator **average treatment days per three-month community care period** can be used for benchmarking *adult, older persons, forensic* and *child and adolescent* mental health services as nationally defined and specified. However, the indicator should be stratified for different forensic ambulatory service types within a mental health service organisation.
- Consideration should be given to the use of **average contacts per treatment day** and, where possible, a **measure of contact duration** as an alternate measure of efficiency.

Forum recommended targets

Adult	Older persons	Child and adolescent	Forensic
• Alert target: *Less than or equal to six treatment days.* • Alert target: *Equal to or more than 18 treatment days.*	• Alert target: *Less than or equal to eight treatment days.*	• Alert target: *Less than or equal to three treatment days.*	• No target identified.

Table 10

Average cost per three-month community care period	
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.

- A statistically derived community episode is defined as each three-month period of ambulatory care of an individual identified patient where the patient was under 'active care', defined as one or more treatment days in the period.
- The National Project used age as a parameter (child and adolescent < 18 years, adult 18 < 65 years, older persons 65+ years and forensic 18+ years).

Forum Output

Adult			Older persons			Child and adolescent			Forensic		
2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07
$2088	$2033	$1975	$1663	$1536	$1835	$1720	$1787	$1784	$2704	$2717	$3094

Findings

Interpretation

- As calculated for the National Project, community care period costs are largely driven by the number of episodes and number of treatment days. Therefore the influences on treatment days also affects costs. The double counting of treatment days increases the complexity of the interpretation.
- The indicator is susceptible to poor compliance with local information reporting requirements, particularly contact reporting (i.e. low reporting rates increases costs).
- The concept of efficiency should not be viewed in isolation. For example, a single clinician that provides services to 100 consumers may be able to provide cheaper period-of-care costs but it may not be efficient as the level of care is unlikely to meet the needs of the consumers.
- It is difficult to define efficient community care as there are substantial differences in service models, staffing mix and target populations. It cannot be assumed that an episode of community care in service A is the same or even similar to an episode of community care in service B.
- At the organisational level there is a need to break down costs and identify associated issues (such as FTE and staffing profile) to enable understanding of efficiency.

Table 10 (Continued)

Cost data

- The reliability of the indicator is dependent on good quality, accurate and consistent financial reporting (especially regarding organisational overheads). However, there are significant concerns regarding the accuracy and consistency of mental health expenditure data, particularly differences in the apportioning of indirect costs (e.g. costs associated with stand-alone hospitals versus units aligned to general hospitals). Consequently there is potential for the indicator to skew analysis of an organisation's efficiency and performance.
- Changing of accounting practices, costing methods and other financial rules within organisations limits the use of trend analysis. There is significant difficulty in determining causes of differences with financial data. For example, a single organisation with three units was unable to accurately determine the causes of the differences in results on this indicator.
- A range of factors outside the control of individual organisations such as staffing mix, wage rates, organisational changes and restructures, accounting practices (such as how costs are apportioned and distributed) and recruitment practices (including number of overseas trained staff) will affect the output of this indicator and limit the comparability and trend analysis.
- Considerable work is required to develop consistent costing methods across mental health services, both within and across jurisdictions.

Contextual information

National indicators	Supplementary indicators	Contextual information
• Comparative area resources. • Average treatment days per three-month community care period.	• Average cost per treatment day. • Annual average cost per consumer treated.	• Staffing profile. • Ambulatory data coverage and data collection protocols.

Recommendations

- The indicator **average cost per three-month community care period** can be used for benchmarking *forensic* and *child and adolescent* mental health services as currently nationally defined and specified. However, the inclusion and use of **average cost per treatment day** as a supplementary indicator should be considered when benchmarking these mental health services.
- The indicator **average cost per three-month community care period** is not appropriate for benchmarking *older persons or adult* mental health services as currently nationally defined and specified. Using **average cost per treatment day** should be considered for benchmarking *older persons* and *adult* mental health services.

Forum recommended targets

Adult	Older persons	Child and adolescent	Forensic
• No target identified.	• No target identified.	• No target identified.	• No target identified.

Table 11

Population receiving care	
The percentage of persons resident in the mental health service organisation's defined catchment area who received care from the organisation's mental health (inpatient/ambulatory/residential) services.	
Numerator	Total number of persons resident in the defined catchment area who were recorded as receiving a service from the mental health service organisation's in-scope (inpatient/ambulatory/residential) mental health services within the reference period.
Denominator	Total number of persons in the target population who were resident in the defined catchment area for the organisation's in-scope (inpatient/ambulatory/residential) mental health services at the mid-point of the reference period.

Forum output

Adult			Older persons			Child and adolescent			Forensic		
Inpatient			Inpatient			Inpatient			Inpatient		
2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07
0.3%	0.3%	0.3%	0.2%	0.2%	0.2%	0.07%	0.06%	0.07%	0.01%	0.01%	0.01%
Ambulatory			Ambulatory			Ambulatory			Ambulatory		
1.2%	1.4%	1.5%	0.9%	0.9%	0.9%	1.4%	1.4%	1.4%	0.04%	0.06%	0.08%
Residential			Residential			Residential			Residential		
0.03%	0.03%	0.02%	0.2%	0.1%	0.1%	0.01%	0.01%	0.02%	n.a.	n.a.	n.a.

