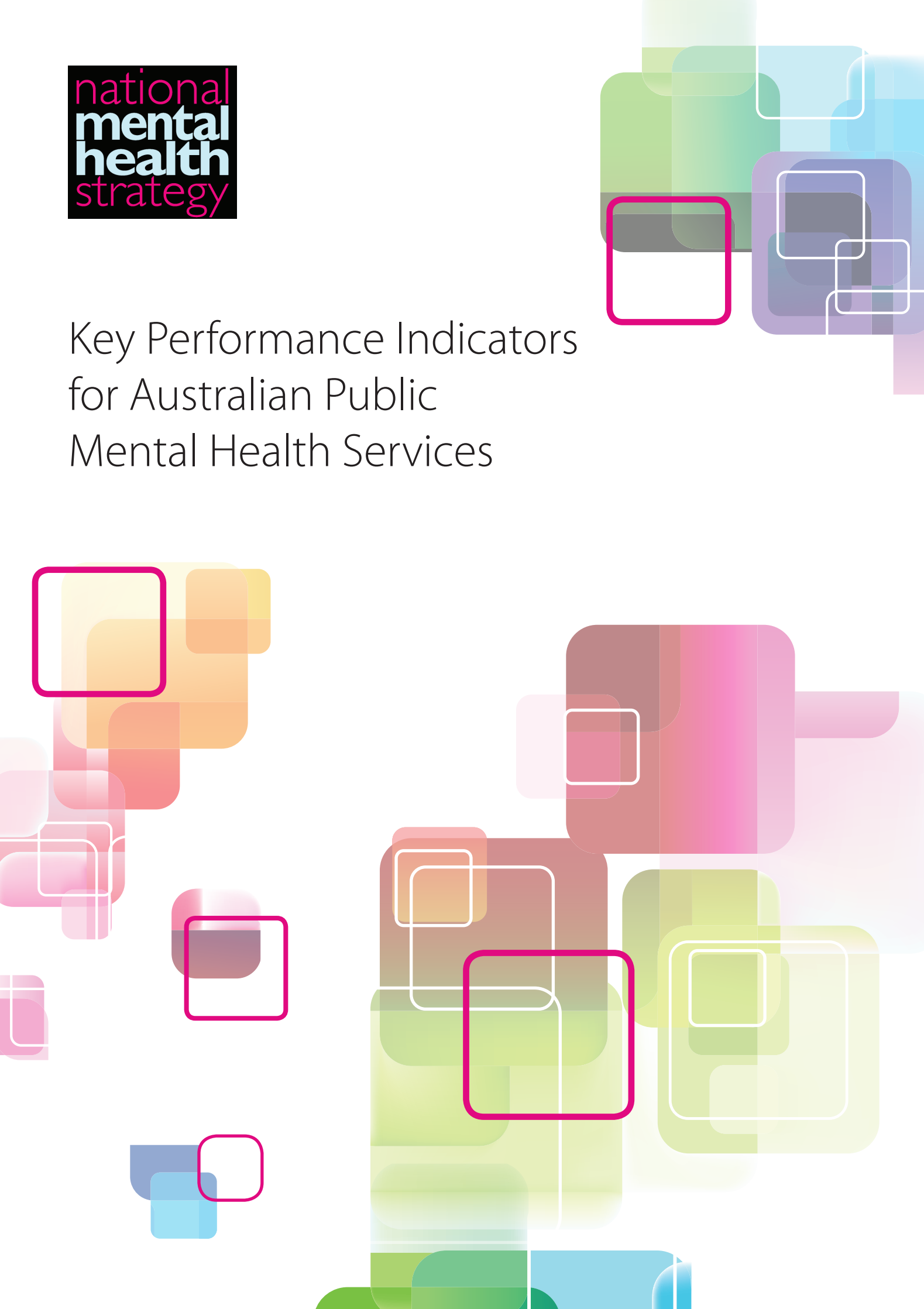
national mental health strategy

Key Performance Indicators for Australian Public Mental Health Services



Key Performance Indicators

for Australian Public Mental Health Services

Third Edition

2013

Key Performance Indicators for Australian Public Mental Health Services, Third Edition

A report produced for the Australian Health Ministers Advisory Council's Mental Health Drug and Alcohol Principal Committee (MHDAPC) by the National Mental Health Performance Subcommittee (NMHPSC)

Publications Approval Number XXXX

An electronic copy of this publication is available at the Mental Health Information Strategy Standing Committee website www.health.gov.au/mhsc

National Mental Health Performance Subcommittee

C/- NMHPSC Secretariat
Mental Health and Palliative Care Unit
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601

Telephone 02 6244 1000
Email nmhpsc@aihw.gov.au

Foreword

The first edition of the Key Performance Indicators for Australian Public Mental Health Services, released in July 2005, was an important milestone for mental health services in Australia. Drawing on several years of collaborative work between the Australian and state and territory governments, it was the first attempt by the mental health sector to define a common framework and a standardised set of indicators to measure performance in a way that supported quality improvement activities at the level of the mental health service organisation.

The indicators covered the concepts of effectiveness, efficiency, appropriateness, access, continuity and capability, all central ideas to understanding how a mental health organisation functions. An important characteristic of the indicators was that they could be produced from available datasets. A key design feature of the framework was its intended use at all levels of the health system – that is, for assessing an individual service or at higher levels of aggregation, such as state and territory or national.

The Foreword to the original release of the performance framework noted that the mental health sector lagged behind development of the acute health sector in the use of performance indicators. Primarily this was due to lack of consensus on the application of fundamental performance measurement concepts to mental health care, but was also impacted by the lack of suitable data. It was expected that further refinement to the indicators outlined in the framework would occur as performance measurement was introduced within the mental health sector.

Much progress has occurred since the release of the first and second editions. All states and territories have implemented initiatives to utilise the framework and support performance reporting, monitoring and measurement at jurisdiction and local levels. The indicators have also been incorporated in benchmarking work in most Australian jurisdictions. Additionally, a number of the indicators outlined in the original publication are linked to the strategic directions of the Fourth National Mental Health Plan and have been important references for indicators developed as part of broader health reform initiatives, including the National Healthcare Agreement and the National Health Reform Agreement. Twelve of the 15 indicators defined in the framework are reported nationally in one or more publications, including the annual Report on Government Services, the Council of Australian Governments Reform Council annual report on the National Healthcare Agreement and the National Mental Health Report.

This third edition brings together the most current statement of the national mental health performance framework and draws on advances made by states and territories as the framework has been progressively implemented and refined. This experience combined with enhancements to data sources and other national development activity, has informed changes to both the specifications and indicator set. While the domains and sub domains of the framework remain unchanged, technical modifications have been made to a number of indicators. Further definition and clarification provided to improve understanding and utility of the majority of indicators. In addition to technical changes, additional information has been included to support understanding regarding the use, and variation, of the indicators in national reporting.

Performance frameworks are dynamic, evolving tools that need to be updated regularly. It is expected that, with the release of this third edition, the public mental health sector will continue to refine and develop the indicator set in light of ongoing developments in relation to the national health reform agenda and supporting public performance reporting. Ongoing work will also take into account the requirement to support states and territories as they continue to establish and embed a culture of continuous quality improvement. Most importantly, work lies ahead to broaden the indicator set from its current exclusive focus on clinical mental health services operating in the public sector to other sectors providing support for Australians with mental health difficulties.

I would like to thank everyone who participated and supported the development of this third edition of Key Performance Indicators for Australian Public Mental Health Services, and look forward to your continued

support as we work towards further improvements in the development of the national mental health performance framework.

Chair,

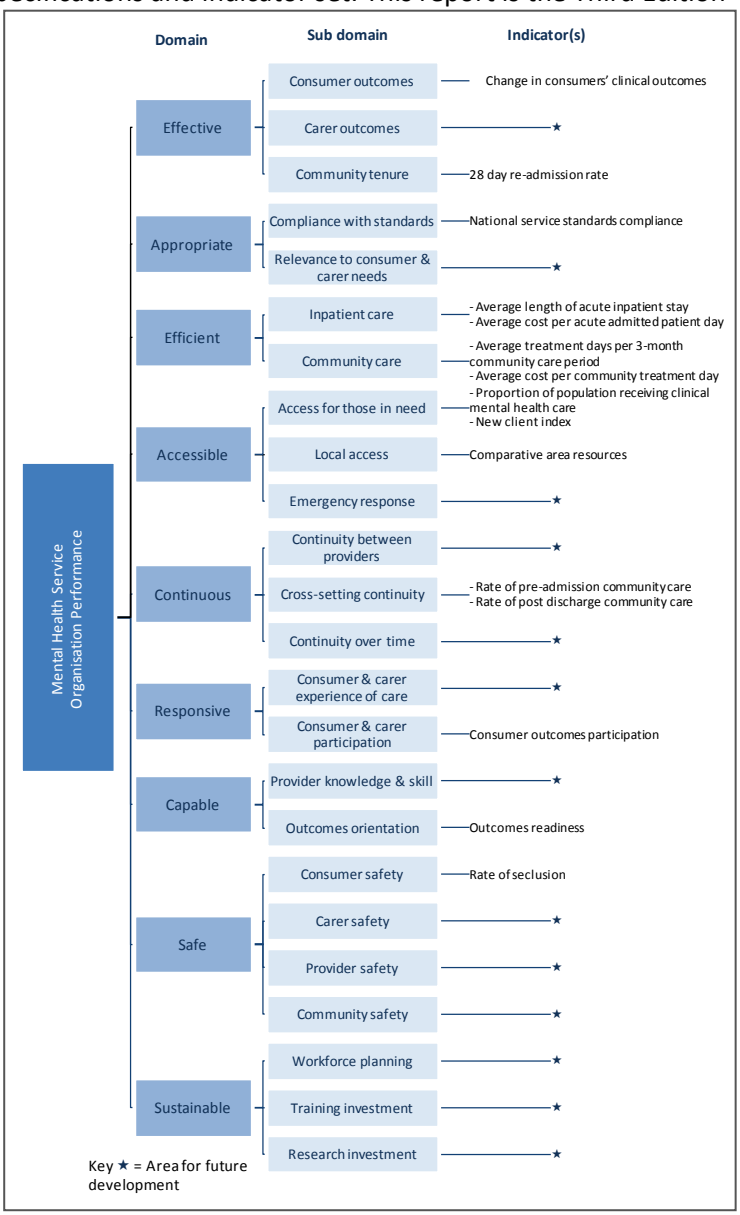
Mental Health, Drug and Alcohol Principal Committee

Contents

Executive Summary

The National Mental Health Performance Framework (NMHPF) is a key strategy for facilitating a culture of continuous quality improvement in mental health service delivery. The framework supports Australian and state and territory governments' commitment to improving accountability and transparency at the Mental Health Service Organisation (MHSO) level.

The focus of the NMHPF and the national key performance indicators (KPIs) remains on public MHSOs. Significant advances have been made by states and territories over the past eight years as the NMHPF has been progressively implemented. This experience, combined with enhancements to data sources and other national activity, has informed changes to the specifications and indicator set. This report is the Third Edition of the *Key Performance Indicators for Australian Public Mental Health Services* specifications and supersedes previous editions published in 2005 and 2011.



While the domains and sub domains of the NMHPF have remained unchanged, technical modifications have been made to a number of indicators, and further definition and clarification provided to improve understanding and utility of the majority of indicators. However, three indicators have undergone relatively substantial changes. A lower unit of counting has been adopted for the two cost indicators and have consequently been replaced with 'average cost per acute admitted patient day' (MHS PI 5) and 'average cost per community treatment day' (MHS PI 7). These indicators are now more reflective of the way in which most states and territories report cost related performance. Finally, the indicator 'outcomes readiness' (MHS PI 14) has been redesigned around four different consumer groups also utilised in 'change in consumers' clinical outcomes' (MHS PI 1). The figure right summarises the current national indicator set.

In addition to technical changes, new information has been introduced to improve understanding regarding the use, and variation, of these indicators in national reporting.

The public mental health sector will continue to refine and develop the current indicator set, taking into consideration ongoing developments in relation to the national health reform agenda and supporting public performance reporting. Ongoing work will also require supporting states and territories as they continue to establish and embed a culture of continuous quality improvement.

1. Introduction

1.1 Document purpose

This publication is the Third Edition of the *Key Performance Indicators for Australian Public Mental Health Services*. It collates development and activity to date, delivering into the public domain the most current set, and specifications, of KPIs for use in Australia's public mental health system. The indicator set outlined in this publication has been primarily informed by states and territories routinely implementing the indicator set and national data development activity.

The indicator set has been endorsed for implementation by the Australian Health Ministers' Advisory Council Mental Health, Drug and Alcohol Principal Committee (MHDAPC). Since all of the 15 indicators published in this Third Edition have undergone changes to some extent, it is recommended to disregard technical specifications published in previous editions.

1.2 National Mental Health Performance Framework

A key commitment under the current and previous National Mental Health Plans has been to improve accountability and transparency at the MHSO level. The NMHPF at Figure 1 lends itself as a key strategy for facilitating a culture of continuous quality improvement within mental health service delivery.

Figure 1: National Mental Health Performance Framework

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

Determinants of Health ('TIER 2')			*Are the factors determining health changing for the better? Is it the same for everyone? Where and for whom are they changing for the worse?*	
Environmental Factors	**Socio-economic Factors**	**Community Capacity**	**Health Behaviours**	**Person-related Factors**
Physical, chemical and biological factors such as air, water, food and soil quality resulting from chemical pollution and waste disposal	Socio-economic factors such as education, employment per capita expenditure on health, and average weekly earnings	Characteristics of communities and families such as population density, age distribution, health literacy, housing, community support services and transport	Attitudes, beliefs knowledge and behaviours (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	The care, intervention or action provided is relevant to the consumer's and/or carer's needs and based on established standards	Achieving desired results with most cost effective use of resources
Responsive	**Accessible**	**Safe**
Service provides respect for persons and is consumer and carer orientated: respect for dignity, confidential, participate in choices, prompt, quality of amenities, access to social support networks, and choice of provider	Ability of people to obtain health care at the right place and right time irrespective of income, geography and cultural background	Potential risks of an intervention or the environment are identified and avoided or minimised
Continuous	**Capable**	**Sustainable**
Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.	An individual or service's capacity to provide a health service based on skills and knowledge	System or organisation's capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring)

The NMHPF is based on the initial National Health Performance Framework (NHPF) developed in 2001 and outlines three tiers of performance. Combined the tiers provide a comprehensive picture of population health and provides a structure through which key questions can be posed concerning how well the mental health system is performing.

The tiers are not intended to be hierarchical in nature and are reflective of the fact that health status and health outcomes are influenced by health determinants and overall health system performance. While the original NHPF was modified in 2010, it was determined that the structure of the existing NMHPF was more appropriate for continued development and use within the mental health sector.

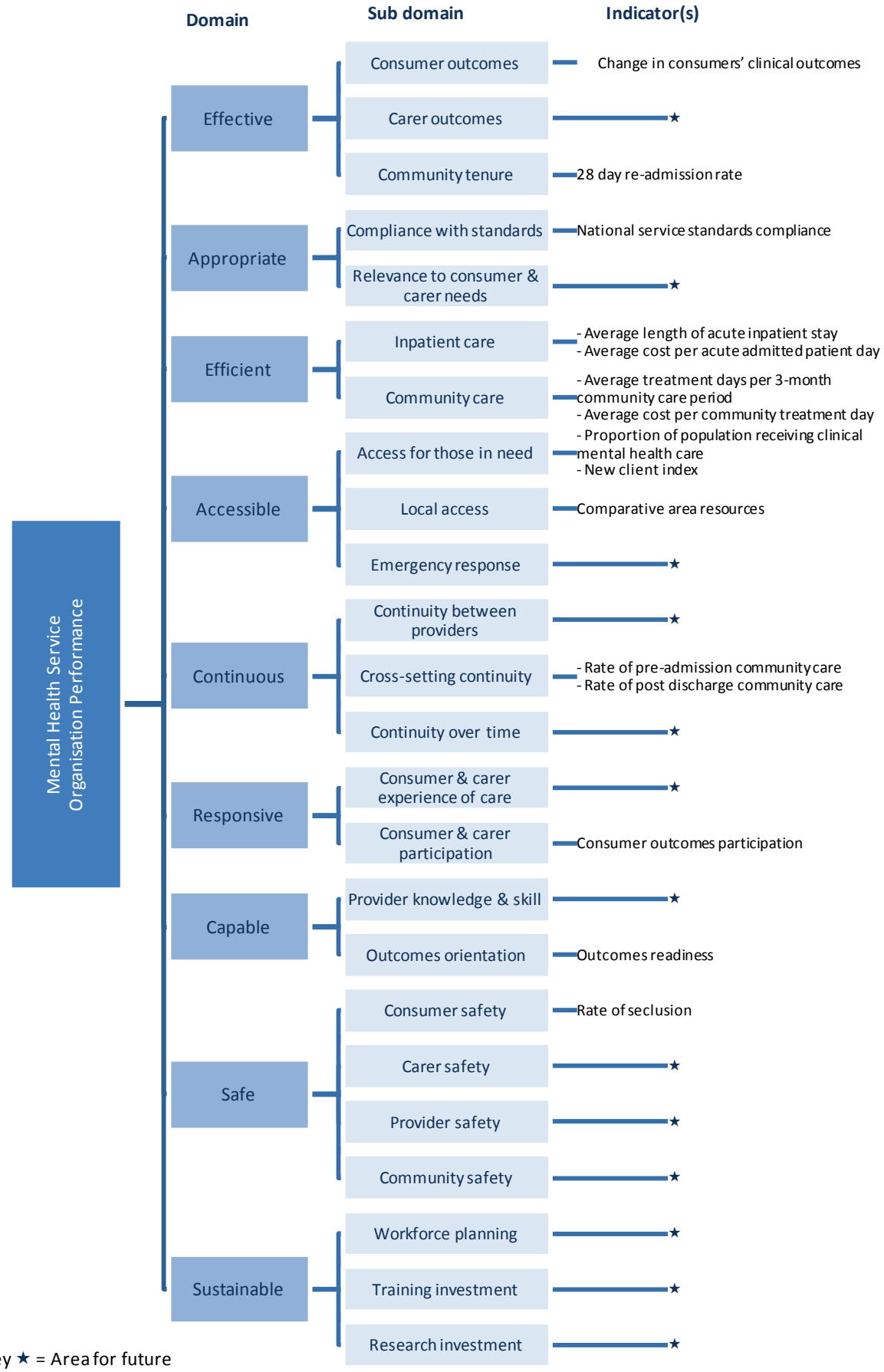
1.3 Scope of the national indicators

While the NMHPF advocates that indicators are needed for all three tiers, the focus has been on the development and refinement of indicators for *Tier 3 – Health System Performance*.

