



Mental Health Information Development

National Information Priorities and Strategies under the Second National Mental Health Plan 1998–2003

First Edition
June 1999

national
mental
health
strategy

Mental Health Information Development

National Information Priorities and Strategies under the Second National Mental Health Plan 1998–2003

First Edition

June 1999

©Commonwealth of Australia 1999
ISBN 0 642 36767 1

Prepared by the Mental Health Branch, Commonwealth Department of Health and Aged Care, Canberra.

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an acknowledgment of the source and no commercial usage or sale. Reproduction for purposes other than those indicated above requires the written permission of the Department of Health and Aged Care, GPO Box 9848, Canberra, ACT 2601.

Additional copies of the report are available from the Mental Health Branch, Commonwealth Department of Health and Aged Care, telephone 1800 066 247 or facsimile 1800 634 400.

A copy may also be downloaded from the Mental Health Branch website at:

<http://www.health.gov.au/hsdd/mentalhe>

Copies of other publications produced under the National Mental Health Strategy are also available at this site.

SUGGESTED CITATION

Department of Health and Aged Care. *Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998-2003 (First Edition June 1999)*. Commonwealth of Australia, Canberra, 1999

Foreword

Access to quality information will be essential in achieving the goals of the Second National Mental Health Plan. This document presents the national priorities and strategies for developing mental health information over the next five years. It outlines a proposed work program agreed to by the Commonwealth, State and Territory Governments.

The term ‘information’ is used here in the broad sense, referring to the ‘management intelligence’ required to effectively plan, resource, manage and deliver mental health services in a way that best meets community needs. It therefore refers to both the collection and use of information.

This broader view of the information concept recognises that the need for quality information exists at all levels of the health system.

- At the service delivery level, clinicians need to have access to a core set of information to conduct a needs assessment, formulate an individual care plan, monitor progress and evaluate outcome. Consumers and carers also need access to information to evaluate the value of the treatments they receive.
- At the service management level, access to specific data is necessary to manage resources, monitor workflows, conduct clinical audits, and monitor the overall efficiency and effectiveness of the service.
- At the policy level, information is necessary to assess the population needs for mental health care, plan and pay for services, determine priorities and systems for the allocation of resources and monitor the achievement of outcomes set by government.

Included within the scope of this document are the following aspects of mental health information:

- systems for the routine collection of patient-level and service utilisation data by mental health service providers;
- the development and use of national collections built from routine service delivery data reported by mental health service providers; and
- the development and use of other data collections to inform about the population’s need for mental health care, its use of services, the quality of those services and the outcomes achieved.

The paper summarises progress in information development made over the period 1993-1998 under the first National Mental Health Plan, identifying areas of significant gain as well as those where only limited achievement has been made. This is followed by a review of the information requirements arising from the Second National Mental Health Plan.

Four priorities have currently been agreed to guide information development over the next five years. Together, these aim to build and apply an information base that:

- strengthens the focus on consumer outcomes;
- supports improvements in service quality;
- shifts the focus of concern from cost to value for money; and
- improves our understanding of population needs.

These priorities stem from the directions advocated under the Second National Mental Health Plan, particularly its emphasis on quality and effectiveness as a key theme that will underpin the next period of mental health reform.

The information priorities and strategies will develop over the course of the Second National Mental Health Plan. This document will be amended to incorporate new mental health information developments, particularly as further strategies are agreed to address the information needs of the Partnerships in Service Reform and Delivery, and Promotion and Prevention themes of the Second National Mental Health Plan.

The paper describes an agenda of actions to advance the priority areas, noting that two conditions are fundamental to achieving progress.

First, adequate information infrastructure is needed at the service delivery level, both in terms of tools and standards to collect data as well as a capacity to report on key service indicators. There is wide agreement that existing clinical information systems are ill equipped to deliver results in the priority areas, particularly in terms of their lack of meaningful patient-level data, undeveloped systems for community-based care and lack of an efficient and effective process for national reporting.

Second, the knowledge base necessary to support service delivery, policy and planning needs to be enhanced through an ongoing research and development program. The focus of research and development activity will be varied, but primarily serve to inform about the population's need for and use of mental health services as well as contributing standards to support monitoring of the costs and effectiveness of those services and to monitor the effectiveness of promotion and prevention activity under the Second National Mental Health Plan.

Due to the central role of the National Information Priorities and Strategies under the Second National Mental Health Plan, national oversight of the work program will be undertaken by the Australian Health Ministers Advisory Council National Mental Health Working Group. The work program will comprise, under a coordinated national framework, activities jointly managed by the Commonwealth, States and Territories, activities managed solely by the Commonwealth, and activities managed solely by individual States and Territories. The work program will include activities fully or partly funded by:

- the \$250 million Mental Health Reform and Incentive funding available to States and Territories from the Commonwealth under the Australian Health Care Agreements (AHCAs);
- the \$50 million National Mental Health Initiatives funding provided under the AHCAs;
- State and Territory funding;
- the \$28 million Commonwealth National Mental Health Strategy project funding; and
- a combination of the above.

Six information development 'modules' in the paper lay out the specific steps proposed and identify the relative roles and responsibilities of the stakeholder groups, including:

1. The development of routine consumer outcome measurement in mental health services;
2. Development and Implementation of National Service Quality Indicators for Mental Health Services;
3. Further development of national mental health casemix classification building on the findings of the Mental Health Classification and Service Costs Project;

4. Understanding Population Mental Health Needs;
5. Continuing Development and Implementation of the National Minimum Data Set (NMDS) for Mental Health Care; and
6. Annual Monitoring and Reporting of Progress Under the Australian Health Care Agreements and the Second National Mental Health Plan.

The plans outlined in this document are ambitious in their scope and will be complex to implement. Processes to coordinate the various elements, and bring them together into a coherent national approach will need to be developed in full partnership between the Commonwealth, States and Territories and other key stakeholders including consumers and carer representatives and professional organisations.



Alan Clayton
Chair
Australian Health Ministers' Advisory Council
National Mental Health Working Group

Information in mental health is grossly undeveloped. The lack of nationally comparable data on service outputs, costs, quality and outcomes places major limitations on the extent to which the National Mental Health Strategy can achieve its objectives. A precondition to the changes proposed above is the existence of an information infrastructure built from the clinical services level that contributes to individual consumer care and service quality improvements as well as feeding into higher level planning and policy review. The models exist elsewhere and have demonstrated that much is possible. Putting such systems in place needs to be identified as an imperative for the next Strategy period.

(AHMAC Evaluation Steering Committee, *Evaluation of the National Mental Health Strategy: Final Report*, Australian Health Ministers' Advisory Council, December 1997)

Contents

Foreword.....	iii
List of tables	ix

PART ONE: CONTEXT

Information Development Under the National Mental Health Strategy 1993–98.....	3
National Mental Health Policy Indicators	3
National Minimum Data Set—Mental Health Care	4
Measures of consumer outcomes	9
Alternative measures of casemix.....	11
Estimating the mental health needs of the Australian population	13
Other related research and development activities	14
The Current Status of Mental Health Information.....	15
Limited patient data	15
No standard outcome measures	15
No method for classifying the ‘products’ of mental health services	15
No process for collection of data on community mental health care	16
Lack of benchmarks to evaluate services	16
No capacity for data linkage.....	16
Limited understanding of the broader population mental health needs	16
No mechanism for coverage of the specialised psychiatric disability support sector	17
The Second National Mental Health Plan	19
Promotion and prevention	19
Partnerships in service reform	19
Quality and effectiveness	20
Information implications of the Second National Mental Health Plan	20
Implications for local clinical information infrastructure	20
Implications for research and development	21

PART TWO: PRIORITIES AND STRATEGIES FOR INFORMATION DEVELOPMENT

Strengthening the focus on consumer outcomes	25
Selection of measures	25
Implementation strategies	26
Module One: Implementation Strategy for Introducing Routine Consumer Outcome Measurement in Mental Health Services	28

Supporting improvements in service quality	33
Measuring quality	33
National Quality Indicators	34
Implementation strategies	36
Module Two: Development and Implementation of National Service Quality Indicators for Mental Health Services	38
Shifting the focus of concern from cost to value for money	41
Informing value for money judgments	41
The role of casemix classification	42
Module Three: Further Development and Implementation of a National Mental Health Casemix Information System	45
Improving understanding of population needs	51
Measuring population need	51
Future strategies	52
Module Four: Understanding Population Mental Health Needs	54
Additional Priorities and Strategies	59
Module Five: Continuing development and implementation of the National Minimum Data Set—Mental Health Care	60
Module Six: Annual Monitoring and Reporting of Progress Under the Australian Health Care Agreements and the Second National Mental Health Plan	64

List of tables

Table 1:	Key areas to be addressed by the National Minimum Data Set–Mental Health Care	5
Table 2:	Patient-level data elements agreed for collection in the National Minimum Data Set–Institutional Mental Health Care from 1 July 1997	7
Table 3:	Data elements included in the National Minimum Data Set–Community Mental Health Care	8
Table 4:	Information development strategies to strengthen the focus on consumer outcomes	27
Table 5:	Care consumer outcome instruments for general adult psychiatry services	31
Table 6:	National Standards for Mental Health Services	34
Table 7:	Characteristics of a successful National Quality and Outcome Indicator Program	35
Table 8:	Information strategies to support improvements in service quality	37
Table 9:	Examples of coverage of National Service Quality Indicators	39
Table 10:	Information strategies to support value for money analyses of mental health service	44
Table 11:	Description of Measurement Instruments used for the MH–CASC classification	48
Table 12:	Recommended data collection cycle required to assign episodes to classes within the MH– CASC classification	49
Table 13:	Information strategies to improve population needs assessment	53

PART ONE

Context

In April 1992, Australian Health Ministers endorsed the National Mental Health Strategy, which foreshadowed a major reform process over the period 1993–1998. An important factor contributing to the Strategy was recognition that lack of quality information, and the absence of a consistent data collection, were key historical factors which had both isolated mental health services from the mainstream health system and restricted service reforms.

The Strategy accordingly gave priority to improving the quality and availability of mental health data. A wide range of projects were funded by the Commonwealth, designed to stimulate new developments as well as complement initiatives being taken by individual States and Territories.

In June 1998, the first five-year period of the National Mental Health Strategy was completed, creating the opportunity for review and realignment of priorities. The Commonwealth has indicated its commitment to maintaining the Strategy and, in the 1997–98 budget, provided an additional \$28 million over three years to continue national processes of reform. Subsequently, a Second National Mental Health Plan has been drafted, backed by a further \$300 million from the Commonwealth to be provided over a five year period through the Australian Health Care Agreements. This represents the largest financial commitment ever offered by the Commonwealth specifically for mental health.

Considerable opportunity therefore exists to consolidate recent gains as well as address issues that were not possible to resolve in the first five years. Information-related issues remain prominent on the agenda and their development is an essential means to achieving many of the wider goals espoused under the Strategy.

Information Development Under the National Mental Health Strategy 1993–98

Perhaps more than in any other area of activity commissioned under the Strategy, an understanding of context is essential to determine priorities for future information development. A diverse array of information-related initiatives has been undertaken during the last five years, several without international precedent. Most importantly, much of the work was of a research and development nature, requiring several years to reach an outcome that could be considered for application in the practical world of mental health services.

Five information-related priorities were set at the beginning of the Strategy, broadly divided into two categories.

- Data development projects, where the aim was to achieve consistency within the health service industry in the definitions and collection of mental health data elements. Projects included here were the development of indicators to monitor progress of the National Mental Health Strategy and development of a National Minimum Data Set (NMDS)—Mental Health Care.
- Research and development projects, where the aim was to acquire new knowledge or test new concepts through specific research studies. Included here were projects which aimed to develop consumer outcome measures for routine use, design a casemix classification system appropriate for mental health services and assess the level of mental health in the community.

Progress on each of these fronts is reviewed below.

National Mental Health Policy Indicators

The first priority concerned the need to monitor the progress of the Strategy itself. This requirement arose from the Ministers' agreement to:

‘...develop nationally agreed measures of performance in relation to each of the objectives in this [National Mental Health] policy...’

(National Mental Health Policy, 1992)

and

‘...to report annually and publicly, in a timely fashion, on the progress of the Commonwealth and each State and Territory in relation to [these] performance indicators and to compare them to their previous performance.’

(National Mental Health Plan, 1992)

Achieving this goal required a separate data collection process to commence immediately, specifically tied to the policy directions of the Strategy. None of the existing national health collections, including the mainstream hospital collection, had the capability for delivering the type and range of information needed within the time frame set by the Ministers' agreement. Thus, a separate collection was required that could be used as the basis for an annual National Mental Health Report.

In order to implement this special purpose collection, the Commonwealth, States and Territories first agreed in 1993 on performance indicators and associated data elements. A collection strategy was then designed that subsequently evolved into the annual National Survey of Mental Health Services. This survey, now in its fifth year, involves the manual (paper-based) collection of establishment level data from all public funded mental health services. It aims to build a picture of the range, level and costs of services available in each of the States and Territories.