Table 11 (Continued)

Findings

- Access to mental health services is an ongoing issue for most services. However, this indicator does not account for demand for services. Services may restrict access to care to manage resources.
- The model of service, especially where some components of the service are provided outside the organisation (such as the external or shared triage model), will affect how this data can be interpreted and compared.
- There are a range of issues (structural, population and service) that affect this indicator that are not necessarily in the control of the mental health service organisation, including:
  - inaccuracies caused by different registration activities across community services
  - catchment size, number and size of vulnerable populations, changes in boundaries and how the catchment population is counted (particularly for interpreting the trend series)
  - the level of available resources, such as the amount of productive versus unproductive FTE.
- As a measure of performance this indicator cannot be looked at in isolation of other initiatives, such as those funded through the Council of Australian Governments (COAG) National Action Plan on Mental Health. These initiatives have the potential to reduce the output without it being an indication of service performance (e.g. more people contact general practitioners or psychologists rather than the local mental health service).

Forensic mental health services

- There are differences in the target population for the different forensic ambulatory services (prison mental health, court liaison, community forensic). The indicator should be further stratified by ambulatory service types for accurate interpretation, analysis and action for the forensic target population.

Contextual information

National indicators	Supplementary indicators	Contextual information
• Average treatment days per three-month community care period. • New client index.	• FTE per 100 000 population. • Proportion of consumers from catchment area receiving care outside local catchment. • Proportion of consumers from outside catchment area receiving services from local service.	• Population characteristics (such as demographic and epidemiological profiles). • Staffing profile. • Model of service. • Availability of alternate services, such as general practitioners. • Treatment outcomes. • Ambulatory data coverage and data collection protocols.

Table 11 (Continued)

Recommendations			
• The indicator **population under care** can be used for benchmarking *adult, older persons, forensic* and *child and adolescent* mental health services as nationally defined and specified. However, further stratification is required to enable accurate interpretation, analysis and action for the forensic target population. • The focus of analysis and investigation should be on ambulatory population under care as these services undertake the majority of activity within the public sector.			
Forum recommended targets			
Adult	Older persons	Child and adolescent	Forensic
• Good practice target: *2.0 per cent or higher of the ambulatory catchment population.*	• No target identified.	• Good practice target: *Between 1.9–2.4 per cent of the ambulatory catchment population.*	• No target identified.
• Epidemiological evidence suggests *2.4 per cent* of the child and adolescent population have a serious mental illness that would require access to tier three public sector child and adolescent mental health services (Kurtz 1996; NSW Health 2001). • Epidemiological evidence suggests *2.6 per cent* of the adult population have a serious mental illness that would require access to mental health services (NSW Health 2001).			

Table 12

Local access to acute inpatient care

The percentage of separations from acute psychiatric inpatient units for persons resident in the mental health service organisation's defined catchment area, where the person was treated within the local inpatient unit.

Numerator	Total number of acute psychiatric inpatient separations in the reference period for residents of the defined area where the person was treated within the local public sector psychiatric inpatient unit.
Denominator	Total number of acute psychiatric inpatient separations in the reference period for residents of the defined area who received the acute inpatient service from any public sector mental health service organisation.

Forum output

Adult			Older persons			Child and adolescent			Forensic		
2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07
79%	85%	84%	78%	84%	82%	75%	68%	84%	100%	100%	100%

Findings

- The concept of 'local' is difficult to define. The indicator defines local as being within the specified catchment area which may not actually be local from the perspective of the consumer, carer or clinician. Catchments are generally defined at a broader level than mental health service organisation and may include a large geographic region (for example Northern Queensland) and changes to catchment boundaries through jurisdictional and organisational restructuring affect trend analysis.
- The use of the indicator is limited as acute mental health inpatient services for all target populations are not available in all areas. Services, particularly child and adolescent and forensic, have broad 'local' catchments.
- Proximity to alternate acute inpatient services and arrangements (such as general aged-care beds with input from the mental health service or access to general adult psychiatric inpatient service) affect output of this indicator. There may be a benefit in specifying the indicator for different target populations and stakeholders, for instance older person mental health services would benefit from the capacity to identify mental health patients in aged-care wards.

Recommendations

- The indicator **local access to acute inpatient care** should not be used for benchmarking *adult*, *older persons*, *child and adolescent* or *forensic* mental health services as a measure of access as currently defined and specified in the National Mental Health Performance Framework.

Forum recommended targets

Adult	Older persons	Child and adolescent	Forensic
• No target identified.	• No target identified.	• No target identified.	• No target identified.

Table 13

New client index

Proportion of total clients seen in the reference period who had not received a service from the organisation in the year (365 days) preceding the date of the first service in the reference period.

Numerator	Total number of persons who were recorded as receiving one or more services from the mental health service organisation's in-scope mental health services within the reference period who did not receive any mental health service from the organisation in the year (365 days) preceding their first service received in the reference period.
Denominator	Total number of persons who were recorded as receiving one or more services from the organisation's in-scope mental health services within the reference period.