The initial KPI set associated with the NMHPF was endorsed and published in 2005. Since then, all states and territories have commenced a process of embedding performance management and monitoring within public sector mental health service delivery. Over this time, the mental health sector, led by the Mental Health Information Strategy Standing Committee's National Mental Health Performance Subcommittee (NMHPSC), has continued to refine and develop the indicator set. Figure 2 summarises the Tier 3 domains, sub domains and the current endorsed indicator set.

The NMHPF and the national KPI set are specifically targeted towards measuring performance of public mental health services. However, a longer term aspiration is that this work might be aligned with private and non-government MHSO activity to provide a whole of service measurement framework.

Figure 2: Summary of 'Tier 3' of the National Mental Health Performance Framework and current indicator set



Key ★ = Area for future development

1.4 Development of Australian mental health key performance indicators

The first edition of this publication highlighted issues and concerns in relation to good data development practices and designing quality indicators for multiple purposes. The criteria outlined in Table 1 were used in the development of the initial indicator set and are still applicable.

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

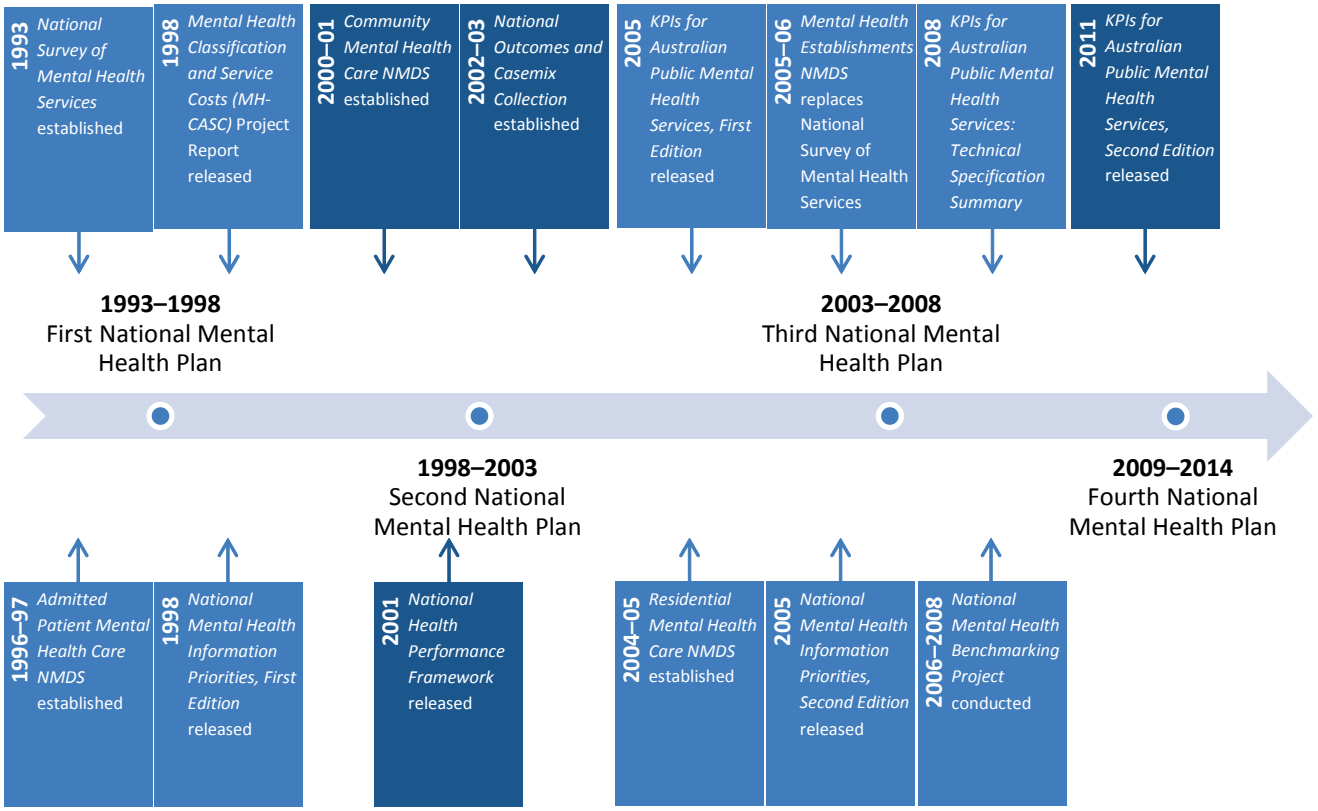
Table 1: Criteria used to evaluate candidate indicators

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

Milestones contributing to the current indicator set

Australia's mental health sector has been a world leader in reporting on indicators of mental health reform. The process began in 1992–93 with the National Mental Health Strategy and the First National Mental Health Plan. The current national health reform agenda, including the *Fourth Plan* and reforms agreed by the Council of Australian Governments (COAG) throughout 2010–2012, continue to emphasise the importance of performance monitoring and influence the need for embedding this activity within mental health service delivery and policy development.

Figure 3: Key activity contributing to indicator development



1.5 Summary of changes to the indicators

Over the past eight years a number of modifications have been made to refine and enhance the indicator set. These modifications were based on knowledge and experience gained through state and territory implementation, outcomes of national projects (such as the National Mental Health Benchmarking Project conducted over 2006–2008) and improvements to data sources. A detailed description of changes over time is provided at Appendix 5.2.

This section summarises the key changes made since the Second Edition was released in 2011.

Replacement indicators

As implementation of the NMHPF progressed, the most consistent feedback from states and territories has been that cost related indicators should be revised from 'cost of episode of care' to 'cost of a treatment day'. Treatment day is a lower unit of counting and is more in line with how states and territories report performance. As such, in the Third Edition, the following two indicators have replaced the previous indicators:

- MHS PI 5 *'average cost per acute admitted patient day'* (previously average cost per acute inpatient episode).
- MHS PI 7 *'average cost per community treatment day'* (previously average cost per three-month community care period).

Revised indicators

Although minor modifications have been made to most indicators to improve the clarity of the specifications, the following three indicators have had relatively substantial revisions made in the Third Edition:

- MHS PI 1 *'change in clinical outcomes'* now specifies a fourth consumer group for residential mental health care services.
- MHS PI 8 *'proportion of population receiving clinical mental health care*' modified to include all settings of mental health care.
- MHS PI 14 *'outcomes readiness'* has been redesigned and is now specified for four consumer groups.

Renamed indicators

To align to similar (or same) national indicators the following three indicators have been renamed in the Third Edition:

- MHS PI 8, 'population receiving care' has been renamed to '*proportion of population receiving clinical mental health care*'.
- MHS PI 11 'pre-admission community care' has been renamed to '*rate of pre-admission community care'*.
- MHS PI 12 'post-discharge community care' has been renamed to '*rate of post-discharge community care*'.

Changes to the indicator template

In this Third Edition, it has been explicitly acknowledged that there are issues with constructing the majority of these indicators using the national data sets. These limitations have led to the development of proxy solutions for national construction and reporting. A new section has been added to the technical specifications template and information specific to each of the indicators has been provided to explain what proxy solutions are currently undertaken to address these issues.

Finally, possible supplementary indicators that may help services find additional context to the 'key' performance indicators have been identified in the relevant technical specifications. The supplementary indicators have not been specified since they are not 'headline' performance measures.

1.6 The context for performance measurement and reporting in Australia

Mental health performance measurement has developed on multiple fronts over the past two decades, primarily driven through initiatives of the National Mental Health Strategy. Increasingly, broader health sector reforms and processes are influencing the direction and scope of performance measurement and reporting for the mental health sector.

National reform

Reform in the health sector

Major reforms to the organisation, funding and delivery of Australian health care have occurred since 2011 under the **National Health Reform Agreement (NHRA).** The NHRA introduced new financial and governance arrangements for Australian public hospitals and new governance arrangements for primary health care.

NHRA initiatives have committed governments to increase availability of public information to ensure improved transparency and accountability of public hospital services. The three main national bodies responsible for reporting are: COAG Reform Council (CRC), National Health Performance Authority (NHPA) and the Australian Commission on Safety and Quality in Health Care (ACSQHC). Although the focus is on the whole health system, the scope of these bodies provides direction for and reporting on the mental health sector.

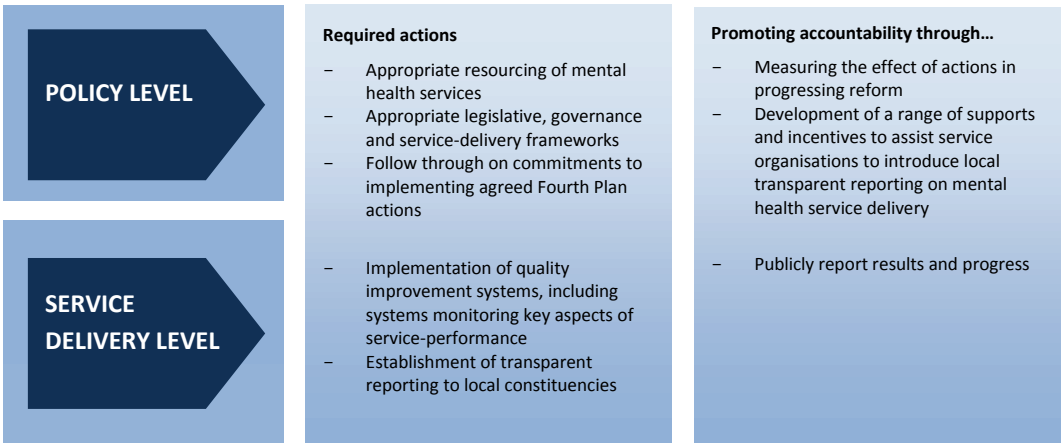
Reform in the mental health sector

In conjunction with the national reforms implemented across the Australian health care system, there are a range of initiatives and activity driving ongoing development of mental health performance measurement at both the service delivery and policy levels. Activity in relation to mental health reform continues under the direction of the Fourth National Mental Health Plan 2009–2014, the National Mental Health Commission and the Roadmap for National Mental Health Reform 2012–2022.

Performance reporting

Under the NHRA all governments have committed to increasing publicly available information to increase transparency and accountability and to inform consumers and the broader community. This requires strengthening accountability at both the policy and service delivery levels. The Fourth National Mental Health Plan articulates a multi-level approach to building accountability and transparency within the system (Figure 4). Combined, the two levels of reporting will provide coverage of the mental health sector and place a wide range of performance information into the public domain.

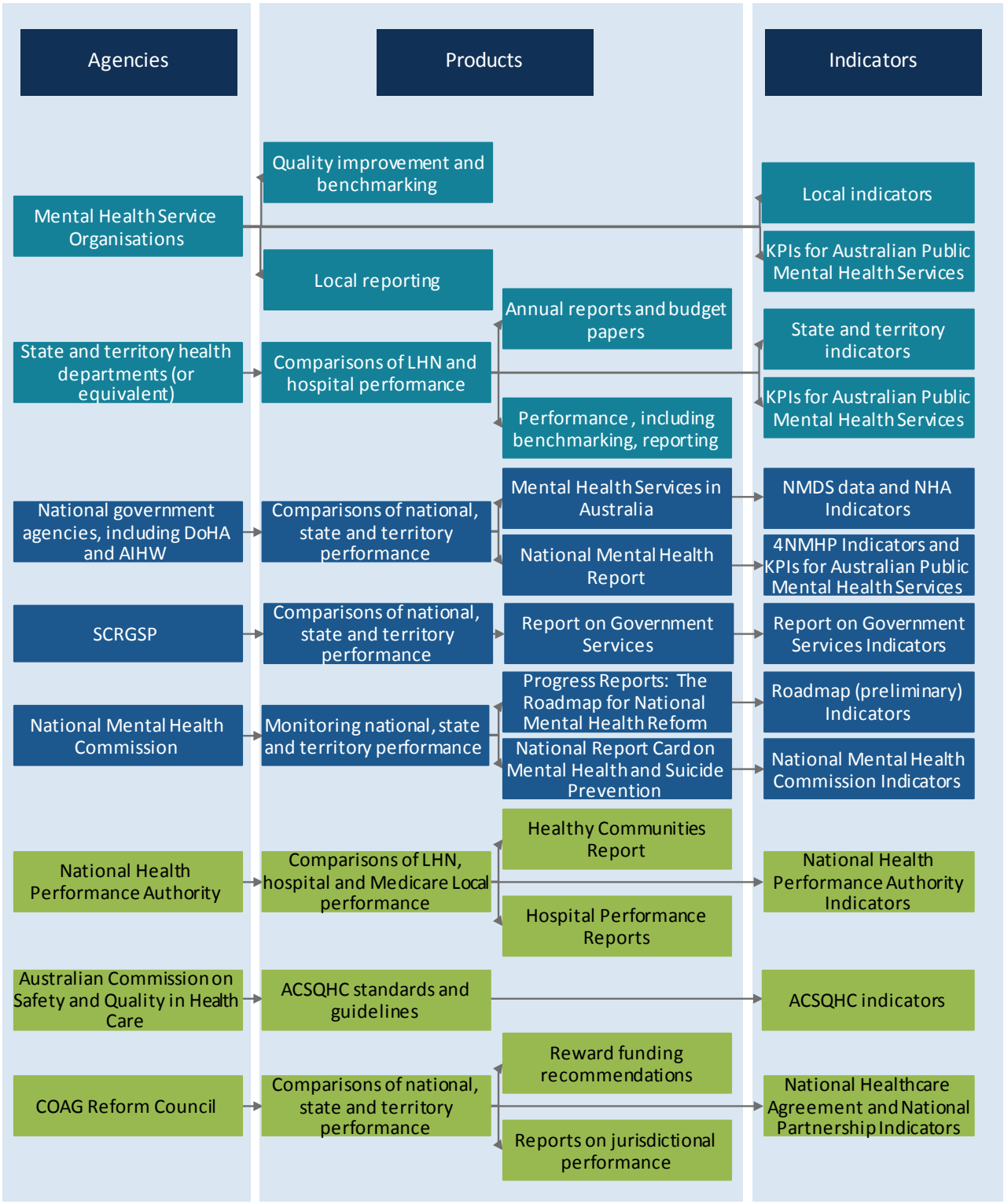
Figure 4: Multi-level approach to building an accountable and transparent mental health system



As a consequence of the need to report at all levels of the system, there are a range of indicators used to monitor service and policy performance. While the national indicator set was developed specifically for use

at MHSO level, several of the indicators have provided a reference point for other measures used for monitoring and reporting national progress in delivery of a range of health reforms. Twelve of the 15 indicators are reported nationally in one or more publications, including the annual Report on Government Services (RoGS), the CRC annual report on the National Healthcare Agreement and the National Mental Health Report. The agencies currently responsible for monitoring and reporting performance at various levels of the mental health system are outlined in Figure 5.

Figure 5: Scope of mental health related performance measurement and reporting



2. Understanding the National Mental Health Performance Framework

The domains of performance identified under 'tier three' of the NMHPF represent the broad areas of concern for health service performance. The nine domains are: Effective, Appropriate, Efficient, Responsible, Accessible, Sustainable, Capable, Safe and Continuous.

It is important to note that although focussed on different aspects of quality, there is considerable overlap between these domains. For example, *appropriateness* includes elements relevant to *responsiveness* and *continuity.* The implication is that any one indicator may be relevant across multiple performance domains. For the purpose of simplicity, where an indicator can be mapped to more than one domain of the NMHPF, it has been assigned to a 'primary domain' and the relevant secondary domain has also been identified.

Table 2 provides a summary of the mapping of the current indicator set across the tier three domains, as well as the levels at which the indicators can be used for benchmarking purposes.

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

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

▲ = Primary domain
■ = Secondary domain
✓ = Valuable at this level
○ = Limited value at this level
✗ = Not useful at this level

As outlined in Figure 2, the nine domains have been defined further into 24 sub-domains and these sub-domains have specific relevance to the delivery of MHSOs. Each sub-domain can be regarded as describing a topic of concern or the most salient aspects of organisation performance. It is important to recognise that sub-domains considered most relevant are likely to change over time in response to community expectations or specific challenges facing the service delivery system. Decisions regarding future

development will be influenced by determination of aspects of service delivery considered most important in the current service delivery and policy climate.

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

2.1 Explanation of domains and sub domains

This section works through the domains, clarifying definitions and interpretation within a mental health context and provides an overview of the strategic direction that has influenced the development of the national KPIs.

Effective: '*Care, intervention or action achieves desired outcome*'

Strategic context

The need to improve mental health service effectiveness has been a central goal of the National Mental Health Strategy (the Strategy) since its inception in 1992. Establishing a system for the routine monitoring of consumer outcomes has also been an objective of the Strategy since it was first agreed. The National Mental Health Policy included as one of its original objectives *"to institute regular review of client outcomes of services provided to persons with serious mental health problems and mental disorders as a central component of mental health service delivery."*[1] The revised National Standards for Mental Health Services also identified the need to be able to review services and outcomes at an individual consumer and mental health service level.

Over the past decades, states and territories have established an information infrastructure to embed the measurement of consumer outcomes as a routine part of service delivery. By 2008, routine measurement of consumer outcomes was in place in an estimated 98% of public mental health services[2]. It is important to recognise that the embedding of routine outcome measurement into public sector mental health services is a 'work in progress'. Uptake by public sector mental health services is variable both within and across states and territories.

Interpretation of the domain

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

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

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

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

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

Sub-domains

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

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

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

Strategic context

Concerns about the appropriateness of care remain a key driver of the reform agenda progressed through the National Mental Health Strategy. The primary focus of the reform effort in the early years of the Strategy was on structural reform to reduce Australia's historical reliance on separate psychiatric hospitals and to develop a better mix of clinical community-based and general hospital services. The National Standards for Mental Health Services (NSMHS) were introduced in 1996 and a revised set of standards, applicable to all mental health services (government, non-government and private sectors), were released in 2010. The NSMHS complement a range of inter-connected clinical and community service options to support provision of the right care at the right time, including primary care, acute care and community support services.[3]

The National Safety and Quality Health Service (NSQHS) Standards have also been progressively implemented across all settings of health care since 2011. The NSQHS Standards provide a nationally consistent statement of the level of care consumers should be able to expect from health services. Although the NSQHS have mandatory accreditation requirements for all health services, the focus remains firmly on the implementation of the mental health specific standards.

The Australian Commission on Safety and Quality in Health Care in collaboration with the Safety and Quality Partnership Standing Committee and the Department of Health and Ageing has developed an accreditation workbook for mental health services to assist them to become accredited to both sets of national standards. This accreditation workbook for mental health services is to be published in mid-2013.

In addition to service standards, the National Practice Standards for the Mental Health Workforce were introduced in 2002 to complement each of the professional groups' discipline-specific practice standards or competencies and address the shared knowledge and skills required when working in a multidisciplinary

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

mental health environment. The Practice Standards are currently being reviewed by the MHDAPC's Mental Health Workforce Advisory Committee and expected to be released during 2014.