Despite the limitations of this approach, much has been achieved. Five annual National Mental Health Reports have been published. These reports are widely regarded as presenting the most comprehensive compilation of information about mental health services produced in Australia and have few precedents internationally in terms of their scope and potential to inform government policy. Publication of the reports has been timely relative to comparable reports produced elsewhere in the health industry. And, of most significance, it is clear that the national report process has created its own pressure for information collection standards to be improved in the mental health services industry.

One further report is scheduled to complete the monitoring cycle covering the final year of the Medicare Agreements (1997–98). Similar reports will be maintained throughout the Second National Mental Health Plan.

National Minimum Data Set—Mental Health Care

It was recognised at the outset of the National Mental Health Strategy that the structure and content of existing national health data did not provide the framework to guide data collection at the mental health service delivery level, nor to build a national picture of services and the consumers of those services.

Consequently, an early priority agreed by the Commonwealth, States and Territories was the development of a first version of the national mental health data dictionary and data set for mental health services. The objective was to achieve agreement across all States and Territories to a consistent set of data definitions (the ‘data dictionary’) and to a timetable and process for the supply of the agreed data (the ‘data set’).

The previous lack of information development in mental health reflected the isolation of mental health service delivery from mainstream health care. The emphasis on developing data standards and investing in information infrastructure that occurred in the acute health sector over the 10 years preceding the National Mental Health Strategy bypassed mental health services. A critical step for the future was to translate the Strategy’s emphasis on ‘mainstreaming’ to the information aspects of mental health reform and ensure that new developments were both tested and incorporated within the broader health information environment.

The establishment of a mental health work program within the Australian Institute of Health and Welfare (AIHW) in 1995, funded by the Strategy, was an important initiative in mental health data development. Through its national role in health information management, the AIHW had the capacity to coordinate the development and implementation of a National Minimum Data Set (NMDS) for mental health care in both institutional and community settings.

Progress in this area has been achieved, but the annual data collection demands associated with the production of the National Mental Health Report have dominated the work of the AIHW and the National Mental Health Information Strategy Committee over the past five years, overshadowing the longer term development tasks necessary to establish the NMDS.

At the close of the first five-year period of the National Mental Health Strategy, the NMDS—Institutional Mental Health Care has been collected only for one reporting period, that is 1997–98. Following the first release of data in August 1999, the NMDS will be reviewed for its consistency with information requirements under the Strategy. The NMDS—Community Mental Health Care has been agreed for collection from 1 July 2000, with best efforts to be undertaken by States and Territories for collection from 1 July 1999. A substantial amount of developmental work is required before this collection can satisfy the wide range of information needs identified under the Strategy.

Further work is required to achieve collection of quality national aggregate information about consumers under mental health care. The special issues concerning how an integrated area mental health service, with its mix of inpatient and community-based services, can efficiently collect and report a single data set have not yet been resolved in all States and Territories.

Most importantly, the unique problems concerning the processes and ‘counting rules’ for community-based mental health services, and the methods to be used in capturing such data at the national level, are only now beginning to be tackled. Completion of this task will be a high priority in the Second National Mental Health Plan period.

In summary, some significant milestones, both conceptual and practical, have been achieved towards a comprehensive data set for mental health services. These are summarised below.

Identifying data elements required for the National Minimum Data Set—Mental Health Care

Early in the Strategy, agreement was reached that the National Minimum Data Set—Mental Health Care should be designed to answer five general questions, summarised succinctly by Leginski et al (1989) as: ‘Who receives what services from whom, at what cost, and with what effect?’¹ The information required to report on the five elements of this question (Table 1) identify the key areas where efforts are needed for data element definition and ‘rules’ to govern their collection. The five key areas have provided direction and focus for work completed over recent years.

Table 1: Key areas to be addressed by the National Minimum Data Set—Mental Health Care

<i>Question</i>	<i>Information required</i>
Who receives	Demographic and clinical characteristics of service consumers
... what services...	Details of mental health programs delivered (volume and type of services)
... from whom ...	Service characteristics Details of mental health workforce
... at what cost...	Mental health program expenditure
... with what effect?	Client outcome data

¹ Leginski W, Croze C, Driggers J, Dumpman S, Geersten D, Kamis–Gould E, Namerow J, Patton R, Wilson N and Wurster C. (1989) Data Standards for Mental Health Decision Support Systems: A Report of the Task Force to Revise the Data Content and System Guidelines of the Mental Health Statistics Improvement Program, National Institute of Mental Health, US Department of Health and Human Services, Washington.

The mental health service taxonomy

Development of a services taxonomy is the first step to agreeing on the standard concepts and definitions that will be used to describe services, their outputs and costs. This is necessary because a data element relevant to one setting may not be so in another. Further, a service classification is needed to ensure like-with-like comparisons and provide a means for aggregating data from services that share common characteristics.

While a basic classification of health services underpinned the version of the National Health Data Dictionary current when the Strategy commenced, its focus was on inpatient services. The issues had not previously been addressed in the context of a service system like mental health services, with its mix of short and long term inpatient units and diversity of community program types, all potentially provided by a single 'health establishment'.

These issues were satisfactorily resolved in the second year of the Strategy, and provided a basis for the data collected through the National Survey of Mental Health Services. The service taxonomy promoted through that Survey is now used widely to describe mental health service types in Australia.

National Minimum Data Set—Institutional Mental Health Care

The first version of the National Minimum Data Set—Institutional Health Care (the mainstream collection reported for all hospitals and all admitted patients) was adopted in 1988. This defined a wide range of data elements at three levels—the patient, the health service establishment and the wider health system—identifying a subset of these for agreed national collection and reporting. By the time National Mental Health Strategy was endorsed by Health Ministers in 1992, the data set had progressed to its second version.

Mental health services were represented in the national data set in two ways. First, stand alone psychiatric hospitals, public and private, were created as a category of 'health establishment', separate from acute (general) hospitals. A specific set of patient-level and establishment data elements was defined for these institutions which, while having much in common with data required of acute hospitals, contained a number of unique inclusions and exclusions. Second, a set of data elements was defined for non-admitted patients of the psychiatric hospitals, primarily as a means of isolating the activities directed to these patients from estimates of hospital activity.

The first version of the data set was primarily of 'theoretical' value, having little influence on mental health service delivery in the early years. Significant problems emerged including:

- the inability to distinguish the activity of, and patients treated by, specialist psychiatric units within general ('acute') hospitals;
- anomalous variations in data element definitions between public psychiatric hospitals and collections for admitted patients in designated units of acute hospitals;
- outdated or inappropriate definitions for several data elements; and
- poor compliance by stand alone public psychiatric hospitals in the reporting of patient-level data.

The work of the AIHW under the Strategy has largely corrected these problems. Public psychiatric hospitals are now required to report on a similar basis to acute hospitals, and there is now a capacity to collect information on admitted patients in specialist psychiatric units in acute hospitals. Definitions have also been revised in relation to several patient level data elements. These definitions and changes have been implemented by all jurisdictions since July 1996.

The amendments to the National Health Data Dictionary provided the capacity for patient-level data elements to be reported as unit records by all psychiatric inpatient services, effective from 1 July 1997. These elements are intended to enable a picture to be constructed of the sociodemographic and, to a lesser extent, the clinical characteristics of patients admitted to hospitals for specialist psychiatric care. Table 2 summarises the data elements.

Table 2: Patient-level data elements agreed for collection in the National Minimum Data Set—Institutional Mental Health Care from 1 July 1997

IDENTIFIER	SERVICE AND ADMINISTRATIVE
<ul style="list-style-type: none"> • Establishment identifier • Person Identifier 	<ul style="list-style-type: none"> • Pension Status ^{(a),(c)} • Type of Episode of care • Admission date • First admission for psychiatric treatment ^{(a),(b)} • Discharge date • Total leave days • Mode of separation • Mental health legal status ^(b) • Total psychiatric care days ^(b) • Referral to further care ^{(a),(b)} • Source of referral ^(b)
SOCIODEMOGRAPHIC	
<ul style="list-style-type: none"> • Sex • Date of birth • Country of birth • Indigenous status • Marital Status • Area of Usual residence • Type of usual accommodation ^{(a),(b)} • Employment Status ^(a) 	
CLINICAL	
<ul style="list-style-type: none"> • Principal diagnosis • Additional diagnosis • Diagnostic Related Group • Major Diagnostic Category • Intended length of hospital stay 	

^(a) This element is not collected for the mainstream admitted patient collection.

^(b) This element has been revised for collection from 1 July 2000 (with best efforts for collection from 1 July 1999), and/or further revisions are planned.

^(c) This element is to be retired from the collection from 1 July 2000.

National Minimum Data Set—Community Mental Health Care

In contrast to the development of the institutional minimum data set, designing a data set and collection for community-based mental health services has fewer precedents to offer guidance. At the national level, a number of community health minimum data sets have been agreed but these have been constructed around the specific requirements of their constituent services (eg, community nursing), and have limited applicability for mental health.

In November 1997, the National Health Information Management Group endorsed the NMDS—Community Mental Health Care for collection from 1 July 1998. This covers collection of data at two levels. First, establishment-level data (resources and expenditure) are to be reported on an annual basis by public sector organisations providing community-based mental health services. For the purposes of this collection, it has been proposed that ‘establishment’ be reported in a way that links to the organisations that have previously responded to the National Survey of Mental

Health Services. Community-based mental health services to be covered by the proposed collection include all specialised mental health services provided to non-admitted patients, incorporating ambulatory care, community-based residential units, hospital outpatient departments and so forth.

Table 3 summarises the data elements included in the establishment collection.

Table 3: Data elements included in the National Minimum Data Set—Community Mental Health Care

<i>Data elements</i>	<i>Ambulatory services</i>	<i>Residential services</i>
ESTABLISHMENT LEVEL DATA ^(a)		
• Establishment identifier	✓	✓
• Separations	✗	✓
• Geographic location	✓	✓
• Number of available beds	✗	✓
• Total full-time equivalent staff	✓	✓
• Salaries and wages	✓	✓
• Payments to visiting medical officers	✓	✓
• Non salary operating costs	✓	✓
PATIENT LEVEL DATA ^(b)		
• Establishment identifier	✓	✓
• Person Identifier	✓	✓
• Sex	✓	✓
• Date of birth	✓	✓
• Indigenous status	✓	✓
• Number of service contact dates	✓	✗
• Total psychiatric care days	✗	✓
• Principal diagnosis	✓	✓
• Total psychiatric care days	✗	✓
• Mental health legal status	✓	✓

✓ indicates that the data element is required in this setting.

✗ indicates that the data element not required in this setting.

^(a) Establishment level data are agreed for collection from 1 July 1998.

^(b) Patient level data are agreed for collection from 1 July 2000, with best efforts to collect from 1 July 1999.

Agreement at this stage is for the establishment-level data to be collected from 1 July 1998, and the first reports will be forwarded by States and Territories to AIHW by December 1999.

The second component of the proposed collection covers patient-level data. A core set of data elements has been defined, with an expectation that each organisation covered in the establishment collection will provide unit record data for all patients treated by community mental health services, covering both residential and non-residential services. Within this design, a unit record is proposed for each patient who is treated in a 24-hour staffed community-based residential unit or receives any ambulatory service contact during the reporting period. Data elements covered in the patient-level collection are also summarised in Table 3.

The most complex issue to be resolved in the proposed collection relates to the ‘units of counting’ rather than the specific data elements to be collected. Historically, activity data for inpatient services has been reported in terms of episodes of admission to hospital, while community services are usually reported as simple counts of occasions of service, however defined. The latter is limited as a means of describing the volume and type of care provided to an individual patient. However, no alternative concept of episode has yet been agreed that can be used to quantify units of service provision in community care. Resolving this issue, by deciding on an agreed definition of ‘episode’ to guide collection and reporting by community mental health services, is a high priority in further developing and implementing the NMDS—Community Mental Health Care.

Recognising the complexity of issues that need resolution for such a collection to proceed, the States and Territories, through the National Health Information Management Group (NHIMG), deferred introduction of patient-level collection to July 2000, with a request that jurisdictions would make best efforts to collect data from 1 July 1999. The implementation strategy also needs to be considered in the broader context of the other developments outlined in this paper.

The integrated patient record

The issue of record linkage systems is central to the development of a national conceptual framework to guide mental health information systems in Australia. A minimum data set that is centred around the concept of health establishments which report on activity and patients treated, or to promote data collection systems that focus on the patient under care, not the facilities providing care.

Current health information in Australia consists mainly of the collection and analysis of unlinked individual treatment episodes. Risks in transferring this model to the mental health field, where the majority of patients have chronic illnesses requiring care over extended periods, were recognised at the outset of the Strategy. A data collection model more consistent with the key themes of the National Mental Health Strategy – continuity of care and service integration – is required.