- The national indicator currently does not specify a time period for determining 'new' and the method for identifying new clients requires further development. The definition used in this project represents an initial approach that is expected to be achievable with the resources available to participating organisations.

Forum output

Adult			Older persons			Child and adolescent			Forensic		
2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07
61%	68%	60%	74%	69%	61%	60%	62%	65%	55%	65%	65%

Findings

- Access to mental health services is an ongoing issue for most services and capacity to monitor and improve access is relevant. An organisation's throughput can be considered by the proportion of 'new' clients. The point of entry (where the consumer first contacted the organisation) is important supplementary information that needs to be considered when interpreting this indicator.
- This is a conceptually complex indicator, primarily because 'new' has many interpretations and definitions. A client can be new to a service, setting, target population or diagnostic group. The indicator covers those who are new to an organisation, regardless of the setting or target population.

Table 13 (Continued)

Interpretation

- Although the indicator can identify issues associated with access it does not identify the cause of access. Further analysis of structural, legislation, population and practice issues is required to interpret the indicator. Organisational restructures and boundary changes will affect the time series associated with the indicator.
- There are likely to be strong regional differences in the performance of this indicator, particularly where there are alternate (non-public sector) services available.
- The definition of 'new' may need to vary depending on the level of analysis (for example new to a setting for inpatient units only or new to a team).

Specification

- The use of 'new' as 365 days before the first contact with any component of the mental health service organisation is arbitrary and is an attempt to deal with information system constraints rather than determining whether or not a consumer is actually new to the overall system.
- When used for state-wide (or stand-alone) services this indicator can be interpreted as new to target population type rather than new to the service organisation. This limits the capacity to compare between state-wide (or stand-alone) and integrated services.
- The definition of the indicator within the National Mental Health Performance Framework (that is, new to mental health care by the organisation) provided information on consumer throughput; however, the benchmarking definition was considered appropriate for defining access to care because even if consumers do have a history with a mental health service there will be a need to re-engage or re-connect for consumers who have not accessed public mental health services for an extended period of time.

Contextual information

National indicators	Supplementary indicators	Contextual information
• Population under care.	• New client index (point of entry). • New client index (new to setting). • New client index (new to mental health care). • A measure of discharge (such as case closure or throughput index).	• Population characteristics (such as demographic and epidemiological profiles). • Ambulatory data coverage and data collection protocols.

Table 13 (Continued)

Recommendations			
• The indicator **new client index** can be used for benchmarking *adult, older persons, forensic* and *child and adolescent* mental health services as defined and specified for the *National Mental Health Benchmarking Project*. • Where possible, the new client index as defined within the National Mental Health Performance Framework should be used as a supplementary indicator for benchmarking mental health services as it provides a more comprehensive picture of service throughput. • Consideration should be given to supplementary indicators of new to setting (acute inpatient or ambulatory mental health care) and new to target population (transition adult to older persons, or new to forensic mental health).			
Forum recommended targets			
Adult	Older persons	Child and adolescent	Forensic
• No target identified.	• Alert target: *50 per cent or less* • Alert target: *80 per cent or more.*	• Alert target: *50 per cent or less.*	• No target identified.

Table 14

Comparative area resources	
Per capita recurrent expenditure by the organisation on (ambulatory/inpatient/residential) mental health services for the target population within the organisation's defined catchment area.	
Numerator	Total expenditure on in-scope (ambulatory/inpatient/residential) mental health services during the reference period.
Denominator	Total number of persons in the target population who were resident in the defined catchment area for the organisation's in-scope (inpatient/ambulatory/residential) mental health services during the reference period.

Forum output

Adult			Older persons			Child and adolescent			Forensic		
Inpatient			Inpatient			Inpatient			Inpatient		
2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07
$37	$38	$43	$63	$55	$67	$16	$16	$18	$5.96	$5.58	$5.45
Ambulatory			Ambulatory			Ambulatory			Ambulatory		
$51	$53	$57	$29	$30	$33	$37	$39	$39	$1.19	$1.11	$1.46
Residential			Residential			Residential			Residential		
$12	$13	$14	$93	$91	$93	$4	$3	$5	n.a.	n.a.	n.a.

Findings

- Comparative area resources is not necessarily an indicator of service performance as funding allocation is generally not within the control of individual mental health service organisations. However, it has the potential to provide significant leverage for influencing policy and funding decisions and information to service managers to assist with interpreting other indicators.
- The reliability of output is dependent on good quality, accurate and consistent financial reporting (especially regarding organisational overheads). Considerable work is required to develop consistent costing methods across mental health services, both within and across jurisdictions.
- Differences in the catchments of the different forensic ambulatory services (prison mental health, court liaison, community forensic). For accurate interpretation, analysis and action for the forensic target population the indicator should be further stratified by ambulatory service types
- The interface between mental health and other services (such as with aged care services) is important when identifying relevant resources for mental health services.

Forensic mental health services

- There are differences in the target population for the different forensic ambulatory services (prison mental health, court liaison, community forensic). For accurate interpretation, analysis and action for the forensic target population the indicator should be further stratified by ambulatory service types.

