Key Performance Indicators
for Australian Public Mental Health Services

Technical Specification Summary

June 2008

national mental health strategy

Purpose

This document was prepared on behalf of the National Mental Health Performance Subcommittee to provide a comprehensive summary of the technical specifications of the Key Performance Indicators currently included in the National Mental Health Performance Framework. The document provides modifications made to initial phase 1 indicators and specifications for Key Performance Indicators added to the national indicator set since the publication of the document, *Key Performance Indicators for Australian Public Mental Health Services*[1] in 2005. The contextual information and rationale for the development of the National Mental Health Performance Framework remains in the document *Key Performance Indicators for Australian Public Mental Health Services*, which can be found on the following internet sites: www.health.gov.au or www.mhnocc.org.

[1] National Mental Health Working Group Information Strategy Subcommittee 2005, *Key Performance Indicators for Australian Public Mental Health Services.* ISC Discussion Paper No. 5 Australian Government Department of Health and Ageing.

Contents

"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"

Eagar K et al. 2005 *Towards national benchmarks for Australian mental health services*, ISC Discussion Paper No. 4, Department of Health and Ageing, Canberra.

Introduction and Background

Since the endorsement and publication of the *National Mental Health Performance Framework* and 13 'Tier 3' Key Performance Indicators (KPIs) in 2005, considerable work has been undertaken to progress and develop the mental health performance agenda. This work has been led by the National Mental Health Performance Subcommittee (NMHPSC), which was established by the Mental Health Information Strategy Subcommittee (MHISS), to progress the ongoing development of the national performance framework and support benchmarking for mental health services. Significant activity has occurred in relation to the development of indicators for the *safe* and *responsive* domains of the framework and the establishment and oversight of the *National Mental Health Benchmarking Project*.

Modifications to 'Phase 1' Key Performance Indicators

In May 2007 the Mental Health Standing Committee endorsed a number of modifications to some of the agreed 'phase 1' indicators: National Service Standards Compliance, Average Length of Acute Inpatient Stay, Average Cost Per Acute Inpatient Episode, Population Receiving Care and Comparative Area Resources. These refinements were based on advice from States and Territories following initial implementation of the KPIs and feedback from the technical specification workshops of the *National Mental Health Benchmarking Project*.

Development of Key Performance Indicators for the safe domain

In 2005 the then National Mental Health Working Group (now the Mental Health Standing Committee) endorsed the *National safety priorities in mental health: a national plan for reducing harm*[2] (the 'National Safety Plan'). This plan identified four priority areas for initial action:

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

Focusing on the priorities established through National Safety Plan the NMHPSC investigated a range of issues associated with the definition and collection of safety data. The concept of safety in mental health care encompasses many different aspects, including the safety of the consumer, health service providers, carer and the community. It was

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

agreed that to facilitate the portrayal and definition of the diversity and complexities of safety in mental health care four sub-domains should be included within the framework to cover the key areas of safety that are impacted on by mental health service delivery.

- *Consumer Safety:* This sub-domain concerns the extent to which health care environment and/or service provided to and/or for consumers of mental health services is safe. A consumer is "a person who is currently utilising, or has previously utilised, a mental health service".[3]
- *Provider Safety:* This sub-domain concerns the extent to which the working environment established and/or maintained for providers of mental health services is safe. A provider is defined as a paid or unpaid employee, contractor or volunteer of a mental health service organisation.
- *Carer Safety:* This sub-domain concerns the extent to which a safe environment is supported for mental health carers, with a carer defined as a "person whose life is affected by virtue of a family or close relationship and caring role with a consumer".[4]
- *Community Safety:* This sub-domain concerns the extent to which a safe environment is supported for the broader community. There is currently no standard or sufficient definition of community available.

In 2008 the Mental Health Standing Committee endorsed the inclusion of the four sub-domains and the *rate of seclusion* as a Key Performance Indicator for the national framework. The NMHPSC and the Safety and Quality Partnership in Mental Health Subcommittee (SQPS) will continue to work together to further refine and develop appropriate Key Performance Indicators for the *safe* domain.

Development of Key Performance Indicators for the responsive domain

The active involvement by consumers and carers in treatment planning, decision-making, and definition of treatment goals is a key goal of the National Mental Health Strategy and consumer self-assessment outcome measures is one mechanism through which consumers (and carers/parents of children and adolescents) can be actively involved. The responsive domain requires that the *service provides respect for persons and is client orientated, it includes respect for dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks, and choice of provider*'[5]. Two sub-domains were identified for indicator development: client perceptions of care; and consumer and carer participation.

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[3] Australian Health Ministers 2003, *National Mental Health Plan 2003 – 2008*, Department of Health and Ageing, Canberra, p. 33.

[4] Ibid, p. 23.

[5] National Mental Health Working Group Information Strategy Subcommittee 2005, *Key Performance Indicators for Australian Public Mental Health Services*, ISC Discussion Paper No. 5, Australian Government Department of Health and Ageing, Canberra, p. 34.

To facilitate the process of collecting a consumer self-assessment outcome measure, mental health services must have an adequate degree of engagement (both clinically and organisationally) with consumers (and carers in regards to child and adolescent services). Given the current limitation of other national data sources, it was considered that the uptake of the the consumer self-assessment outcome measures from the National Outcomes and Casemix Collection were an appropriate source to identify consumer participation until other data sources were available.

In 2008, the MHSC endorsed the indicator *Consumer Outcomes Participation* for inclusion within the national framework mapping primarily to the consumer and carer participation sub-domain of the *responsive* domain, with a secondary link to the *capable* domain.

National Mental Health Benchmarking Project

The *National Mental Health Benchmarking Project* was developed as a collaborative initiative between the Australian and State and Territory governments. During 2006-07 and 2007-08 the Project convened demonstration benchmarking forums in each of the main mental health program areas: general adult, child and adolescents, older persons and forensic mental health services. Four core objectives were identified for the *National Mental Health Benchmarking Project*:

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

The outcomes of the evaluation of the *National Mental Health Benchmarking Project* will be available in early 2009.

Summary of proposed Key Performance Indicator set

A summary of the performance framework and currently nationally agreed performance indicators is shown in Figure 1. Overall, 24 sub-domains are identified as key areas for performance indicator development. A total of 15 indicators have been identified for implementation and utilisation within jurisdictions. Table 1 maps each of the 15 indicators to a primary domain of the national health performance framework, also showing secondary linkages to related domains.

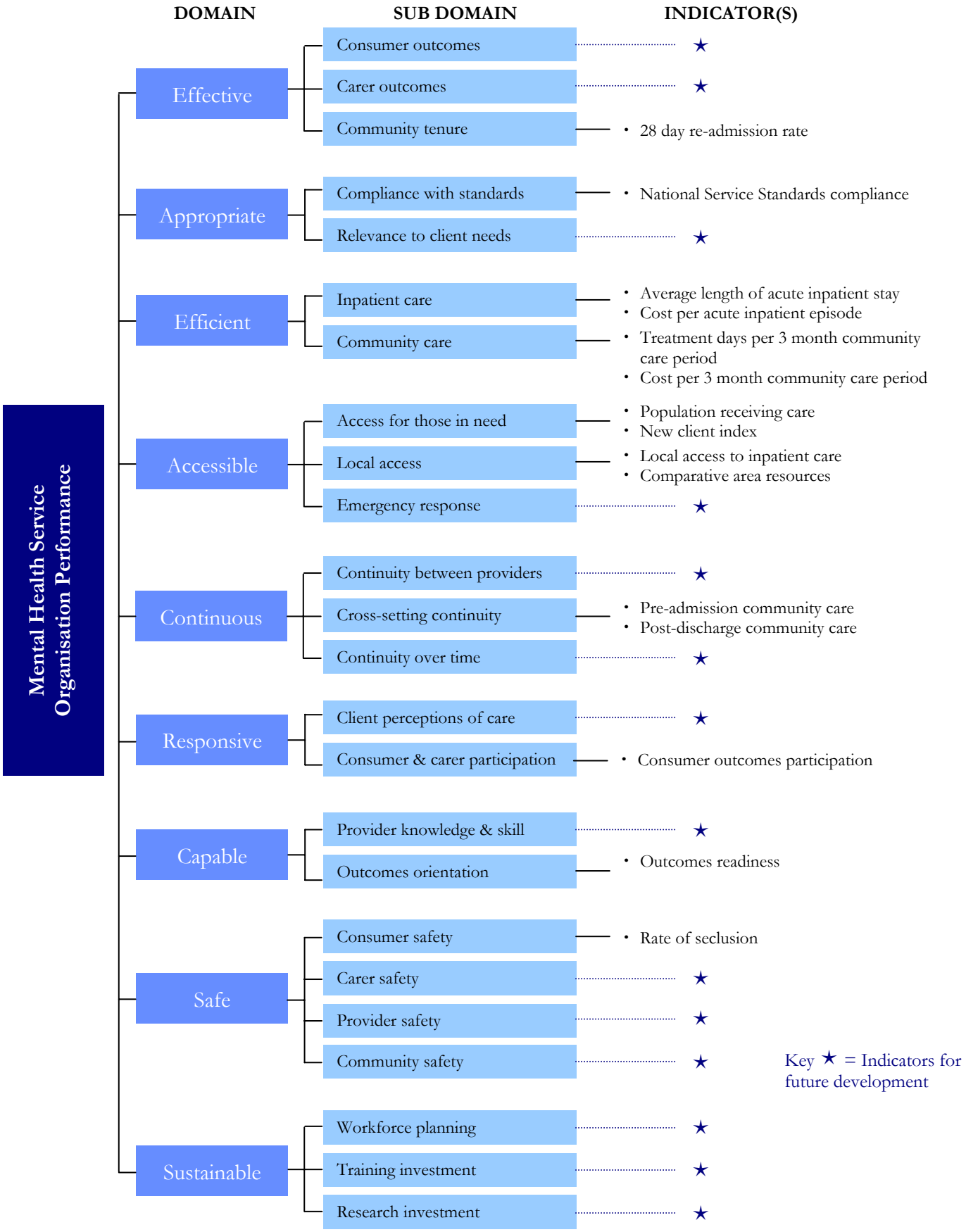
Table 1: Phase 1 key performance indicators – primary and secondary coverage of the National Health Performance domains