An alternative collection strategy involves the use of case record linkage to assemble information about clients over time and across treatment settings. Health data systems based on record linkage allow clinicians to better manage their patients, through the access provided to relevant treatment history details and coordination with other service providers. They also facilitate the type of data sets needed by health planners and researchers to describe overall patterns of care and the outcomes for consumers of services.

The principle of the integrated clinical record has been strongly endorsed by the National Mental Health Information Strategy Committee. It is widely regarded as providing the optimal basis to organise future mental health data collection. Putting this principle ‘on the ground’ remains a challenge in the years ahead.

Measures of consumer outcomes

Improving mental health service outcomes was stated as a primary goal of the National Mental Health Strategy. To advance this, the Strategy emphasised the need for outcomes to be reviewed on a regular basis.

Outcomes of mental health care can be described at the level of whole populations (eg, suicide rates), or for service systems (eg, percent of discharges to homeless shelters) or at the level of the individual consumer. The latter may be assessed directly, such as by use of scales designed to

measure change in health status, or indirectly through the use of one or more proxy indicators (eg, readmission rates).

Particular focus was given in the Strategy to the direct measurement of individual consumer outcomes. For example, the National Mental Health Policy states as one of its 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.’

However, instruments for measuring consumer outcomes were not available at the commencement of the Strategy. Similarly, most Australian mental health services did not routinely collect clinical and service delivery data that could be used to compile indicators of outcome, which might serve as proxies in the absence of more direct measures.

In response to this need, a major research and development program was initiated early in the Strategy to develop direct consumer outcome measures that would serve two needs:

- to be useful in routine clinical practice in monitoring progress of the individual patient; and
- to be suitable for monitoring outcomes at the broader service level.

This work was anticipated to extend over most of the five year Strategy period, and comprised three elements.

- **The Measurement of Consumer Outcome in Mental Health²:** Early in the Strategy, a review was completed of the suitability of various measures of consumer outcome for routine clinical use in mental health services. The consultants argued that ‘...the measurement of outcome should be multidimensional, covering symptoms and disability’, and that both clinician ratings and patient self-reports were required. The report was principally concerned with the identification of the best instruments for general use. Six instruments of acceptable reliability, validity and sensitivity to change were identified as likely to be of practical use and acceptable for routine application. These were the Health of the Nation Outcome Scales (HoNOS), the Role Functioning Scale (RFS), the Life Skills Profile (LSP), the Behaviour and Symptom Identification Scale (BASIS), the Mental Health Inventory (MHI) and the Medical Outcomes Study Short Form 36 (SF36).
- **Measuring Consumer Outcomes in Mental Health³:** This report extended the above review and field-tested the six adult outcome measures in a range of private and public sector clinical practice settings. The final report, released in April 1998, argued that the process of measuring consumer outcomes is as important as the selection of the measures themselves.
- **Measurement of Consumer Outcomes in Child and Adolescent Mental Health Services:** Work commenced to review consumer outcomes in the specific area of child and adolescent mental health, focusing on the development and implementation of an outcome measurement system for children’s mental health services. The first phase of the project has been completed.⁴ Phase Two, which will involve pilot implementation and further development of identified measures, is expected to commence during 1999.

2 Andrews G, Peters L and Teeson M (1994). *The Measurement of Consumer Outcome in Mental Health: A Report to the National Mental Health Information Strategy Committee*. Australian Government Publishing Service, Canberra.

3 Stedman T, Yellowlees P, Mellsoy G, Clarke R., and Drake S (1997). *Measuring Consumer Outcomes in Mental Health: Field Testing of Selected Measures of Consumer Outcomes in Mental Health*. Department of Health and Aged Care, Canberra.

4 Bickman L, Nurcombe B, Townsend C, Belle M, Schut J, Karver M. (1999) *Consumer Measurement Systems for Child and Adolescent Mental Health*. Department of Health and Aged Care, Canberra.

In a related national project, funded to develop a casemix classification for mental health services (see below), significant experience was gained in the use of two of the ‘short listed’ instruments (HoNOS and LSP). This project collected data on approximately 18,000 patients and provided experience in patient measurement scales for 25% of the mental health clinical workforce.

Apart from Victoria and Tasmania, which have committed to statewide implementation in 1999, and in Victoria’s case, completed trials of the HoNOS,^{5,6} little parallel of these national developments has been undertaken by individual State and Territory governments, although there is clear interest in finding a ‘common ground’ solution.

The experience over recent years points to several conclusions.

- Consumers and service providers generally support the concept of routine assessment of consumer outcomes.
- The attribution of a change in a person’s condition to any single factor, including intervention, is problematic.
- Given the varying needs of consumers and differences in the focus of service provision, no single measure will address all clinical information needs across all settings.
- Although all trialed measures have limitations and require further work, the HoNOS is the preferred clinician-rated measure for use across all settings. The LSP or RFS are also suitable where high levels of disability are expected.
- Consumer self ratings of change need to be included in a comprehensive approach to outcome monitoring. The MHI has been identified as a suitable measure for wider use.
- More research is required to improve the specificity of measures.
- Assistance is required for service providers to implement appropriate methods and processes for routine outcomes assessment.
- Outcome data need to be developed as an integral component of local clinical information systems.
- A process is required for the ongoing improvement of measures, based on experience in their use.
- The Commonwealth, State and Territory governments should foster environments that encourage and support routine outcomes assessment.

The key task in the Second National Mental Health Plan period is to find the most effective means for putting these ideas into practice.

Alternative measures of casemix

Significant initiatives commenced in the 1980’s to introduce casemix classification systems to describe the ‘products’ of health care. By the time the National Mental Health Strategy began, Australia’s Health Ministers had endorsed the establishment of a nationally consistent casemix-based management and information system which could serve as the basis for alternative funding arrangements for mental health services in Australian hospitals.

5 Trauer T, Callaly T, Hantz P, Little J, Shields R and Smith J. Health of the Nation Outcome Scales (HoNOS): Results of the Victorian Field Trials (1999). *British Journal of Psychiatry*, 174, 380–388.

6 Health Status and Outcomes in Victoria’s Mental Health Services: Discussion Paper (1999) Aged, Community and Mental Health Division, Department of Human Services, Victoria, February 1999.

As occurred in the development of information standards for the general health sector, mental health services ‘stood aside’ from the national casemix development program. Recognising that the accepted casemix standard (AN-DRG’s or Australian National Diagnosis Related Groups) was not appropriate for describing the ‘outputs’ of mental health services, the National Mental Health Strategy set as one of its priorities the development of an alternative classification model that was consistent with the principles of the Strategy. This subsequently became one of the largest investments on any single project funded over the period with significant implications for future data collections.

The Mental Health Classification and Service Costs Project (MH-CASC) commenced in 1995 and continued over the next three years under the Mental Health Funding Models National Work Program.⁷ The study collected detailed socio-demographic and service use data on approximately 18,000 consumers attending specialised mental health services. The sample was significant, covering 25% of Australia’s private and public mental health services. Service utilisation data were provided by approximately 4,500 staff who maintained daily diaries of all activities over the three month period 1 September to 30 November 1996. The scale and complexity of the study has no international precedent.

The aim of the Project was to determine whether clinical factors explained service costs, and whether these could be used to build a patient classification that was both clinically meaningful as well as resource homogeneous. Clinical measures were selected to cover the broad domains of diagnosis, clinical severity and level of functioning (disability). Of most importance, the Project based its design on using patient measures that were seen as clinically useful in their own right, drawn from the same ‘family’ of outcome instruments described above.

The project found that there is an underlying episode classification, not just in inpatient care but also in the community. The level of service provided to patients does in fact bear a clinically and statistically logical relationship to the patient’s clinical status.

The project recommends a first version casemix classification model which includes 42 patient classes—19 for community episodes, and 23 for inpatient episodes. Adoption of this classification schema would require routine use of a small number of clinical scales, applied at periodic intervals. A description of the scales and their measurement schedules are provided later in this paper.

The Project final report, completed in September 1998, is not yet widely known but its results have major implications for future mental health data collections. The Project found:

- driven by provider variations, reducing the overall variance that can be explained by clinical factors. In fact, provider variation emerged as a major explanatory factor for the volume of services received by any particular patient.
- The variables driving costs in inpatient settings are also driving costs in the community but the patterns of care are different, so the importance of the variables differs across the two settings.
- While explanation of variance was found to be at the low end of acceptability, it was above that achieved using the AN-DRG mental health classification system. Thus, while diagnosis in itself was important in understanding differences between patients, a ‘mix’ of measures including clinical severity (measured by the HoNOS) and level of functioning (measured by the LSP) was required to better differentiate care patterns.

7 Buckingham W, Burgess P, Solomon S, Pirkis J and Eagar K (1998). Developing a Casemix Classification for Australia’s Mental Health Services, Department of Health and Family Services, Commonwealth of Australia, Canberra.

From the perspective of the information strategy under the Second National Mental Health Plan, four conclusions from the MH-CASC Project are particularly relevant.

- First, the Project demonstrated that a meaningful classification is possible which can subsequently be used to describe the activities of mental health services.
- Second, there is a clear convergence in the measures used for this purpose with those with demonstrated utility in outcome measurement.
- Third, it demonstrated the value of casemix information tools in highlighting the degree of variation in mental health clinical practice. Such tools are essential in distinguishing patient-driven variation from provider variation, a fact that has particular relevance for the new focus on service quality advocated under the Second National Mental Health Plan.
- And finally, the Project added important new concepts for defining episodes in the community, by using a definition based on the concept of 'period of care'. The implications of this for resolving conceptual obstacles that have restricted the development of a national minimum data set for community mental health care are yet to be considered.

Estimating the mental health needs of the Australian population

An accurate estimate of the community's need for mental health care was recognised as critical to planning services, allocating resources and evaluating the overall effectiveness of the Strategy. Estimates made prior to the Strategy pointed to a substantial level of unmet need, although these were based on a small number of local studies and overseas evidence. A more direct measure was deemed to be required as a base for future planning. Consequently, the final priority set at the outset of the Strategy was to conduct a national survey of the prevalence of mental disorders in the Australian community.

The National Survey of Mental Health and Wellbeing was commissioned for this purpose by the Commonwealth Department of Health and Aged Care. The survey comprises three studies, one for adult Australians from the age of 18, one for children and adolescents within the age range 4–17, and one in relation to 'low prevalence disorders', such as psychosis and bipolar disorders, within the age range 15–64. Design of the studies has been a collaborative effort, involving psychiatric epidemiologists, psychiatrist practitioners, government agencies and consumer representatives.

The national survey aims to:

- estimate the prevalence of the main categories of mental disorder and of significant psychological symptoms in the Australian population;
- determine the amount of disablement associated with those disorders; and
- determine service utilisation by persons with mental disorders, including an estimation of unmet need.

A report of the adult study, conducted by the Australian Bureau of Statistics, was released in April 1998, based on interviews with over 10,000 Australian adults.⁸ The results showed that, over a 12 month period, an estimated 18% of Australians are affected by one or more mental disorder. The finding parallels similar studies conducted overseas and points to significant unmet need in the community. Further analysis of the data has already commenced.

Interviewing for the Child and Adolescent study has taken place and involved a sample of approximately 4,500. A preliminary report is expected by the end of 1999.

⁸ Australian Bureau of Statistics (1998) National Survey of Mental Health and Wellbeing: Profile of Adults. ABS Catalogue No. 4326.0

The Low Prevalence Disorders Study involves a survey of 1,200 people and is being conducted in four large urban areas in Queensland, Victoria, Western Australia and the Australian Capital Territory. Data collection for this study has also been completed, and the study is expected to provide a final report by October 1999.

Together, these studies will provide a rich information source to guide further development of mental health services under the Second National Mental Health Plan.

The designation by Australian Health Ministers in 1996 of mental health as one of the five National Health Priority Areas (NHPA) has further highlighted the importance of information about population mental health.⁹ The NHPA initiative seeks to focus public attention and health policy on those areas that contribute most to the burden of illness in the community. Inclusion of mental health as a priority recognises that mental illness affects a significant percentage of the population and that there are increasing opportunities to reduce its impact through a range of specific interventions targeted at particular groups. To monitor progress, each priority area must be reported every two years, requiring a wide range of data development activities to be undertaken.

Other related research and development activities

Two additional developments in the first five years of the Strategy period have implications for the direction of future information related projects.

National Standards for Mental Health Services

Complementing the work on development of standardised consumer outcome measures, the National Standards for Mental Health Services were released in 1997. Developed by a consortium comprising the Australian Council on Healthcare Standards (ACHS), the Quality Improvement Council (formerly CHASP—Community Health Accreditation and Standards Program) and the Sydney-based Area Integrated Mental Health Services (AIMHS), the standards were developed for use in assessing service quality and as a guide for continuous quality improvement in all mental health services across Australia.¹⁰ Assessment of services against the standards will need to be supported by local information systems that provide a wide range of data for review and monitoring purposes.