Table 14 (Continued)

Contextual information		
National indicators	Supplementary indicators	Contextual information
	• FTE per 100 000 population. • Beds per 100 000 population.	• Population characteristics. • Staffing profile.

Recommendations

- The indicator **comparative area resources** can be used for benchmarking mental health service organisations as defined and specified for the *National Mental Health Benchmarking Project*. Further stratification is required for accurate interpretation, analysis and action for the *forensic* target population.
- Due to variation in costing methods and accounting practices, supplementary indicators should be developed, such as **FTE per 100 000 population** and **beds per 100 000 population**, when benchmarking at the mental health service organisation level.

Forum recommended targets			
Adult	Older persons	Child and adolescent	Forensic
• No target identified.	• No target identified.	• No target identified.	• No target identified.

Table 15

Pre-admission community contact

Percentage of admissions to the mental health service organisation's in-scope acute inpatient unit(s) from within the organisation's ambulatory services catchment area for which a community ambulatory service contact was recorded in the seven days immediately preceding that admission by ambulatory care services managed by the organisation.

Numerator	Number of in-scope admissions to the mental health service organisation's acute inpatient unit(s) within the reference period for which a community mental health ambulatory contact was recorded in the seven days immediately preceding the admission by ambulatory care services managed by the organisation.
Denominator	Total number of in-scope admissions from within the organisation's ambulatory services catchment area to the mental health service organisation's acute inpatient unit(s) within the reference period.

- The national indicator specifications require that all pre-admission service contacts be included not just those conducted by mental health service organisation's ambulatory service(s).

Forum output

Adult			Older persons			Child and adolescent			Forensic		
2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07
53%	54%	55%	48%	59%	51%	65%	79%	75%	52%	76%	80%

Findings

- This indicator is based on the concept that pre-admission community care can potentially (i) ease transition into acute care, (ii) reduce the length of stay, or (iii) reduce the times that the inpatient setting is used as the 'front-door', or entry point to a mental health service organisation.
- The indicator does not identify the proportion of admissions that could have been prevented or averted and does not assume that a high percentage of pre-admission to community care is an indication of failure of community care. It attempts to identify those consumers who are not seen—those who are not receiving a service or are falling through 'the gaps' in community care prior to admission. There will always be a small proportion of people who escalate so quickly that pre-admission contact is unlikely, but overall systems should be set up so the community is aware of services, and has timely access to them.
- The indicator provides information about the mental health service organisation as a whole, not just the inpatient setting or the community setting. For instance, an increase in emergency admissions could be an indication of poor resources in the community.

Table 15 (Continued)

Interpretation

- The indicator is vulnerable to poor community data collection adherence and variation in practice used to record contacts (particularly triage contacts). Participants suggested that it is possible that ambulatory contacts in the week prior to admission are less likely to be recorded into electronic information systems due to the crisis nature of the work, for example a crisis team may be seeing a consumer on a daily basis but not recording the contacts. Additionally, consistent definitions of 'case' would facilitate interpretation and comparison of this indicator.
- The indicator is sensitive to a range of factors, including:
  - services being located in rural areas (consumers may wait longer for admission due to distance)
  - transient populations
  - differing models of service (such as combined intake processes with general aged-care services)
  - differing clinical practice and service procedures (such as the threshold for admission)
  - collaboration of service components
  - partnerships within primary care, private sector or non-government mental health services.
- As a measure of performance this indicator cannot be looked at in isolation from other services (including non-government services or general practitioners). These initiatives have the potential to reduce the output without it being an indication of service performance (for example more people contact general practitioners or psychologists rather than the local mental health service).

Contextual information

National indicators	Supplementary indicators	Contextual information
• New client index (*adult*).	• Bed occupancy. • Pre-admission contact setting (e.g. forensic versus general).	• Available resources (FTE per 100 000, collaboration with other service providers). • Model of service. • Admission processes, policies and pathways. • Case mix factors (including HoNOS and diagnosis profiles). • Ambulatory data coverage and data collection protocols.

Table 15 (Continued)

Recommendations
• The indicator **pre-admission community contact** can be used for benchmarking *adult, older persons, forensic* and *child and adolescent* mental health services as nationally defined and specified. • Research into the most appropriate length of time to count pre-admission contact for the different target populations should be considered. • Determination of consistent and accurate data capture for all contacts, and consistent definitions of 'cases' should be considered. • The adult forum recommends that the primary domain should be *access* and the secondary domains: continuous, appropriate and responsiveness.

Forum recommended targets			
Adult	Older persons	Child and adolescent	Forensic
• Good practice target: *75 per cent and above.* • Alert target: *50 per cent or less.*	• Good practice target: *80 per cent and above.*	• Alert target: *70 per cent or less.*	• Good practice target: *100 per cent.* Note this target is based on the definition used in the National Mental Health Benchmarking Project.

Table 16

Post-discharge community contact	
Percentage of separations from the mental health service organisation's in-scope acute inpatient unit(s) from within the organisation's ambulatory services catchment area for which a community ambulatory service contact was recorded in the seven days immediately following that separation by ambulatory care services managed by the organisation.	
Numerator	Number of in-scope separations to the mental health service organisation's acute inpatient unit(s) within the reference period for which a community mental health ambulatory contact was recorded in the seven days immediately following the separation by ambulatory care services managed by the organisation.
Denominator	Total number of in-scope separations from within the organisation's ambulatory services catchment area to the mental health service organisation's acute inpatient unit(s) within the reference period.