Key Performance Indicator	Effective	Appropriate	Efficient	Responsive	Accessible	Sustainable	Capable	Safe	Continuous
28-day readmission rate	▲								■
National Service Standards compliance		▲					■		
Average length of acute inpatient stay		■	▲						
Cost per acute inpatient episode			▲						
Treatment days per three month community care period		■	▲						
Cost per three month community care period			▲						
Population receiving care					▲				
Local access to inpatient care					▲				
New client index					▲				
Comparative area resources					▲	■			
Pre-admission community care					■				▲
Post-discharge community care					■			■	▲
Outcomes readiness	■						▲		
Consumer outcomes participation				▲			■		
Rate of seclusion		■						▲	

▲ = Primary domain

■ = Secondary domain

Figure 1: Summary of 'Tier 3' of the National Mental Health Performance Framework and current indicator set.



Appendix 1: Indicator specifications

This Appendix includes a technical specification of the selected indicators, with the format and definitions as specified below.

Dimensions Covered:

Details the relationship of the Key Performance Indicator against the nine Dimensions of the Third Tier of the National Health Performance Framework. A single indicator may be relevant across several dimensions with the primary dimension appearing in bold font.

Strategic Issue:

Reflects the key issue about which the Key Performance Indicator seeks to address.

Rationale:

A detailed explanation of the issues and reasons for the proposed implementation of the Key Performance Indicator.

Definition:

Defines the Key Performance Indicator in terms of its construction and the specifications of its Numerator and Denominator.

Technical Issues:

Details the range of parameters and principles upon which the Key Performance Indicator is based.

Data Sources:

Specifies the immediate origin of the data used to populate the numerator and denominator components of the Key Performance Indicator.

Coverage/Scope:

Service types within the public mental health sector covered.

Assessment against Criteria:

Provides an overview of the Key Performance Indicators against the NHPC criteria for selecting Key Performance Indicators, Additional criteria that the National Key Performance Indicator Drafting Group deemed relevant and appropriate, the levels of Aggregation at which the Key Performance Indicators would have relevance and meaning, and the Service Delivery population against which the Key Performance Indicators could be applied.

Recommendation for Implementation:

Specifies timeline for implementation

Implications for Data Development:

Discusses issues that will require consensus and or further discussion in the development and specification of the Key Performance Indicator

Key Stratification Options:

Details possible cuts or stratification of the Key Performance Indicator that may prove of benefit to jurisdictions. For example: Aboriginal and Torres Strait Islander (ATSI), Culturally and Linguistically Diverse (CALD), Remoteness.

Notes:

Any other relevant matters not covered by the above.

28 Day Readmission Rate

Dimensions covered:

Effective	☑	Appropriate	☐	Efficient	☐
Responsive	☐	Accessible	☐	Safe	☐
Continuous	☑	Capable	☐	Sustainable	☐

Strategic Issue:

High levels of unplanned readmissions within a short time frame are widely regarded as reflecting deficiencies in inpatient treatment and/or follow-up care and point to inadequacies in the functioning of the overall system.

Rationale:

- Psychiatric inpatient services aim to provide treatment that enables individuals to return to the community as soon as possible. Unplanned admissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital. In this sense, they potentially point to deficiencies in the functioning of the overall care system.
- Avoidable rapid readmissions place pressure on finite beds.
- International literature identifies the concept of one month as an appropriate defined time period for the measurement of unplanned readmissions following separation from an acute inpatient mental health service.

Definition:

Percentage of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient units that are followed by an unplanned readmission to the same or to another public sector acute psychiatric inpatient unit within 28 days of discharge.

Numerator: All in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) occurring within the reference period, that are followed by an unplanned readmission to the same or another acute psychiatric inpatient unit within 28 days.

Denominator: All in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) occurring within the reference period.

Coverage/Scope:

- All public mental health acute inpatient services.

Exclusions:

- Same day separations.
- Statistical and change of care type separations.
- Separations that end by transfer to another acute or psychiatric inpatient hospital.
- Separations that end by death, left against medical advice/discharge at own risk.

Technical Issues:

Terminology:

- Same day separations are defined as inpatient episodes where the admission and separation dates are the same.
- Where a mental health service organisation has more than one acute psychiatric inpatient unit, for the purposes of this indicator the units should be pooled.

Methodology:

- Ideally, readmission is considered to have occurred if the person has been admitted to any public sector mental health acute inpatient unit within the State/Territory but this requires statewide unique identifiers to be in place. For consistency between jurisdictions, initial implementation could restrict readmission criteria to within an organisation's inpatient units.

28 Day Readmission Rate

Data Sources:

Numerator:	National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.
Denominator:	National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☑	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☑	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☑

Recommendation for Implementation:

- Given differences in operational and performance expectations of the various program types, public sector adult mental health services should be the initial focus of implementation.

Key Stratification Options:

- *By program type (or age as a proxy)*: Because data suggests that there is variation in performance between adult, child, and older persons on this measure.
- *By remoteness*: Because community mental health services that may prevent readmission are perceived to be less accessible in rural areas.
- *By diagnosis groupings*: Because variation in readmission rates is often a function of the need for clinical care.
- *By involuntary status*.

Implications for Data Development:

Immediate:
- Nil.

Short Term:
- Same day admissions are a confounding issue that require the identification of intent of admission (i.e. day care or overnight stay).
- Need to identify program type by separation in National Minimum Dataset - Admitted Patient Mental Health Care National Minimum Dataset if age is not a suitable proxy.
- Further work is required to resolve issues related to the identification of planned and unplanned readmissions to enable future determination of whether the readmission is planned as part of the treatment process to be determined.

Long Term:
- Full implementation of this measure requires unique statewide patient identifiers not currently available in most jurisdictions.

28 Day Readmission Rate

Notes:

- Casemix adjustment is needed to interpret variation between organisations to facilitate the identification of patient and provider factors.
- Readmission usually (but not exclusively) occurs within a mental health service organisation rather than between organisations.
- For most jurisdictions, lack of statewide identifiers means that only within-hospital readmissions can be counted.
- This indicator will not track readmissions across State/Territory boundaries or track movement between public and private hospitals.
- The accountability for unplanned readmission (if from inappropriate discharge) may not lie with the admitting facility.

Allied Indicators:

- Pre-admission community care.
- Post-discharge community care.
- Average length of acute inpatient stay.

National Service Standards Compliance

Dimensions covered:

Effective	☐	Appropriate	☑	Efficient	☐
Responsive	☐	Accessible	☐	Safe	☐
Continuous	☐	Capable	☑	Sustainable	☐

Strategic Issue:

National standards are one way in which concerns regarding quality of mental health service delivery may be addressed.

Rationale:

- Implementation of the National Standards for Mental Health Services has been agreed by all jurisdictions and was only partially implemented by the end of the Second National Mental Health Plan.
- Service quality has been a driving force for the National Mental Health Strategy.

Definition:

Percentage of the mental health service organisation's services (weighted by expenditure) that have been reviewed against the National Standards for Mental Health Services. The indicator grades services into four categories:

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

Numerator: Total expenditure by mental health service organisations on mental heath 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 mental health services.

Coverage/Scope:

- All public mental health service organisations.

Exclusions:

- Older Persons Mental Health Community Residential Services approved under or working towards the accreditation standards gazetted as part of the Australian Government *Aged Care Act 1997*.

Technical Issues:

Terminology:

- Mapping of levels to National Minimum Data Set – Mental Health Establishments (MHE) codes as follows: *Level 1*: MHE code 1; *Level 2*: MHE codes 2; *Level 3*: MHE codes 3-4; *Level 4*: MHE codes 5-8.

Methodology:

- Weighted by expenditure within various levels of aggregation above service unit/team.

Data Sources:

Numerator: National Minimum Data Set – Mental Health Establishments or State/Territory central health administration.

Denominator: National Minimum Data Set – Mental Health Establishments or State/Territory central health administration.

National Service Standards Compliance

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☐	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☑	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☑

Recommendation for Implementation:

- This indicator should be implemented for all public sector mental health services and reviewed 12 months following implementation to confirm that the classification system adopted appropriately reflects the indicator intent.

Key Stratification Options:

- *By program type*: Because jurisdictions will want to monitor progress across the different program types.