Interpretation of the domain

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

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

Sub-domains

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

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

Efficient: '*Achieving desired results with the most cost effective use of resources*'

Strategic context

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

In the context of significant pressures on health budgets and increased demands by government to ensure efficient use of resources, the introduction of Activity Based Funding (ABF), driven through the Council of Australian Governments (COAG) national health reforms, will inform future development and directions in relation to measuring efficiency. To enable appropriate and effective ABF implementation for mental health care, the Independent Hospital Pricing Authority (IHPA) has embarked on a substantial body of work to develop and implement nationally consistent definitions, classification and reporting of activity based funding which is expected to be operational from 2014–15.

Interpretation of the domain

Measurement of health sector efficiency has historically focused on technical efficiency rather than allocative efficiency. The ABF program is progressing; however it is still in the developmental stages. Until the work of ABF comes to fruition, the indicators of mental health sector efficiency will remain concerned with technical efficiency issues, focusing on cost per unit of output. The unit of output for efficiency indicators is currently a patient day (inpatient) or treatment day (community) of mental health care.

Sub-domains

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

- *Inpatient care:* in 2010–11 inpatient services (acute, sub-acute and non-acute) accounted for approximately 43% of national expenditure on public sector mental health services, and have very different unit cost characteristics from community-based care.
- *Community (ambulatory) care:* ambulatory care services account for approximately 39% of mental health services expenditure in 2010–11.

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

Strategic context

One in five Australians experienced mental illness[4] in 2007, but just over one third had received services for their mental health problems. Improving access to services has been a continuing priority theme throughout the history of the National Mental Health Strategy. National objectives to improve access to mental health care have been multifaceted and cover local access to specialist services through decentralisation of resources, increasing access to mainstream health and community support programs for people affected by mental illness, and improving service availability for special needs groups and specific populations (Aboriginal and Torres Strait Islanders, consumers with complex needs). The *Fourth Plan* maintains and enhances the focus on improving accessibility through the development of a national mental health service planning framework and establishing regional partnerships with relevant stakeholders to facilitate local solutions for community mental health needs.

Interpretation of the domain

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

- Access implies that people in need of care actually receive services. Despite increased funding for primary and specialist services, access to mental health services is still not considered adequate. The issue of unmet need continues to be a priority with evidence suggesting that almost two thirds of adults who are affected by mental illness do not receive any form of treatment[5].
- Access also implies geographical proximity, with services delivered in a way that minimises dislocation of the consumer from family and local supports.
- Access also concerns timeliness, or responding to needs when they arise. Timely access to services is a major factor in ensuring that consumers receive needed services. It includes prompt attention to emergencies as well as reasonable wait times for other referrals.

Sub-domains

Three sub-domains cover the different aspects of access:

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

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

[5] Ibid.

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

Strategic context

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

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

Interpretation of the domain

Continuity of care embraces several concepts, including:

- *Care provided over time:* during the course of an illness and across the lifespan.
- *Care and support provided by different services:* the specialist mental health sector, primary health care, other areas of the health sector and community services.
- *Across structural boundaries:* between the public and private sectors and between the government and non-government sectors.

Sub-domains

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

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

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

Strategic context

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

Interpretation of the domain

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

Sub-domains

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

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

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

Strategic context

Several significant national reforms, projects, policy and governance initiatives that affect the mental health workforce are being progressed. Some of these are directly related to work under the *Fourth Plan*, such as the development of a national mental health service planning framework and the revision and implementation of the National Standards for Mental Health Services. The need to develop the workforce and increase its capacity is noted in both the *Fourth Plan* and the COAG National Action Plan on Mental Health 2006–2011.

The National Mental Health Policy emphasises that to achieve the desired outcomes for individual consumers as well as the overarching reform agenda, there must be ongoing development and support of a skilled workforce delivering quality services that are based on the best available evidence[6].

The *Fourth Plan* acknowledges that having clear guidelines to determine roles, competencies, skill mix and professions required for a capable workforce will improve consistency of care and increase the effective and efficient use of the available workforce. In line with this objective, the National Mental Health Workforce Strategy[7] was endorsed by the Australian Health Ministers' Conference in September 2011.

This strategy provides an overarching framework for the ongoing development of the mental health workforce in Australia. Out of the five outcome areas covered by this strategy, two outcome areas are specifically dedicated to building the various aspects of the mental health workforce capacity.

Interpretation of the domain

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

Sub-domains

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

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

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

[7] Victorian Government Department of Health, Melbourne, Victoria, on behalf of the Mental Health Workforce Advisory Committee (2011), *National Mental Health Workforce Strategy*, Department of Health and Ageing, Canberra.

Safe: '*Potential risks of an intervention or environment are identified and avoided or minimised*'

Strategic context

Safety is a core component of both the National Standards for Mental Health Services and the National Practice Standards for the Mental Health Workforce, with the expectation that a service will ensure the safety and wellbeing of its consumers, carers, staff and others. The current national safety priorities in mental health[8]were endorsed in 2005 and 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.

Further development and implementation of initiatives related to these priority areas are led by the Safety and Quality Partnership Standing Committee of the MHDAPC.

Interpretation of the domain

Safety is a key component of quality and involves "the avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered."[9] The concept of safety in mental health services is diverse and complex, encompassing many different aspects, including the safety of the consumer, health service providers, carer and the community.

Sub-domains

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

- *Consumer Safety:* concerns the extent to which health care environment and/or service provided to and/or for consumers of mental health services is safe.
- *Carer Safety:* concerns the extent to which a safe environment is supported for mental health carers.
- *Provider Safety:* concerns the extent to which the working environment established and/or maintained for providers of mental health services is safe.
- *Community Safety:* concerns the extent to which a safe environment is supported for the broader community. There is currently no standard or sufficient definition of community available to support data and/or indicator development.

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

Strategic context

Workforce development is a crucial aspect of quality service delivery and reform. The *Fourth Plan* highlights the need to support the implementation of evidence-based and innovative service models and practices, underpinned by an active research agenda, including both quantitative and qualitative research led by or involving consumers. However, the recruitment, retainment and availability of suitably qualified staff across the diverse range needed in mental health service delivery is a challenge for all governments.

[8] 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.

[9] Ibid, p. 34.

The future workforce investments have been underpinned by the *National Mental Health Workforce Strategy*[10]which was endorsed by the Australian Health Ministers' Conference in September 2011. This strategy provides an overarching framework for the ongoing development of the mental health workforce in Australia. The documents chart the way forward for a nationally coordinated approach to the mental health workforce over a ten-year period.

Interpretation of the domain

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

Sub-domains

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

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

[10] Victorian Government Department of Health, Melbourne, Victoria, on behalf of the Mental Health Workforce Advisory Committee (2011), *National Mental Health Workforce Strategy*, Department of Health and Ageing, Canberra.

3. Constructing and using national indicators

Designed to assist MHSOs identify challenges and achievements in their performance, the NMHPF and the national KPIs are used in a variety of ways to support local, jurisdictional and national reporting and to drive change across a variety of service delivery areas. However, the complexity of mental health service delivery and associated information infrastructure has meant there are issues in constructing and using the KPIs, particularly at the national level.

3.1 Using indicators to drive change

Mental health care is delivered by diverse providers operating in a variety of settings under different public and private governance, management and financial arrangements. As such data is collected from multiple sources and for various purposes. The NMHPF and national KPIs provide common language for describing service delivery and measuring performance and quality of care.

Incorporating benchmarking activity into everyday practice is primarily a state and territory responsibility. However, over the past ten years a range of activities occurred at the national level with the aim to support state and territory services to develop capacity in benchmarking for quality improvement. The most significant national investment in mental health benchmarking was the National Mental Health Benchmarking Project, a collaborative initiative between the Australian and state and territory governments, which ran from May 2006 to November 2008.

The National Mental Health Benchmarking Project provided an opportunity for participating organisations from across Australia to deconstruct complex processes of making data and indicators relevant to service and clinical practice, to explore and analyse differences in performance through peer comparisons, and to test how benchmarking concepts can be used within mental health services. While participants found the experience to be useful for informing improvements in service delivery, considerable support was required to generate the required information and for it to then be interpreted in a meaningful way. Evaluation of the project highlighted that sustainable benchmarking processes are evolutionary by nature and influenced by a range of factors including data quality and service models.

Subsequent to the national project the primary focus of national activity has been on identifying support for highly specialised mental health services that, due to their low numbers, are typically unable to identify peer groups within their own jurisdiction for performance benchmarking purposes. For this to occur, these services would need to compare their performance with similar services in other jurisdictions.

The model has been trialled by the Australian forensic mental health services, who meet periodically to share performance data in a way that allows each organisation to target areas for quality improvement. More recently, the forensic group has incorporated web-based interactive technology to reduce the cost and burden of face to face meetings. Based upon this model, the Mental Health Information Strategy Standing Committee is canvassing the establishment of benchmarking forums targeted at highly specialised mental health services.

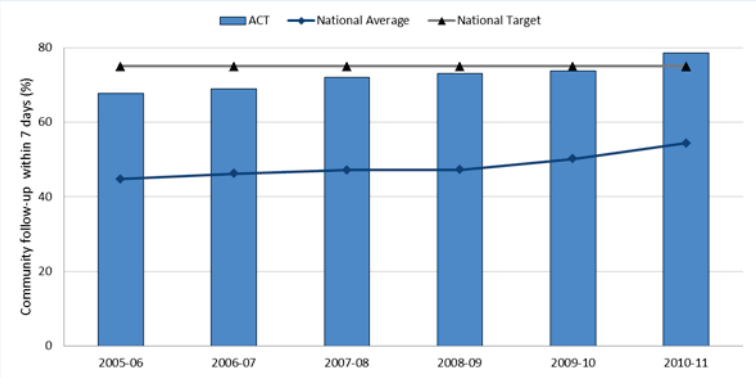
In addition to coordinated national activity, each state and territory are progressing a range of activities that utilise indicators from the national set to inform and monitor improvements in service delivery. The case studies from the Australian Capital Territory (Box 1) and New South Wales (Box 2) illustrate some of the uses of performance information to achieve positive change.

Box 1: Reducing psychiatric inpatient hospital re-admission within 28 days influenced by seven day follow-up contact

The relationship between acute psychiatric inpatient re-admission and contact with mental health services post-discharge has been explored in the ACT. Results indicate that reduction in re-admissions is influenced by the amount and type of follow-up contact when the consumer is returned to the community. Furthermore, the quality and type of contact is critical, including who, beyond the consumer, is involved.

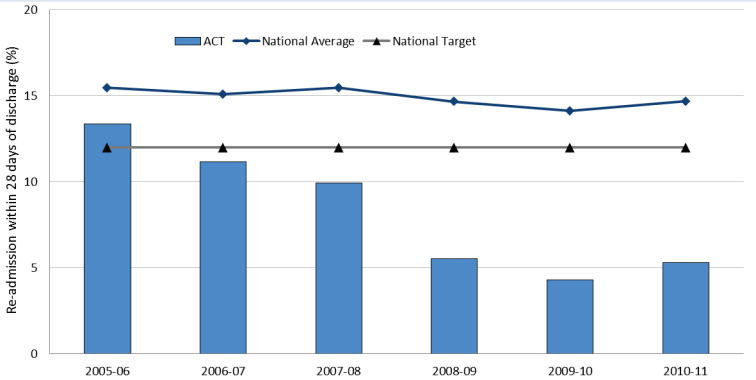
Mental health services in the ACT are provided by one central organisation. Public mental health service provision is captured in a centralised electronic system, covering both inpatient and community services. The system enables service providers to coordinate and be aware of clinical care within inpatient services and across the community. Following up acute inpatient episodes with public mental health community support services, including engagement with family and carers, is a key factor in reducing the need for further inpatient care. The ACT has been able to provide high level of follow-up services, including high frequency contact over a number of days to weeks, due to the size of the jurisdiction, service accessibility and system attributes.

Rates of community seven day follow-up



In the ACT, rates of community follow-up within seven days of discharge have improved progressively over the period 2005-06 to 2010-11 and are relatively high compared to the national average. The ACT rate exceeded the national target agreed under the Fourth National Mental Health Plan (75%) in 2010-11.

Re-admission within 28 days of discharge from an initial inpatient episode



Rates of psychiatric inpatient hospital re-admission within 28 days have decreased and are relatively low compared to the national average. The ACT rate has been below the national target agreed under the Fourth National Mental Health Plan since 2006-07.

Community support services and engagement with family and friends where possible also influences the degree of acuity and coping ability of the consumer and prolongs the functional capacity of the person to minimise their need for further acute inpatient care.

Follow-up contact that includes direct face-to-face contact and also involves significant others in the consumer's life has been demonstrated to improve the likelihood of the consumer remaining in the community for longer and reduces the chance of relapse to a degree requiring an inpatient re-admission.

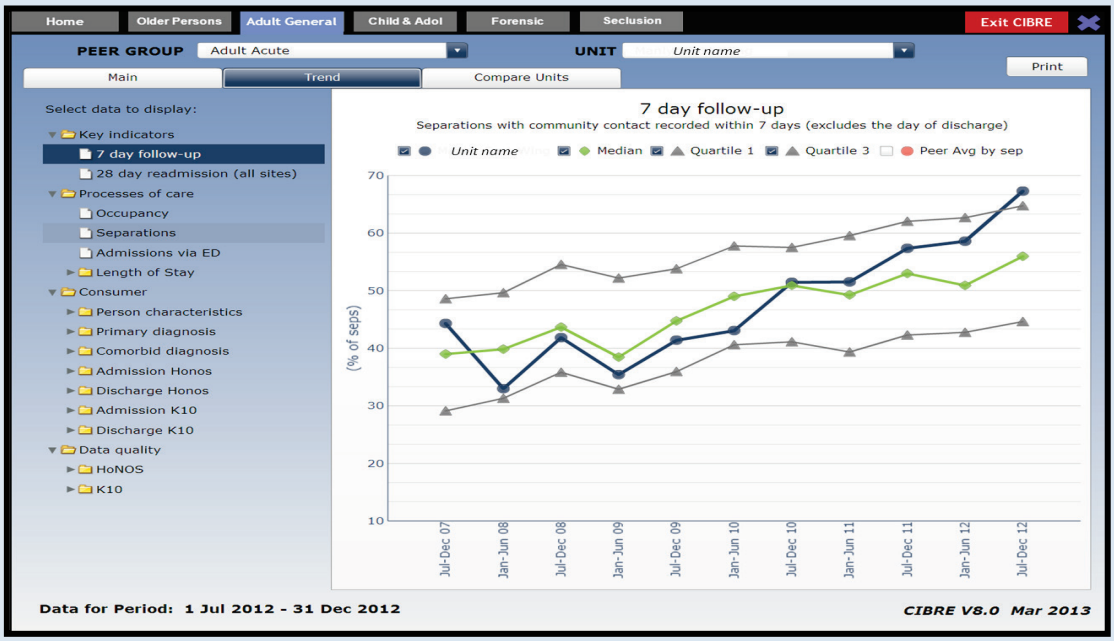
Box 2: Building key performance indicators into clinical benchmarking

The national KPIs have provided an important framework for the New South Wales clinical benchmarking program which aims to support change in clinical services. The program supports clinical benchmarking activities for acute and non-acute inpatient units, specialist older person's mental health services and child and adolescent mental health services. Work has recently commenced for community mental health services.

A central strategy has been the development of regular data reports for mental health services. These reports are distributed in an interactive format using the Clinical Information Benchmarking Reporting Engine (CIBRE) which allows units to compare their own data with identified peer units throughout NSW. Reports focus on three national KPIs:

- 28 day re-admission rate
- Rate of post-discharge community care
- Rate of seclusion

A sample screen from CIBRE (below) shows change over time in relation to 'Rate of post-discharge community care' for the "Adult Acute" peer group. The green and Grey lines show the median and the 25th and 75th percentiles for units in this peer group. The blue line graphs an individual unit (original name replaced with "Unit name"). Follow-up rate at that unit has improved and for the most recent period they were in the top 25% of peer group units for follow-up.



CIBRE also reports a wide range of other data to help explore possible reasons for variation between services. Including; data on service resources, processes of care (e.g. turnover, pathways to care, unit occupancy, length of stay), consumer characteristics (age, gender and demographic profiles, diagnoses), outcome measures (HoNOS, K10) and measures of data quality.

The program has implemented other strategies to make KPIs more effective in supporting change, including:

- Project priorities and content are designed in consultation with clinical and policy leaders, and with consumer and carer representatives.
- Regular site visits are conducted to present and discuss data.
- The program hosts forums and working groups which bring services together to discuss data and practice on specific topics, such as seclusion reduction or prevention of readmission.
- Data literacy updates have been provided for service managers and consumer workers.

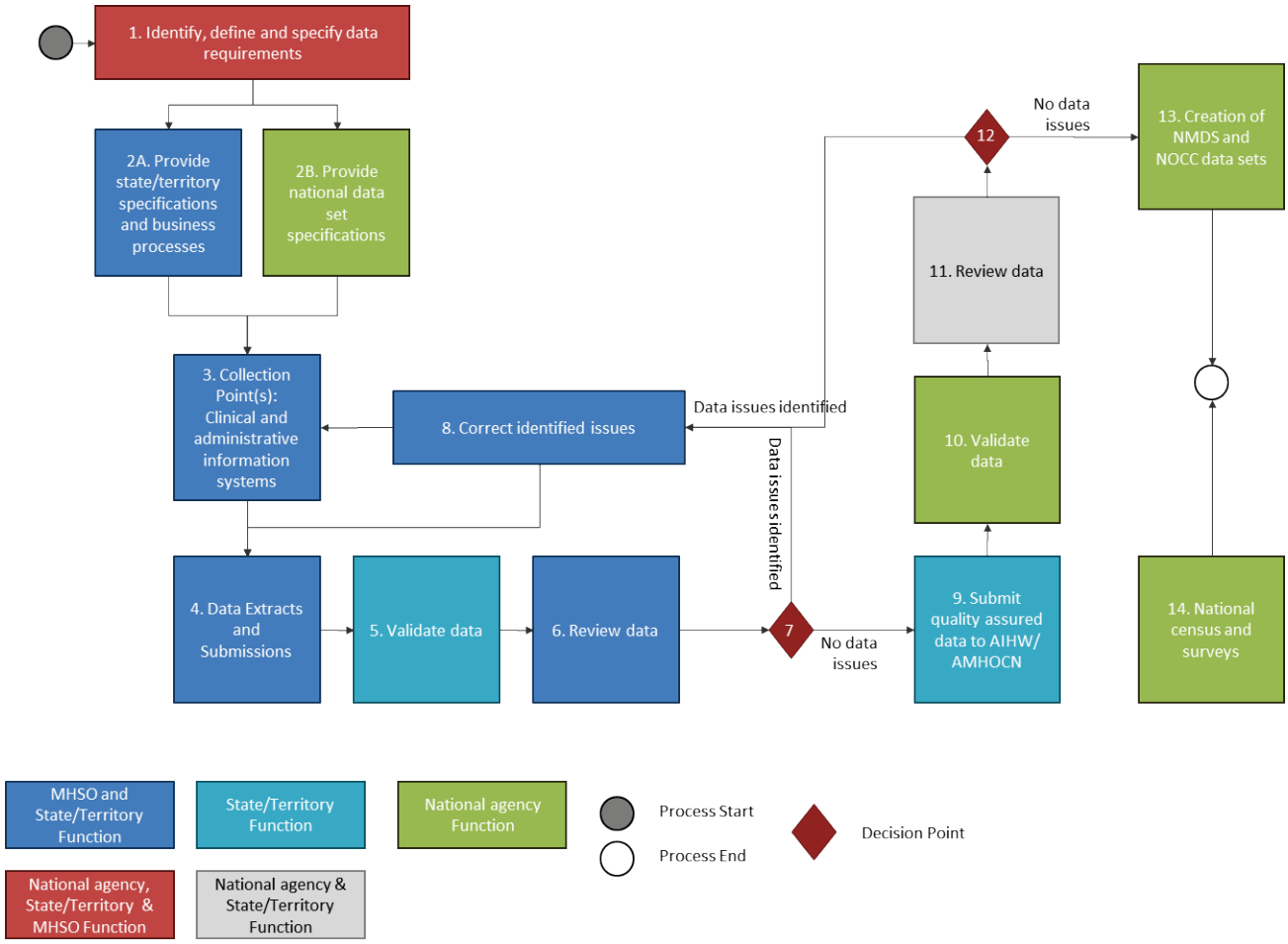
The clinical benchmarking project has contributed to positive changes in performance for those KPIs. A consistent national approach to KPI specification has been integral for the project and continues to support ongoing efforts.