Local Area Clinical Information Systems

Much of the emphasis in information development during the first period of the National Mental Health Strategy has been on 'top down' approaches to collecting information, with little attention given to the role that information should play at the service delivery level. Recognising the inherent problems with this approach, particularly with data quality and compliance, a set of functional specifications was prepared to guide the development of local clinical information systems in mental health services.¹¹ These defined the essential features of an information system designed around the needs of clinicians and consumers, from which higher level aggregate data can be reported as an administrative by-product. The development of local area information systems will require substantial funding for infrastructure and systems implementation in all jurisdictions.

9 Australian Institute of Health and Welfare and Commonwealth Department of Health & Family Services (1997) First Report on National Health Priority Areas 1996. AIHW Cat. No PHE 1. Canberra: AIHW and DHFS.

10 National Standards for Mental Health Services, Commonwealth of Australia, 1996.

11 Morris-Yates A, and Andrews G (1997) Local-Area Clinical Information Systems for Mental Health Services: General Principles and Guidelines. Developing Outcome-Oriented Information Systems for Mental Health Services. Discussion Paper No. 1. Department of Health and Aged Care, Canberra.

The Current Status of Mental Health Information

While much has been achieved since the commencement of the National Mental Health Strategy, there are many gaps in existing mental health information across all stakeholder groups. An assessment of the current status of mental health information collections highlights the areas for priority action over the next five years.

Limited patient data

In the acute health system, substantial investment has been made over the past ten years in national collections of a broad range of patient-level data and establishing systems to streamline national reporting and ensure data quality.

However, the type and quality of patient-level data found in most mental health collections provides little value in answering the central questions ‘who receives services...with what effect?’. Collections defined at State and Territory level incorporate only a limited range of demographic and clinical data, the latter primarily comprising clinical diagnosis.

No standard outcome measures

Similarly, lack of consensus about which outcome measures are appropriate for routine use has supported the inertia that surrounds the patient-level data collections in mental health services. Apart from a number of notable exceptions, standard outcome measures are not used in the day-to-day delivery of mental health services in Australia.

Much of the data collection effort during the first National Mental Health Plan was directed toward monitoring the resource base and changes in the structure of mental health services. While these are important, they do not substitute for knowledge about outcomes achieved for consumers of those services. A better balance is required that provides a picture of the needs of people who enter mental health care and the effectiveness of services in meeting those needs.

No method for classifying the ‘products’ of mental health services

Current methods used to describe outputs in mental health services provide counts of bed days and occasions of service. In systems terms, these represent throughputs or processes, not outputs. The model for describing health output used widely throughout the general health system, where the ‘treated patient’ is the ‘product’, is yet to be adopted in the mental health industry. Redefining ‘output’ using a method to describe different classes of ‘treated patients’, is needed to achieve the focus on quality and effectiveness advocated by the Second Plan.

No process for collection of data on community mental health care

Despite the fact that the majority of patients treated by specialised mental health services are seen in community settings, issues regarding the collection and reporting of community data have not been satisfactorily resolved. As a consequence, little is known about ‘who receives what services at what cost and with what effect’ for community-based care, the most common form of mental health service delivery.

Lack of benchmarks to evaluate services

The first National Mental Health Plan set clear directions for service reform without imposing specific targets or performance benchmarks. While this was appropriate to the first period of reform, continuation of such an approach creates obstacles to further development. A wide range of benchmarks is needed to enable review and evaluation of services, as well as to inform the broader community about the performance of mental health services.

No capacity for data linkage

As described earlier in this paper, few mental health services operate linked record systems that enable consumers to be tracked over time and across service boundaries. Without this, meaningful concepts of episodes of mental health care for people with long term-illnesses cannot be defined.

Limited understanding of the broader population mental health needs

Information is not available to monitor trends in the prevalence of mental disorders in Australia, or progress against the indicators established under the National Health Priority Areas (NHPA) initiative. Inadequate mental health information in these areas in fact prevented baselines and targets being set for several indicators of the NHPA initiative.¹² Similarly, information about the needs of special sub-populations, particularly indigenous people and people from non-English speaking backgrounds, cannot be readily accessed. The National Survey of Mental Health and Well Being has made a major contribution in these areas, but further steps are required for this to be useful in monitoring outcomes of the Second National Mental Health Plan.

¹² See Footnote 9.

No mechanism for coverage of the specialised psychiatric disability support sector

The increasing role of the psychiatric disability support sector needs to be reflected in information planning. Provided by organisations collectively referred to as the ‘non-government sector’, the role of specialised disability support services is expanding as governments progressively contract-out services. At present, an unknown proportion of these services is covered by the reporting requirements of the Commonwealth-State Disability Agreement, without linkage to existing mental health data sets. The issues here are complex but will need to be resolved as the sector continues to expand.

In summary, there is much to be improved in the information available about mental health services in Australia. The recent report of the evaluation of the National Mental Health Strategy, completed in 1997, emphasised the critical role of information and pointed to the existing problems as major obstacles to further reform. The evaluation, conducted by an independent steering committee appointed by the Australian Health Ministers Advisory Council, concluded with the comments quoted at the start of this chapter, highlighting the need for further development of mental health information systems in Australia.

The Second National Mental Health Plan

The Second National Mental Health Plan is a joint statement by the Health Ministers of the Commonwealth, State and Territory governments of Australia, and provides the future framework for policy development and activity in mental health service reform.

This five-year Plan commenced on 1 July 1998 and will come to a close on 30 June 2003. Progress in achieving strategies will be monitored by the Commonwealth, States and Territories and reported annually through future national reports. A formal evaluation of the Plan will be conducted.

The second Plan aims to build on the achievements of the first National Mental Health Plan by identifying additional areas for national activity. It also recognises that, given the size of the reform task, it has not been possible to achieve all the outcomes desired within the first five years of the Strategy. This perspective is particularly relevant in considering progress on the information development agenda that has guided activity over the past five years.

The Second Plan gives prominence to three additional themes to guide further reform.

Promotion and prevention

This theme has been couched broadly to include mental health promotion, community education, prevention of mental disorder, and early intervention. Desired outcomes are stated to include: reduced incidence and prevalence of mental disorder and associated disabilities; reduced rate and number of completed suicides, particularly amongst young men in rural and remote areas, and older men; reduction in the incidence and prevalence of depressive disorders; consumers and carers more informed about signs of relapse and how to respond; increased consumer and carer satisfaction with clinicians' response to early warning signs; and improved range, quality and effectiveness of public health strategies which promote mental health among the Australian population.

Partnerships in service reform

This theme recognises that specialised mental health services can only meet some of the needs of people with mental disorder. Consumers have the same needs as other people for general health care, stable housing, home support, recreation, employment, education and friendship. When their disorder results in disability they require non-discriminative access to disability support services. Building and strengthening partnerships between mental health services and the broader community is promoted to achieve the following outcomes: improved consumer and carer satisfaction with their participation in all areas of mental health services; increased participation of a wide range of health, welfare and disability professionals and organisations in the provision of services to people with mental disorder; increased knowledge and understanding of mental health and mental disorder and an awareness of additional needs; improved coordination of services provided to consumers and carers; and increased community interest and involvement in mental health issues.

Quality and effectiveness

The third additional theme in the Plan focuses on the quality and effectiveness of mental health services with a particular emphasis on improved consumer outcomes across the life span. While the Plan calls for structural reform of the service delivery system to be maintained, it also seeks to balance this by increasing attention to the impact on consumers and carers, and issues relating to service quality and effectiveness. Expected results from initiatives in this area include: improved responsiveness of services to the needs of consumers and carers across the life span; improved clinical outcomes and quality of life for consumers; consumer and carer satisfaction with services; improved outcomes for Aboriginal and Torres Strait Islander people, people from non-English speaking backgrounds and people living in rural and remote areas; improved access and outcomes for children and adolescents, young adults and older people with mental disorder.

Information implications of the Second National Mental Health Plan

The central role of information permeates all aspects of the Second National Mental Health Plan. The plan presupposes an informed mental health service system, where a broad range of information is available to guide decisions at all levels.

- At the service delivery level, quality clinical care requires clinicians to have access to a core set of information to conduct a needs assessment, formulate an individual care plan, monitor progress and evaluate outcome. Consumers and carers also need access to information to evaluate the value of the treatments they receive.
- At the service management level, access to specific data is necessary to manage resources, monitor workflows, conduct clinical audits, and monitor overall efficiency and effectiveness of the service.
- At the policy level, information is necessary to assess the population needs for mental health care, plan and pay for services, determine priorities and systems for the allocation of resources and monitor the achievement of outcomes set by government.

Information to support implementation of the Plan needs to be drawn from a variety of sources, including collections derived from the routine service delivery data, formal research studies and other ‘ad hoc’ data collections.

Two conditions are fundamental to further progress. First, effective local clinical information systems need to be in place to support service delivery. Second, a program of ongoing research and development is needed that sets standards for data collection and converts that data into ‘intelligence’ to be distributed through the service system. Each of these is discussed below.

Implications for local clinical information infrastructure

Quality local clinical information systems provide a ‘mirror’ to service providers and act as ‘feeder systems’ for the type of data required to plan and monitor service provision. To achieve this, adequate information infrastructure is needed at the service delivery level, both in terms of appropriate tools and standards to collect data as well as a capacity to report regularly on key service indicators.

A concern that has been recognised with ‘top down’ clinical data collections, designed solely for the purpose of reporting to higher levels, is that they may not produce quality information. These collections can be seen as an irrelevant burden by the clinicians responsible for data collection, causing serious compromises in data quality and reporting compliance. Where local systems are designed around the information needs of service providers and consumers, the benefits are more likely to be seen to offset the data collection burden. Such systems aim to produce higher level aggregate data as an administrative product, rather than the primary goal.

Work conducted under the first National Mental Health Plan has previously defined the ‘vision’ for local mental health information systems.¹³ It promoted as an objective the development of clinical information systems that:

- support and encourage good practice;
- regularly inform about consumer outcomes;
- inform judgements about value for money; and
- produce national and State/Territory data as a by-product.

The reality is far removed from this vision. There is wide agreement that existing clinical information systems in most mental health settings are ill equipped to deliver results in the priority areas, particularly in terms of their lack of meaningful patient-level data, undeveloped systems for community-based care and limited processes for national reporting. At the completion of the first National Mental Health Plan, services operated by the States and Territories had significant limitations in their data collection capacity.

Over the past two years, several major initiatives have commenced to design quality clinical information systems that support the delivery and management of mental health services. Continuing investment in these will be necessary to create an infrastructure of local clinical information systems that meet the criteria outlined above. This will be a key aspect of the strategies to be pursued under the Second National Mental Health Plan.

Implications for research and development

While clinical information systems are a basic building block, additional research and development activities are required to complement data contributed by service providers. The focus of research and development activity will be varied, but should serve to inform about the population’s needs for and use of mental health services as well as contributing standards and new knowledge to support service delivery monitoring.

The activities are of three types.

First, a formal process is needed to compile, analyse and report on service delivery, drawing on the data supplied by providers. The purpose here is to assemble a national database from which normative standards or benchmarks can emerge, covering all aspects of the service delivery system. These form the basis for evaluation and comparison between services.

¹³ Morris-Yates A and Andrews G *ibid.* See Footnote 11.

Second, ongoing review is required of the range and quality of service delivery data, with a view to ensuring that it gives us what we need to know to answer the question of ‘who receives what services from whom at what cost and with what effect’. Such a review process aims to regularly refine the definitional standards used in data collection as well as developing new or improved data measures.

Third, a range of independent research is needed to address issues that cannot be resolved using information provided by routine service delivery information systems. The potential ‘list’ here is broad, but from the perspective of information development, would include as high priorities, for example:

- periodic surveys of population mental health;
- studies of longer-term outcomes and differential effectiveness of treatment programs; and
- trials of new organisational and funding models for mental health services.

As stated earlier, much of the work conducted under the first National Mental Health Plan was of a research and development nature, providing a base for subsequent application of new concepts into clinical practice. While the emphasis of information development will be on implementation under the Second National Mental Health Plan, there is a continuing need for strategic research to guide future development of mental health care.

PART TWO

Priorities and Strategies for Information Development

Four initial priorities have been agreed by the Commonwealth, States and Territories to guide information development under the Second National Mental Health Plan. These focus predominantly on the Quality and Effectiveness theme of the Plan. Further work will be undertaken to identify the information development priorities of the Partnerships in Service Reform and Delivery and Promotion and Prevention themes of the Plan, and an evaluation strategy for the Plan. The initial priorities are:

- strengthening the focus on consumer outcomes;
- supporting improvements in service quality;
- shifting the focus of concern from cost to value for money; and
- improving understanding of population needs.