Implications for Data Development:

Immediate:
- Nil

Short Term:
- Nil

Long Term:
- Nil

Notes:

- External review is a process of negotiation between mental health service organisations and the accrediting agency. Accordingly, variations may exist in the extent to which all or some Standards are deemed to be applicable to individual service units.
- A review may apply to the service units within a mental health service organisation, not the mental health service organisation as an entity in itself.
- External accreditation agencies such as ACHS and QIC use differing review methodologies.

Allied Indicators

- Outcomes readiness.

Average Length of Acute Inpatient Stay

Dimensions covered:

Effective	☐	Appropriate	☑	Efficient	☑
Responsive	☐	Accessible	☐	Safe	☐
Continuous	☐	Capable	☐	Sustainable	☐

Strategic Issue:

- To better understand the factors underlying variation in inpatient episode costs.

Rationale:

- Length of stay is the main driver of variation in inpatient episode cost and reflects differences between mental health service organisations in practice, casemix or both. Inclusion of this indicator promotes a fuller understanding of an organisation's episode costs as well as providing a basis for utilisation review. For example, it allows services provided to particular patient groups to be assessed against any clinical protocols developed for those groups.
- This measure enables average bed day costs to be derived when used in conjunction with a measure of average cost per overnight acute inpatient episode.

Definition:

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 during the reference period.
Denominator:	Total number of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) occurring within the reference period.

Coverage/Scope:

- All public sector acute psychiatric inpatient units.

Exclusions:

- Same day separations.
- Statistical and change of care type separations.
- Separations that end by transfer to another acute or psychiatric inpatient hospital.
- Separations that end by death, left against medical advice/discharge at own risk.

Technical Issues:

Terminology:

- Episodes are defined as 'acute' on the basis of the classification of the inpatient unit according to the definitions used in the National Minimum Data Set – Mental Health Establishments.
- Same day separations are defined as inpatient episodes where the admission and separation dates are the same.

Methodology:

- Length of stay is measured in patient days. A same-day patient is allocated a length of stay of one patient day. Length of stay of an overnight stay patient is calculated by subtracting the admission date from the date of separation and deducting total leave days.

Data Sources:

Numerator:	National Minimum Dataset – Admitted Patient Mental Health Care (or State/Territory equivalent).
Denominator:	National Minimum Dataset – Admitted Patient Mental Health Care (or State/Territory equivalent).

Average Length of Acute Inpatient Stay

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☑	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☑	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☑

Recommendation for Implementation:

- Inpatient units that have a designated highly specialised function (for example, statewide intensive care units) may be excluded in deriving this indicator to enable like with like comparisons.
- As the program type of greatest expenditure, public sector adult mental health services should be the initial focus of implementation.

Key Stratification Options:

- *By program type (or age as a proxy)*: Because evidence suggests that there is variation in performance between adult, child, older persons and forensic on this measure.
- *Specialist/non-specialist function*: To enable like with like service comparison within program types.

Implications for Data Development:

Immediate:	• Nil.
Short Term:	• Need to identify acute units that serve a specialist function within jurisdictions. • Need to identify program type in National Minimum Dataset – Admitted Patient Mental Health Care (or State/Territory equivalent) if age is not a suitable proxy. • Methodology for casemix adjustment required.
Long Term:	• Comparable efficiency indicators for extended care and residential facilities need to be developed.

Notes:

- Casemix adjustment is needed to interpret variation between organisations – to distinguish patient and provider factors.
- Same day admissions are a confounding issue that require the identification of intent of admission (that is, day care or overnight stay).
- Leave presents special complexities in the mental health area and further work is required to ensure that it does not distort this indicator.

Allied Indicators

- Cost per Acute Inpatient Episode.
- 28 Day Readmission Rate.

Average Cost Per Acute Inpatient Episode

Dimensions covered:

Effective	☐	Appropriate	☐	Efficient	☑
Responsive	☐	Accessible	☐	Safe	☐
Continuous	☐	Capable	☐	Sustainable	☐

Strategic Issue:

Efficient functioning of public mental health acute inpatient units is critical to ensuring that finite funds are used effectively to deliver maximum community benefit.

Rationale:

- Unit costs are a core feature of management-level indicators in all industries and are necessary to understand how well an organisation uses its resources in producing services. They are fundamental to value for money judgements.
- Acute mental health inpatient units account for 70 percent of the total costs of specialised mental health inpatient care and 36 percent of overall delivery costs.
- This indicator is based on the concept of the episode as the patient care product that should be the focus for indicator development, and is designed to give more direct estimates of technical efficiency.

Definition:

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

Numerator:	Total recurrent expenditure occurring within the mental health service organisation's acute psychiatric inpatient unit(s) during the reference period.
Denominator:	Total number of in-scope overnight acute inpatient episodes occurring within the mental health service organisation's acute psychiatric inpatient unit(s) during the reference period.

Coverage/Scope:

All public sector acute psychiatric inpatient units.

Exclusions:

- Same day separations.
- Statistical and change of care type separations.
- Separations that end by transfer to another acute or psychiatric inpatient hospital.
- Separations that end by death, left against medical advice/discharge at own risk.

Technical Issues:

Terminology:

- Episodes are defined as 'acute' on the basis of the classification of the inpatient unit according to the definitions used in the National Minimum Data Set – Mental Health Establishments.
- Same day separations are defined as inpatient episodes where the admission and separation dates are the same day.
- Recurrent costs include costs directly attributable to the unit(s) plus a proportional share of indirect costs. Cost data for this indicator is based on gross recurrent expenditure as compiled by Health Departments according to the specifications of the National Minimum Data Set – Mental Health Establishments. As such, it is subject to the concepts, definitions and costing methodology developed for the NMDS.

Average Cost Per Acute Inpatient Episode

Methodology:	• Episode cost is calculated as (Total patient days) x (Average patient day cost) where (Average patient day cost) = (Total recurrent expenditure) / (Total patient days).

Data Sources:

Numerator:	National Minimum Data Set – Mental Health Establishments (or State/Territory equivalent).
Denominator:	National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☐	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☑	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☑

Recommendation for Implementation:

- Inpatient units that have a designated highly specialised function (for example, statewide intensive care units) may be excluded in deriving this indicator to enable like-with-like comparisons.
- As the program type of greatest expenditure, public sector adult mental health services should be the initial focus of implementation.

Key Stratification Options:

- *Program type (or age as a proxy)*: Because very different cost structures exist across program types.
- *Specialist/non-specialist function*: To enable like-with-like service comparison within program types.

Implications for Data Development:

Immediate:	• Nil.
Short Term:	• Need to identify acute units that serve a specialist function within jurisdictions. • Need to identify program type in National Minimum Dataset – Admitted Patient Mental Health Care (or State/Territory equivalent) if age is not a suitable proxy. • Methodology for casemix adjustment required.
Long Term:	• Comparable efficiency indicators for extended care and residential facilities need to be developed.

Average Cost Per Acute Inpatient Episode

Notes:

- Casemix adjustment is needed to interpret variation between organisations – to distinguish patient and provider factors.
- Same day admissions are a confounding issue that require the identification of intent of admission (that is, day care or overnight stay).
- Episode costs may be affected by provider factors beyond management control (for example, high fixed costs in institutions during downsizing, structural or design problems with units that need to be countered through higher rostering levels, etc).
- There is a need for considerable development of episode costing within mental health (for example, the inclusion /exclusion of teaching and research expenditure, costing according to actual service use, etc).
- Variations in costing methodologies may occur between mental health service organisations.
- Leave presents special complexities in the mental health area and further work is required to ensure that it does not distort this indicator.

Allied Indicators

- Average length of acute inpatient stay.

Average Treatment Days Per Three Month Community Care Period

Dimensions covered:

Effective	☐	Appropriate	☑	Efficient	☑
Responsive	☐	Accessible	☐	Safe	☐
Continuous	☐	Capable	☐	Sustainable	☐

Strategic Issue:

- To better understand the factors underlying variation in community care costs.

Rationale:

- The number of treatment days is the community counterpart of length of stay and provides an indication of the relative volume of care provided to people seen in ambulatory care.
- Frequency of servicing is the main driver of variation in community care costs and may reflect differences between health service organisation practices. Inclusion of this indicator promotes a fuller understanding of an organisation's community care costs as well as providing a basis for utilisation review. For example, it allows the frequency of servicing of particular patient groups in the community to be assessed against any clinical protocols developed for those groups.
- When combined with average costs per three month community care period, it allows average treatment day costs to be derived should this be required.
- May also demonstrate degrees of accessibility to public sector community mental health services.

Definition:

Average number of community treatment days per three month period of ambulatory care provided by the mental health service organisation's community mental health services.

Numerator:	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.

Coverage/Scope:

- All public sector community mental health services.

Exclusions:

- Activities of community based residential services

Technical Issues:

Terminology:

- A statistically derived community episode is defined as each three month period of ambulatory care of an individual registered patient where the patient was under 'active care', defined as one or more treatment days in the period. Each patient is counted uniquely at the mental health service organisation level, regardless of the number of teams or community programs involved in his/her care.
- Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode.

Methodology:

- Episode based datasets to be constructed from contact data at analysis rather than collected as discrete variable.
- For the purposes of this measure, community care periods will consist of the following fixed three monthly periods; January to March, April to June, July to September, and October to December.