3.2 Utility of national data sets for performance reporting

The National Minimum Data Sets (NMDS) are the building blocks of all national information strategies in the health field. Over the past two decades NMDSs for mental health care have been developed to enable a range of clinical and non-clinical information to be collected and reported nationally. In addition, since implementation in 2001, the National Outcomes and Casemix Collection (NOCC) has captured information regarding the outcomes of consumers accessing specialised mental health care.

The NMHPF indicators have been developed and specified for use at the MHSO level. States and territory services collect a broad range of clinical and non-clinical information regarding consumers accessing care and the service provided. A process of review and validation is implemented to enhance the quality of information used for reporting at all levels of the health system, however, as depicted in Figure 6, only a sub set of this information is reported through to the national collections.

Figure 6: Simplified schema of mental health data flow from MHSO to national collections



Despite the achievements to date, and availability of a substantial amount of data, there remain significant gaps in the information available at the national level. Consequently, not all indicators can be constructed utilising the national data sets.

These limitations have led to the adoption of proxy solutions in order to construct and report nationally on a number of indicators. These proxy solutions involve specific data submissions by states and territories to national reporting agencies. As summarised in Table 3, eight of the 15 indicators can be constructed from either the NMDSs or the NOCC, albeit some with relatively substantial limitations. However, the remaining seven indicators can only be constructed using data that is available to states and territories.

Table 3: Summary of current capacity of national datasets to construct national indicators

The following indicators can be constructed from national datasets:

Mental Health Services Key Performance Indicators		Data source for national reporting
MHS PI 3:	National Service Standards compliance	NMDS Mental Health Establishments
MHS PI 5:	Average cost per acute admitted patient day	NMDS Mental Health Establishments
MHS PI 6:	Average treatment days per three month community care period	NMDS Community Mental Health Care
MHS PI 7:	Average cost per community treatment day	NMDS Mental Health Establishments

The following indicators can be constructed from national datasets with limitations:

Mental Health Services Key Performance Indicators		Data source for national reporting
MHSPI 1:	Change in consumers' clinical outcomes	NOCC
MHS PI 4:	Average length of acute inpatient stay	NMDS Mental Health Establishments
MHS PI 13:	Consumer outcomes participation	NOCC and NMDS (Community Mental Health Care, Admitted Patient Mental Health Care and Residential Mental Health Care)
MHS PI 14:	Outcomes readiness	NOCC and NMDS (Community Mental Health Care, Admitted Patient Mental Health Care and Residential Mental Health Care)

The following indicators cannot be constructed from national datasets:

Mental Health Services Key Performance Indicators		Data source for national reporting
MHS PI 2:	28 day readmission rate	State and Territory data
MHS PI 8:	Proportion of population receiving clinical mental health care	State and Territory data
MHS PI 10:	Comparative area resources	State and Territory data
MHS PI 9:	New client index	State and Territory data
MHS PI 11:	Rate of pre-admission community care	State and Territory data
MHS PI 12:	Rate of post-discharge community care	State and Territory data
MHS PI 15:	Rate of seclusion	State and Territory data

Further details as to the nature of the proxy solutions are provided for each of the relevant indicators at Section 5.

3.3 State and Territory implementation of the national indicators

The high-level and generic nature of the NMHPF combined with the complexity of capturing the diversity of individual services has meant there are issues in constructing and using the national KPIs. Variable information systems and capacity within each state and territory has meant that progress with performance reporting and benchmarking using the NMHPF and national indicators has advanced at different rates.

The NMHPSC surveys states and territories to ascertain the nature of issues impacting on the implementation of the NMHPF and national indicators. Survey results are published on the NMHPSC website at www.health.gov.au/mhsc

Overall, all states and territories construct and utilise a subset of the national indicators for a variety of purposes, including performance management of MHSOs and internal reporting within state and territory health departments (or their equivalents) to Ministers, central agencies and Cabinet. However, there is large variation in the amount and level of information provided publicly.

The following key issues and activity have been identified by most states and territories in recent surveys:

1. ***Information systems:*** reporting information requires the capacity to link data from discrete information systems using state-wide unique client identifiers in order to match data between inpatient and community settings or across MHSOs. When this capacity is not available local reporting results differ to publicly published results. A number of states and territories are in the process of implementing automated reporting systems and are reviewing data collection processes to identify areas for improvement.

2. ***Data collection and quality:*** Data information structures are complex, with feeds progressing from local source systems to local hospital information systems and up to state and territory information systems. Most states and territories are working towards data flow improvements, addressing issues with integrity and timing and reducing collection burden by enhancing information systems and increasing data literacy amongst clinical managers, clinicians and other stakeholders.

3. ***Business practices and capacity:*** State and territory specialist resources focus on a diverse range of operational and strategic activity. As such, local business rules governing data collection practices have lead some states and territories to modify the national KPI specifications to fit their requirements. While this results in increased utility within that particular jurisdiction, it has in some instances decreased comparability at a national level. A program of work is being progressed, both nationally and within individual states and territories, to address such issues. Additionally, managers and clinical leaders across all states and territories are encouraged to play a greater role in leveraging clinical teams to utilise the national KPIs.

4. Next steps for national Framework and indicators

Since the endorsement and publication of the NMHPF and "Tier 3" national KPIs in 2005, considerable work has been undertaken to progress and develop the Australian mental health performance agenda. A solid information foundation has been developed over the past decade and ongoing work is occurring at both policy and service delivery levels to keep data sources up to date, as well as addressing gaps in current national collections.

The NMHPF and indicators have been a key strategy for facilitating a culture of continuous quality improvement in mental health service delivery and have also provided a common ground for MHSOs to measure, report and compare performance. While in some areas, clinicians and service managers have had the means to accelerate quality improvement tools and processes, in general this has not been the case. Overall ongoing support for states and territories is necessary to embed and advance sustainable performance measurement system and culture of continuous improvement into the future.

In the context of significant reform agendas, both general and specific to mental health, it is anticipated that the focus of the NMHPF and the national indicators will remain on the clinical services delivered by states and territories. Work will continue to be progressed in relation to the following areas:

1. *Refinement of indicators in context of ongoing reform*

   It is essential that the NMHPF and national indicators retain their currency in relation to ongoing reform of Australia's health and hospital system, including funding, governance and safety and quality. Changes to the way health services are delivered will be monitored to ensure performance measurement reflects improvements applied at all levels as the system aims to provide better access to high quality integrated care designed around the needs of consumers. As indicators are reviewed and revised longer term, MHSOs will have improved accessibility to innovations in performance measurement.

2. *Supporting public performance reporting*

   Sound technical capacity underpins the development and maximum utility of public reporting systems. Relative to other parts of the health sector, the mental health sector is in a good position to publicly report using the data currently available. Mental health information advisory structures are well established and will continue to contribute to the implementation of public reporting systems. It is anticipated that public reporting of performance will provide ongoing opportunities to ensure consistency, accuracy and timeliness of data made publicly available.

3. *Continued investment in benchmarking and the use of performance information*

   Benchmarking is a core responsibility of states and territories and a range of activities are currently being undertaken in most jurisdictions. MHSOs are provided with data in relation to their performance compared with similar organisations within their state or territory. There is work currently being progressed to provide opportunities for nationally coordinated benchmarking activity where a need cannot be filled by state-based initiatives.

   Web based benchmarking forums targeted at highly specialised mental health services are being scoped and the concept is based on a model currently being trialled by the Australian forensic mental health services. These services meet periodically to share performance data in a way that allows each organisation to target areas for quality improvement. More recently, the forensic group has incorporated web-based interactive technology to reduce the cost and burden of face to face meetings.

5. Technical specifications

This section features a technical specification for each indicator, with the format and definitions as specified below.

Indicator name		
Rationale	The issues and reasons for inclusion of the indicator in the national set.	
Endorsement status	The authoritative body responsible for approving the KPI set.	
Date last updated	Date of endorsement.	
Indicator details		
Description	An explanation of the specific service or performance to be measured.	
Numerator	A description of the number above the line in a fraction showing how many of the parts indicated by the denominator are taken.	
Denominator	A description of the number below the line in a fraction.	
Computation	The formula used to calculate the indicator.	
Calculation conditions	Coverage/Scope:	The services and elements to be included or excluded in the indicator.
	Methodology:	Key components of the approach required to construct the indicator.
Definitions	Key technical terminology relevant to indicator.	
Presentation	The description of the type of number utilised to present the indicator (e.g. percentage)	
Disaggregation	Details of possible stratifications of indicator that may prove beneficial to jurisdictions.	
Notes	Relevant information pertaining to the indicator not reflected elsewhere in the specification.	
Is specification interim or long-term?	Identifies whether further development or modification is anticipated to enhance the indicator.	
Reported in	National reports where the indicator is published.	
National Mental Health Performance Framework		
Tier	The Tier of the NMHPF the indicator relates to.	
Primary domain	Where an indicator can be mapped to more than one of the nine domains of the NMHPF, it has been assigned to a primary domain.	
Secondary domain(s)	As some indicators may be relevant across several domains relevant secondary domains have also been identified.	
Mental health sub-domain	Sub-domains express the multidimensionality of the broader domains. Each sub-domain describes a topic of concern or the focal points of organisation performance.	
Type of measure	States whether the indicator measures inputs, processes, outputs or outcomes.	
Level at which indicator can be useful for benchmarking	Service unit ☐	Mental Health Service Organisation ☐
	Regional group of services ☐	State/Territory ☐
Related national key performance indicators	Details where there is a relationship with other indicators in this national set.	
Supplementary indicators	Lists other indicators that could be used to provide additional context to the 'key' performance indicator. (Note - supplementary indicators are not specified as they are not 'headline' performance measures.)	

Indicator name		
Data collection details		
Data source(s)	Numerator:	Specifies the immediate origin of the data used to populate the numerator component of the indicator.
	Denominator:	Specifies the immediate origin of the data used to populate the denominator component of the indicator.
Data source(s) type	Numerator:	Can be either — administrative by product, clinical outcome measure, census based, or register.
	Denominator:	As above
Frequency of data source(s) collection	Numerator:	States the frequency of collections.
	Denominator:	As above
Data development	Short-term:	Outlines areas identified for further development.
	Medium-term:	As above
	Long-term:	As above
Construction of indicator from national data sets		
Can the indicator to be constructed accurately from currently available national datasets?	Reflects issues with accurately constructing indicators using the national data sets and provides details of proxy solutions that have been developed in order to produce various national reports.	
If not, is there a proxy solution to construct the indicator from available national data?	Reflects proxy solutions utilised in national reporting.	
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	Identified activity required to enhance use of national data sets for national reporting of the indicator.	

MHS PI 1: Change in consumers' clinical outcomes

Rationale	• Mental health services aim to reduce symptoms and improve functioning. Their effectiveness can be compared using routinely collected measures. This will assist in service benchmarking and quality improvement. • The implementation of routine mental health outcome measurement in Australia provides the opportunity to monitor the effectiveness of mental health services across services and jurisdictions.
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee
Date last updated	28 August 2013

Indicator details

Description	The proportion of episodes of mental health care where: • significant improvement; • significant deterioration; • no significant change; was identified between baseline and follow-up of completed outcome measures.	
Numerator	Number of completed or ongoing episodes of mental health care with completed outcome measures, partitioned by setting, where significant change/significant deterioration/no significant change was identified between *baseline* and *follow-up* within the reference period.	
Denominator	Number of completed or ongoing episodes of mental health care with completed outcome measures, partitioned by mental health setting within the reference period.	
Computation	(Numerator ÷ Denominator) x 100 Calculated separately for each group.	
Calculation conditions	Coverage/Scope:	All public mental health service organisations. The following episodes of care are excluded: • Brief ambulatory episodes of mental health care; • Brief inpatient episodes of mental health care; • Ambulatory episodes of mental health care that end because of admission to hospital or residential mental health care ('reason for collection' equals change of setting).
	Methodology:	• Only the Health of the Nation Outcome Scales (HoNOS) family of measures (including HoNOS, HoNOS65+ and HoNOSCA) is considered in the calculation of this indicator. • Outcomes are calculated for the following consumer groups: – **Group A: Consumers discharged from hospital** All people who were discharged from an acute psychiatric inpatient unit within the reference period. Scores should be calculated as the difference between the total score recorded at admission (the 'baseline') and discharge (the 'follow-up'). – **Group B: Consumers discharged from ambulatory care** All people who were discharged from an ambulatory care episode within the reference period. Scores should be calculated as the difference between the total score recorded at admission to the episode (the 'baseline'), and discharge from the episode (the 'follow-up'). Ambulatory episodes that are completed because the consumer was admitted to hospital or residential mental health care must be excluded from the analysis that is, where the National Outcomes Casemix Collection (NOCC) 'reason for collection' equals change of setting. – **Group C: Consumers in ongoing ambulatory care** All people who have an 'open' ambulatory episode of care at the end of reference period. Scores should be calculated as the difference between the total score recorded on the first occasion rated within the reference period which will be either admission or review, (the 'baseline') and the last occasion rated which will be a review (the 'follow-up') in

	the same reference period. – **Group D: Consumers discharged from residential mental health care** All people who were discharged from a residential mental health service unit within the reference period, excluding statistical separations. Scores should be calculated as the difference between the total score recorded at admission (the 'baseline') and discharge (the 'follow-up'). • Group change analyses can only be determined for episodes of care where both baseline and follow-up ratings are present. This excludes specific episodes defined by the NOCC data collection protocol as not requiring follow-up as well as episodes where either the baseline or follow-up measure is not available. • The total score is determined for each individual baseline and follow-up score. This is the sum total of the 12 HoNOS/65+ scales or the first 13 items of the 15 HoNOS Children and Adolescents (HoNOSCA). Where one or more of the HoNOS/65+ or HoNOSCA items have not been completed correctly, the collection occasion should only be regarded as valid and complete if: – For the HoNOS and HoNOS65+: A minimum of 10 of the 12 items have a valid severity rating (i.e. a rating of either 0, 1, 2, 3 or 4); – For the HoNOSCA a minimum of 11 of the first 13 items have a valid severity rating; – There are no corrections made for missing items. • Scores are classified as either 'significant improvement', 'significant deterioration' or 'no significant change', based on the effect size statistic. • The reference period for this indicator is typically a single financial year, and the impact of modifying the reference period is unknown.
Definitions	• For the purposes of this KPI, a medium effect size of 0.5 is used to assign outcome scores to the three outcome categories. A medium effect size is equivalent to an individual change score of at least one half (0.5) of a standard deviation. • Individual episodes are classified as either: 'significant improvement' if the effect size index is greater than or equal to positive 0.5; 'significant deterioration' if the effect size index is less than or equal to negative 0.5; or 'no change' if the index is greater than -0.5 and less than 0.5. • Analyses of the 2010–11 national pool of NOCC data identified that for: – Inpatient and ambulatory settings a four point threshold indicates a medium effect size. In practice this means an individual change score of a least four points equates to a medium effect size and significant change. This threshold is the same for all three HoNOS measures. – Residential settings a five point threshold indicates a medium effect size. In practice this means an individual change score of a least five points equates to a medium effect size and significant change. There was only sufficient data to construct for the HoNOS measure. • See glossary for further information regarding the following term/s relevant to this indicator: – Brief ambulatory episodes of mental health care; – Brief inpatient episodes of mental health care; – Episode of mental health care; – Effect size; – Open episode of mental health care.
Presentation	Percentage by group by setting
Disaggregation	• Service variables: Target population (adult only) • Consumer attributes: Diagnosis, age, SEIFA, remoteness, indigenous status
Notes	• This indicator measures one type of outcome for mental health consumers. Where

MHS PI 1: Change in consumers' clinical outcomes

	possible, NOCC-based measures should be complemented by other measures of consumer outcomes (e.g. social outcomes such as employment or social participation) that capture different perspectives on consumer outcomes. • Greater variability in HoNOS scores can be expected, if effect sizes were calculated using 'locally' derived standard deviations. Statistically, fewer observations generally give rise to greater variability. • This indicator was designed as a measure of aggregate group change.
Is specification interim or long-term?	Long-term
Reported in	• National Mental Health Report • Report on Government Services

National Mental Health Performance Framework

Tier	Tier III – Health System Performance			
Primary domain	Effective			
Secondary domain(s)	-			
Mental health sub-domain	Consumer outcomes			
Type of measure	Outcome			
Level at which indicator can be useful for benchmarking	Service unit	☑	Mental Health Service Organisation	☑
	Regional group of services	☑	State/Territory	☑
Related national key performance indicators	MHS PI 14 – Outcomes readiness			
Supplementary indicators	-			

Data collection details

Data source(s)	Numerator:	State/territory data as reported to National Outcomes and Casemix Collection
	Denominator:	State/territory data as reported to National Outcomes and Casemix Collection
Data source(s) type	Numerator:	Clinical outcome measure
	Denominator:	Clinical outcome measure
Frequency of data source(s) collection	Numerator:	Annually
	Denominator:	Annually
Data development	Short-term:	-
	Medium-term:	-
	Long-term:	-

Construction of indicator from national data sets

Can the indicator to be constructed accurately from currently available national datasets?	The NOCC maintained by the Department of Health and Ageing compiles all state and territory consumer outcomes data on an annual data submission basis. However, NOCC does not allow linkage of episodes of care across financial years. This limitation does not exist for states and territories own data sets.
If not, is there a proxy solution to construct the indicator from available national data?	A proxy solution using a sub set of episodes, which have commenced within the same financial year, is used for producing this indicator from NOCC. Compared to data constructed from state and territory datasets and using complete episodes, this limitation is likely to result in calculation of the indicator based on a significantly smaller pool of episodes. It may also have a systematic effect on apparent results on this indicator, but the direction and size of this effect has not been systematically tested.
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	Longer term, a process is needed that allows data reported by states and territories to the NOCC for consumers who begin an episode in a given year to be tracked when the episode continues into subsequent years. Work is underway to build in an episode identifier into NOCC. Additionally, consistent, cross-year use of service identifiers and unique identifiers for consumers is necessary to enable full capacity to construct this indicator.