- The national indicator specifications require that all pre-admission service contacts be included not just those conducted by mental health service organisation's ambulatory service(s).

Forum output											
Adult			Older persons			Child and adolescent			Forensic		
2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07
56%	60%	60%	58%	59%	60%	70%	80%	75%	46%	54%	49%

Table 16 (Continued)

Findings
Interpretation • The indicator is a direct measure of good clinical practice. It has clinical meaning and relevance at the individual clinician level and can drive practice improvement and change. Further analysis and stratification by client participation and diagnosis groups may be of use to individual services. • Public mental health services cannot be expected to identify everyone discharged from public inpatient units as some consumers are appropriately followed up by GPs, private psychiatrists or other services. • The indicator is vulnerable to poor community data collection adherence and variation in practice used to record contacts. • The indicator is sensitive to a range of factors, including: – services being located in rural areas (consumers may wait longer for admission due to distance) – transient populations – differing models of service (such as combined intake processes with general aged-care services) – differing clinical practice and service procedures (such as the threshold for admission) – collaboration of service components – partnerships within primary care, private sector or non-government mental health services. • The indicator provides information about the mental health service organisation as a whole, not just the inpatient setting or just the community setting. For example an increase in emergency admissions could be an indication of poor resources in the community. For state-wide services the indicator is for both service and system measurement.
Specification • Currently there is no differentiation between people who are not contacted versus those where contact is attempted by service but refused or failed. This is due to limitation of current information systems to capture the appropriate data. • Older persons and child and adolescent mental health services agreed that the inclusion of all service contacts as follow-up contact was appropriate as these services often coordinate post-discharge care in collaboration with other services. For example the most appropriate follow-up for a consumer with a low mental status may be with the residential aged-care facility. • Adult and forensic mental health services agreed that the indicator should only count those contacts in which the consumer participated. • The seven day parameter was chosen due to substantial literature indicating increased risk of suicide within the first seven days following discharge from acute care. There is less evidence that follow-up within seven days makes a difference for the consumer in regards to community tenure. Further analysis of different reference periods should be considered to determine the appropriateness of this period for each target population.

Table 16 (Continued)

Contextual information		
National indicators	Supplementary indicators	Contextual information
	• Bed occupancy. • Referral destination.	• Available resources (e.g. FTE per 100000, collaboration with other service providers). • Model of service. • Case mix factors (including HoNOS and diagnosis profiles). • Ambulatory data coverage and data collection protocols.

Recommendations

- The indicator **post-discharge community contact** can be used for benchmarking *older persons* and *child and adolescent* mental health services as nationally defined and specified.
- The indicator **post-discharge community contact** can be used for benchmarking *adult* and *forensic* mental health services as with modification to the national specifications to only count follow-up contacts where the consumer participated.
- Research into the most appropriate length of time to count post-discharge contact for the different target populations should be considered.

Forum recommended targets			
Adult	Older persons	Child and adolescent	Forensic
• Good practice target: *90 per cent and above.*	• Good practice target: *80 per cent and above.*	• Good practice target: *90 per cent and above.*	• Good practice target: *100 per cent.* Note this target is based on the definition used in the National Mental Health Benchmarking Project.

Table 17

Outcomes readiness

Percentage of expected collection occasions with a valid Health of the Nation Outcome Scale appropriate to target population (that is, HoNOS, HoNOS65+ or HoNOSCA) recorded.

Numerator	Number of collection occasions with a valid HoNOS/HoNOS65+/HoNOSCA recorded by the organisation's in-scope inpatient and ambulatory care services in the reference period.
Denominator	Estimated number of collection occasions recorded by the organisation's in-scope inpatient and ambulatory care services if the outcomes reporting protocol was fully implemented.

- The National Project approximated each organisation's 'take up' of outcome measurement by comparing the number of collection occasions that included a valid measure with the number that could be expected on the basis of the volume of activity (separations or 3-month periods of ambulatory care). The National Project used the age parameters of the HoNOS measures.

Forum output

Adult			Older persons			Child and adolescent			Forensic		
Inpatient			Inpatient			Inpatient			Inpatient		
2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07	2004-05	2005-06	2006-07
79%	78%	89%	113%	110%	133%	36%	62%	84%	105%	102%	73%
Ambulatory			Ambulatory			Ambulatory			Ambulatory		
39%	33%	36%	61%	46%	57%	31%	44%	47%	25%	29%	25%

Table 17 (Continued)

Findings

- Compliance with data collection protocols is not an indication of data quality.
- As currently defined and specified, this is not a measure of capability.
- The indicator is generous in its calculation of participation, limiting its interpretability and face validity (e.g. when services can have 150 per cent participation). The indicator is skewed in the favour of residential or long-stay services. Being able to link between outcomes and activity collections to accurately identify episodes of care will improve the appropriateness and use of this indicator.
- The national specifications do not allow for monitoring of compliance against individual measures which are included in the National Outcomes and Casemix Collection, requiring all measures to be completed to be in-scope for the indicator.
- Additionally, the specifications are unclear on whether consumer self-assessment is included in the definition of compliance. Given the significant low rate of offering and completion of self-assessment measures inclusion would significantly impact on the output and use of the indicator.
- Compliance with offering consumer self-assessment measures should be constructed separately.
- Differences in service models and protocols may dictate that not all services collect the outcome information, for example forensic liaison services supporting case management services.