These priorities will be advanced through a series of information development ‘modules’ that outline the specific actions proposed. Details of the modules are presented in the sections that follow.

Work in each of the priority areas should aim to extend the achievements made in recent years, while also responding to the policy themes advocated under the Second National Mental Health Plan. It is important to recognise that progress in such areas will be more dependent upon changes in attitudes and practices of service providers than technical developments.

The objectives and strategies to be pursued in the priority areas are summarised in the sections that follow. While they are discussed separately, in reality the four priorities are strongly interdependent. For example, assessment of service quality needs to take account of the end results of services (consumer outcomes). Similarly, interest in the ‘value for money’ aspect of actual services delivered needs to be balanced by knowledge about those in need but who do not receive care (population needs).

Consideration of whether a mental health service meets population needs, delivers quality, achieves good outcomes and represents value for money therefore represent different views of the same, complex endeavour to design a better future health care system. Separation of these issues in the following discussion is done only to highlight the particular aspects of this endeavour requiring priority attention over the next five years.

Strengthening the focus on consumer outcomes

Work completed under the first National Mental Health Plan set the stage for the introduction of routine consumer outcome measurement in mental health services. The experience gained has put Australia at the cutting edge in this field, but now needs to be taken to the next logical step. This involves implementation in the day to day world of clinical practice.

Routine assessment of consumer outcomes will assist clinicians, consumers and carers in key ways.

- First, for consumers and carers it provides a point of feedback and dialogue to evaluate the value of the treatments they receive.
- Second, for providers, it informs treatment decisions and contributes to the evaluation of the effectiveness of interventions and monitoring of client progress.

In addition, at the broader system level, outcome data can be used to inform a variety of other processes that guide policy, service development and funding decisions. These include, for example, preparation of patient profiles and outcome benchmarks used in the development of clinical guidelines.

Selection of measures

While it is acknowledged that there is no single, ‘perfect measure’ of consumer outcome that meets all needs, there is broad support for identifying a core set of measures that can be applied across all settings. Introduction of core outcome measures will, through trial and application, provide a base for development of national outcome standards as well as stimulating ongoing improvement in the practice of outcome measurement and the measures themselves.

Three instruments have been agreed for introduction as core measures within adult mental health services, on the basis of recommendations to date¹⁴

- The Health of the Nation Outcome Scales
- The Life Skills Profile
- The Mental Health Inventory

These instruments have been adopted because:

- of the measures trialed in Australian studies, they represent the most acceptable to clinicians and consumers across a broad range of treatment settings;
- substantial normative Australian data has been developed through their use in a number of major studies;
- together, they provide a ‘package’ of measures that covers three critical dimensions of the outcome concept (clinical severity, disability and consumer self ratings);

14 Stedman, T., Yellowlees, P., Mellsop, G., Clarke, R., and Drake, S. (1997). *Measuring Consumer Outcomes in Mental Health*. Canberra, ACT: Department of Health and Family Services.

- two of the measures—the HoNOS and LSP—serve purposes beyond outcome measurement, having been shown to be useful instruments in the development of a mental health casemix classification. Linking of consumer outcome measurement to classification represents a desirable step in the application of casemix in Australia; and
- to achieve the collection of nationally consistent data it is necessary to limit the number of core instruments chosen.

Specification of the three instruments as ‘core’ does not restrict the use or development of additional measures, but simply identifies the common ground for beginning the process of routine outcome measurement. In particular, limited Australian research has been undertaken on consumer rated measures, and additional work in this area is important.

As indicated earlier, work is ongoing to identify standard outcome measures suitable for routine use in specialised Child and Adolescent mental health services. Once this work is finalised, the implementation steps summarised below can proceed.

Implementation strategies

Module One provides the detailed outline of the range of actions proposed to be taken over the next five years by the Commonwealth, States and Territories. Together, these aim to work on multiple fronts and incorporate:

- the principle that participation should be tailored to the different stages of development and capacities of individual jurisdictions;
- support to be provided by the Commonwealth to participating service jurisdictions in the introduction of core measures through training, technical infrastructure and access to customised benchmark reports;
- a process for the national aggregation, analysis and reporting of outcome data; and
- a mechanism for the ongoing refinement of core measures and development of additional condition-specific measures for potential application in future years.

Table 4 provides an overview of the strategies proposed for strengthening the focus on consumer outcomes, separating those that are concerned with improvements in local information systems from those involving research and development activity at the national level.

Table 4: Information development strategies to strengthen the focus on consumer outcomes

<i>Local Information System Strategies</i>	<i>National Research and Development Strategies</i>
<ul style="list-style-type: none"> • Broad adoption by service organisations of outcome measurement as an integral component of mental health service delivery. • Regular reporting by agencies of core outcome measures. • Financial grants to support re-design of local information systems to accommodate outcome measurement, with capacity for both local reporting and extraction of agreed minimum data set. • Preparation, training and motivation of the clinical workforce in outcome measurement. • Development of supplementary software tools to facilitate outcome monitoring at the individual patient level. 	<ul style="list-style-type: none"> • Development of agreed measurement standards for monitoring consumer outcomes. • Development of national reporting guidelines that define the reporting 'rules': who to report, when to report, how to report. • Establishment of national network of accredited organisations to provide clinician training in the use of outcome measures. • Establishment of a central 'mental health outcomes bureau' to be responsible for: <ul style="list-style-type: none"> – national training accreditation; – collection, analysis and reporting of outcome data; – development and publication of national consumer outcome benchmarks, prepared as a component of a broader set of 'national service quality indicators (see Table 8); and – ongoing development of core consumer outcome measures. • Commissioning of special research studies to develop condition-specific and other consumer outcome measures. • Ongoing refinement of standard outcome measures based on developing knowledge base.

MODULE ONE

Implementation Strategy for Introducing Routine Consumer Outcome Measurement in Mental Health Services

Short Title: Outcomes Implementation Module

1 Purpose

- 1.1 This module outlines strategies to enable the introduction of routine measurement of consumer outcomes in public and private sector mental health services. Details are provided of actions to be undertaken and the relative roles of funders and service providers in implementation.

2 Objective

- 2.1 The objective is to establish routine collection and reporting of consumer outcome data by all public funded mental health services with specialist psychiatric units within the period of the Second National Mental Health Plan.

3 Rationale

- 3.1 For consumers and carers, outcome assessment provides a point of feedback to evaluate the value of the treatments they receive.
- 3.2 For providers, it informs treatment decisions and contributes to evaluating the effectiveness of interventions and monitoring of client progress.
- 3.3 At the broader system level, collection of outcomes data can be used to inform a variety of other processes that guide policy, service development and funding decisions.

4 Principles to be followed in introduction of routine outcome assessment

- 4.1 **Participation:** Participation in the collection and reporting of core outcome data should be tailored to the different stages of development of individual jurisdictions.
- 4.2 **Confidentiality:** Protocols designed to protect the confidentiality of patients and health service organisations in national health collections will be applied to all data collected for the purposes of mental health consumer outcome measurement.
- 4.3 **Ongoing review and refinement:** The processes outlined in this Module will be subject to ongoing review and refinement, to ensure their relevance and appropriateness in light of experience gained in mental health consumer outcome measurement.

5 Definitions

- 5.1 The term ‘core outcome data’ is used to refer to the data obtained from the application of selected standardised measurement instruments designed to assess clinical and social functioning of individual consumers of mental health services.
- 5.2 The term ‘outcomes data set’ refers to patient-level unit record data which comprises relevant fields within the NMDS-Mental Health Care, plus core outcome data items.
- 5.3 ‘National service quality indicators’ refers to the measures of service quality that will be developed under the implementation strategy for national service quality indicators (see Module Two).
- 5.4 ‘Participating organisations’ refers to publicly funded mental health service organisations that agree to the routine collection and reporting of core outcome data.

6 Strategies for implementation

- 6.1 Core Outcome Measures—Adult Services: The following measurement instruments have been agreed for collection of core outcome data by organisations that provide general adult mental health services (see Table 5 for brief descriptions).
 - 6.1.1 The Health of the Nation Outcomes Scales (HoNOS)
 - 6.1.2 The Life Skills Profile (LSP) (Full or Abbreviated version)
 - 6.1.3 The Mental Health Inventory (MHI)
- 6.2 Core Outcome Measures—Child & Adolescent Services: Measurement instruments for use in specialised Child and Adolescent mental health services will be finalised in the second year of operation of the Second National Mental Health Plan. Once these have been agreed, equivalent implementation processes as outlined in this module should be followed.
- 6.3 Outcome Measures Implementation: States and Territories will prepare plans for the collection and reporting of core outcome data. The plans will be prepared in conjunction with the Commonwealth and will include:
 - 6.3.1 Identification of proposed participating organisations.
 - 6.3.2 Identification of changes required to the existing information infrastructure to allow routine collection and reporting of consumer outcome data, the costs in achieving this and the proposed sources of funds to allow implementation over the course of the Second National Mental Health Plan.
 - 6.3.3 Identification of the resources required, and support and incentives to be put in place to assist participation by mental health service providers in the collection and national reporting of consumer outcome data.
 - 6.3.4 A strategy that addresses the workforce training requirements arising from the introduction of consumer outcome measurement.
 - 6.3.5 A timetable for implementation over the course of the Second National Mental Health Plan.

- 6.4 Outcomes training network: The Commonwealth will contribute funds to establish a national network of training organisations to provide training resources and support to service providers in the use of consumer outcome measurement instruments. To establish the training network:
- 6.4.1 A process of ‘accreditation’ will be developed by the Commonwealth in consultation with the States and Territories.
 - 6.4.2 A central body will be identified to conduct the training accreditation process, as outlined in paragraph 6.4.
 - 6.4.3 Systems for the ongoing training and development of the workforce will be considered as part of the establishment of the network.
- 6.5 Mental health outcomes bureau: A mental health outcomes bureau, or bureaus, will be established which will have the responsibilities outlined below:
- 6.5.1 Establishment of a national training network to provide training in the use of mental health outcomes instruments.
 - 6.5.2 Development of a national training program that will form the basis for accreditation of training agencies.
 - 6.5.3 Development and maintenance of guidelines that define procedures for collection and reporting of core outcome data by participating organisations.
 - 6.5.4 Collection and analysis of consumer outcome data provided by participating organisations.
 - 6.5.5 Development of ‘outcome benchmarks’ for publication as a component of national service quality indicators.
 - 6.5.6 Preparation of standard summary reports to participating organisations that provide comparative benchmark data.
 - 6.5.7 Promoting the exchange of information on the role of different outcome measures in different clinical areas.
 - 6.6.8 Coordination and liaison with related organisations operating in the field of health outcome measurement.

7 Research and development

- 7.1 Further priorities for research and development in the field of mental health consumer outcome measurement will be agreed between the Commonwealth, States and Territories, and will include:
- 7.1.1 Identification or development for national implementation of a range of supplementary ‘condition-specific’ outcome measures relevant to particular mental health disorder groups.
 - 7.1.2 The ongoing refinement of measurement instruments used to collect core outcome data.

8 Review

- 8.1 The procedures outlined above will be subject to regular review to ensure that they reflect knowledge gained from the trial and application of routine outcome measurement.
- 8.1.1 Procedures used for the collection and reporting of core outcome data will be reviewed annually by the Commonwealth, States and Territories.
- 8.1.2 The specific instruments used for the collection of core outcome data will be reviewed on a bi-annual basis.

Table 5: Core consumer outcome instruments for general adult psychiatry services

<i>Measure</i>	<i>Description</i>
Health of the Nation Outcome Scales (HoNOS)	A clinician completed, 12-item, rating scale designed by the Royal College of Psychiatrists in London. The scale was commissioned by the Department of Health explicitly for use in monitoring progress towards the UK National Health Service's target of 'improving significantly the health and social functioning of mentally ill people'.
Life Skills Profile (LSP)	A clinician completed, 39-item, rating scale developed by an Australian clinical research group to assess patients' abilities with respect to basic life skills over the preceding three months. The profile has five scales: Self-Care, Non-Turbulence, Social Contact, Communication, and Responsibility. An abbreviated 16-item version has also been developed as an alternative covering the following scales: Withdrawal; Anti Social Behaviour; Self-Care; Compliance.
Mental Health Inventory (MHI)	A self administered, 38-item, questionnaire assessing general psychological distress and well-being. Summary scores on sub-scales representing anxiety, depression, loss of behavioural or emotional control, general positive affect and emotional ties, as well as a global score representing general well-being can be derived.

Supporting improvements in service quality

Quality of health services has been described as the extent to which health care meets predefined standards of good or acceptable care.¹⁵ In reality it has two sides, one concerned with maintaining minimum standards or avoiding harm, and the other about promoting continuous improvement.

Since the commencement of the National Mental Health Strategy, several projects aimed at improving the quality of mental health services have been initiated. These have sought to improve the standards of service provision by encouraging the review of services and assessing outcomes from the perspective of a wide range of participants, including consumers, carers, health professionals, allied health workers, and governments. A central objective of the work has been to inform and change practices amongst service providers.