MHS PI 2: 28 day readmission rate

Rationale	• Readmissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was incomplete or ineffective, or that follow-up care was inadequate to maintain the person's treatment out of hospital. In this sense, rapid readmissions may point to deficiencies in the functioning of the overall care system. • Avoidable rapid readmissions place pressure on finite beds and may reduce access to care for other consumers in need. • International literature identifies one month as an appropriate defined time period for the measurement of unplanned readmissions following separation from an acute psychiatric inpatient service.	
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee	
Date last updated	28 August 2013	
Indicator details		
Description	Proportion of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient units that are followed by readmission to the same or to another public sector acute psychiatric inpatient unit within 28 days of discharge.	
Numerator	Number of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) occurring within the reference period, that are followed by a readmission to the same or another acute psychiatric inpatient unit within 28 days.	
Denominator	Number of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) occurring within the reference period.	
Computation	(Numerator ÷ Denominator) x 100	
Calculation conditions	Coverage/Scope:	All public mental health service organisations acute psychiatric inpatient units. The following separations are excluded: • Same day separations; • Statistical and change of care type separations; • Separations that end by transfer to another acute or psychiatric hospital; • Separations that end by death, left against medical advice/discharged at own risk; • Separations where length of stay is one night only and procedure code for ECT is recorded.
	Methodology:	• Readmission is considered to have occurred if the person is admitted to any public acute psychiatric inpatient unit within the state/territory. Consequently, a state-wide unique patient identifier is required for accurate construction of this indicator. • For the purpose of this indicator, when a mental health service organisation has more than one unit of a particular admitted patient care program, those units should be combined. • The categorisation of the admitted patient unit is based on the principal purpose(s) of the admitted patient care program rather than the care type of individual consumers. • One of the following ECT procedure codes are recorded: – ACHI 5th edition (2006–2008) use ICD-10 procedure codes 93340-02 and 93340-43. – ACHI 6th and 7th editions (2008 to current) use ICD-10 procedure codes 93341-00 to 93341-99. – ACHI 5th, 6th and 7th editions (2006 to current) Electroconvulsive therapy Block 1907 may be selected to capture all data regardless of code changes over time.
Definitions	• See glossary for further information regarding the following term/s relevant to this indicator: – Acute psychiatric inpatient units; – Same day separations. • For the purposes of this indicator 'same or another public acute psychiatric inpatient unit' means within the same jurisdiction.	

MHS PI 2: 28 day readmission rate

Presentation	Percentage
Disaggregation	• Service variables: Target population. • Consumer attributes: Diagnosis, age, SEIFA, remoteness, indigenous status, involuntary status.
Notes	• Due to data limitations this indicator cannot differentiate between planned and unplanned readmissions. • This indicator does not track readmissions across state and territory boundaries or track movement between public and private hospitals.
Is specification interim or long-term?	Long-term
Reported in	• National Mental Health Report • Report on Government Services

National Mental Health Performance Framework

Tier	Tier III – Health Service Performance			
Primary domain	Effective			
Secondary domain(s)	Continuous			
Mental health sub-domain	Community tenure			
Type of measure	Outcome			
Level at which indicator can be useful for benchmarking	Service unit	☑	Mental Health Service Organisation	☑
	Regional group of services	☑	State/Territory	☑
Related national key performance indicators	• MHS PI 4 - Average length of acute inpatient stay • MHS PI 11 - Pre-admission community care • MHS PI 12 - Post-discharge community care			
Supplementary indicators	• Bed occupancy		• Readmission from acute medical units (Older persons)	

Data collection details

Data source(s)	Numerator:	State/territory data as reported to the National Minimum Data Set Admitted Patient Mental Health Care.
	Denominator:	State/territory data as reported to the National Minimum Data Set Admitted Patient Mental Health Care.
Data source(s) type	Numerator:	Administrative by-product
	Denominator:	Administrative by-product
Frequency of data source(s) collection	Numerator:	Annually
	Denominator:	Annually
Data development	Short-term:	-
	Medium-term:	-
	Long-term:	• Future development of this indicator should consider the impact of the evolving and growing sub-acute mental health sector. • Development of unique state-wide patient identifiers in all jurisdictions.

Construction of indicator from national data sets

Can the indicator be constructed accurately from currently available national datasets?	This indicator cannot be accurately constructed using the NMDS Admitted Patient Mental Health Care. While the data set comprehensively provides a collection of separations from Australian public hospitals; its inability to uniquely identify a patient across episodes and across hospitals limits its capacity to count readmissions.
If not, is there a proxy solution to construct the indicator from available national data?	There is no proxy solution available. In order to report this indicator at a national level, states and territories are required to individually provide separate indicator data.
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	A reliable system of patient identifiers within the NMDS Admitted Patient Mental Health Care is required to enable unique identification of individual consumers across multiple years, multiple admitted episodes and multiple hospitals.

MHS PI 3: National Service Standards compliance		
Rationale	• The National Standards for Mental Health Services provide an agreed national framework for service quality and consistency. All Australian mental health services are required to be accredited against the National Standards. • Implementation of the National Standards for Mental Health Services has been agreed by all jurisdictions.	
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee	
Date last updated	28 August 2013	
Indicator details		
Description	Proportion of the mental health service organisation's services (weighted by expenditure) that have been reviewed against the National Standards for Mental Health Services. This 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 are: (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known; or (ii) booked for review by an external accreditation agency • Level 4: Mental health services that do not meet criteria detailed under Levels 1 to 3. (i) Services engaged in self-assessment in relation to the National Standards but did not have a contractual arrangement with an external accreditation agency for review; (ii) Services had not commenced the preparations for review by an external accreditation agency but this was intended to be undertaken in the future; and (iii) It had not been resolved whether the service unit would undertake review by an external accreditation agency under the National standards.	
Numerator	Total expenditure by mental health service organisations on specialised public mental health services that meet the definition of Level X where X is the level at which the indicator is being measured (either Level 1, Level 2, Level 3 or Level 4)	
Denominator	Total mental health service organisation expenditure on specialised public mental health services	
Computation	(Numerator ÷ Denominator) x 100 Calculated separately for each level	
Calculation conditions	Coverage/Scope:	All specialised public mental health services, with the following exceptions: • Older Persons Mental Health Community Residential Services approved under or working towards the accreditation standards gazetted as part of the Australian Government *Aged Care Act 1997*
	Methodology:	• Expenditure on service units reaching each of the four levels are to be summed when calculating numerator.
Definitions	• Mapping of levels to National Minimum Data Set Mental Health Establishments (MHE) codes as follows: *Level 1*: MHE code 1; *Level 2*: MHE codes 2; *Level 3*: MHE codes 3-4; *Level 4*: MHE codes 5-7. Refer to Glossary for further information. • Expenditure for services that meet MHE Code 8 should be excluded from the calculation of this indicator.	
Presentation	Percentage	
Disaggregation	-	
Notes	• External review is a process of negotiation between mental health service organisations and the accrediting agency. Accordingly, variations may exist in the extent to which all or some National 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.	
Is specification interim or long-term?	Interim	

MHS PI 3: National Service Standards compliance

Reported in	• Mental Health Services in Australia • National Mental Health Report • Report on Government Services

National Mental Health Performance Framework

Tier	Tier III – Health Service Performance			
Primary domain	Appropriate			
Secondary domain(s)	Capable			
Mental health sub-domain	Compliance with standards			
Type of measure	Process			
Level at which indicator can be useful for benchmarking	Service unit	☐	Mental Health Service Organisation	☑
	Regional group of services	☑	State/Territory	☑
Related national key performance indicators	MHS PI 14 - Outcomes readiness			
Supplementary indicators	-			

Data collection details

Data source(s)	Numerator:	State/territory data as reported to the National Minimum Data Set Mental Health Establishments.
	Denominator:	State/territory data as reported to the National Minimum Data Set Mental Health Establishments.
Data source(s) type	Numerator:	Administrative by-product
	Denominator:	Administrative by-product
Frequency of data source(s) collection	Numerator:	Annually
	Denominator:	Annually
Data development	Short-term:	New approach to be developed that is more suited to monitoring implementation of the National Standards for Mental Health Services (2010).
	Medium-term:	-
	Long-term:	-

Construction of indicator from national data sets

Can the indicator be constructed accurately from currently available national datasets?	This indicator can be accurately constructed using the NMDS Mental Health Establishments. This is based on the method used to track services developed for the previous National Standards for Mental Health Services (1996). This method will be used until a new approach is developed and implemented in national data collections.
If not, is there a proxy solution to construct the indicator from available national data?	Not applicable.
What needs to be done in the longer term to allow this indicator to be constructed from national data set?	Not applicable.

MHS PI 4: Average length of acute inpatient stay

Rationale	• Length of stay is a key driver of variation in admitted patient day costs and reflects differences between mental health service organisations in practice and casemix, or both. • The aim of this indicator is to better understand the factors underlying variation (such as costs) as well as providing a basis for utilisation review. For example, it allows for the assessment of services provided to particular consumer groups against clinical protocols developed for those groups.	
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee	
Date last updated	28 August 2013	
Indicator details		
Description	Average length of stay of in-scope overnight separations from acute psychiatric inpatient units managed by the mental health service organisation.	
Numerator	Number of patient days in the mental health service organisation's acute psychiatric inpatient unit(s) accounted for by in-scope overnight separations during the reference period.	
Denominator	Number of in-scope overnight separations from the mental health service organisation's acute psychiatric inpatient unit(s) occurring within the reference period.	
Computation	Numerator ÷ Denominator	
Calculation conditions	Coverage/Scope:	All public mental health service organisations acute psychiatric inpatient units. The following separation and associated patient days are excluded: • Same day separations. For jurisdictional level reporting the following separation and associated patient days are excluded: • Forensic services.
	Methodology:	• Length of stay is measured in patient days. • Length of an overnight patient stay is calculated by subtracting the admission date from the date of separation and deducting total leave days. • For the purpose of this indicator, when a mental health service organisation has more than one unit of a particular admitted patient care program, those units should be combined. • The categorisation of the admitted patient unit is based on the principal purpose(s) of the admitted patient care program rather than the classification of individual consumers.
Definitions	• See glossary for further information regarding the following term/s relevant to this indicator: – Acute psychiatric inpatient units. – Same day separations.	
Presentation	Number	
Disaggregation	• Service variables: Target population, disorder specific services. • Consumer attributes: Diagnosis, age, SEIFA, remoteness, indigenous status, involuntary status.	
Notes	• Casemix adjustment is needed to interpret variation between organisations – to distinguish consumer and provider factors. • Leave presents special complexities in the mental health area and further work is required to ensure that it does not distort this indicator.	
Is specification interim or long-term?	Long-term	
Reported in	Report on Government Services (Note – data reported using proxy solution. Refer to construction from national data sets section for more information.)	

MHS PI 4: Average length of acute inpatient stay

National Mental Health Performance Framework

Tier	Tier III – Health Service Performance			
Primary domain	Efficient			
Secondary domain(s)	Appropriate			
Mental health sub-domain	Inpatient Care			
Type of measure	Process			
Level at which indicator can be useful for benchmarking	Service unit	☑	Mental Health Service Organisation	☑
	Regional group of services	☑	State/Territory	☑
Related national key performance indicators	• MHS PI 2 – 28 day readmission rate • MHS PI 5 – Average cost per acute admitted patient day			
Supplementary indicators	• Median, mode and range of length of stay		• Bed occupancy	

Data collection details

Data source(s)	Numerator:	State/territory data as reported to National Minimum Data Set Admitted Patient Mental Health Care
	Denominator:	State/territory data as reported to National Minimum Data Set Admitted Patient Mental Health Care
Data source(s) type	Numerator:	Administrative by-product
	Denominator:	Administrative by-product
Frequency of data source(s) collection	Numerator:	Annually
	Denominator:	Annually
Data development	Short-term:	-
	Medium-term:	• Nationally consistent definitions and terminology are required for identification of acute units responsible for providing particular functions, such as disorder specific services, to enable comparisons within and between jurisdictions. • Appropriate methodology for casemix adjustment.
	Long-term:	Development of comparable efficiency indicators for admitted patient programs other than acute (e.g. rehabilitation or extended care) and residential facilities.

Construction of indicator from national data sets

Can the indicator be constructed accurately from currently available national datasets?	The NMDS Admitted Patient Mental Health Care allows length of stay to be calculated for individual hospitals but it does not allow sub-units of individual hospitals (e.g. specialised psychiatric units) to be identified separately. The implication is that average length of stay for specific specialised psychiatric unit, acute or otherwise, cannot be directly constructed at a national level from the current NMDS.
If not, is there a proxy solution to construct the indicator from available national data?	There are two main approaches that enable construction of the indicator from national data: • The use of the 'psychiatric care days' flag in the NMDS Admitted Patient Mental Health Care enables identification of the subset of separations from hospitals that received treatment and care in a specialised psychiatric unit. While the flag does not distinguish acute and non-acute units, the vast majority of separations are attributable to acute units. A trimming process to isolate separations with extreme length of stay (e.g. > 365 days) can be used to approximate acute units. However, the data source cannot disaggregate acute psychiatric units by target population. • The RoGS uses the NMDS Mental Health Establishments as an alternative data source for reporting average length of stay. Subsequently the RoGS includes all patient days in the reference period. However, these days are not necessarily linked to separations in the same reference period. Consequently, the results of the two approaches are not strictly comparable.
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	Data regarding the type of admitted patient unit would need to be added to the NMDS Admitted Patient Mental Health Care. Alternatively, admitted patient unit identifiers that could be linked to data captured in the NMDS Mental Health Establishments would provide the necessary information.

MHS PI 5: Average cost per acute admitted patient day		
Rationale	• Efficient functioning of public acute psychiatric inpatient units is critical to ensuring finite funds are used effectively to deliver maximum community benefit. • Unit costs are a core feature of management level indicators in all industries. They are required to measure how well an organisation uses its resources in producing services and are fundamental to value for money judgements. • Acute psychiatric inpatient units account for 74% of the total costs of specialised mental health inpatient care and 31% of overall delivery costs. • 'Admitted patient day' is the 'intermediate product' for acute inpatient episodes and can be the focus activity aimed at improvements in technical efficiency.	
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee	
Date last updated	28 August 2013	
Indicator details		
Description	Average cost of patient day within acute psychiatric inpatient units managed by the mental health service organisation.	
Numerator	Total recurrent expenditure within the mental health service organisation's acute psychiatric inpatient unit(s) during the reference period.	
Denominator	Number of patient days occurring within the mental health service organisation's acute psychiatric inpatient unit(s) during the reference period.	
Computation	Numerator ÷ Denominator	
Calculation conditions	Coverage/Scope:	All public mental health service organisations acute psychiatric inpatient units.
	Methodology:	• Recurrent costs include costs directly attributable to the acute psychiatric inpatient unit(s) plus a proportional share of overhead costs. Cost data for this indicator are 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. • Leave days are excluded from the national definition for reporting and counts of patient days. • Categorisation of the admitted patient unit is based on the principal purpose(s) of the program rather than the classification of individual consumers.
Definitions	• See glossary for further information regarding the following term/s relevant to this indicator: – Acute psychiatric inpatient units.	
Presentation	Currency	
Disaggregation	• Service variables: Target population; disorder specific services • Consumer attributes: Nil	
Notes	• Casemix adjustment is needed to interpret variation between organisations – to distinguish consumer and provider factors. • Patient day 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.). • Costing methodologies are relatively underdeveloped in within the mental health sector, and vary across organisations, impacting on the quality of this indicator. Further work is required to achieve consistency in costing methodologies.	
Is specification interim or long-term?	Interim	
Reported in	Report on Government Services	
National Mental Health Performance Framework		
Tier	Tier III – Health Service Performance	
Primary domain	Efficient	
Secondary domain(s)	-	
Mental health sub-domain	Inpatient	

MHS PI 5: Average cost per acute admitted patient day

Type of measure	Process			
Level at which indicator can be useful for benchmarking	Service unit	☑	Mental Health Service Organisation	☑
	Regional group of services	☑	State/Territory	☑
Related national key performance indicators	MHS PI 4 - Average length of acute inpatient stay			
Supplementary indicators	Average cost per acute inpatient episode			

Data collection details

Data source(s)	Numerator:	State/territory data as reported to National Minimum Data Set Mental Health Establishments.
	Denominator:	State/territory data as reported to National Minimum Data Set Mental Health Establishments
Data source(s) type	Numerator:	Administrative by-product
	Denominator:	Administrative by-product
Frequency of data source(s) collection	Numerator:	Annually
	Denominator:	Annually
Data development	Short-term:	• Developments in Activity Based Funding will inform future modifications of this indicator.
	Medium-term:	• Nationally consistent definitions and terminology to identify acute units that provide particular functions, such as disorder specific services, to enable comparisons within and between jurisdictions. • Methodology for casemix adjustment is required.
	Long-term:	• Comparable efficiency indicators for extended care and residential facilities need to be developed.

Construction of indicator from national data sets

Can the indicator be constructed accurately from currently available national datasets?	The indicator can be accurately constructed using the NMDS Mental Health Establishments.
If not, is there a proxy solution to construct the indicator from available national data?	Not applicable.
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	Not applicable.