Contextual information		
National indicators	Supplementary indicators	Contextual information
		• Quality of data.

Recommendations

- The indicator **outcomes readiness** should **not** be used as a measure of capability of *adult* mental health services as currently defined and specified in the National Mental Health Performance Framework.
- The indicator **outcomes readiness** can be used as a measure of capability of *older person, forensic and child and adolescent* mental health services as defined and specified in the National Project.
- An indicator using mental health clinical outcomes (such as change scores over time) should be developed to measure the effectiveness of mental health services.

Forum recommended targets			
Adult	Older persons	Child and adolescent	Forensic
• No target identified.	• No target identified.	• Good practice target: *85 per cent and above.*	• Good practice target: *85 per cent and above.*

Appendix 8.5

Review of supplementary indicators

Participants identified a range of supplementary indicators for use in benchmarking mental health service organisations. These indicators included both performance indicators and contextual indicators. The latter were considered to provide **context** to the service and other indicators but were not deemed to be a measure of a service's performance.

Not all forums used all indicators and only those deemed relevant and useful for at least one forum are included. Issues outlined in the main report, such as the impact of data quality (particularly expenditure data) and service models on comparability of data, apply to the advice provided on supplementary indicators.

Contextual indicators

Indicator	Comments	Forums
Total in-scope expenditure Sum of all in-scope expenditure during the reference period.	• Although there are considerable differences in costing methods which have an impact on the comparability of this data, some forums identified it was informative for estimating the overall available resources.	• Child and adolescent • Adult • Older persons • Forensic
Proportion of indirect expenditure	• This information is useful at local level to explain expenditure variation, particularly for information obtained from local finance staff.	• Child and adolescent • Older persons • Forensic
Proportion of expenditure on salaries and wages	• This provides information on how services are spending funds. This allows comparison and understanding of resource availability and allocation, rather than focusing on actual numbers.	• Child and adolescent • Adult • Older persons • Forensic
Inpatient expenditure and funding per capita differentials	• This involved a comparison of total inpatient expenditure over total catchment population (KPI#10) with total inpatient funding over total catchment population.	• Child and adolescent • Forensic
Ambulatory expenditure and funding per capita differentials	• This involved a comparison of total ambulatory expenditure over total catchment population (KPI#10) with total ambulatory funding over total catchment population.	• Child and adolescent • Forensic

Contextual indicators

Indicator	Comments	Forums
Full-year cost per acute inpatient bed	• It was considered that this information **complements** the indicator *average cost per acute inpatient episode.*	• Child and adolescent • Adult • Older persons • Forensic
Full year cost per community ambulatory direct care FTE	• It was considered that this information **complements** the indicator *average cost per three-month community care period.*	• Child and adolescent • Adult • Older persons • Forensic
Bed-based services as a percentage of total expenditure	• This provides information on how services are spending their funds. This allows comparison and understanding of resource availability and allocation, rather than focusing on actual numbers.	• Child and adolescent
Acute beds per 100 000 population	• Indicators using bed data are useful for understanding resources as this overcomes many of the issues arising from different costing methods for financial data, the concept has more operational meaning and provides a better basis for jurisdictional comparisons.	• Child and adolescent • Adult • Older persons • Forensic
Non-acute beds per 100 000 population	• Indicators using bed data are useful for understanding resources as this overcomes many of the issues arising from different costing methods for financial data, the concept has more operational meaning and provides a better basis for jurisdictional comparisons.	• Forensic
Community residential beds per 100 000 population	• Community residential services often have broad catchments and a mental health service organisation may not be responsible for its management but may be a user of the service as part of its catchment. • This information was considered useful for advocating for additional resources for these types of services.	• Older persons

Contextual indicators

Indicator	Comments	Forums
Community ambulatory mental health services direct care FTE per 100 000 population	• Indicators using FTE data are useful for understanding resources as this overcomes many of the issues arising from different costing methods for financial data, the concept has more operational meaning and provides a better basis for jurisdictional comparisons. • Variations in staffing mix will affect the indicator, e.g. medical staff are more expensive which may lower FTE for the same level of expenditure as another service with fewer medical staff. • Productive and unproductive (that is, paid but not working) FTE affects the use of FTE information.	• Child and adolescent • Adult • Older persons • Forensic
Staffing mix per acute patient day	• Indicators using FTE data are useful for understanding resources as they overcome many of the issues arising from different costing methods for financial data, the concept has more operational meaning and provides a better basis for jurisdictional comparisons. • Staffing mix is not completely under the control of each organisation as the overall mix of the different disciplines can be dictated by industry requirements, which may differ across jurisdictions.	• Child and adolescent • Adult
Proportion of consumers who reside outside community ambulatory catchment	• This gives an indication of the impact of catchment boundary issues.	• Adult • Older persons
Proportion of assessment only ambulatory episodes	• This gives an indication of the amount of assessment activity undertaken by the services.	• Forensic
Proportion of acute inpatient separations where the consumer resides outside acute inpatient catchment	• This gives an indication of the impact of catchment boundary issues.	• Adult • Older persons