Average Treatment Days Per Three Month Community Care Period

Data Sources:

Numerator:	National Minimum Dataset – Community Mental Health Care (or State/Territory equivalent).
Denominator:	National Minimum Dataset – Community Mental Health Care (or State/Territory equivalent).

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☑	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☑	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☑

Recommendation for Implementation:

- As the program type of greatest expenditure, public sector adult mental health services should be the initial focus of implementation.

Key Stratification Options:

- *By program type (or age as a proxy)*: Because evidence suggests that there is variation in performance between adult, child, older persons and forensic mental health services on this measure.
- Assessment only episodes, where an assessment only episode is defined as an episode of less than two treatment days. Like same day admissions in inpatient care, assessment only episodes are a confounding factor and require segregation to ensure like-with-like comparisons.

Implications for Data Development:

Immediate:	• Nil.
Short Term:	• Identification of assessment only ambulatory episodes. • Need to identify program type in National Minimum Dataset – Community Mental Health Care if age is not a suitable proxy. • Methodology for casemix adjustment required.
Long Term:	• Accurate reporting at levels above that of mental health service organisation would benefit from unique statewide patient identifiers.

Notes:

- Casemix adjustment is needed to interpret variation between organisations – to distinguish patient and provider factors.
- Initially community '3-month episode' data to be derived from NMDS data, with the option to be explored to use episodes statistically derived from NOCC collection at a future date.

Allied Indicators

- Cost per Three Month Community Care Period

Average Cost Per Three Month Community Care Period

Dimensions covered:

Effective	☐	Appropriate	☐	Efficient	☑
Responsive	☐	Accessible	☐	Safe	☐
Continuous	☐	Capable	☐	Sustainable	☐

Strategic Issue:

- Efficient functioning of public community mental health services is critical to ensure that finite funds are used effectively to deliver maximum community benefit.

Rationale:

- Unit costs are a core feature of management-level indicators in all industries and are necessary to understand how well an organisation uses its resources in producing services. They can be fundamental to value for money judgements.
- Previous estimates of unit costs in community care have been compromised by inadequate product definition. Most commonly, estimates have been based on average cost per occasion of service, and provide little indication of the overall costs of care.
- This indicator is based on the concept of a statistically derived episode as the patient care product that should be the focus for indicator development for community mental health services.

Definition:

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.

Coverage/Scope:

- All public sector ambulatory care mental health services.

Exclusions: Activities of public sector community based residential services.

Technical Issues:

Terminology:

- Recurrent costs include costs directly attributable to the unit(s) plus a proportional share of indirect costs. Cost data for this indicator is based on gross recurrent expenditure as compiled by Health Departments according to the specifications of the National Minimum Data Set – Mental Health Establishments. As such, it is subject to the concepts, definitions and costing methodology developed for the NMDS.
- A statistically derived community episode is defined as each three month period of ambulatory care of an individual registered patient where the patient was under 'active care', defined as one or more treatment days in the period. Each patient is counted uniquely at the mental health service organisation level, regardless of the number of teams or community programs involved in his/her care.

Methodology:

- Three month episode based datasets to be constructed from contact data at analysis rather than collected as discrete variable.
- For the purposes of this measure, community care periods will consist of the following fixed three monthly periods; January to March, April to June, July to September, and October to December.

Average Cost Per Three Month Community Care Period

Data Sources:

Numerator:	National Minimum Data Set – Mental Health Establishments (or State/Territory equivalent).
Denominator:	National Minimum Dataset – Community Mental Health Care (or State/Territory equivalent).

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☑	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☑	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☑

Recommendation for Implementation:

- As the program type of greatest expenditure, public sector adult mental health services should be the initial focus of implementation.

Key Stratification Options:

- *Program type (or age as a proxy)*: Because data suggests that there is variation in performance between adult, child, and older persons on this measure.
- Assessment only episodes, where an assessment only episode is defined as an episode of less than two treatment days. Like same day admissions in inpatient care, assessment only episodes are a confounding factor and require segregation to ensure like-with-like comparisons.

Implications for Data Development:

Immediate:	• Nil.
Short Term:	• Contact duration data is needed for a more sophisticated cost modelling methodology. • Identification of assessment only ambulatory episodes. • Need to identify program type in the National Minimum Dataset – Community Mental Health Care if age is not a suitable proxy. • Methodology for casemix adjustment required.
Long Term:	• Accurate reporting at levels above that of mental health service organisation would benefit from unique statewide patient identifiers.

Average Cost Per Three Month Community Care Period

Notes:

- Casemix adjustment is needed to interpret variation between organisations – to distinguish patient and provider factors.
- Variation in community care costs is driven primarily by frequency of servicing, or the number of treatment days within the episode.
- Variations in costing methodologies may occur between mental health service organisations.
- Cost data for this indicator is based on gross recurrent expenditure as compiled by health departments or reported via the National Survey of Mental Health Services. As such, it is subject to the concepts, definitions and costing methodology developed for the National Mental Health Survey as well as variations among the mental health service organisations in costing.
- A more sophisticated episode costing methodology is desirable where each individual episode is costed and subsequently aggregated to derive averages. This would allow review of distribution of costs plus estimates of 'average' to be based upon median or mode. This requires agreement on which allocation statistic to use in assigning costs to community '3-month episodes'. In the absence of cost duration data, there are only two options, either contacts or treatment days.
- Initially community '3-month episode' data is to be derived from NMDS data, with option to be explored to use episodes statistically derived from NOCC collection at a future date.

Allied Indicators

- Treatment days per three month community care period.

Population Receiving Care

Dimensions covered:

Effective	☐	Appropriate	☐	Efficient	☐
Responsive	☐	Accessible	☑	Safe	☐
Continuous	☐	Capable	☐	Sustainable	☐

Strategic Issue:

- Access to public sector mental health services is an issue of significant public concern.

Rationale:

- The issue of unmet need has become prominent since the National Survey of Mental Health and Well Being indicated that a majority of adults and younger persons affected by a mental disorder do not receive treatment.
- The implication for performance indicators is that a measure is required to monitor population treatment rates and assess these against what is known about the distribution of mental disorders in the community.
- Access issues figure prominently in concerns expressed by consumers and carers about the mental health care they receive. More recently, these concerns are being echoed in the wider community.
- Most jurisdictions have organised their mental health services to serve defined catchment populations, allowing comparisons of relative population coverage to be made between organisations.

Definition:

The percentage of persons resident in the mental health service organisation's defined catchment area (stratified by ambulatory, inpatient and community residential services) who received care from a public sector mental health service.

Numerator:	Total number of persons resident in the defined area who are recorded as receiving one or more services from a public sector mental health service in the reference period, stratified by ambulatory, inpatient and community residential services.
Denominator:	Total number of persons resident in the defined area within the reference period, stratified by ambulatory, inpatient and community residential services.

Coverage/Scope:

- All public sector mental health services that have defined catchment populations.

Exclusions:
- Nil

Technical Issues:

Terminology:
- 'Receiving one of more services' defined as any period of care in a public sector psychiatric inpatient unit or community residential service, or one or more community contacts.

Methodology:
- Requires a non-duplicated person count within levels of aggregation.

Data Sources:

Numerator:	National Minimum Dataset – Community Mental Health Care; National Minimum Dataset - Admitted Patient Mental Health Care; National Minimum Dataset – Community Residential Care (or State/Territory equivalents).
Denominator:	Australian Bureau of Statistics (or equivalent).

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☑	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Population Receiving Care

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☐	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☑

Recommendation for Implementation:

- This indicator should be implemented for all public sector mental health services with an initial focus on adult mental health services and child and adolescent mental health services as these programs service populations highlighted in the National Survey of Mental Health and Well Being.

Key Stratification Options:

- *By setting:* Because there are often catchment differences between acute inpatient, community residential and ambulatory services within a mental health service organisation.
- *By age*: Because data indicates differential need for mental health services on an age basis.
- *By remoteness*: Because mental health services are perceived to be less available in rural areas.
- *By indigenous status*: To measure equity of access by these sectors of the population.
- *By diagnosis groupings*: To facilitate the measurement by proxy of treated prevalence.

Implications for Data Development:

Immediate:	• Statistical local area codes or postcodes recorded at time of community contact and/or admission to hospital need to be mapped to mental health service organisation catchment population boundaries.
Short Term:	• Nil.
Long Term:	• Full implementation of this measure requires unique statewide patient identifiers not currently available in all jurisdictions.

Notes:

- As defined populations may receive services from organisations other than their catchment provider, this measure is not a 'pure' indicator of mental health service organisation performance but more about service utilisation by the population they serve. However, it is regarded as an important indicator to understand the overall relationship of the mental health service organisation in relation to its catchment population needs.
- Resource allocation based on psychiatric epidemiology, associated morbidity and disability, mortality and socio-demographic factors is generally regarded as resulting in more equitable distribution of resources in relation to local need than funding strategies based on service-utilisation and population size alone. The proposed indicator advances these concepts by creating scope in the future to compare expected treatment rates to actuals.
- This measure does not consider the roles of primary mental health care or the specialist private mental health sector. While people who received care from specialist non-government organisations are not counted, it is expected that these people will be captured by the activities of clinical services.
- This measure may be used as a proxy for treated prevalence.
- This measure may under report levels of service access in areas where persons are able to access public sector mental health services across jurisdictional boundaries.