MHS PI 6: Average treatment days per three-month community care period

Rationale	• The purpose of this indicator is to better understand underlying factors which cause variation in community care costs. • The number of treatment days is the community counterpart of length of stay and it indicates the relative volume of care provided to people 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 consumer 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. • This indicator may also demonstrate degrees of accessibility to public sector community mental health services.
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee
Date last updated	28 August 2013

Indicator details

Description	Average number of community treatment days per three month period of ambulatory care provided by the mental health service organisation's community mental health services.	
Numerator	Number of community treatment days provided by the mental health service organisation's ambulatory mental health services within the reference period.	
Denominator	Number of ambulatory care statistical episodes (three month periods) treated by the mental health service organisation's ambulatory services within the reference period.	
Computation	Numerator ÷ Denominator	
Calculation conditions	Coverage/Scope:	All public mental health service organisations community mental health services. The following activity of community mental health services are excluded: • All activity (treatment days and statistical episodes) associated with non-uniquely identified consumers.
	Methodology:	• Datasets to be constructed from contact data at analysis rather than collected as discrete variable. • For the purposes of this measure, ambulatory community care statistical episodes consist of the following fixed three monthly periods; January–March, April–June, July–September, and October–December.
Definitions	• An ambulatory care statistical episode is a statistically derived community episode defined as each three month period of ambulatory care of an individual registered consumer where the consumer was under 'active care', defined as one or more treatment days in the period. A registered consumer is a uniquely identifiable consumer at the mental health service organisation level, regardless of the number of teams or community programs involved in his/her care. • See glossary for further information regarding the following terms relevant to this indicator: – Non-uniquely identified consumer – Treatment day	
Presentation	Number	
Disaggregation	• Service variables: Target population • Consumer attributes: Age, SEIFA, remoteness, indigenous status, involuntary status	
Notes	• Casemix adjustment is needed to interpret variation between organisations to distinguish consumer and provider factors. Longer term a methodology for casemix adjustment is required. • Further development of national funding models, including episode-based or casemix models, will enable more meaningful measurement than the arbitrary three month period used in this indicator.	

MHS PI 6: Average treatment days per three-month community care period

Is specification interim or long-term?	Interim			
Reported in	• National Mental Health Report • Report on Government Services			

National Mental Health Performance Framework

Tier	Tier III – Health Service Performance			
Primary domain	Efficient			
Secondary domain(s)	Appropriate			
Mental health sub-domain	Community			
Type of measure	Process			
Level at which indicator can be useful for benchmarking	Service unit	☑	Mental Health Service Organisation	☑
	Regional group of services	☑	State/Territory	☑
Related national key performance indicators	MHS PI 7 - Average cost per community treatment day			
Supplementary indicators	• Average contacts per treatment day • Average duration of contacts • Proportion of contacts in which a consumer participates		• Proportion of assessment only contacts • Average treatment hours per 3 month community care period	

Data collection details

Data source(s)	Numerator:	State/territory equivalent as reported to National Minimum Data Set Community Mental Health Care.
	Denominator:	State/territory equivalent as reported to National Minimum Data Set Community Mental Health Care.
Data source(s) type	Numerator:	Administrative by-product
	Denominator:	Administrative by-product
Frequency of data source(s) collection	Numerator:	Annually
	Denominator:	Annually
Data development	Short-term:	-
	Medium-term:	• Methodology to collect multifaceted levels of service usage, such as intensity and complexity issues and the impact on contact duration, is needed in order to improve cost modelling and efficiency measurement in general. • Accurate reporting at levels above that of mental health service organisation requires unique state-wide patient identifiers that are not currently available in all jurisdictions.
	Long-term:	-

Construction of indicator from national data sets

Can the indicator be constructed accurately from currently available national datasets?	The indicator can be accurately constructed using the NMDS Community Mental Health Care.
If not, is there a proxy solution to construct the indicator from available national data?	Not applicable
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	Not applicable

MHS PI 7: Average cost per community treatment day

Rationale	• Efficient functioning of public community mental health services is critical to ensure that finite funds are used effectively to deliver maximum community benefit. • 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 judgments. • 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. • Nationally agreed definition of treatment episodes in the community have not yet been developed. In the meantime, community treatment day is used as valid intermediate product for comparing efficiency. Noting other options are available.
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee
Date last updated	28 August 2013

Indicator details

Description	Average cost per community treatment day provided by the organisation's ambulatory mental health care services.	
Numerator	Total of the mental health service organisation's recurrent expenditure on mental health ambulatory care services within the reference period.	
Denominator	Total number of community treatment days provided by the organisation's mental health ambulatory services within the reference period.	
Computation	Numerator ÷ Denominator	
Calculation conditions	Coverage/Scope:	All public mental health service organisations' ambulatory mental health care services.
	Methodology:	• Recurrent costs include costs directly attributable to the community treatment day plus a proportional share of overhead 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.
Definitions	• See glossary for further information regarding the following terms relevant to this indicator: – Treatment day	
Presentation	Number	
Disaggregation	• Service variables: Target population • Consumer attributes: Nil	
Notes	• Casemix adjustment is needed to interpret variation between organisations to distinguish consumer and provider factors. • Further development of national funding models, including episode-based or casemix models will enable more meaningful measurement. • There is a need for considerable development of costing within mental health (for example, the inclusion/exclusion of teaching and research expenditure, costing according to actual service use, etc.).	
Is specification interim or long-term?	Interim	
Reported in	-	

National Mental Health Performance Framework

Tier	Tier III – Health Service Performance			
Primary domain	Efficient			
Secondary domain(s)	-			
Mental health sub-domain	Community			
Type of measure	Process			
Level at which indicator can be useful	Service unit	☑	Mental Health Service Organisation	☑

MHS PI 7: Average cost per community treatment day		
for benchmarking	Regional group of services ☑	State/Territory ☑
Related national key performance indicators	MHS PI 6 - Average treatment days per three-month community care period	
Supplementary indicators	• Average contact hours per treatment day • Average number of contacts per treatment day	

Data collection details

Data source(s)	Numerator:	State/territory data as reported to National Minimum Data Set Mental Health Establishments.
	Denominator:	State/territory data as reported to National Minimum Data Set Community Mental Health Care.
Data source(s) type	Numerator:	Administrative by-product
	Denominator:	Administrative by-product
Frequency of data source(s) collection	Numerator:	Annually
	Denominator:	Annually
Data development	Short-term:	-
	Medium-term:	• Contact duration data is needed for a more sophisticated cost modelling methodology. • Methodology for casemix adjustment is required. • Accurate reporting at levels above that of mental health service organisation requires unique state-wide patient identifiers which are not currently available in all jurisdictions.
	Long-term:	-

Construction of indicator from national data sets

Can the indicator be constructed accurately from currently available national datasets?	This indicator can be accurately constructed using the NMDS Mental Health Establishments and NMDS Community Mental Health Care.
If not, is there a proxy solution to construct the indicator from available national data?	Not applicable.
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	Not applicable.

MHS PI 8: Proportion of population receiving clinical mental health care

Rationale	• The issue of unmet need has become prominent since the National Survey of Mental Health and Wellbeing indicated that a majority of people 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 have been echoed in the wider community. • Most jurisdictions have organised their mental health services to serve defined catchment populations, allowing comparisons of relative population coverage to be made between organisations.
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee
Date last updated	28 August 2013

Indicator details

Description	Percentage of consumers who reside in the mental health service organisation's defined catchment area who received care from a public sector mental health service (including inpatient, ambulatory and community residential).
Numerator	Number of consumers who reside in the defined catchment area who received services from the mental health service organisation's specialised mental health services within in the reference period.
Denominator	Number of consumers who reside in the defined mental health service organisation's catchment area within the reference period.
Computation	(Numerator ÷ Denominator) x 100
Calculation conditions	Coverage/Scope: All public mental health service organisations Methodology: • Requires a non-duplicated consumer count across all settings. • Statistical local area codes or postcodes recorded at time of community contact need to be mapped to mental health service organisation catchment population boundaries.
Definitions	• See glossary for further information regarding the following terms relevant to this indicator: – Consumer in receipt of services
Presentation	Percentage
Disaggregation	• Service variables: Nil • Consumer attributes: Age, SEIFA, remoteness, indigenous status
Notes	• As defined populations may receive services from organisations other than their catchment provider, this measure is not a 'pure' indicator of mental health service organisation performance but more about service utilisation by the population they serve. However, it is regarded as an important indicator to understand the overall relationship of the mental health service organisation in relation to its catchment population needs. • Resource allocation based on psychiatric epidemiology, associated morbidity and disability, mortality and socio-demographic factors is generally regarded as resulting in more equitable distribution of resources in relation to local need than funding strategies based on service-utilisation and population size alone. This indicator advances these concepts by creating scope in the future to compare expected treatment rates to actuals. • This measure does not consider the roles of primary mental health care or the specialist private mental health sector. While people who received care from specialist non-government organisations are not counted, it is expected that majority of these people will be captured by the activities of clinical services. • This measure may under report levels of service access in areas where persons are able to access public sector mental health services across jurisdictional boundaries.
Is specification interim or long-term?	Interim
Reported in	• COAG Reform Council reports on National Healthcare Agreement • National Mental Health Report

MHS PI 8: Proportion of population receiving clinical mental health care

	• Report on Government Services (Note – data reported using proxy solution refer to construction from national data sets section for more information)

National Mental Health Performance Framework

Tier	Tier III – Health Service Performance			
Primary domain	Accessible			
Secondary domain(s)	-			
Mental health sub-domain	Access for those in need			
Type of measure	Process			
Level at which indicator can be useful for benchmarking	Service unit	☐	Mental Health Service Organisation	☑
	Regional group of services	☑	State/Territory	☑
Related national key performance indicators	• MHS PI 9 - New client index • MHS PI 10 - Comparative area resources			
Supplementary indicators	• FTE per 100,000 population		• Proportion of consumers from catchment area receiving care outside local catchment	

Data collection details

Data source(s)	Numerator:	State/territory data as reported to National Minimum Data Sets - Community Mental Health Care, Admitted Patient Mental Health Care, Residential Mental Health Care.
	Denominator:	Australian Bureau of Statistics Estimated Resident Population
Data source(s) type	Numerator:	Administrative by-product
	Denominator:	Census-based
Frequency of data source(s) collection	Numerator:	Annually
	Denominator:	Annually
Data development	Short-term:	-
	Medium-term:	-
	Long-term:	Development of unique state-wide patient identifiers in all jurisdictions.

Construction of indicator from national data sets

Can the indicator be constructed accurately from currently available national datasets?	This indicator cannot be accurately constructed using the NMDS's because the data sets do not include unique patient identifiers that allow linkage across data sets.
If not, is there a proxy solution to construct the indicator from available national data?	A proxy solution is to use only the NMDS Community Mental Health Care, which is estimated to include more than 90% of all persons by public mental health services. The accuracy of this solution is limited by the fact that states and territories vary in the extent to which unique patient identifiers are available on a state-wide basis. Accurate construction of this indicator at a national level requires separate indicator data to be provided individually by states and territories.
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	Development of state-wide unique patient identifiers within all mental health NMDSs is needed to improve this capacity.

MHS PI 9: New client index

Rationale	• Access to services by persons requiring care is a key issue and there is concern that public mental health service system is inadequately responding to new people requiring care. • Existing population treatment rates (generally less than 1%) 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 consumers as they present.
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee
Date last updated	28 August 2013

Indicator details

Description	Percentage of new consumers under the care of the mental health service organisation's mental health services.
Numerator	Number of new consumers who received services from the mental health service organisation's specialised mental health services within the reference period.
Denominator	Number of consumers who received services from the mental health service organisation's specialised mental health services within the reference period.
Computation	(Numerator ÷ Denominator) x 100
Calculation conditions	Coverage/Scope: All public mental health service organisations. Methodology: • Tracking a consumer's service use back from the date of first contact in the reference period should be calculated as the five years preceding the date of first contact rather than on a calendar or financial year basis. • Consumer counts should be unique at the organisation level.
Definitions	• A new client is defined as a consumer who has not been seen in the five years preceding the first contact with the mental health service organisation in the reference period (inpatient, residential or community). • See glossary for further information regarding the following terms relevant to this indicator: – Consumer in receipt of services
Presentation	Percentage
Disaggregation	• Service variables: Setting, target population • Consumer attributes: Age, SEIFA, remoteness, indigenous status
Notes	• This indicator presents complexities at the analysis stage. For example, 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: Consumers new to a particular organisation may be existing consumers of other organisations. Counts of new consumers at the state/territory level would certainly yield lower estimates than those derived from organisation-level counts. – Diagnosis criteria for defining 'newness': A consumer may present with a new condition, although they have received previous treatment for a different condition. • To date, the approach has been 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 consumer and the possible implementation of unique state-wide patient identifiers within all jurisdictions. • This work does not take into account the activities of private mental health services, primary mental health care or the specialist private mental health sector.
Is specification interim or long-term?	Interim
Reported in	• Report on Government Services • National Mental Health Report

MHS PI 9: New client index

National Mental Health Performance Framework

Tier	Tier III – Health Service Performance			
Primary domain	Accessible			
Secondary domain(s)	-			
Mental health sub-domain	Access for those in need			
Type of measure	Process			
Level at which indicator can be useful for benchmarking	Service unit	☐	Mental Health Service Organisation	☑
	Regional group of services	☑	State/Territory	☑
Related national key performance indicators	MHS PI 8 - Population receiving care MHS PI 10 - Comparative area resources			
Supplementary indicators	• New client index (new to mental health care versus new episode)		• A measure of discharge (such as case closure or throughput index)	

Data collection details

Data source(s)	Numerator:	State/territory data as reported to National Minimum Data Set Community Mental Health Care, National Minimum Data Set Admitted Patient Mental Health Care and National Minimum Data Set Residential Mental Health Care
	Denominator:	State/territory data as reported to National Minimum Data Set Community Mental Health Care, National Minimum Data Set Admitted Patient Mental Health Care and National Minimum Data Set Residential Mental Health Care
Data source(s) type	Numerator:	Administrative by-product
	Denominator:	Administrative by-product
Frequency of data source(s) collection	Numerator:	Annually
	Denominator:	Annually
Data development	Short-term:	-
	Medium-term:	State-wide reporting requires unique patient identifiers not currently available in most jurisdictions.
	Long-term:	-

Construction of indicator from national data sets

Can the indicator be constructed accurately from currently available national datasets?	This indicator cannot be accurately constructed using the NMDSs because they do not include unique patient identifiers that allow links across data sets and financial reporting years.
If not, is there a proxy solution to construct the indicator from available national data?	There is no proxy solution available. Construction of this indicator at a national level requires separate indicator data to be provided individually by states and territories.
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	Development of state-wide unique patient identifiers within all mental health NMDSs is needed to improve this capacity.

MHS PI 10: Comparative area resources

Rationale	• Equity of access to mental health services is, in part, a function of differential level of resources allocated to area populations. • Review of comparative resource levels is essential for interpreting overall performance data, for example, an organisation may achieve relatively lower treatment rates because it has relatively less resources available rather than because it uses those resources inefficiently. • When used with measures of population under care this indicator may illustrate relative resourcing in terms local mental health service delivery and therefore accessibility by proxy.
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee
Date last updated	28 August 2013

Indicator details

Description	Per capita recurrent expenditure by the organisation on mental health services for the target population within the organisation's defined catchment area.	
Numerator	Recurrent expenditure on mental health services partitioned by mental health service setting.	
Denominator	Number of consumers who reside in the defined mental health service organisation's catchment area, partitioned by mental health service setting.	
Computation	Numerator ÷ Denominator Calculated separately for setting and target population.	
Calculation conditions	Coverage/Scope:	All public mental health service organisations. The following services are excluded: • Public sector mental health services that provide a cross regional or a state-wide specialist function.
	Methodology:	• Estimates of expenditure for defined population are based on expenditure reported by the mental health service organisation with specific catchment responsibility for the population, adjusted to remove any cross-regional and state-wide services included in the organisation's expenditure. • Defined populations should match with catchment areas of the mental health service organisations.
Definitions	• Recurrent costs include costs directly attributable to the unit(s) plus a proportional share of indirect costs. Cost data for this indicator is based on gross recurrent expenditure as compiled by Health Departments according to the specifications of the NMDS Mental Health Establishments. As such, it is subject to the concepts, definitions and costing methodology developed for the NMDS.	
Presentation	Number	
Disaggregation	• Service variables: Target population, service setting • Consumer attributes: 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.	
Is specification interim or long-term?	Long-term	
Reported in	-	

National Mental Health Performance Framework

Tier	Tier III – Health Service Performance
Primary domain	Accessible
Secondary domain(s)	Sustainable
Mental health sub-domain	Local access
Type of measure	Process

MHS PI 10: Comparative area resources				
Level at which indicator can be useful for benchmarking	Service unit		☐ Mental Health Service Organisation	☑
	Regional group of services		☑ State/Territory	☑
Related national key performance indicators	MHS PI 8 - Population receiving care MHS PI 9 - New client index			
Supplementary indicators	• FTE per 100,000 population		• Beds per 100,000 population	
Data collection details				
Data source(s)	Numerator:	State/territory data as reported to National Minimum Data Set Mental Health Establishments		
	Denominator:	Australian Bureau of Statistics Estimated Resident Population		
Data source(s) type	Numerator:	Administrative by-product		
	Denominator:	Census-based		
Frequency of data source(s) collection	Numerator:	Annually		
	Denominator:	Annually		
Data development	Short -term:	Population catchments for public mental health services to be defined.		
	Medium-term:	-		
	Long-term:	-		
Construction of indicator from national data sets				
Can the indicator be constructed accurately from currently available national datasets?	This indicator cannot be constructed using the NMDS Establishments because information about catchment areas is not available for all public mental health service organisations.			
If not, is there a proxy solution to construct the indicator from available national data?	There is no proxy solution available. To construct this indicator at a national level requires separate indicator data to be provided individually by states and territories.			
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	Catchment area data for all public mental health service organisations needs to be available to report this indicator from national sources.			

MHS PI 11: Rate of pre-admission community care

Rationale	• To monitor the continuity/accessibility of care via the extent to which public sector community mental health services are involved with consumers prior to the admission to hospital to: – support and alleviate distress during a period of great turmoil; – relieve carer burden; – avert hospital admission where possible; – ensure that admission is the most appropriate treatment option; – commence treatment of the patient as soon possible where admission may not be averted. • The majority of consumers admitted to public sector acute psychiatric inpatient units are known to public sector community mental health services and it is reasonable to expect community teams should be involved in pre-admission care.
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee
Date last updated	28 August 2013

Indicator details

Description	Proportion of admissions to the mental health service organisation's acute psychiatric inpatient unit(s) for which a community mental health service contact, in which the consumer participated, was recorded in the seven days immediately preceding that admission.	
Numerator	Number of in-scope admissions to the mental health service organisation's acute psychiatric inpatient unit(s) for which a public sector community mental health service contact in which the consumer participated, was recorded in the seven days immediately preceding that admission.	
Denominator	Number of admissions to the mental health service organisation's acute psychiatric inpatient unit(s).	
Computation	(Numerator ÷ Denominator) x 100	
Calculation conditions	Coverage/Scope:	All public mental health service organisations acute psychiatric inpatient units. The following admissions are excluded: • Same day admissions; • Statistical and change of care type admissions; • Admissions by transfer from another acute or psychiatric inpatient hospital; • Admissions by transfer from community residential mental health services. • Separations where length of stay is one night only and procedure code for ECT is recorded; The following community service contacts are excluded: • Service contacts on day of admission. • Contacts where a consumer does not participate.
	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. • For the purpose of this indicator, when a mental health service organisation has more than one unit of a particular admitted patient care program, those units should be combined. • The categorisation of the admitted patient unit is based on the principal purpose(s) of the admitted patient care program rather than the classification of individual consumers. • One of the following ECT procedure codes are recorded: – ACHI 5th edition (2006–2008) use ICD-10 procedure codes 93340-02 and 93340-43. – ACHI 6th and 7th editions (2008 to current) use ICD-10 procedure codes 93341-00 to 93341-99. – ACHI 5th, 6th and 7th editions (2006 to current) Electroconvulsive therapy Block 1907 may be selected to capture all data regardless of code changes over time.