Concerns about poor service quality were a major factor leading to Commonwealth, States and Territories agreement to the National Mental Health Strategy. Recent evidence obtained from the MH-CASC project¹⁶ has provided further grounds to maintain the momentum built over recent years. As indicated earlier, the study found that a major factor predicting the level of care received by a patient was the provider of care rather than the clinical problems of the patient. Provider factors accounted for a significant share of the variation between patients in the amount of services received.

Measuring quality

Progress on service quality improvement will continue under the Second National Mental Health Plan through a range of strategies, all of which depend on access to information. In considering the role that information plays in supporting quality improvement, it is useful to consider the three perspectives from which quality of health care can be assessed.

First, quality can be measured by reviewing the inputs of health services. These include, for example, the physical environment, the range and structure of services, the level and composition of the clinical workforce and so forth.

Second, quality can be assessed by review of the processes of health care. Processes refer to the activities of the health service, measured in terms of procedures, practices and activities.

Third, quality of health care can be assessed by its outcomes, or what changes (or does not change) as a result of the care that is delivered. These include direct measures of individual consumer health status, as described in the previous section, or system-wide measures such as the proportion of consumers who return to employment.

15 Wells, K and Beck, R (1987) *The Quality of Mental Health Services: Past Present and Future*, in *The Future of Mental Health Services Research*, National Institute of Mental Health, US Department of Health and Human Services, Washington.

16 See Footnote 7.

While different views exist about how to best measure quality, there is general acceptance that a mixture of approaches offers most potential. From the consumer’s perspective, the health ‘product’ is as much about inputs and process (who provides treatment and how) as it is about outcomes (whether benefit occurs).¹⁷ Working on all fronts, and having the information systems to support that work, will be the approach promoted under the Second National Mental Health Plan.

To date, most effort has been focused on defining standards for inputs and processes, culminating in the release in 1997 of the National Standards for Mental Health Services.¹⁸ The standards give meaning to the concept of ‘good quality care’ in the mental health field by defining criteria covering all aspects of a service, including its structure, procedures, interactions with consumers and carers, and internal regulatory processes. They address eleven areas of health care delivery, summarised in Table 6 below.

Table 6: National Standards for Mental Health Services

1	Rights	7	Cultural Awareness
2	Safety	8	Integration
3	Consumer and Carer Participation	9	Service Development
4	Promoting Community Acceptance	10	Documentation
5	Privacy and Confidentiality	11	Delivery of Care
6	Prevention and Mental Health Promotion		

A key element of each of the national standards is the requirement that a mental health service organisation ‘...monitors its performance in regard to the...criteria and utilise data collected to improve performance as a part of a quality improvement performance process.’

Implementing the National Service Standards is an agreed priority during the Second National Mental Health Plan, placing considerable demand on local information systems to provide the type of data necessary for review and monitoring purposes. A wide range of ‘quality indicators’, covering the spectrum of service inputs, processes and outcomes, is needed to support implementation of the Standards.

National Quality Indicators

An agreed set of national indicators will be developed over the course of the Second National Mental Health Plan for use in monitoring mental health service quality. By way of example to demonstrate the range of information to be considered, national mental health service quality indicators may include measures of:

- population access to services;
- the utilisation of services, both generally and by particular populations (eg Aboriginal and Torres St Islander Peoples, people from non-English speaking backgrounds);

¹⁷ Health Issues Centre (1992), Casemix, Quality and Consumers, Health Issues Centre, Melbourne

¹⁸ National Standards for Mental Health Services, *ibid.* See Footnote 10.

- service delivery, including admission and re-admission rates, community service provision, and throughput rates;
- service levels, mix and clinical workforce availability measured against agreed norms (eg beds and community staffing per capita);
- consumer satisfaction with services;
- consumer and carer participation in services;
- ‘appropriateness of care’ measured against agreed clinical protocols for particular clinical conditions;
- system level outcomes, based on aggregated individual consumer data as well as broader indicators covering longer term social and clinical outcomes (eg employment, housing, disability); and
- adverse outcomes (suicide, homelessness) in consumers following treatment intervention.

Significant initiatives to develop national health quality indicators have been taken elsewhere in the health system, which may serve as a model for mental health services. For example, a process for the introduction of national ‘quality and outcome indicators’ in acute health care was developed in 1997, which defined the range of information to be included and criteria for indicator selection (Table 7).¹⁹ In a parallel development, the Australian Health Ministers’ Benchmarking Group has been established to define desired levels of health service performance on a select number of indicators. There is a strong focus in the initial report to Health Ministers on the development of evidence based practice and the use of practice guidelines, supported by clinical information systems to help identify problem areas that mitigate against a safe, high quality health care system.²⁰

Table 7: Characteristics of a successful National Quality and Outcome Indicator Program

<ul style="list-style-type: none"> • Comprehensive: A sufficient breadth of indicators should be used to guarantee that a range of dimensions of care for common, relevant conditions is covered. • Collaborative: The program should evolve with the active participation of all interested parties pursuing a common goal of attaining a credible indicator set which can satisfy accountability requirements, guide consumer-choice and promote quality improvement. • Consumer-focused: Indicators must embrace consumer involvement in the identification of areas of care delivery warranting monitoring and in the design, implementation, interpretation and feedback on indicators of quality of care and outcomes. 	<ul style="list-style-type: none"> • Current: National indicator should be updated regularly to keep abreast of developments in quality of care monitoring and mental health services delivery. • Cost-efficient: Wherever practical, indicators should utilise existing data for indicator construction, making incremental changes to routine databases as the needs for additional data points are identified by appropriate research and field trials.
--	--

(Adapted from Quality and Outcome Indicators for Acute Healthcare Services, 1997)

19 Boyce N., McNeil J, Graves D. and Dunt D (1997) Quality and Outcome Indicators for Acute Healthcare Services, Department of Health and Aged Care, Australian Government Publishing Service, Canberra .

20 National Health Ministers Benchmarking Working Group (1996) The First National Report on Health Sector Performance Indicators, Australian Institute of Health & Welfare, February 1996.

Alongside the national indicators, individual service organisations need similar information to support local monitoring and quality assurance processes.

While a small number of indicators require specially collected samples, the majority should be derived from routine clinical information collections. Developing meaningful national indicators of service quality therefore relies on the availability of clinically-oriented service delivery information systems. As discussed earlier in this paper, information infrastructure is a major development issue for mental health services in Australia, which will require addressing as a pre-condition to indicator development.

Implementation strategies

The Commonwealth, States and Territories will develop and implement national mental health service quality indicators in consultation with consumer and carer organisations and professional bodies. This will involve four main areas of development.

- 1 Development of a national service quality indicator set: Research and consultation are needed to guide indicator development, along the lines of similar work conducted for other areas of the health industry. This is best progressed as a collaborative exercise between the parties. The national quality indicators will be based on a range of data to inform about inputs, processes and outcomes of service delivery.
- 2 National performance benchmarks for mental health services: Desired levels of performance will be defined on a selected number of service quality benchmarks, based on experience in their use. Information Development Module Two, presented in the following pages, provides details of this proposal.
- 3 National Minimum Data Set for Mental Health Services: Development of the indicators should be approached from the position of deciding what data are needed rather than being restricted to data contained in existing collections. The long term success of quality indicators will require that the necessary data, once identified, are defined and collected in a consistent way and where practical, incorporated within the NMDS—Mental Health Care. Information Development Module 5, summarises the actions agreed by the States and Territories as being required to advance the NMDS—Mental Health Care and provides details of further work to progress national collection of agreed data.
- 4 Local Clinical Information Systems: Routine reporting of the data used to build the national indicators relies on appropriate data systems being in place at the service delivery level.

Alongside these ‘information-based’ strategies, investment will be made in defining clinical protocols for particular classes of patients, developed in consultation with professional bodies. This work will be progressed outside of the information development framework, but has clear implications for the range of data required to monitor adherence to the protocols.

Table 8 summarises the range of strategies proposed for developing national indicators to support service quality improvements, separating those that are concerned with improvements in local information systems from those involving research and development activity at the national level.

Table 8: Information strategies to support improvements in service quality

<i>Local Information System Strategies</i>	<i>National Research and Development Strategies</i>
<ul style="list-style-type: none"> • Development of systems that support local quality improvement processes including: <ul style="list-style-type: none"> – monitoring of individual consumer outcomes (as per Table 4) – aggregate reporting on outcomes to inform local quality reviews; – capacity to signal problems in service quality when they occur (eg patients ‘lost to care’); – capacity to monitor adherence to National Mental Health Service Standards. • Development of capacity to collect and report agreed national quality indicator data set. 	<ul style="list-style-type: none"> • Establishment of a process to develop, test and refine service quality indicators suitable for national application. • Development and annual publication of ‘service quality benchmarks’ based on the agreed national indicators. • Development of clinical protocols to define treatment pathways for particular disorder groups and agreement on indicators to monitor adherence to the protocols. • Development of a national taxonomy of services and service interventions for monitoring ‘appropriate care’. • Implementation of a national casemix classification that: <ul style="list-style-type: none"> – provides a focus for clinical protocol development; – allows indicators of service quality to be adjusted for casemix differences(as per Table 10). • Development of agreed measurement standards for monitoring consumer outcomes (as per Table 4). • Continuing development of the NMDS–Mental Health Care to incorporate data requirements for national quality indicators.

MODULE TWO

Development and Implementation of National Service Quality Indicators for Mental Health Services

Short Title: National Service Quality Indicators Module

1 Purpose

- 1.1 This module outlines plans to develop and implement national service quality indicators for use in promoting improvement in the quality of care provided by mental health services.

2 Objective

- 2.1 The objective is to develop a set of indicators for monitoring service quality in mental health services and establish a process for their regular publication.

3 Rationale

- 3.1 Improvement of the quality and effectiveness of services is one of the three key policy themes advocated under the Second National Mental Health Plan.
- 3.2 Development and publication of national service quality indicators will provide the basis for monitoring mental health services during the Second National Mental Health Plan.
- 3.3 Service quality indicators are necessary to support the comprehensive introduction of the National Standards for Mental Health Services.

4 Principles to be followed in development of national service quality Indicators

- 4.1 **Participation:** Participation in the collection and reporting of the national service quality indicators should be tailored to the different stages of development of individual jurisdictions.
- 4.2 **Confidentiality:** Protocols designed to protect the confidentiality of patients and health service organisations in national health collections will be applied to all data collected for the purposes of the national service quality Indicators.
- 4.3 **Ongoing review and refinement:** The strategies outlined here are based on learning from the trial and application of national service quality indicators for mental health services and, as such, will be subject to ongoing review and refinement.

5 Definitions

- 5.1 The term ‘outcomes data set’ refers to the data outlined in the outcomes implementation module of this document (see Module One).
- 5.2 The term ‘casemix data set’ refers to the data outlined in the Casemix Information proposal (see Module Three).
- 5.3 ‘Participating organisations’ refers to publicly funded mental health service organisations which agree to the collection and reporting of the outcomes and casemix data sets.

6 Strategies for implementation

- 6.1 National indicator development: The Commonwealth, States and Territories will support development of a national set of indicators for use in monitoring the quality of mental health services. The development of the indicators will be undertaken by the National Mental Health Information Strategy Committee (ISC), a subcommittee of the AHMAC National Mental Health Working Group. The ISC will draw on input from service providers, professional bodies, consumers and carers in developing the indicators.
- 6.2 Range of Indicators: Indicators considered for national application should be selected to inform on the inputs, process and outcomes dimensions of service quality. Examples of indicator coverage are provided in Table 9 below.

Table 9: Examples of coverage of National Service Quality Indicators

<i>Input indicators</i>	<i>Process Indicators</i>	<i>Output and Outcome Indicators</i>
<ul style="list-style-type: none"> • Service levels, mix and clinical workforce availability measured against agreed norms (eg beds and community staffing per capita). • Relative per capita spending across service mix. 	<ul style="list-style-type: none"> • Population access to services, including service delivery levels to special need groups. • Consumer and carer participation in services. • ‘Appropriateness of care’ measured against agreed clinical protocols for particular clinical conditions. 	<ul style="list-style-type: none"> • Service delivery, including admission and re-hospitalisation rates, community service provision, and throughput rate. • Comparative costs adjusted for casemix variations (as developed under the Casemix Implementation Strategy). • Consumer satisfaction with services. • Consumer outcome benchmarks. • System-level outcomes, based on aggregated individual consumer data as well as broader indicators covering longer term social and clinical outcomes (eg employment, housing, disability). • Adverse outcomes (eg suicide, homelessness) in consumers following treatment intervention.