Contextual indicators

Indicator	Comments	Forums
Proportion of out-of-scope overnight separations	• This provides context to the representativeness of bed-based indicators to the majority of inpatient activity.	• Adult • Older persons • Forensic
Diagnosis profile	• Forms part of case mix profile required to understand variation in performance.	• Child and adolescent • Adult • Older persons • Forensic
Mental health outcomes profile	• Forms part of case mix profile required to understand variation in performance.	• Child and adolescent • Adult • Older persons • Forensic
Stratification of key indicators by diagnosis groups	• The stratification of a range of information by diagnostic groupings can facilitate more targeted investigation of performance.	• Older persons

Performance indicators

Domain(s)	Indicator	Comments	Forums
Efficient	**Average cost per acute inpatient bed day**	• This indicator limits the influence of length of stay, has more operational meaning and provides a better basis for jurisdictional comparisons. • There was variable advice from the forums as to whether this indicator should replace or be used to complement the indicator 'average cost per acute inpatient episode'.	• Child and adolescent • Adult • Older persons • Forensic
	Average annual cost per community residential bed	• This indicator is relevant for understanding costs associated with residential services.	• Adult
	Average cost per contact hour	• This limits the influence of number of episodes, has more operational meaning and provides a better basis for jurisdictional comparisons. • This information can also be used to identify issues of under-reporting of ambulatory collections.	• Child and adolescent
	Average cost per community treatment day	• This limits the influence of number of episodes, has more operational meaning and provides a better basis for jurisdictional comparisons. • This information can also be used to identify issues of under-reporting of ambulatory collections.	• Child and adolescent • Adult • Older persons • Forensic
	Median length of stay	• The median provides information that is important for understanding the average length of acute inpatient stay.	• Child and adolescent • Adult • Older persons
	Proportion of overnight separations with acute length of stay ≥ XX days	• Child and adolescent ≥ 35 days • Older persons ≥ 60 days • Forensic ≥ 180 days	• Child and adolescent • Older persons • Forensic

Performance indicators

Domain(s)	Indicator	Comments	Forums
Efficient	**Average direct care staff hours per acute inpatient day**	• This information will provide greater understanding of length of stay information.	• Child and adolescent • Adult • Older persons
	Average weekly contacts per direct care FTE	• This information provides some clarity on issues related to case loads, under-reporting and non-consumer related activity.	• Child and adolescent • Adult • Older persons • Forensic
	Average weekly contact hours per direct care FTE	• This information provides some clarity on issues related to case loads, under-reporting and non-consumer related activity.	• Child and adolescent
	Average weekly treatment days per direct care FTE	• This information provides some clarity on issues related to case loads, under-reporting and non-consumer related activity.	• Child and adolescent • Adult • Older persons • Forensic
	Average contacts per treatment day	• This information identifies potential sources of variation in treatment days.	• Child and adolescent • Adult
	Average contacts per three-month community care period	• This information identifies potential sources of variation in treatment days.	• Child and adolescent
	Proportion of single treatment day consumers per three-month community care period	• This information identifies potential sources of variation in treatment days.	• Child and adolescent • Adult • Older persons
	Average number of persons seen per year per ambulatory direct care FTE	• This information provides some clarity on issues related to case loads, under-reporting and non-consumer related activity.	• Child and adolescent • Adult • Older persons • Forensic

Performance indicators

Domain(s)	Indicator	Comments	Forums
Safe **Efficient**	**Bed occupancy**	• Bed occupancy is important for understanding a range of indicators and can have a significant impact on a service's performance on those indicators, such as readmission rates. • Although there was divergent views it was generally considered that action could be taken to influence performance on bed occupancy, although resource availability was a significant issue. • For forensic services this was seen to be contextual rather than a measure of performance.	• Child and adolescent • Adult • Older persons • Forensic
Efficient **Responsive**	**'Did not attend' as a proportion of total contact**	• The impact of 'did not attend' service contacts can be significant on the interpretation of community indicators. • This indicator may also be a measure of capacity of service to appropriately engage with target population.	• Child and adolescent
Efficient **Effective**	**Open clients per direct care FTE**	• This describes the case load of a clinician and is important for identifying what is happening within a service. Interpretation is, however, dependent on the model of service.	• Child and adolescent
	Staff activity survey	• Proportion of direct care FTE time spent on direct clinical care, indirect clinical care, non-clinical activity and other. • The activity of mental health clinicians in the community is broader than direct clinical care. Understanding other activity is important for understanding the efficiency and effectiveness of a service.	• Child and adolescent