MHS PI 11: Rate of pre-admission community care

Definitions	• See glossary for further information regarding the following term/s relevant to this indicator: – Acute psychiatric inpatient units – Mental health service contact – Same day admissions.
Presentation	Percentage
Disaggregation	• Service variables: Target population • Consumer attributes: Age, SEIFA, remoteness, indigenous status
Notes	• The reliability of this indicator is dependent on the implementation of state-wide unique patient identifiers as the community services may not necessarily be delivered by the same mental health service organisation that admits the consumer to hospital care. Access to state-wide data is required to construct this indicator accurately. • When reported at an individual service or catchment level, interpretation of this indicator needs to consider that catchment areas for inpatient and ambulatory services may differ. • This measure does not consider variations in intensity or frequency of contacts prior to admission to hospital. • This measure does not distinguish qualitative differences between phone and face-to-face community contacts.
Is specification interim or long-term?	Long-term
Reported in	National Mental Health Report

National Mental Health Performance Framework

Tier	Tier III – Health System Performance			
Primary domain	Continuous			
Secondary domain(s)	Accessible			
Mental health sub-domain	Cross-setting continuity			
Type of measure	Process			
Level at which indicator can be useful for benchmarking	Service unit	☑	Mental Health Service Organisation	☑
	Regional group of services	☑	State/Territory	☑
Related national key performance indicators	• MHS PI 2 - 28-day readmission rate • MHS PI 4 - Average length of acute inpatient stay • MHS PI 12 - Post-discharge community care			
Supplementary indicators	• Bed occupancy			

Data collection details

Data source(s)	Numerator:	State/territory data as reported to National Minimum Data Set Admitted Patient and Community Mental Health Care.
	Denominator:	State/territory data as reported to National Minimum Data Set Admitted Patient Mental Health Care.
Data source(s) type	Numerator:	Administrative by-product
	Denominator:	Administrative by-product
Frequency of data source(s) collection	Numerator:	Annually
	Denominator:	Annually
Data development	Short-term:	-
	Medium-term:	-
	Long-term:	Full implementation of this measure requires unique state-wide patient identifiers not currently available in all jurisdictions.

Construction of indicator from national data sets

Can the indicator be constructed accurately from currently available national datasets?	This indicator cannot be accurately constructed using the NMDS Admitted Patient and NMDS Community Mental Health Care because they do not share a common unique identifier that would allow persons admitted to hospital to be tracked in the community services data. Additionally, states and territories vary in the extent to which state-wide

MHS PI 11: Rate of pre-admission community care	
	unique identifiers are in place to that would allow accurate tracking of persons who are seen by multiple organisations.
If not, is there a proxy solution to construct the indicator from available national data?	There is no proxy solution available. To construct this indicator at a national level requires separate indicator data to be provided individually by states and territories.
What needs to be done in the longer term to allow this indicator to be constructed from national datasets?	Development of a system of state-wide unique patient identifiers within all mental health NMDSs is needed to improve this capacity.

MHS PI 12: Rate of post-discharge community care

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. • Consumers 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 consumers have increased vulnerability immediately following discharge, including higher risk for suicide.	
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee	
Date last updated	28 August 2013	
Indicator details		
Description	Proportion of separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a community mental health service contact, in which the consumer participated, was recorded in the seven days following that separation.	
Numerator	Number of in-scope separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a public sector community mental health service contact in which the consumer participated, was recorded in the seven days following that separation.	
Denominator	Number of in-scope separations for the mental health service organisation's acute psychiatric inpatient unit(s).	
Computation	(Numerator ÷ Denominator) x 100	
Calculation conditions	Coverage/Scope:	All public mental health service organisations acute psychiatric inpatient units. The following separations are excluded: • Same day separations; • Statistical and change of care type separations; • Separations that end by transfer to another acute or psychiatric hospital; • Separations that end by death, left against medical advice/discharge at own risk; • Separations where length of stay is one night only and procedure code for ECT is recorded; • Separations that end by transfer to community residential mental health services. The following community service contacts are excluded: • Community service contacts on day of separation. • Contacts where a consumer does not participate.
	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. • For the purpose of this indicator, when a mental health service organisation has more than one unit of a particular admitted patient care program, those units should be combined. • The categorisation of the admitted patient unit is based on the principal purpose(s) of the admitted patient care program rather than the classification of individual consumers. • One of the following ECT procedure codes are recorded: – ACHI 5th edition (2006–2008) use ICD-10 procedure codes 93340-02 and 93340-43. – ACHI 6th and 7th editions (2008 to current) use ICD-10 procedure codes 93341-00 to 93341-99. – ACHI 5th, 6th and 7th editions (2006 to current)

MHS PI 12: Rate of post-discharge community care

	Electroconvulsive therapy Block 1907 may be selected to capture all data regardless of code changes over time.
Definitions	• See glossary for further information regarding the following term/s relevant to this indicator: – Acute psychiatric inpatient units – Mental health service contact – Same day separations.
Presentation	Percentage
Disaggregation	• Service variables: Target population • Consumer attributes: Age, SEIFA, remoteness, indigenous status
Notes	• The reliability of this indicator is dependent on the implementation of state-wide unique patient identifiers as the community services may not necessarily be delivered by the same mental health service organisation that discharges the consumer from hospital care. Access to state-wide data is required to construct this indicator accurately. • When reported at an individual service or catchment level, interpretation of this indicator needs to consider that catchment areas for inpatient and ambulatory services may differ. Ideally services should implement processes to ensure a shared responsibility for following up with consumers who reside out of area. • This measure does not consider variations in intensity or frequency of service contacts following discharge from hospital. • This measure does not distinguish qualitative differences between phone and face-to-face community contacts.
Is specification interim or long-term?	Long-term
Reported in	• COAG Reform Council reports on National Healthcare Agreement • National Mental Health Report • Report on Government Services

National Mental Health Performance Framework

Tier	Tier III – Health System Performance			
Primary domain	Continuous			
Secondary domain(s)	Accessible and Safe			
Mental health sub-domain	Cross-setting continuity			
Type of measure	Process			
Level at which indicator can be useful for benchmarking	Service unit	☑	Mental Health Service Organisation	☑
	Regional group of services	☑	State/Territory	☑
Related national key performance indicators	• MHS PI 2 - 28-day readmission rate • MHS PI 4 - Average length of acute inpatient stay • MHS PI 11 - Pre-admission community care			
Supplementary indicators	• Bed occupancy		• Referral destination	

Data collection details

Data source(s)	Numerator:	State/territory data as reported to National Minimum Data Set Admitted Patient and Community Mental Health Care
	Denominator:	State/territory data as reported to National Minimum Data Set Admitted Patient Mental Health Care
Data source(s) type	Numerator:	Administrative by-product
	Denominator:	Administrative by-product
Frequency of data source(s) collection	Numerator:	Annually
	Denominator:	Annually
Data development	Short-term:	-
	Medium-term:	-

MHS PI 12: Rate of post-discharge community care		
	Long-term:	Full implementation of this measure requires unique state-wide patient identifiers not currently available in all jurisdictions.
Construction of indicator from national data sets		
Can the indicator be constructed accurately from currently available national datasets?	This indicator cannot be accurately constructed using the NMDS Admitted Patient and NMDS Community Mental Health Care because they do not share a common unique identifier to allow persons admitted into hospital to be tracked in the community services data. Additionally, states and territories vary in the extent to which state-wide unique identifiers are in place to allow accurate tracking of persons who are seen by multiple organisations.	
If not, is there a proxy solution to construct the indicator from available national data?	There is no proxy solution available. To construct this indicator at a national level requires separate indicator data to be provided individually by states and territories.	
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	Development of a system of state-wide unique patient identifiers within all mental health NMDSs is needed to improve this capacity.	

MHS PI 13: Consumer outcomes participation

Rationale	• A key goal of the National Mental Health Strategy is for consumers and carers to be actively involved in treatment planning, decision making, and definition of treatment objectives. Consumer self-assessment outcome measures provide one mechanism for achieving this goal. • Self-assessment measures provide useful information about how well consumers feel they are able to cope with their usual activities and are an opportunity for consumers, carers and clinicians to track progress through comparison of ratings over time. • Offering a self-assessment measure can be useful for engagement as well as collaboration between consumers, carers and clinicians and can enrich treatment and care planning. • Obtaining a consumer self-assessment measure requires mental health services to have an adequate degree of engagement (both clinically and organisationally) with consumers to facilitate this process.	
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee	
Date last updated	28 August 2013	
Indicator details		
Description	Proportion of episodes of ambulatory mental health care with completed consumer outcome measures.	
Numerator	Number of in-scope episodes of ambulatory mental health care with completed consumer self-assessment outcome measures.	
Denominator	Number of in-scope episodes of ambulatory mental health care in the reference period.	
Computation	(Numerator ÷ Denominator) x 100	
Calculation conditions	Coverage/Scope:	All public community mental health service organisations. The following episodes (and related outcomes measures) are excluded: • Brief ambulatory care episodes.
	Methodology:	• Consumer self-assessment measures that are specific to each jurisdiction need to be considered in the construction of this indicator, that is, Mental Health Inventory (MHI), Behaviour and System Identification Scale (BASIS-32) and Kessler-10-Plus (K10+). • Only the following versions of the Strengths and Difficulties Questionnaire (SDQ) are to be considered in the construction of this indicator: – The *parent-rated* version for children aged 4–10 years; – Either the *parent-rated* version and/or the *self-report* version for adolescents aged 11–17 years. • Non-mandated measures (such as the teacher-version of the SDQ) should not be considered in the construction of this indicator. • All completed returns (of mandated measures) are to be considered in the construction of the numerator. For example, if both a parent-rated version and self-report version of the SDQ is received this would count as two completed outcome measures.
Definitions	• 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. • See glossary for further information regarding the following term/s relevant to this indicator: – Brief ambulatory care episodes.	
Presentation	Percentage	
Disaggregation	• Service variables: Target population • Consumer variables: Age	

MHS PI 13: 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. • 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.			
Is specification interim or long-term?	Long-term			
Reported in	-			

National Mental Health Performance Framework

Tier	Tier III – Health System Performance			
Primary domain	Responsive			
Secondary domain(s)	Capable			
Mental health sub-domain	Consumer and carer participation			
Type of measure	Process			
Level at which indicator can be useful for benchmarking	Service unit	☑	Mental Health Service Organisation	☑
	Regional group of services	☑	State/Territory	☑
Related national key performance indicators	MHS PI 14 - Outcomes readiness			
Supplementary indicators	-			

Data collection details

Data source(s)	Numerator:	State/territory data as reported to National Outcomes and Casemix Collection
	Denominator:	State/territory data as reported to National Minimum Data Set Community Mental Health Care
Data source(s) type	Numerator:	Clinical outcome measures
	Denominator:	Administrative by-product
Frequency of data source(s) collection	Numerator:	Annually
	Denominator:	Annually
Data development	Short-term:	-
	Medium-term:	-
	Long-term:	-

Construction of indicator from national data sets

Can the indicator be constructed accurately from currently available national datasets?	This indicator cannot be constructed, as estimates of the total number of episodes requiring outcome measures are not provided directly to the National Outcomes and Classification Collection.
If not, is there a proxy solution to construct the indicator from available national data?	A proxy solution is to use estimates from the NMDS Community Mental Health Care.
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	Longer term, a process is needed that allows data reported to the national collection for consumers who begin an episode in a given year to be tracked when the episode continues into subsequent years. Work is underway to build in an episode identifier into the NOCC to enable this. Additionally, consistent, cross-year use of service identifiers and unique identifiers for consumers by states and territories is necessary to enable full capacity to construct this indicator using the NOCC.

MHS PI 14: Outcomes readiness

Rationale	• Capable services are results oriented and regularly monitor consumer outcomes. • All states and territories have committed to routinely measuring public sector mental health service outcomes. • Sufficient coverage of outcome measures will enable a standard where information can be effectively used and interpreted to inform and improve clinical practice and service delivery.	
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee	
Date last updated	28 August 2013	
Indicator details		
Description	Proportion of mental health care episodes with completed clinical outcome measures at both baseline and follow-up.	
Numerator	Number of in-scope episodes of mental health care with completed outcome measures at both baseline and follow-up within the reference period.	
Denominator	Number of in-scope episodes of mental health care within the reference period.	
Computation	(Numerator ÷ Denominator) x 100 Calculated separately for each group.	
Calculation conditions	Coverage/Scope:	All public mental health service organisations. Only the HoNOS family is considered. The following episodes of mental health care (and related outcomes measures) are excluded: • Brief ambulatory episodes of mental health care; • Brief inpatient episodes of mental health care. The following services are excluded: • Australian Government funded aged residential services.
	Methodology:	Outcomes readiness is calculated for the following consumer groups: – **Group A: Consumers discharged from hospital** All people who were discharged from an acute psychiatric inpatient unit within the reference period, with a completed clinical outcome measure collected at both admission (the 'baseline') and discharge (the 'follow-up'). – **Group B: Consumers discharged from ambulatory care** All people who were discharged from an ambulatory care episode within the reference period, with a completed clinical outcome measure collected at both admission (the 'baseline') and discharge (the 'follow-up'). Ambulatory episodes that are completed because the consumer was admitted to hospital or residential mental health care must be excluded from the analysis (that is, where the National Outcomes Casemix Collection (NOCC) 'reason for collection' equals change of setting). – **Group C: Consumers in ongoing ambulatory care** All people who have an 'open' ambulatory episode of mental health care at the end of reference period, where there is a completed clinical outcome measure collected at both the first occasion rated within the reference period, which will be either an admission or review (the 'baseline'), and the last occasion rated, which will be a review (the 'follow-up'), in the same reference period. – **Group D: Consumers discharged from residential mental health care** All people who were discharged from a residential mental health service unit within the reference period, excluding statistical separations, with a completed clinical outcome measure collected at both admission (the 'baseline') and discharge (the 'follow-up').
Definitions	• For purposes of this indicator, a completed clinical outcome measure is defined as one where the number of items completed is consistent with that provided in 95% of	

MHS PI 14: Outcomes readiness

	assessments. Translated to individual rating scales this would mean: – For the HoNOS/65+, a minimum of 10 of the 12 items – For the HoNOSCA, a minimum of 11 of the first 13 items • See glossary for further information regarding the following term/s relevant to this indicator: – Brief ambulatory episodes of mental health care; – Brief inpatient episodes of mental health care; – Discharge; – Episode of mental health care. – Open episode of mental health care.
Presentation	Percentage
Disaggregation	• Service variable: Setting and target population • Consumer variables: Age
Notes	-
Is specification interim or long-term?	Interim
Reported in	Report on Government Services (Note – data reported using proxy solution refer to Construction from National Data Sets section for more information.)

National Mental Health Performance Framework

Tier	Tier III – Health System Performance			
Primary domain	Capable			
Secondary domain(s)	-			
Mental health sub-domain	Outcomes orientation			
Type of measure	Process			
Level at which indicator can be useful for benchmarking	Service unit	☑	Mental Health Service Organisation	☑
	Regional group of services	☑	State/Territory	☑
Related national key performance indicators	MHS PI 1 – Change in consumers' clinical outcomes MHS PI 13 - Consumer outcomes participation			
Supplementary indicators	-			

Data collection details

Data source(s)	Numerator:	State/territory data as reported to National Outcomes and Casemix Collection
	Denominator:	State/territory data as reported to National Minimum Data Set Community Mental Health Care, National Minimum Data Set Admitted Patient Mental Health Care and National Minimum Data Set Community Residential Mental Health Care
Data source(s) type	Numerator:	Clinical outcome measures
	Denominator:	Administrative by-product
Frequency of data source(s) collection	Numerator:	Annually
	Denominator:	Annually
Data development	Short-term:	-
	Medium-term:	Further definition of a 'completed clinical outcome measure' to resolve whether tolerance levels will be set to accept some degree of missing data also needs to be developed.
	Long-term:	-

Construction of indicator from national data sets

Can the indicator be constructed accurately from currently available national datasets?	Estimates of the total number of episodes requiring outcomes assessment is not provided directly to the National Outcomes and Classification Collection, however this can be approximated from the NMDS (Community Mental Health Care, Admitted Patient Mental Health Care and Residential Mental Health Care).

MHS PI 14: Outcomes readiness	
If not, is there a proxy solution to construct the indicator from available national data?	A proxy solution is to use estimates from the NMDS (Community Mental Health Care, Admitted Patient Mental Health Care and Residential Mental Health Care).
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	Longer term, a process is needed that allows data reported to the NOCC for consumers who begin an episode in a given year to be tracked when the episode continues into subsequent years. Work is underway to build in an episode identifier into the NOCC and NMDS Community Mental Health Care to enable this. Additionally, consistent, cross-year use of service identifiers and unique identifiers for consumers by states and territories is necessary to enable full capacity to construct this indicator using the NOCC.

MHS PI 15: Rate of seclusion	
Rationale	• The reduction, and where possible, elimination of seclusion in mental health services has been identified as a priority in the publication *National safety priorities in mental health: a national plan for reducing harm*[11]. • High levels of seclusion are widely regarded as inappropriate treatment, and may point to inadequacies in the functioning of the overall systems and risks to the safety of consumers receiving mental health care. • The use of seclusion in public sector mental health service organisations is regulated under legislation and/or policy of each jurisdiction.
Endorsement status	Endorsed by AHMAC Mental Health, Drug and Alcohol Principal Committee
Date last updated	28 August 2013
Indicator details	
Description	Number of seclusion events per 1,000 patient days within a mental health service organisation.
Numerator	Number of seclusion events occurring in the mental health service organisation's inpatient unit(s) during the reference period, partitioned by acute and non-acute inpatient mental health services.
Denominator	Number of accrued mental health care days within the mental health service organisation's inpatient unit(s) during the reference period, partitioned by acute and non-acute inpatient mental health services.
Computation	(Numerator ÷ Denominator) x 1,000
Calculation conditions	Coverage/Scope: • All public mental health service organisations admitted patient services. • Services where seclusion is not an authorised practice under relevant mental health legislation and/or policy (such as non-gazetted admitted patient units that are not authorised to admit consumers on an involuntary basis) should be excluded (from numerator and denominator). Methodology: • This indicator is to be partitioned by the program type (i.e. acute and non-acute inpatient). Consequently, there would be two potential scores for this indicator. This partitioning will enable appropriate interpretation of the indicator and concept and facilitate accurate and targeted action to reduce the use of seclusion in mental health services. • Leave days should be excluded from the construction of the denominator. • For the purpose of this indicator, when a mental health service organisation has more than one unit of a particular admitted patient care program, those units should be combined.
Definitions	• See glossary for further information regarding the following term/s relevant to this indicator: – Accrued mental health care days – Seclusion – Seclusion event
Presentation	Rate
Disaggregation	• Service variables: Target population, program type • Consumer attributes: Age, SEIFA, remoteness, indigenous status
Notes	• The use of seclusion is governed by either legislation (a Mental Health Act or equivalent) or mandatory policy within each state and Territory. The definitions used within the legislation and policies vary slightly between jurisdictions. These variations should be recognised in the interpretation of the indicator. • 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 an organisation's performance in relation to seclusion use and management.