- 6.3 National performance benchmarks for mental health services: Desired levels of performance will be defined on a selected number of service quality benchmarks, based on experience in their use.
- 6.4 Current and future indicators: Development of national indicators should distinguish those that can be built from existing mental health data collections and those requiring new data collections. The proposed new data collections include data proposed for collection under the under the outcomes and casemix implementation modules (Modules One and Three).
- 6.5 Analysis and reporting of data: Data against the national quality indicators will be published annually in the National Mental Health Report.

7 Review

- 7.1 National service quality Indicators will be subject to regular review to ensure that they reflect knowledge gained in the construction and interpretation of measures to monitor service quality.

Shifting the focus of concern from cost to value for money

Responsible management of scarce mental health resources necessarily requires consideration of the cost and efficiency of existing services. The large-scale service restructuring objectives of the National Mental Health Strategy, and the associated transfer of funds between service settings, also emphasised the need for close fiscal monitoring. As a result, data collections over the first five years of the Strategy were driven largely by a need to understand input costs and did not embrace the more complex issue of cost effectiveness. Nevertheless, a substantial amount of information was gathered about the way in which mental health resources are deployed in Australia, as is demonstrated in the most recent National Mental Health Report.²¹

Under the Second National Mental Health Plan, the focus on mental health funding will be to build on the achievements of the Mental Health Funding Models National Work Program undertaken under the First National Mental Health Plan. There will be a particular emphasis on linking information about resources to the wider issues of quality and effectiveness. This broader view parallels developments elsewhere in the health system, where the focus on costs that characterised the past decade of health policy is shifting to a focus on value for money.²² This evolution is based on an understanding that:

- services of equal cost are not necessarily of equal value; and
- efficiency in itself is not sufficient to guarantee better mental health outcomes.

Informing value for money judgments

Judgements about value for money are complex, and are concerned with how to achieve the best health gain from available resources. In simplified terms, it requires knowledge about the benefits that accrue from investing resources in a particular way, balanced by knowledge about the opportunity costs of those investments, or what could have been achieved if resources were invested differently.

Translating these concepts to the mental health field, a range of information is necessary to monitor the degree to which existing resource allocation patterns deliver best value for money. Broadly, the information required falls into three categories.

First, comparative information is needed about the health outcomes achieved for people in receipt of current services. This requires outcome data of the kind discussed in earlier sections of this paper, measured against some standard that defines the outcomes expected for people affected by particular mental health disorders. The purpose of this information is to provide an indication of the extent to which we are achieving the most effective results possible from our existing resource investments.

21 Commonwealth Department of Health and Aged Care (1999) National Mental Health Report 1997: Changes in Australia's Mental Health Services Under the National Mental Health Strategy 1996–97, Canberra.

22 Eagar K (1994). Striking the right balance- Health care financing in Australia, In The Health Insurance Debate—Widening the Options. Proceedings from the AHA Health Financing Seminar, Australian Hospitals Association, Canberra.

Second, comparative information is needed about the costs incurred in achieving those outcomes, measured against a standard to indicate what such outcomes should cost in the current circumstances. The purpose of this information is to determine whether we are achieving the most efficient results from current services.

Third, information is required about the overall population needs for mental health care and the level of need being met by current service arrangements. This information is necessary to inform of the potential demand on available resources and the possible benefits that may flow from allocating resources in a different way, or to different ‘needy’ groups. This then begins to define the choices available in allocating resources for the overall benefit of the community.

The importance of including ‘unmet need’ in any value-for-money analysis has been emphasised through the recent publication of the National Mental Health Survey which pointed to an estimated 18% of the Australian population who meet diagnostic criteria for a mental disorder.²³ Of these, approximately two thirds did not receive any form of treatment for the mental health problem over the preceding 12 months.²⁴ Other research commissioned under the Strategy suggests that only 2–3% of the population receive treatment.²⁵ While not all people who meet clinical criteria for a disorder need care from mental health services, the Second National Mental Health Plan advocates strongly for the mental health service system to be sensitive to examining the issue of untreated need.

Information development to support value for money analyses is drawn from a variety of sources. At the population level, it requires information about the extent of need for mental health care, the degree to which needs are being met, and the capacity for services to meet those needs.

At the service delivery level, data are required about each of the five elements of the Leginski paradigm (‘Who receives what services from whom, at what cost, and with what effect?’).²⁶ Like other information development priorities, little progress can be made in improving value for money decisions until quality local clinical information systems are established in mental health services. Strategies described elsewhere in this paper to improve routine service delivery collections are therefore relevant in this context.

The role of casemix classification

Casemix classifications provide a standardised method for describing the activities of health services in terms of the types of patients treated, their treatment episodes and associated resource use. They add an important dimension to value for money assessments because they provide tools that distinguish variation between health services that are attributable to patients from those that are caused by provider factors. Separating these two sources of variation in health service data – provider differences and casemix differences – is an essential step in developing benchmarks to compare services on costs, outcomes and quality.

Casemix classifications are now routinely used as information tools throughout the Australian health system. Since the mid 1980s, Commonwealth, State and Territory governments have actively encouraged the development of such classifications as a method to describe health service activity,

23 National Survey of Mental Health and Wellbeing, *ibid.* See Footnote 8.

24 National Mental Health Report 1997, *ibid.* See Footnote 21.

25 Solomon S, Buckingham W and Epstein M. (1993) Report of Consultancy for the Medical Workforce Committee on Medical Workforce Financing Arrangements, Department of Health and Family Services, Canberra.

26 Leginski et al, (1989) *ibid.* See Footnote 26.

encouraged by a significant Commonwealth-funded research and development program. This encouragement has taken different forms, and has been both direct (eg funding for specific casemix projects) and indirect (eg support for standard definitions and uniform coding practices). An effect of this work has been the substantial development of information infrastructure and improvements in data quality within general health services. As indicated earlier in this report, mental health services have been largely isolated from these developments.

Casemix is often wrongly viewed as solely concerned with the funding of health services, and as such, has been viewed with concern by the mental health community. However, its original purpose was to provide a basis for quality assurance. In Australia, casemix was introduced initially as a management information system to assist in improving efficiency, standards and patient outcomes, not as a basis for determining payments.

This role of a casemix classification is often lost in discussions about its potential in the mental health field. Opinion is shifting towards the view that the future of casemix in Australia is in restoring these original purposes to the casemix agenda. The Secretary of the then Commonwealth Department of Health & Family Services commented at the 1996 National Casemix Conference that:

‘Measuring outcomes and quality is not an easy or straight forward task. It is essential nonetheless that we head down this path. What we learn from casemix information should help us to do this more effectively. In time we may be able to move the use of output based funding to funding based on outcomes and the achievement of quality of care.’²⁷

There is a good case for introducing casemix classification into mental health services as a clinical and management information tool. Its key contribution would be in providing a standard system for describing the products of mental health services, a necessary step in considering the broader value for money issues. Linking of a casemix classification to outcomes data is also essential in making best use of outcome measurement as a tool for assessing the quality and effectiveness of service delivery. Once a standard method for describing mental health casemix has been introduced, work can then commence to define the appropriate care packages (or clinical protocols) required for each patient class.

Implementation strategies

The Commonwealth, States and Territories have agreed to four strategies to strengthen the capacity to conduct value for money analyses.

The first is the further development of the MH-CASC classification through its introduction across a range of mental health services. This is based on the premise that refinement of the classification as a method to describe mental health ‘care products’ will best occur through experience gained in its day-to-day use. The MH-CASC classification represents a ‘first generation’ system for describing services in casemix terms, and provides a base for further development. Most importantly, there is significant overlap between the outcomes and casemix data requirements. Specific details of the implementation strategy and casemix data requirements are presented in Module Three at the conclusion of this section.

27 Podger Charts Course for Casemix, Australian Casemix Bulletin, December 1996, Vol 8, No 3.

The second is that, as an aspect of the development of clinical care protocols, ‘appropriate care’ packages for each of the MH–CASC classes be documented and costed. This contributes to definitions of service quality by establishing indicators of the relative resource needs of patients that are based on ‘good practice’ rather than ‘actual practice’.

Thirdly, ‘value for money’ benchmarks will be developed and published regularly, that bring together cost, casemix and outcome data reported by service delivery organisations. These will form a component of the broader set of national service quality indicators described in the previous section. Benchmark development was discussed earlier (see Module Two).

Fourth, further work will be undertaken to improve our understanding of the range and extent of mental health disorders in the community, with a view to quantifying the level of unmet need. This issue is discussed at greater length in the next section of this paper.

A summary of the strategies that will contribute to improved ‘value for money’ analyses of mental health services is presented in Table 10.

Table 10: Information strategies to support value for money analyses of mental health services

<i>Local Information System Strategies</i>	<i>National Research and Development Strategies</i>
<ul style="list-style-type: none"> • Establishment of information systems that provide required data on: <ul style="list-style-type: none"> – services provided by casemix class; and – outcomes by casemix class • Regular collection and reporting of patient data (as per above) to allow casemix profiles to be developed – at agency, State and national levels 	<ul style="list-style-type: none"> • Implementation and development of the MH–CASC casemix classification as a management information tool to monitor service output. • Development of a national taxonomy of services to enable ‘like with like’ service comparisons (as per Table 8). • Development of agreed measurement standards for monitoring consumer outcomes (as per Table 4). • Development and annual publication of ‘value for money’ benchmarks, prepared as a component of a broader set of ‘national service quality indicators (see Table 4). These will include: <ul style="list-style-type: none"> – Costs by service type – Costs per casemix class – Cost per outcome level per case type • ‘Appropriate care packages’ to be designed and costed for each of the MH–CASC classes. • Development of measures of relative population need, and indicators of service utilisation (as per Table 13). • Ongoing refinement of the NMDS–Mental Health Care to incorporate casemix data requirements following implementation trials.

MODULE THREE

Further Development and Implementation of a National Mental Health Casemix Information System

Short Title: Casemix Information Module

1 Purpose

- 1.1 This module outlines plans to develop further and to refine a national casemix information tool for use in mental health services based on the findings of the Mental Health Classification and Service Costs Project.
- 1.2 The module is designed to strengthen the data collection strategies described in the outcomes implementation module (Module One) and should be read in conjunction with that module.

2 Objective

- 2.1 The objective is to develop a basis for the introduction of casemix information tools into publicly funded mental health services within the period of the Second National Mental Health Plan.

3 Rationale

- 3.1 Casemix classifications provide information tools to facilitate the management, monitoring planning and delivery of services.
- 3.2 Introduction of casemix measures to mental health services will:
 - 3.2.1 Assist in the interpretation of consumer outcome data.
 - 3.2.2 Contribute to the development of quality improvement initiatives.
 - 3.2.3 Facilitate the interpretation of service utilisation data.
 - 3.2.4 Facilitate the interpretation of cost and practice variations between service providers.
 - 3.2.5 Provide a basis for the development of clinical protocols and 'good practice costing' for particular classes of mental health consumers.
 - 3.2.6 Inform funding decisions by providing a focus on how resources are allocated to the population under care.
 - 3.2.7 Strengthen the development of cost benchmarks.

4 Principles to be followed in casemix information and development

- 4.1 **Participation:** Participation in the collection and reporting of the casemix data set should be tailored to the different stages of development of individual jurisdictions.
- 4.2 **Confidentiality:** Protocols designed to protect the confidentiality of patients and health service organisations in national health collections will be applied to all data collected for the purposes of national casemix classification development.
- 4.3 **Ongoing review and refinement:** The strategies outlined in this module are based on learning from the trial and application of a casemix classification in mental health services and, as such, will be subject to ongoing review and refinement.

5 Definitions

- 5.1 The term ‘casemix information system’ is used to refer to a standardised method for describing the activities of health services in terms of the types of patients treated, their treatment episodes and associated resource use.
- 5.2 MH–CASC refers to the Mental Health Classification and Service Costs Project funded under the National Mental Health Strategy.
- 5.3 The MH–CASC casemix classification refers to a system for assigning patients to casemix classes developed by the MH–CASC project.
- 5.4 The term ‘casemix data set’ refers to the patient data required to assign cases to the MH–CASC casemix classification. A description of the instruments used for the classification is provided in Table 11. Details on when those measures need to be collected are summarised in Table 12.
- 5.5 ‘National service quality indicators’ refers to the measures of service quality that will be developed under the service quality indicators module (see Module Two).
- 5.6 ‘Participating organisations’ refers to publicly funded mental health service organisations that agree to the collection and reporting of the casemix data set.
- 5.7 Outcomes implementation module refers to the strategies outlined in Module One.

6 Strategies for implementation

- 6.1 **Casemix information:** States and Territories will develop plans for the introduction and use of the MH–CASC casemix information. Due to the significant overlap in data requirements of the casemix data set and the outcomes data set, implementation plans will need to be linked to implementation of consumer outcomes measurement.
- 6.2 **Casemix training network:** A network of training organisations will be established to provide training resources and support to assist implementation of casemix classification measurement. Where possible, training for the casemix information collection will be delivered through the network of training organisations established under the outcomes implementation module.