Allied Indicators

- Comparative Area Resources.

Local Access to Acute Inpatient Care

Dimensions covered:

Effective	☐	Appropriate	☐	Efficient	☐
Responsive	☐	Accessible	☑	Safe	☐
Continuous	☐	Capable	☐	Sustainable	☐

Strategic Issue:

- Local access to services has been a key principle underpinning mental health reforms over the past decade.

Rationale:

- Access implies geographic proximity so that services are delivered in a way that minimises dislocation of the patient from family and local supports. This measure points to the degree to which persons living within a particular community who require acute inpatient treatment are in fact treated by the local service established to meet the area's needs.
- Significant capital and recurrent resources have been invested to build networks of services that are responsible for serving the needs of their local communities.
- Most jurisdictions have organised their mental health services to serve defined catchment populations, allowing comparisons to be made between organisations in terms the extent to which their populations receive local inpatient care.

Definition:

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 acute psychiatric inpatient unit.

Numerator:	Total number of acute psychiatric inpatient overnight 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 overnight 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.

Coverage/Scope:

- All public sector acute psychiatric inpatient services.

Exclusions:

- Specialist inpatient mental health services as they often provide services on a statewide or cross-regional basis.
- Same day separations.

Technical Issues:

Terminology:

- Nil.

Methodology:

- Patients area-of-residence based on address at time of admission.

Data Sources:

Numerator:	National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.
Denominator:	National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.

Local Access to Acute Inpatient Care

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☑	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☐	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☐

Recommendation for Implementation:

- Given known variation in funding and complexity between program types, adult mental health services should be the initial focus of implementation

Key Stratification Options:

- *By program type (or age as a proxy)*: Because data suggests that there is variation in performance between adult, child, and older persons on this measure.
- *By remoteness*: Because acute psychiatric inpatient services are less available in rural areas.

Implications for Data Development:

Immediate:	• Statistical local area codes or postcodes recorded at time of admission to hospital need to be mapped to mental health service organisation catchment population boundaries.
Short Term:	• Nil.
Long Term:	• Nil.

Notes:

- This indicator will not be possible to implement within those jurisdictions that have not organised their acute psychiatric inpatient services to serve local catchment populations.
- Mental health service organisations that service areas with a large transitory population may find their local patients displaced to adjoining areas. For example, out-of-area presentations to inner city acute units may fill available bed capacity causing admissions of local residents to be transferred to other hospitals.
- Future consideration should be given to the development of an equivalent measure for public sector community mental health care for both residential and ambulatory services. While the same principle applies, it is not currently recommended, as it is more complex to specify and implement.

Allied Indicators

- Population receiving care.
- Comparative area resources.

New Client Index

Dimensions covered:

Effective	☐	Appropriate	☐	Efficient	☐
Responsive	☑	Accessible	☑	Safe	☐
Continuous	☐	Capable	☐	Sustainable	☐

Strategic Issue:

- Access to services by persons requiring care is a key issue. There is significant concern that the public sector mental health service system is inadequately responding to new people requiring care.

Rationale:

- Existing population treatment rates (generally less than one percent) are relatively low.
- There is concern that public sector mental health services invest a disproportionate level of resources in dealing with existing clients and too little in responding to the needs of new clients as they present.

Definition:

New clients as a percentage of total clients under the care of the mental health service organisation's mental health services.

Numerator:	Number of new clients who received services from the mental health service organisation's specialised mental health services within the reference period.
Denominator:	Total number of clients who received services from the mental health service organisation's specialised mental health services within the reference period.

Coverage/Scope:

- All public sector mental health services.

Exclusions:
- Nil.

Technical Issues:

Terminology:
- Clients in receipt of services include all persons who received one or more community contacts or one or more days of inpatient or residential care in the reference period.
- Client counts should be unique at the organisation level.
- A new client is defined as a consumer being seen for the first time by the mental health service organisation, and assigned a unique record number.

Methodology:
- Methodology for identifying new clients requires further development in supplementary technical specifications.

Data Sources:

Numerator:	National Minimum Dataset – Community Mental Health Care and National Minimum Dataset – Admitted Patient Mental Health Care (or State/Territory equivalents).
Denominator:	National Minimum Dataset – Community Mental Health Care and National Minimum Dataset – Admitted Patient Mental Health Care (or State/Territory equivalents).

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☑	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

New Client Index

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☐	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☑

Recommendation for Implementation:

- Nil

Key Stratification Options:

- *By inpatient and community setting*: Because monitoring of new client intake across treatment settings is likely show significant differences.
- By program type (or age as a proxy): Similarly, the ratio of new to existing clients is likely to vary across Adult, Aged and Child & Adolescent programs.

Implications for Data Development:

Immediate:	• Nil.
Short Term:	• Collection of 'new client' status at intake/admission would simplify the production of this indicator.
Long Term:	• Statewide identifiers would be required for this indicator to be produced at the regional or State/Territory level.

Notes:

- This indicator presents some complexity at the analysis stage and will need to be developed over time.
- There are several approaches to defining 'new client' that depend on how the following issues are resolved:
- Level of the mental health system at which 'newness' is defined: Clients new to a particular organisation may be existing clients of other organisations. Counts of new clients at the State/Territory level would certainly yield lower estimates than those derived from organisation-level counts.
- Time period for defining 'newness': New client status may be defined as no previous use of public sector mental health services over the person's life, or no use within a defined period.
- Diagnosis criteria for defining 'newness': A client may present with a new condition, although they have received previous treatment for a different condition.
- The approach here is to specify an initial measure for implementation with a view to further refinement following detailed work to address the complexities associated with the definition of a new client, and the possible implementation of unique statewide patient identifiers within all jurisdictions.
- Does not take into account the activities of private mental health services or of primary mental health care.

Allied Indicators

- Population receiving care.

Comparative Area Resources

Dimensions covered:

Effective	☐	Appropriate	☐	Efficient	☐
Responsive	☐	Accessible	☑	Safe	☐
Continuous	☐	Capable	☐	Sustainable	☑

Strategic Issue:

- Equity of access to mental health services is, in part, a function of differential level of resources allocated to area populations.

Rationale:

- Review of comparative resource levels is essential for interpreting overall performance data, for example, an organisation may achieve relatively lower treatment rates because it has relatively less resources available rather than because it uses those resources inefficiently.
- When used with measures of population under care this indicator may illustrate relative resourcing in terms local mental health service delivery and therefore accessibility by proxy.

Definition:

Per capita recurrent expenditure by the organisation on mental health services (stratified by ambulatory, inpatient and community residential) for the target population within the organisation's defined catchment area.

Numerator: Recurrent expenditure on mental health services stratified by ambulatory, inpatient and community residential services.

Denominator: Total number of persons who were resident in the defined catchment area for the mental health service organisation's services, stratified by ambulatory, inpatient and community residential services.

Coverage/Scope:

- All public sector mental health services.

Exclusions:

- Public sector mental health services that provide a cross regional or a statewide specialist function.

Technical Issues:

Terminology:

- Recurrent costs include costs directly attributable to the unit(s) plus a proportional share of indirect costs. Cost data for this indicator is based on gross recurrent expenditure as compiled by Health Departments according to the specifications of the National Minimum Data Set – Mental Health Establishments. As such, it is subject to the concepts, definitions and costing methodology developed for the NMDS.

Methodology:

- Estimates of expenditure for defined populations are based on expenditure reported by the mental health service organisation with specific catchment responsibility for the population, adjusted to remove any cross-regional and statewide services included in the organisation's expenditure.
- See Notes for issues to be resolved in further development of this indicator.
- Defined populations should match with catchment areas of the mental health service organisations.

Data Sources:

Numerator: National Minimum Data Set – Mental Health Establishments (or State/Territory equivalent).

Denominator: Australian Bureau of Statistics population data (or equivalent).

Comparative Area Resources

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☑	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☐	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☐

Recommendation for Implementation:

- As the program type of greatest expenditure, public sector adult mental health services should be the initial focus of implementation.

Key Stratification Options:

- *By program type (or age as a proxy)*: Because jurisdictions will want to monitor program expenditure within jurisdictions.
- *By remoteness*: Because mental health services are perceived to be less available in rural areas.

Implications for Data Development:

Immediate:	• Population catchments for public sector mental health services to be defined.
Short Term:	• Nil.
Long Term:	• Nil.

Notes:

- This indicator assumes that the expenditure reported by the local mental health service organisation is directed to its catchment population and does not take account of cross border flows. The alternative approach of basing estimates on actual service utilisation by populations is desirable and needs to be explored in the future. Such an approach will require reliable utilisation data and development of cost modelling methodologies.

Allied Indicators

- Population receiving care.

Pre-Admission Community Care

Dimensions covered:

Effective	☐	Appropriate	☐	Efficient	☐
Responsive	☐	Accessible	☑	Safe	☐
Continuous	☑	Capable	☐	Sustainable	☐

Strategic Issue:

- Access to community based mental health services may alleviate the need for, or assist with improving the management of, admissions to inpatient care.