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

MHS PI 15: Rate of seclusion					
	However, the capacity to collect information regarding duration of seclusion episodes varies substantially across jurisdictions. Work continues at a national level that will facilitate the development of a meaningful indicator of duration as it is likely to be easily skewed by outliers.				
Is specification interim or long-term?	Long-term				
Reported in	-				
National Mental Health Performance Framework					
Tier	Tier III – Health system Performance				
Primary domain	Safety				
Secondary domain(s)	Appropriateness				
Mental health sub-domain	Consumer				
Type of measure	Outcome				
Level at which indicator can be useful for benchmarking	Service unit	☑	Mental Health Service Organisation	☑	
	Regional group of services	☑	State/Territory	☑	
Related national key performance indicators	-				
Supplementary indicators	• Proportion of separations in which a seclusion event occurred				
Data collection details					
Data source(s)	Numerator:	State/territory seclusion registers or relevant information systems			
	Denominator:	State/territory data as reported to National Minimum Data Set Admitted Patient Mental Health Care			
Data source(s) type	Numerator:	Register			
	Denominator:	Administrative by-product			
Frequency of data source(s) collection	Numerator:	Annually			
	Denominator:	Annually			
Data development	Short-term:	• Work is required to improve the quality of reporting in seclusion registers and/or relevant information systems to facilitate reporting. • Work is required to scope the actual legislative and/or policy differences in jurisdictional definitions of seclusion.			
	Medium-term:	-			
	Long-term:	-			
Construction of indicator from national data sets					
Can the indicator be constructed accurately from currently available national datasets?	There are no relevant data sets at the national level. Seclusion data is not reported at the national level although patient days can be collected from either the Admitted Patient or Mental Health Establishments National Minimum Data Set.				
If not, is there a proxy solution to construct the indicator from available national data?	No proxy solution is available. To construct this indicator at a national level requires separate indicator data to be provided individually by states and territories.				
What needs to be done in the longer term to allow this indicator to be constructed from national dataset?	National collection of seclusion data needs to be established through amendments to the NMDS processes.				

6. Appendices

6.1 Major changes to the national indicators over time

Mental Health Services Key Performance Indicators		First Edition 2004	Second Edition 2011	Third Edition 2013
MHSPI 1:	Change in consumers' clinical outcomes	n.a.	• Added to national indicator set	• Addition of discharged from residential mental health care group
MHS PI 2:	28 day readmission rate	• Included in national indicator set	• Removal of 'unplanned' from description	• Addition of exclusion of overnight ECT episodes
MHS PI 3:	National Service Standards compliance	• Included in national indicator set	• Editorial only	• Exclusion of expenditure related to MHE Code 8
MHS PI 4:	Average length of acute inpatient stay	• Included in national indicator set	• Removal of exclusion of incomplete episodes (defined as commenced prior to the reference period) • Exclusion of forensic services	• Editorial only
MHS PI 5:	Average cost per acute admitted patient day	n.a.	n.a.	• Replaced average cost per acute admitted episode
MHS PI 6:	Average treatment days per three month community care period	• Included in national indicator set	• Exclusion of activity related to non-uniquely identified consumers.	• Editorial only
MHS PI 7:	Average cost per community treatment day	n.a.	n.a.	• Replaced average cost per 3 month community care period
MHS PI 8:	Proportion of population receiving clinical mental health care	• Included in national indicator set	• Scope modified to consider contact with ambulatory mental health services only	• Scope modified to re-include contact with all settings
MHS PI 9:	New client index	• Included in national indicator set	• 'New' defined as preceding five years	• Editorial only
MHS PI 10:	Comparative area resources	• Included in national indicator set	• Addition of partitioning requirement for setting	• Editorial only
MHS PI 11:	Rate of pre-admission community care	• Included in national indicator set	• Editorial only	• Modified to consider only service contacts where the consumer participated • Clarification of exclusion of transfers from residential mental health care facilities • Addition of exclusion of overnight ECT episodes

Mental Health Services Key Performance Indicators	First Edition 2004	Second Edition 2011	Third Edition 2013
MHS PI 12: Rate of post-discharge community care	• Included in national indicator set	• Modified to consider only service contacts where the consumer participated	• Clarification of exclusion of transfers to residential mental health care facilities • Addition of exclusion of overnight ECT episodes
MHS PI 13: Consumer outcomes participation	n.a.	• Added to national indicator set	• Removal of exclusions relating to Consultation Liaison and death • Modification of scope to exclude brief ambulatory episodes of mental health care
MHS PI 14: Outcomes readiness	• Included in national indicator set	• Exclusion of consumer self-assessment measures from calculation	• Removal of exclusions relating to Consultation Liaison and death • Refinement of indicator to focus only on collection of HoNOS • Stratifies collection within specified groups
MHS PI 15: Rate of seclusion	n.a.	• Added to national indicator set	• Editorial only
Local access to acute inpatient care	• Included in national indicator set	• Removed from national indicator set	n.a.
Average cost per acute inpatient episode	• Included in national indicator set	• Removal of exclusion of incomplete episodes (defined as commenced prior to the reference period) • Exclusion of forensic services	• Replaced by average cost per acute admitted patient day (MHS PI 5)
Average cost per 3 month community care period	• Included in national indicator set	• Exclusion of activity related to non-uniquely identified consumers.	• Replaced by average cost per community treatment day (MHS PI 7)

6.2 Glossary of key technical terms and concepts

Term/concept	Definition	Source
Accrued mental health care day	The total accrued number of mental health care days provided by admitted patient care services and residential mental health care services within the reference period.	http://meteor.aihw.gov.au/content/index.phtml/itemId/286770
Acute psychiatric units	Acute units are those primarily providing specialist psychiatric care for people with acute episodes of mental disorder. These episodes are characterised by recent onset of severe clinical symptoms of mental disorder that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that this treatment effort is focused on short-term treatment. Acute services may be focused on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing mental disorder for whom there has been an acute exacerbation of symptoms.	http://meteor.aihw.gov.au/content/index.phtml/itemId/288889
Admission	Admission is the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical. *Formal admission:* The administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient. *Statistical admission:* The administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay.	http://meteor.aihw.gov.au/content/index.phtml/itemId/327206
Ambulatory care	An ambulatory mental health care service is a specialised mental health service that provides services to people who are not currently admitted to a mental health admitted or residential service. Services are delivered by health professionals with specialist mental health qualifications or training.	http://meteor.aihw.gov.au/content/index.phtml/itemId/409081
Brief ambulatory episode of mental health care	Episodes of community mental health care that are 14 days or less between first and last service contact date.	
Brief inpatient episode of mental health care	Episodes of mental health care provided to a consumer who is admitted for a period of three days or less.	http://amhocn.org/static/files/assets/16e7c0ab/NOCC-1x6-tech-spec-endorsed-20090213.pdf
Carer	A carer is defined as a person who has a caring role for a person with a mental health problem or mental illness. They could be family, friends or staff and be paid or unpaid. The role of the carer is not necessarily static or permanent and may vary over time according to the needs of the consumer and carer.	Fourth National Mental Health Plan http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-f-plan09
Consumer	A consumer is a person who uses or has used a mental health service.	Fourth National Mental Health Plan http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-f-plan09
Consumer in receipt of services	Consumers in receipt of services include all persons who received one or more community mental health service contacts or had one or more days of admitted or residential care in the reference period.	

Term/concept	Definition	Source
Discharge	This refers to the end of an inpatient, ambulatory or community residential episode of mental health care. Episodes may end for a number of reasons such as discharge from an inpatient unit, case closure of a consumer's community care, admission to hospital of a consumer previously under community care. Regardless of the reason, the end of an episode acts as a 'trigger' for a specific set of clinical data to be collected. Discharge' is not formally defined in the National Health Data Dictionary, which uses instead the term 'separation' defined as 'the process by which an episode of care for an admitted patient ceases.' The NOCC protocol uses the term 'discharge' by preference as a generic term to cover the completion of episodes across all treatment settings.	http://amhocn.org/static/files/assets/16e7c0ab/NOCC-1x6-tech-spec-endorsed-20090213.pdf
Effect size	A statistic used to assess the magnitude of a treatment effect. It is based on the ratio of the difference between the baseline and follow-up scores to the standard deviation of the baseline score. As a rule of thumb, effect sizes of 0.2 are considered small, 0.5 considered medium and 0.8 considered large. Full technical details regarding the effect size statistic calculation are documented in *Key Performance Indicators for Australian Public Mental Health Services: Modelling Candidate Indicators of Effectiveness*. The standard deviations of the admission collection occasion (baseline) scores on the HoNOS family of measures are reported in the web-based Decision Support Tool (wDST).	http://amhocn.org/analysis-reporting/publications#a_259 http://wdst.amhocn.org/
Episode of mental health care	A more or less continuous period of contact between a consumer and a Mental Health Service Organisation that occurs within the one Mental Health Service Setting. Episodes of Care may be brief or prolonged, and may be provided in three settings – inpatient, ambulatory or residential. Under the National Outcomes and Casemix Collection protocol, a consumer may be in only one episode of mental health care at any one time.	National Outcomes and Casemix Collection Technical Specifications, v1.6 http://amhocn.org/data-bureau/technical-specifications
Health of the Nation Outcome Scales	A clinical assessment of psychiatric symptoms and psychosocial functioning. The Health of the Nation Outcome Scales (HoNOS) family consists of: • HoNOS • HoNOS 65+ (Older Persons) • HoNOSCA (Children and adolescents)	http://meteor.aihw.gov.au/content/index.phtml/itemId/495880
Mental health service contact	The provision of a clinically significant service by a specialised mental health service provider(s) for patients/clients, other than those patients/clients admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24 hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question	http://meteor.aihw.gov.au/content/index.phtml/itemId/493304
Mental health service organisation	Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.	http://meteor.aihw.gov.au/content/index.phtml/itemId/268984

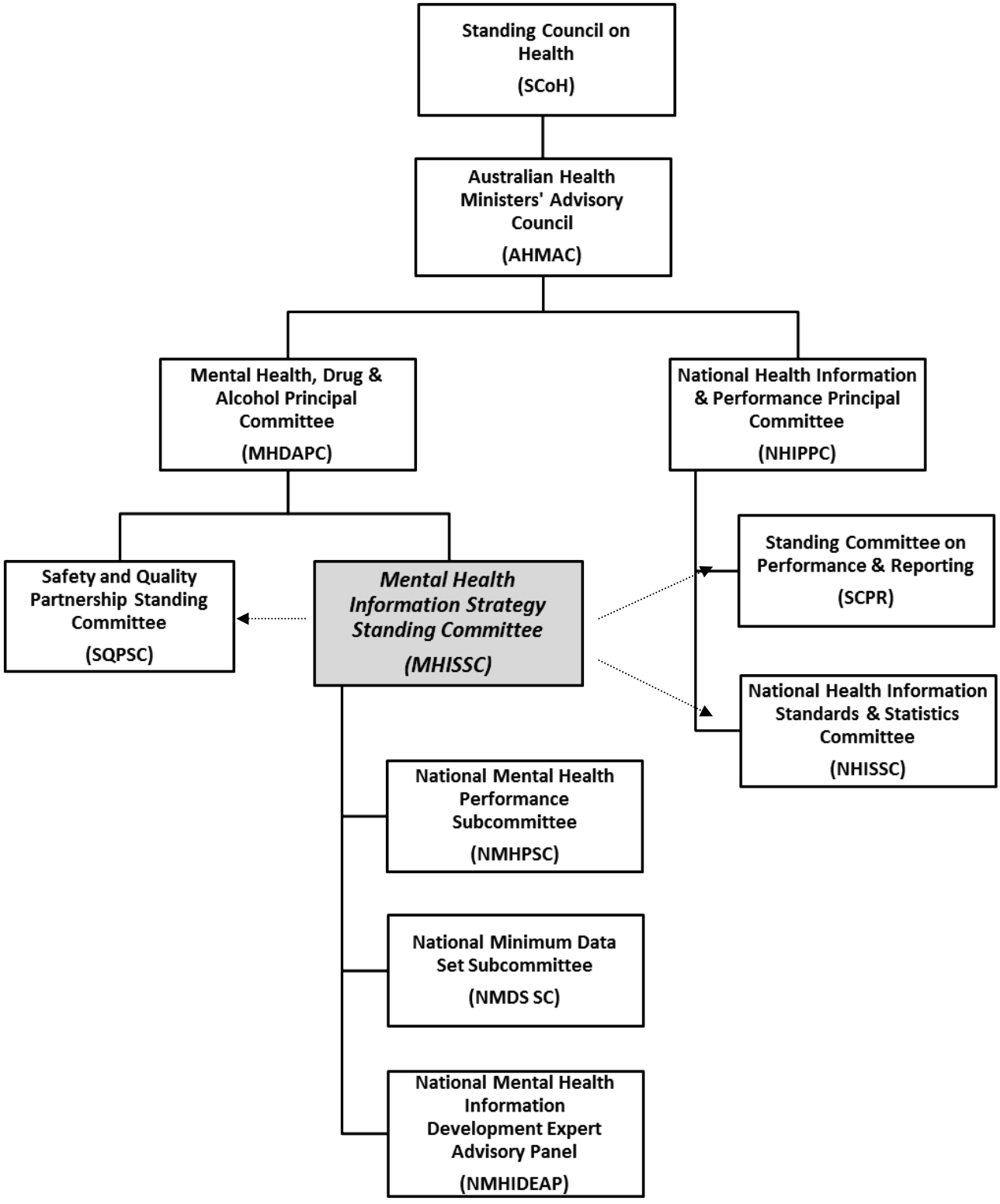
Term/concept	Definition	Source
National Standards for Mental Health Services (levels)	Level 1: The service unit had been reviewed by an external accreditation agency and was judged to have met the national standards. Level 2: The service unit had been reviewed by an external accreditation agency and was judged to have met some but not all of the national standards. Level 3: The service unit was in the process of being reviewed by an external accreditation agency but the outcomes were not known. 4: The service unit was booked for review by an external accreditation agency and was engaged in self-assessment preparation prior to the formal external review. 5: The service unit was engaged in self-assessment in relation to the national standards but did not have a contractual arrangement with an external accreditation agency for review. 6: The service unit had not commenced the preparations for review by an external accreditation agency but this was intended to be undertaken in the future. 7: It had not been resolved whether the service unit would undertake review by an external accreditation agency under the national standards. 8: The national standards are not applicable to this service unit.	http://meteor.aihw.gov.au/content/index.phtml/itemId/287800
Non-uniquely identifiable consumers	Service contacts for which a unique person identifier was not recorded.	
Open episode of mental health care	This refers to episode of mental health care that commenced either during or prior to the reference period but was not ended prior to the end of the reference period.	
Provider	A provider is defined as a paid or unpaid employee, contractor or volunteer of a mental health service.	
Same day admissions / separations	Inpatient episodes where the admission and separation dates are the same.	
Seclusion	The confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. **Key elements**: 1. The consumer is alone 2. The seclusion applies at any time of the day or night 3. Duration is not relevant in determining what is or is not seclusion 4. The consumer cannot leave of their own accord **Implications**: 1. The intended purpose of the confinement is not relevant in determining what is or is not seclusion 2. Seclusion applies even if the consumer agrees or requests the confinement 3. The awareness of the consumer that they are confined alone and denied exit is not relevant in determining what is or is not seclusion 4. The structure and dimensions of the area to which the consumer is confined is not relevant in determining what is or is not seclusion. The area may be an open area (e.g. courtyard) 5. "Seclusion does not include confinement of consumers to High Dependency sections of gazetted	Definitions, principles and protocols relating to the use of seclusion in mental health services developed by Safety Quality and Partnership Standing Committee are available at www.health.gov.au/internet/mhsc.

Term/concept	Definition	Source
	mental health units, unless it meets the local legislative definition" **Exceptions:** Any exceptions that are specified in relevant jurisdictional legislation	
Seclusion event	Refers to when a consumer enters seclusion and 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 used to differentiate it from the different definitions of 'seclusion episode' used across jurisdictions	Definitions, principles and protocols relating to the use of seclusion in mental health services developed by Safety Quality and Partnership Standing Committee are available at www.health.gov.au/internet/mhsc.
Separations	Separation is the process by which an episode of care for an admitted patient ceases. A separation may be formal or statistical. *Formal separation:* The administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient. *Statistical separation:* The administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay	http://meteor.aihw.gov.au/content/index.phtml/itemId/327268
Target population	The population group primarily targeted by a specialised mental health service.	http://meteor.aihw.gov.au/content/index.phtml/itemId/493010
Treatment day	Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a consumer during an ambulatory care episode.	

6.3 List of frequently used abbreviations

ABF	Activity Based Funding
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AIHW	Australian Institute of Health and Welfare
AMHOCN	Australian Mental Health Outcomes Classification Network
COAG	Council of Australian Government
DoHA	Department of Health and Ageing
DALE	Disability Adjusted Life Expectancy
HoNOS	Health of the Nation Outcome Scales
HoNOS 65+	HoNOS 65 years and over
HoNOS family of measures	Includes the HoNOS, HoNOSCA and HoNOS 65+
HoNOSCA	HoNOS Child and Adolescents
KPI	Key Performance Indicators
MHDAPC	Mental Health, Drug and Alcohol Principal Committee
MHE	Mental Health Establishments
MHISSC	Mental Health Information Strategy Standing Committee
MHSO	Mental Health Service Organisation
NHA	National Healthcare Agreement
NHPF	National Health Performance Framework
NMHIDEAP	National Mental Health Information Development Expert Advisory Panel
NMHPF	National Mental Health Performance Framework
NMHPSC	National Mental Health Performance Subcommittee
NMDS	National Minimum Data Set
NOCC	National Outcomes and Casemix Collection
RoGS	Report on Government Services
SCRGSP	Steering Committee for the Review of Government Service Provision
SQPSC	Safety and Quality Partnership Standing Committee

6.4 Australian national mental health information committee structure (as at June 2013)



6.5 National Mental Health Performance Subcommittee – Membership (as at June 2013)

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