Performance indicators

Domain(s)	Indicator	Comments	Forums
Safe	**Rate of falls per consumer (inpatient)**	• Fall prevention is a national safety priority. Falls are among the most common adverse incidents involving older people in hospital, including in mental health units, with significant rates of adverse physical and psychological effects. • A fall is defined as an event that results in a consumer coming to rest inadvertently on the ground or floor or other lower level. Including staff finding the consumer on the floor but not witnessing the event.	• Older persons
	Proportion of inpatient consumers who fall		• Older persons
	Proportion of inpatient consumers who fall three or more times		• Older persons
	Proportion of consumers with at least one seclusion event	• The reduction in seclusion is driven by a number of national and state initiatives. • Seclusion has the potential to negatively affect consumers and the effectiveness of care.	• Forensic
	Proportion of consumers with at least two events of seclusion		• Forensic
	Proportion of seclusion events that are four or more hours in duration		• Forensic
	Proportion of consumers who assault at least once	• Critical incidents, such as assaults, can negatively affect the operation of an organisation.	• Forensic
	Proportion of consumers who assault at least twice	• Literature suggests that this information will facilitate understanding of other issues, including seclusion practices.	• Forensic
Effective	**Readmission rate (91 and 182 days)**	• Readmission following a longer interval from care was seen as important for identifying issues related to case mix, resources and organisational structure.	• Forensic

Performance indicators

Domain(s)	Indicator	Comments	Forums
Effective	**Community tenure**	• Refers to the number of consumers registered in the mental health service organisation's community ambulatory mental health service with no admissions to acute psychiatric inpatient care (following registration with ambulatory service) during the reference period over the number of consumers registered in the mental health service organisation's community ambulatory mental health service during the reference period. • Further work is required on the definition and specification of this indicator.	• Older persons
Responsive	**Average number of contacts (consumer present)** **Average number of contacts (consumer not present)** **Average total contact time (consumer present)** **Average total contact time (consumer not present)**	• These indicators provide a profile of service delivery that can be used to better understand the responsiveness of a service.	• Child and adolescent
	Average days from referral to assessment	• Wait time is an important measure and can be expressed as referral to assessment or referral to treatment. • This indicator is about the responsiveness of the service to see a client.	• Child and adolescent

Performance indicators

Domain(s)	Indicator	Comments	Forums
Responsive	**Average days assessment to discharge**	• The length of time a consumer accesses a mental health service is an important measure of the capacity and responsiveness of services to meet the needs of consumers.	• Child and adolescent
	Average days referral to treatment		
	Consumer outcomes participation	• The proportion of episodes with consumer self-assessment outcome measures.	• Adult
Access	**Proportion of same day separations from acute psychiatric inpatient units**		• Adult • Older persons
	New client Index (alternative)	• The number of people in contact with the mental health service organisation who have never been seen by the organisation prior to the first contact during the reference period, over the total number of people in contact with the mental health service organisation during the reference period.	• Child and adolescent
	Population receiving care (prison mental health services)	• The ambulatory catchment population for forensic services is complicated, as they do not necessarily align with general concept of catchment. The capacity to more accurately identify population receiving care for the distinct populations it serves, will enhance understanding of access issues.	• Forensic
	Population receiving care (forensic community services)		
	Population receiving care (court liaison services)		

Appendix 8.6

National Mental Health Performance Subcommittee membership

Ms Ruth Catchpoole (Chair)	Director, Mental Health Information Unit, Mental Health Branch, Queensland Health.
Dr Grant Sara	Director, InforMH, Mental Health and Drug and Alcohol Office, NSW Health.
Mr Nick Legge	Manager, Service Monitoring and Review, Mental Health Branch, Mental Health and Drugs Division, Department of Human Services, Victoria.
Ms Kristen Breed	Manager, Performance, Evaluation and Analysis Team, Mental Health Information Unit, Mental Health Branch, Queensland Health.
Ms Danuta Pawelek	Director, Systems Development, Division of Mental Health, Department of Health, Western Australia.
Ms Robyn Milthorpe	Ag/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 (AIHW).
Ms Helen Connor	Consumer representative.
Ms Judy Hardy	Carer representative.
Dr Peggy Brown	Chair, Safety and Quality Partnership Subcommittee (SQPS).
Ms Karlyn Chettleburgh	Forensic sector representative.
Dr Paul Lee	Child and Adolescent Mental Health Outcomes Expert Group.
Dr Rod McKay	Older Persons Mental Health Outcomes Expert Group.
Professor Tom Trauer	Adult Mental Health Outcomes Expert Group.
Professor Philip Burgess	Australian Mental Health Outcomes and Classification Network.
Mr Tim Coombs	Australian Mental Health Outcomes and Classification Network.
Mr Bill Buckingham	Director, Buckingham and Associates Pty Ltd, consultant to Department of Health and Ageing.
Mr Richard Bastida (Secretariat)	Principal Project Officer, Performance, Evaluation and Analysis Team, Mental Health Information Unit, Mental Health Branch, Queensland Health.

At 30 June 2009

The challenge for the mental health sector is clear.
The use of performance indicators and the movement towards benchmarking is becoming routine in the Australian health care system. The challenge for the mental health sector is to develop a set of meaningful performance measures and to develop the culture and the processes so that benchmarking becomes the norm.

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All information in this publication is correct as of March 2011