Rationale:

- To monitor the continuity/accessibility of care via the extent to which public sector community mental health services are involved with patients prior to :
- To support and alleviate distress during a period of great turmoil.
- To relieve carer burden.
- To avert hospital admission where possible.
- To ensure that admission is the most appropriate patient option.
- To commence treatment of the patient as soon possible where admission may not be averted.
- The majority of clients admitted to public sector mental health acute inpatient units are known to public sector community mental health services and it is reasonable to expect community teams should be involved in pre-admission care.

Definition:

Percentage of admissions to the mental health service organisation's acute inpatient unit(s) for which a community ambulatory service contact was recorded in the seven days immediately preceding that admission.

Numerator:	Number of admissions to the mental health service organisation's acute inpatient unit(s) for which a public sector community mental health ambulatory contact was recorded in the seven days immediately preceding that admission.
Denominator:	Total number of admissions to the mental health service organisation's acute inpatient unit(s).

Coverage/Scope:

- All public sector mental health acute inpatient units.

Exclusions:

- Community contacts occurring on the day of admission.
- Same day admissions.
- Admissions by inter-hospital transfer or between programs (for example, acute to rehabilitation).

Technical Issues:

Terminology:

- Same day admissions are defined as inpatient episodes where the admission and separation dates are the same.

Methodology:

- Implementation of this indicator requires the capacity to track service use across inpatient and community boundaries and is dependent on the capacity to link patient identifiers.

Pre-Admission Community Care

Data Sources:

Numerator:	National Minimum Dataset – Community Mental Health Care and National Minimum Dataset – Admitted Patient Mental Health Care (or State/Territory equivalents).
Denominator:	National Minimum Dataset – Community Mental Health Care and National Minimum Dataset – Admitted Patient Mental Health Care (or State/Territory equivalents).

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☑	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☐	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☑

Recommendation for Implementation:

- This indicator should be implemented for all public sector mental health services and reviewed 12 months following implementation to assess the appropriateness of the seven day period prior to admission for the purposes of this measure.

Key Stratification Options:

- *By program type (or age as a proxy)*: Because data suggests that there is variation in performance between adult, child, older persons and forensic public sector community mental health services on this measure.
- *By remoteness*: Because community mental health services are perceived to be less accessible in rural areas.

Implications for Data Development:

Immediate:	• Nil.
Short Term:	• Nil.
Long Term:	• Full implementation of this measure requires unique statewide patient identifiers not currently available in all jurisdictions.

Pre-Admission Community Care

Notes:

- The reliability of cross-jurisdictional comparisons on this indicator is dependent on the implementation of statewide unique patient identifiers as the community services may not necessarily be delivered by the same mental health service organisation that admits the patient. Consideration should be given to confining counts of pre-admission community care to only those services managed by the mental health service organisation responsible for the inpatient admission.
- A time period of seven days has been adopted as an initial basis for the measurement of follow up community care pending empirical review. As an alternative to setting a seven-day threshold and only counting contacts within that period, this indicator could be replaced by median days between last contact and admission.
- This measure does not consider variations in intensity or frequency of contacts prior to admission.
- This measure does not distinguish qualitative differences between phone and face-to-face community contacts.

Allied Indicators:

- 28-day readmission rate.
- Average length of acute inpatient stay.
- Post-discharge community care.

Post-Discharge Community Care

Dimensions covered:

Effective	☐	Appropriate	☐	Efficient	☐
Responsive	☐	Accessible	☑	Safe	☑
Continuous	☑	Capable	☐	Sustainable	☐

Strategic Issue:

- Continuity of care and support following discharge from a mental health inpatient service.

Rationale:

- A responsive community support system for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission.
- Patients leaving hospital after a psychiatric admission with a formal discharge plan, involving linkages with community services and supports, are less likely to need early readmission.
- Research indicates that patients have increased vulnerability immediately following discharge, including higher risk for suicide.

Definition:

Percentage of separations from the mental health service organisation's acute inpatient unit(s) for which a community ambulatory service contact was recorded in the seven days immediately following that separation.

Numerator:	Number of separations from the mental health service organisation's acute inpatient unit(s) for which a public sector community mental health contact was recorded in the seven days immediately following that separation.
Denominator:	Total number of separations for the mental health service organisation's acute inpatient unit(s).

Coverage/Scope:

All public acute inpatient mental health services.

Exclusions:

- Same day separations.
- Statistical and change of care type separations.
- Separations that end by transfer to another acute or psychiatric inpatient hospital.
- Separations that end by death, left against medical advice/discharge at own risk.

Technical Issues:

Terminology:

- Same day separations are defined as inpatient episodes where the admission and separation dates are the same.

Methodology:

- Implementation of this indicator requires capacity to track service use across inpatient and community boundaries and is dependent on capacity to link patient identifiers.

Data Sources:

Numerator:	National Minimum Dataset – Community Mental Health Care and National Minimum Dataset – Admitted Patient Mental Health Care (or State/Territory equivalents).
Denominator:	National Minimum Dataset – Community Mental Health Care and National Minimum Dataset – Admitted Patient Mental Health Care (or State/Territory equivalents).

Post-Discharge Community Care

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☑	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☐	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☑

Recommendation for Implementation:

- This indicator should be implemented for all public sector mental health services and reviewed 12 months following implementation to assess the appropriateness of the seven days post discharge period for the purposes of this measure.

Key Stratification Options:

- *By program type (or age as a proxy)*: Because data suggests that there is variation in performance between adult, child, older persons and forensic public sector community mental health services on this measure.
- *By remoteness*: Because mental health services are perceived to be less accessible in rural areas.

Implications for Data Development:

Immediate:	• Nil.
Short Term:	• Nil.
Long Term:	• Full implementation of this measure requires unique statewide patient identifiers not currently available in all jurisdictions.

Notes:

- The reliability of cross-jurisdictional comparisons on this indicator is dependent on the implementation of statewide unique patient identifiers as the community services may not necessarily be delivered by the same mental health service organisation that admits the patient. Consideration should be given to confining counts of post-discharge community care to only those services managed by the mental health service organisation responsible for the inpatient admission.
- A time period of seven days has been adopted as an initial basis for the measurement of follow up community care pending empirical review. As an alternative to setting a seven-day threshold and only counting contacts within that period, this indicator could be replaced by median days between discharge and first community contact.
- This measure does not consider variations in intensity or frequency of contacts prior to admission.
- This measure does not distinguish qualitative differences between phone and face-to-face community contacts.

Allied Indicators

- 28-day readmission rate.
- Average length of acute inpatient stay.
- Pre-admission community care.

Outcomes Readiness

Dimensions covered:

Effective	☑	Appropriate	☐	Efficient	☐
Responsive	☐	Accessible	☐	Safe	☐
Continuous	☐	Capable	☑	Sustainable	☐

Strategic Issue:

A capable service is results-oriented and has systems in place to regularly monitor client outcomes.

Rationale:

- All States and Territories have committed to implementing routine outcome measurement in public sector mental health services.
- This indicator is an interim measure to monitor the uptake of the National Outcomes Casemix Collection (NOCC).
- Indicators derived from outcome assessments should form an integral component of the next stage of key performance indicator development.

Definition:

Percentage of mental health episodes with outcome assessments completed.

Numerator: Number of episodes of care reported with completed outcome assessments.

Denominator: Total number of episodes of mental health care defined as the sum of total separations in the reference period from the mental health service organisation's acute inpatient unit(s) where length of stay is greater than three days, plus, total number of ambulatory episodes in the reference period where an episode is counted for each person seen with two or more treatment days within each of the three month calendar periods.

Coverage/Scope:

- All public mental health services.

Exclusions:

- Residential services excluded pending implementation of National Minimum Data Set – Residential Mental Health Care.
- Episodes that end in death.
- Consultation and liaison.
- Australian Government funded aged residential services.
- Assessment only episodes seen by community teams excluded – defined as community episodes where the consumer is seen on less than two treatment days within each three month period.

Technical Issues:

Terminology:

- Assessments occur at commencement of care and at maximum intervals of 91 days thereafter until completion of care, at which point an exit assessment is made.
- Completed assessment defined as all required clinical items entered (see Notes).

Methodology:

- See Notes for methodological issues to be resolved.

Data Sources:

Numerator: National Outcome Casemix Collection Dataset.

Denominator: National Minimum Dataset – Community Mental Health Care and National Minimum Dataset – Admitted Patient Mental Health Care or potentially National Outcomes and Casemix Collection.

Outcomes Readiness

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☑	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☑	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☑

Recommendation for Implementation:

- This indicator should be implemented for all public sector mental health services.

Key Stratification Options:

- *By Collection Occasion.*

Implications for Data Development:

Immediate:	• Requires completed implementation of outcome measurement.
Short Term:	• Nil.
Long Term:	• Nil.

Notes:

- Exploratory work is required to resolve methodological issues in relation to the denominator, that is, estimates of the total number of episodes requiring outcomes assessment. This is not provided directly by the NOCC data but can be estimated from the National Minimum Data Sets for Admitted Patient Mental Health Care and Community Mental Health Care.
- Similarly, criteria for defining a 'completed outcome assessment' also need to be further developed. The key issue to resolve is whether tolerance levels will be set to accept some degree of missing data. As a guide, a completed assessment might be defined as one where the number of items completed is consistent with that provided in 95 percent of assessments. Translated to individual rating scales this would mean:
  - For the HONOS, a minimum of 10 of the 12 items.
  - For the HONOSCA, a minimum of 11 of the 13 first items.
  - For the LSP, a minimum of 13 of the 16 items.
- The work of the Australian Mental Health Outcomes and Classification Network will contribute to the further refinement of this indicator.

Allied Indicators

- Consumer outcomes participation.

Consumer Outcomes Participation

Dimensions covered:

Effective	☐	Appropriate	☐	Efficient	☐
Responsive	☑	Accessible	☐	Safe	☐
Continuous	☐	Capable	☑	Sustainable	☐

Strategic Issue:

- The active involvement by consumers and carers in treatment planning, decision-making, and definition of treatment goals is a key goal of the National Mental Health Strategy.

Rationale:

- Consumer self-assessment outcome measures are one mechanism through which consumers and carers can be actively involved in treatment planning, and decision-making and definition of treatment goals.
- The self-assessment measures provide useful information about the way clients feel and how well they are able to cope with their usual activities and are an opportunity for consumers, carers and clinicians to track progress through comparison of ratings over time.
- Offering a self-assessment measure can be useful for engagement as well as collaboration between consumers, carers and clinicians and can enrich treatment and care planning.
- Obtaining a consumer self-assessment measure requires mental health services to have an adequate degree of engagement (both clinically and organisationally) with consumers to facilitate this process.

Definition:

Percentage of ambulatory episodes of mental health care with completed consumer self-assessment outcome measures.

Numerator:	Number of ambulatory episodes of mental health care reported with completed consumer self-assessment outcome measures.
Denominator:	Total number of episodes of ambulatory mental health care in the reference period where an episode is counted for each person seen with two or more treatment days within each of three month calendar periods.

Coverage/Scope:

- All public ambulatory mental health services.

Exclusions:

- Assessment only episodes seen by community teams, defined as community episodes where the consumer is seen on less than two treatment days, where the consumer participated on those treatment days, within each three month calendar period.
- Episodes that end in death.

Technical Issues:

Terminology:

- The National Outcomes and Casemix Collection protocol requires that consumer self-assessment outcome measures be offered at the commencement of care and at maximum intervals of 91 days thereafter until completion of care, at which point an exit measure is offered.
- A completed consumer self-assessment outcome measure is defined as a consumer self-assessment outcome measure where at least one of the required items is entered. Note that measures that are offered to consumers and/or parents/carers but not returned are not considered completed.

Methodology:

- The appropriate consumer self-assessment measure utilised within each jurisdiction should be considered in the construction of this indicator, that is, Mental Health Inventory (MHI), Behaviour and System Identification Scale

(BASIS-32) and Kessler-10-Plus (K10+).

- Only the following versions of the Strengths and Difficulties Questionnaire (SDQ) are to be considered in the construction of this indicator:
  - The *parent-rated* version for children aged 4-10 years; and
  - Either the *parent-rated* version and/or the *self-report* version for adolescents aged 11-17 years.
- Non-mandated measures (such as the teacher-version of the SDQ) should not be considered in the construction of this indicator.
- All completed returns (of mandated measures) are to be considered in the construction of the numerator. For example, if both a parent-rated version and self-report version of the SDQ is received this would count as two completed outcome measures.

Data Sources:

Numerator:	National Outcome Casemix Collection Dataset.
Denominator:	National Minimum Dataset – Community Mental Health Care or potentially the National Outcomes and Casemix Collection Dataset.

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☑	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☑	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☑

Recommendation for Implementation:

- This indicator should be implemented for all public sector mental health services.

Key Stratification Options:

- *By program type (or age as a proxy):* Jurisdictions are likely to want to monitor utilisation across the different program types (i.e. Child and Adolescent, Adult, Older Persons and Forensic).
- *By Collection Occasion.*

Implications for Data Development:

Immediate:	• Requires completed implementation of outcome measurement.
Short Term:	• Nil.
Long Term:	• Nil.

Consumer Outcomes Participation

Notes:

- Given the different protocol requirements across service settings the national indicator is only constructed for the ambulatory setting. This is not to diminish the importance of the use of the measures within acute inpatient (for child and adolescent) and residential settings. This indicator can also be constructed within those settings by looking at the proportion of episodes of acute inpatient or residential mental health care with completed consumer self-assessment outcome measures.

  The definition of an *episode of acute inpatient care* utilised in the outcomes readiness (including all appropriate exclusions) should be used in the construction of the indicator for that setting. An *episode of residential mental health care* is defined as the period of care between the start of residential care (either through the formal start of the residential stay or the start of new reference period) and the end of the residential care (either through the formal end of residential care, commencement of leave intended to be greater than seven days or the end of the reference period i.e. 30 June. For residents provided with care intended to be on an overnight basis. This may occasionally include episodes of residential care that unexpectedly ended on the same day as they started (for example, the resident died or left against advice) or began at the end of the reference period (METeOR id: 268968). Australian Government funded aged residential services should be excluded from the construction of this indicator.
- Exploratory work is required to resolve methodological issues in relation to the denominator, i.e., estimates of the total number of episodes requiring outcomes assessment. This is not provided directly by the NOCC data but can be estimated from the National Minimum Data Sets (Community Mental Health Care, Admitted Patient Mental Health Care and Residential Mental Health Care).
- The work of the Australian Mental Health Outcomes and Classification Network (AMHOCN) will contribute to the further refinement of this indicator.

Allied Indicators

- Outcomes readiness.

Rate of Seclusion

Dimensions covered:

Effective	☐	Appropriate	☑	Efficient	☐
Responsive	☐	Accessible	☐	Safe	☑
Continuous	☐	Capable	☐	Sustainable	☐

Strategic Issue:

- The reduction, and where possible, elimination of seclusion in mental health services has been identified as a priority in the document *National safety priorities in mental health: a national plan for reducing harm*.

Rationale:

- High levels of seclusion are widely regarded as inappropriate treatment, and may point to inadequacies in the functioning of the overall systems and risks to the safety of consumers receiving mental health care.
- The use of seclusion in public sector mental health service organisations is regulated under legislation and/or policy of each jurisdiction.

Definition:

The number of seclusion events per 1,000 patient days within a mental health service organisation.

Numerator:	Total number of seclusion events occurring in the mental health service organisation inpatient unit(s) during the reference period, partitioned by acute inpatient, non-acute inpatient and community residential mental health services.
Denominator:	Total number of accrued patient days within the mental health service organisation's inpatient unit(s) during the reference period, partitioned by acute inpatient, non-acute inpatient and community residential mental health services, multiplied by 1,000.

Coverage/Scope:

- All public mental health services organisations.

Exclusions:

- Services where seclusion is not an authorised practice under relevant mental health legislation and/or policy (such as ambulatory mental health services).
- Note that seclusion is not authorised for use in community residential facilities in all jurisdictions.
- Accrued patient days for services which are not authorised to utilise seclusion should not be included in the calculation of the denominator.

Technical Issues:

Terminology:

- In the document *National safety priorities in mental health: a national plan for reducing harm* the term seclusion is defined as the '*act of confining a patient in a room when it is not within their control to leave. It should not be confused with the practice of 'time out' where a patient is requested to seek voluntary social isolation for a minimum period of time*'. The Seclusion and Restraint Working Party (SRWP) of the Safety and Quality Partnership in Mental Health Subcommittee (SQPS) has further defined seclusion as 'the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented'.
- Regardless of duration, a 'seclusion event' commences when a consumer enters seclusion and ends when there is a clinical decision to cease seclusion. Following the clinical decision to cease seclusion, if a consumer re-enters seclusion within a short period of time this would be considered a new seclusion event. The term 'seclusion event' is utilised to differentiate it from the different definitions of 'seclusion episode' used across jurisdictions.

Rate of Seclusion

- Where a mental health service organisation has more than one unit of a particular service type for the purpose of this indicator those units should be combined.

Methodology:

- This indicator is to be partitioned by the service type (i.e. acute inpatient, non-acute inpatient and community residential). Consequently, there would be three potential scores for this indicator, i.e. a rate for acute inpatient services, a rate for non-acute inpatient services and a rate for community residential services. This partitioning will enable appropriate interpretation of the indicator and concept and facilitate accurate and targeted action to reduce the use of seclusion in mental health services.
- Leave days should be excluded from the construction of this indicator.

Data Sources:

Numerator:	State/Territory seclusion registers or relevant information systems.
Denominator:	National Minimum Data Set – Admitted Patient Mental Health Care or State/Territory equivalent.

Assessment Against NHPC Criteria:

Worth Measuring	☑	Relevant to policy/ practice	☑	*Additional Criteria*	
Diverse populations	☑	Measurable over time	☑	Reliable	☑
Understood/ Clear intent	☑	Feasible	☑	Valid	☑
Galvanise action	☑	Definable	☑		

Level at which Indicator Can be Applied:

Level		*Program Type*	
Service Unit/Team	☑	Adult	☑
Health Service Organisation	☑	Child and Adolescent	☑
Regional group of services	☑	Older Persons Care	☑
State/Territory	☑	Forensic	☑

Recommendation for Implementation:

- This indicator should be implemented for all public sector mental health services.

Key Stratification Options:

- *By program type (or age as a proxy):* Jurisdictions are likely to want to monitor utilisation across the different program types (i.e. Child and Adolescent, Adult, Older Persons and Forensic).
- *By Gender:* Data suggests that there is variation in gender across this indicator.

Implications for Data Development:

Immediate:

- Nil.

Short Term:

- Work is required to improve the quality of reporting in seclusion registers and/or relevant information systems to facilitate reporting. Additionally, further work is required to scope the actual legislative and/or policy differences in jurisdictional definitions of seclusion.

Long Term:

- The work of the Seclusion and Restraint Working Party and the Safety and Quality in Mental Health Partnership Subcommittee (SQPS) will contribute to the further development of this indicator.

Rate of Seclusion

Notes:

- The use of seclusion is governed by either the legislation (a Mental Health Act or equivalent) or mandatory policy within each State and Territory. The definitions utilised within the legislation and policies vary slightly between jurisdictions. These variations should be recognised in the interpretation of the indicator.
- The Seclusion and Restraint Working Party of the Safety and Quality Partnership Subcommittee (SQPS) has recently finalised the development of definitions, principles and protocols relating to the use of seclusion in mental health services. This work will further support the collation and comparison of information relating to seclusion.
- The duration of seclusion is an essential piece of information to align with an indicator of the rate or frequency of seclusion as it provides a better understanding of a services performance in relation to seclusion use and management. However, the capacity to collect information regarding duration of seclusion episodes varies substantially across jurisdictions. Work continues as a national level that will facilitate the development of a meaningful indicator of duration as it is likely to be easily skewed by outliers.

Allied Indicators

- Nil.

Appendix 2: Definition of 'Specialised Mental Health Service Organisation'

A separately constituted specialised mental health service that is responsible for the clinical governance, administration and financial management of service units providing specialised mental health care. A specialised mental health service organisation may consist of one or more service units based in different locations and providing services in admitted patient, residential and ambulatory settings.

For example, a specialised mental health service organisation may consist of several hospitals or two or more community centres. Where the specialised mental health service organisation consists of multiple service units, those units can be considered to be components of the same organisation where they:

- operate under a common clinical governance arrangement; ·
- aim to work together as interlocking services that provide integrated, coordinated care to consumers across all mental health service settings; and ·
- share clinical records or, in the case where there is more than one physical clinical record for each patient, staff may access (if required) the information contained in all of the physical records held by the organisation for that patient.

For most States and Territories, the Specialised Mental Health Service Organisation concept is equivalent to the Area/District Mental Health Service. These are usually organised to provide the full range of admitted patient, residential and ambulatory services to a given catchment population. However, the concept may also be used to refer to health care organisations which provide only one type of mental health service (e.g., acute admitted patient care) or which serve a specialised or state-wide function.

Appendix 3: Sources and availability of data for performance indicators

KPI#	Indicator	Data source(s)	Available since
1	28-day readmission rate	National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.	1996-97
2	National Service Standards Compliance	National Minimum Data Set – Mental Health Establishments (previously the National Survey of Mental Health Services) or State/Territory Central Health Administration.	2002-03
3	Average length of acute inpatient stay	National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.	1996-97
4	Cost per acute inpatient episode	National Minimum Data Set – Mental Health Establishments (previously the National Survey of Mental Health Services) or State/Territory equivalent.	1993-94
		National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.	1996-97
5	Treatment days per three month community care period	National Minimum Dataset – Community Mental Health Care or State/Territory equivalent.	2000-01
6	Cost per Three Month Community Care Period	National Minimum Data Set – Mental Health Establishments (previously the National Survey of Mental Health Services) or State/Territory equivalent.	1993-94
		National Minimum Dataset – Community Mental Health Care or State/Territory equivalent.	2000-01
7	Population under care	National Minimum Dataset – Community Mental Health Care or State/Territory equivalent.	1993-94
		National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.	1996-97
		ABS Population data by Area.	
8	Local access to inpatient care	National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.	1996-97
9	New client index	National Minimum Dataset – Community Mental Health Care or State/Territory equivalent.	2000-01
		National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.	1996-97
10	Comparative area resources	National Minimum Data Set – Mental Health Establishments (previously the National Survey of Mental Health Services) or State/Territory equivalent.	1993-94
		ABS Population data by Area.	
11	Pre-admission community assessment	National Minimum Dataset – Community Mental Health Care or State/Territory equivalent.	2000-01
		National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.	1996-97
12	Post-discharge community care	National Minimum Dataset – Community Mental Health Care or State/Territory equivalent.	2000-01
		National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.	1996-97

KPI#	Indicator	Data source(s)	Available since
13	Outcomes readiness	National Outcome and Casemix Collection Dataset.	2002-03
		National Minimum Dataset – Community Mental Health Care or State/Territory equivalent.	2000-01
		National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.	1996-97
14	Consumer outcomes participation	National Outcome and Casemix Collection Dataset.	2002-03
		National Minimum Dataset – Community Mental Health Care or State/Territory equivalent.	2000-01
15	Rate of seclusion	State/Territory Seclusion Registers	Variable
		National Minimum Dataset – Admitted Patient Mental Health Care or State/Territory equivalent.	1996-97

Appendix 4: National Health Performance Framework

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

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

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

Appendix 5: Selection criteria for health performance indicators

Generic indicators when used at a program level to whole of system level should have all or some of the following qualities. They should:

1. **Be worth measuring.**

   The indicators represent an important and salient aspect of the public's health or the performance of the health system.

2. **Be measurable for diverse populations.**

   The indicators are valid and reliable for the general population and diverse populations (i.e. Aboriginal and Torres Strait Islander peoples, rural/urban, socioeconomic etc).

3. **Be understood by people who need to act.**

   People who need to act on their own behalf or on that of others should be able to readily comprehend the indicators and what can be done to improve health.

4. **Galvanise action.**

   The indicators are of such a nature that action can be taken at the national, state, local or community level by individuals, organised groups and public and private agencies.

5. **Be relevant to policy and practice.**

   Actions that can lead to improvement are anticipated and feasible – they are plausible actions that can alter the course of an indicator when widely applied.

6. **Measurement over time will reflect results of actions.**

   If action is taken, tangible results will be seen indicating improvements in various aspects of the nation's health.

7. **Be feasible to collect and report.**

   The information required for the indicator can be obtained at reasonable cost in relation to its value and can be collected, analysed and reported on in an appropriate time frame.

8. **Comply with national processes of data definitions.**

Appendix 6: Selection criteria for sets of performance indicators

Criteria related to sets of indicators or composite indices should:

1. Cover the spectrum of the health issue.

2. Reflect a balance of indicators for all appropriate parts of the framework.

3. Identify and respond to new and emerging issues.

4. Be capable of leading change.

5. Provide feedback on where the system is working well, as well as areas for improvement.

Additional Selection Criteria Specific to NHPC Reporting

In addition to the general criteria for health performance indicators outlined above, NHPC selection criteria should:

- facilitate the use of data at the health industry service unit level for benchmarking purposes; and

- be consistent and use established and existing indicators where possible.

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Appendix 7: National Mental Health Performance Subcommittee – Membership (June 2008)

Ms Ruth Catchpoole (Chair)	Director, Mental Health Information Unit, Mental Health Branch, Queensland Health.
Dr Grant Sara	Director, InforMH, Mental Heath and Drug and Alcohol Office, NSW Health.
Mr Nick Legge	Manager, Service Monitoring & Review, Mental Health Branch, Mental Health and Drugs Division, Department of Human Services, Victoria.
Dr Gopal Bose	Principal Analyst, 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 Therese Merten	A/Director, Monitoring and Evaluation Section, Mental Health Reform Branch, Department of Health and Ageing.
Mr Gary Hansen	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.
Dr Tom Callaly	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.
Ms Kristen Breed (Secretariat)	Principal Project Officer, Mental Health Information Unit, Mental Health Branch, Queensland Health

Appendix 8: Contacts for information about mental health services

AUSTRALIAN GOVERNMENT

Mental Health Reform Branch
Department of Health and Ageing

GPO Box 9848
CANBERRA ACT 2601

Phone: (02) 6289 8070

NORTHERN TERRITORY

Mental Health Branch
Department of Health and Community Services

PO Box 40596
CASUARINA NT 0811

Phone: (08) 8999 2553

NEW SOUTH WALES

Mental Heath and Drug and Alcohol Office
NSW Health

Locked Mail Bag 961
NORTH SYDNEY NSW 2059

Phone: (02) 9391 9307

VICTORIA

Mental Health Branch
Department of Human Services

GPO Box 4057
MELBOURNE VIC 3001

Phone: (03) 9616 8592

QUEENSLAND

Mental Health Branch
Queensland Health

GPO Box 48
BRISBANE QLD 4001

Phone: (07) 3234 0680

WESTERN AUSTRALIA

Division of Mental Health
Department of Health Western Australia

189 Royal St
EAST PERTH WA 6004

Phone: (08) 9222 4099

SOUTH AUSTRALIA

Mental Health Unit
Department of Health

PO Box 287
Rundle Mall
ADELAIDE SA 5000

Phone: (08) 8226 6286

TASMANIA

Mental Health Services
Department of Health and Human Services

GPO Box 125
HOBART TAS 7001

Phone: (03) 6230 7727

AUSTRALIAN CAPITAL TERRITORY

Mental Health ACT
ACT Health

GPO Box 825
CANBERRA ACT 2601

Phone: (02) 6207 1066