- 6.3 Software development: Grouper software for public domain distribution will be developed to enable agencies to use the MH-CASC classification.
- 6.4 Collection, analysis and reporting of data: A suitable organisation will be engaged to manage the data provided by participating sites. This organisation will have the following responsibilities:
 - 6.4.1 Provision of advice and support to participating sites on procedures for data collection and reporting of the casemix minimum data set.
 - 6.4.2 Analysis of data provided by participating organisations.
 - 6.4.3 Development of national ‘casemix benchmarks’ for publication as a component of the national service quality indicators.
 - 6.4.4 Preparation of standard summary reports that provide comparative casemix benchmarks for review by participating organisations.
 - 6.4.5 Coordination and liaison with related organisations operating in the field of casemix information development.

7 Research and development

- 7.1 Expert input to further development: A range of expertise will be sought to contribute clinical and technical advice for the ongoing development and implementation of casemix information in mental health services. Individuals with appropriate expertise will be invited to:
 - 7.1.1 Contribute advice based on the experience gained in using casemix in mental health services.
 - 7.1.2 Conduct additional studies where these are needed to resolve classification development issues.
 - 7.1.3 Promote the use of casemix information as a tool to assist in improving service quality, consumer outcomes and to inform funding of mental health services.
- 7.2 Research and Development Program: The Commonwealth, States and Territories will undertake a range of projects to support the introduction of casemix information in public and private sector mental health services. Priorities for funding will be based on broad stakeholder consultation. Priorities may include:
 - 7.2.1 Research projects addressing classification issues in specialty branches of mental health services.
 - 7.2.2 Cost weight refinements and related costing studies.
 - 7.2.3 Preparation of educational materials to promote an understanding of the uses of casemix information in mental health services.
 - 7.2.4 Quality assurance projects aimed at improving data quality and adherence to national definitional standards.
 - 7.2.5 Development of associated databases that can inform the introduction of casemix information in mental health services.

Table 11: Description of Measurement Instruments used for the MH-CASC Classification

<i>Measure</i>	<i>Description</i>
Measures for Patients of Adult Mental Health Services	
Health of the Nation Outcome Scales (HoNOS)	An instrument developed in the United Kingdom as a tool for use by clinicians in their routine clinical work to measure consumer outcomes. Contains 12 items, monitoring progress across four outcome domains: Behaviour, Impairment, Symptoms and Social.
Life Skills Profile (LSP)	A clinician completed, 39 item, rating scale designed to assess patients' abilities with respect to basic life skills over the preceding three months. The profile has five scales: self-care, non-turbulence, social contact, communication, and responsibility. Note: the MH-CASC classification uses the abbreviated 16-item version of the LSP scale.
Focus of Care	Clinician judgement about the main goal of care: Acute, Functional Gain, Intensive Extended Care, Maintenance.
Resource Utilisation Groups-Activities of Daily Living Scale (RUG-ADL)	An instrument developed by Fries et al. for the measurement of nursing dependency in skilled nursing facilities. Measures the patients needs for assistance in activities of daily living. (eating, bed mobility, transferring and toileting).
Measures for Patients of Child and Adolescent Mental Health Services	
Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)	Child and Adolescent equivalent to the HoNOS. Contains 14 items.
Children's' Global Assessment Scale (CGAS)	An instrument developed by Schaffer and colleagues at the Department of Psychiatry, Columbia University to provide a global measure of severity of disturbance in children and adolescents. Global rating only, on scale of 0-100.
ICD-10 Factors Influencing Health Status	Checklist of 'psychosocial complications' based on ICD-10 Factors Influencing Health Status

Table 12: Recommended data collection cycle required to assign episodes to classes within the MH-CASC classification

<i>Inpatient settings</i>	<i>Data collected at</i>
Age RUG-ADL (for over 65 years only – within 24 hours of admission) Episode Start Date Reason for Episode Start	At admission
HoNOS/HoNOSCA	At admission, based on preceding two weeks and At discharge, based on preceding 3 days. If Episode continues beyond three months: • reassess at three months and • repeat at 3 monthly intervals thereafter; and • repeat at discharge.
Principal Diagnosis Legal Status (1) Episode End Date Reason for Episode End	At discharge. If Episode continues beyond three months: • collect at three months and • repeat at 3 monthly intervals thereafter; and • repeat at discharge.
<i>Community settings</i>	<i>Data collected at</i>
Age Episode Start Date Reason for Episode Start	At registration
HoNOS/HoNOSCA Focus of Care (1) Children's Global Assessment of Functioning Scale (2) ICD-10 Factors Influencing Health Status (2)	One week following registration, based on preceding two weeks And At discharge from care. If Episode continues beyond 3 months: • reassess at 3 months; and • repeat at 3 monthly intervals thereafter; and • repeat at discharge from care.
Principal Diagnosis (2) Legal Status (1) Life Skills Profile (1) Episode End Date Reason for Episode End	At 3 months following episode start or discharge from care if occurs sooner. If Episode continues beyond 3 months: • reassess at 3 months; and • repeat at 3 monthly intervals thereafter; and • repeat at discharge from care.

Notes

- 1 Required for adult patients only.
- 2 Required for child/adolescent patients only.

Source: Based on the collection cycle recommended in the MH-CASC Report, modified to incorporate use of data both for casemix classification and outcome measurement purposes. Detailed data protocols will be developed to guide agencies in collecting data under a range of circumstances.

Improving understanding of population needs

Interest in the value of services provided to those who receive care is largely concerned with managing supply. Under the Second National Mental Health Plan, with its increased emphasis on prevention and early intervention, equal concern needs to be given to managing demand for mental health care, both actual and potential. This requires an understanding of the population's needs for mental health services, and the extent to which those needs are being met.

Inclusion of mental health as one of the five National Health Priority Areas, and the requirement for monitoring reports to be published on a two-yearly basis, has strengthened the case for a wide range of data development activities to be undertaken. The National Health Priority Committee and the Australian Health Ministers' Advisory Council National Mental Health Working Group have agreed to focus their initial efforts on depression as the most appropriate area to improve mental health nationally. This is in recognition of the high social, human and economic costs and public health impact of depression in Australia.

A Depression Action Plan will be developed during 1999 under the renewed National Mental Health Strategy. The action plan will provide a framework for activity to address depression across the health care continuum. The Plan will be based on the priorities and strategies identified in a report to Health Ministers on depression, to be released later in 1999.

Measuring population need

Methods available for estimating population needs for health care can be described in three categories.²⁸

- The epidemiological assessment of need is based on knowledge of the prevalence and incidence of mental disorders in the general population and the efficacy of available services to meet the estimated level of need. Estimates of the level of unmet need can be derived from these two information sources.
- The comparative assessment of need contrasts the services utilised by the population in one area with those of another and draws conclusions from this about relative needs.
- The consultative approach to needs assessment is based on a synthesis of the demands, wishes and perspectives of a range of informed parties, including health providers, consumers and carers, and other groups interested in health care delivery.

Each of these approaches makes a unique contribution to the overall understanding of what the community needs from its mental health services.

As discussed earlier in this paper, only limited work had been conducted prior to the National Mental Health Strategy to quantify the Australian population's need for mental health services. This primarily comprised a small number of local epidemiological studies initiated by independent

²⁸ Stevens, A and Raftery J (1992) *Health Care Needs Assessment: The Epidemiologically Based Needs Assessment Reviews*, Radcliffe Medical Press, Oxford.

academic bodies, and analyses by several States of comparative service utilisation data. Early in the Strategy, the National Health Goals and Targets Project noted that the lack of data relating to mental health needs was a significant obstacle to the setting of relevant population health goals and targets.²⁹

Activities in each of the three approaches to population needs assessment have been initiated under the National Mental Health Strategy.

- The National Survey of Mental Health and Well Being. The first stage, a survey of Australian adults undertaken by the Australian Bureau of Statistics, represents the first major mental health epidemiological survey conducted in Australia and is significant on an international scale. Similar studies of low prevalence disorders and child and adolescent mental health are being undertaken. Summary data from the adult survey have been published, and considerable analysis will be required to fully exploit the survey's potential to inform future decisions about service priorities.
- Similarly, a study of comparative service utilisation between populations has been funded to identify sociodemographic predictors of 'need' as a basis for informing new models for allocation of mental health funds. This project, due to report in 1999, will provide a base for further refinement.
- Finally, the consultative approach promoted by the Strategy has provided the opportunity for many groups to contribute their knowledge and views on needs within the population that are poorly served by current mental health services. This has been an important factor in shaping the Second National Mental Health Plan.

Future strategies

Continuing effort will be needed over the next few years to extend these initiatives, and will require collaboration between the Commonwealth Department of Health and Aged Care, the Australian Institute of Health and Welfare (AIHW), the Australian Bureau of Statistics (ABS), State and Territory health authorities and academic units.

The work will comprise a mix of the following.

- Supplementary research arising from the National Survey of Mental Health and Well Being, particularly focused on providing a better understanding of unmet need and the mental health requirements of specific populations.
- Negotiation of a process for the monitoring and reporting of population mental health in the range of national health status surveys and publications released on a regular basis by the ABS, AIHW and the Commonwealth Department of Health and Aged Care.
- Ongoing development of indicators and targets under the National Health Priority Areas initiative, and publication of bi-annual reports to monitor progress against targets.
- Analysis of existing health information collections that contribute to improved understanding of the role of the primary health care sector in responding to mental health need in the community.
- Initiatives to improve the capacity of the States and Territories in monitoring population service utilisation trends.

²⁹ Department of Health and Aged Care (1994) *Better Health Outcomes for Australians: National Goals, Targets and Strategies for Better Health Outcomes Into the Next Century*, Australian Government Publishing Service, Canberra.

Table 13 provides a summary of strategies proposed to improve population needs assessment in Australia. Information development Module Four, presented in the following pages, provides more specific details on these proposals.

Table 13: Information strategies to improve population needs assessment

<i>Local Information System Strategies</i>	<i>National Research and Development Strategies</i>
<ul style="list-style-type: none"> • Establishment of data quality procedures to improve the quality of patient level data collected in local mental health information systems. 	<ul style="list-style-type: none"> • Further analysis of the National Survey of Mental Health and Well Being data, to improve understanding of the level of unmet need and barriers restricting access to care. • Completion of surveys on low prevalence adult mental health disorders and mental health of children and adolescents. • Negotiation with the Australian Bureau of Statistics to incorporate a mental health monitoring component in its regular survey program. • Development of indicators and targets under the National Health Priority Areas initiative, and publication of two-yearly reports to monitor progress against targets. • Analysis of existing health information collections that contribute to improved understanding of the role of the primary health care sector in responding to mental health need in the community. • National analysis of social predictors of mental health service utilisation, based on the NMDS—Mental Health Care and National Survey of Mental Health and Well Being data.

MODULE FOUR

Understanding Population Mental Health Needs

Short Title: Population Needs Module

1 Purpose

- 1.1 This Module outlines strategies for the further development and application of knowledge about the nature and distribution of mental health problems in the Australian community.
- 1.2 Development of these strategies will be undertaken by the Commonwealth, States and Territories in consultation with the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, professional organisations, academic units with expertise in the mental health of the Australian population and the Mental Health Council of Australia.

2 Objectives

- 2.1 The objectives are to
 - 2.1.1 Improve the quality and quantity of information available that contributes to a broad understanding of the mental health needs of the population.
 - 2.1.2 Develop an understanding of the mental health needs of specific groups within the community.
 - 2.1.3 Develop ‘tools’ that support the application of this knowledge to advance mental health policy and service development.

3 Rationale

- 3.1 Accurate estimates of the community’s needs for specific types of mental health care are critical to planning services, allocating resources and evaluating the overall effectiveness of the Strategy.
- 3.2 Under the Second National Mental Health Plan, emphasis is given to mental health promotion, community education, prevention of mental disorder, and early intervention. Progress in each of these areas requires an understanding of the population’s need for mental health services, and the extent to which those needs are being met.
- 3.3 Mental health is included as one of five priority areas under the National Health Priority Areas initiative, with depression identified as the first mental health issue for action and reporting. Ongoing development of indicators and targets, and publication of two-yearly reports to Australian Health Ministers to monitor progress against these targets, are required.

- 3.4 Survey work initiated under the first National Mental Health Plan has highlighted substantial unmet mental health need in the community, and the prominent role of the primary health care system in providing assistance to people with mental health disorders. Substantial further work is required to build on this work and guide service development over the life of the Second National Mental Health Plan.

4 Principles to be Followed in the Development of Population Mental Health Information

- 4.1 National Agreements: Development of information on population mental health will proceed in the context of two national agreements.
 - 4.1.1 The Second National Mental Health Plan outlines the directions for mental health reform agreed between the Commonwealth, and the States and Territories for the next period 1 July 1998 to 30 June 2003.
 - 4.1.2 The National Health Priority Areas (NHPA) initiative, endorsed jointly by the Commonwealth, State and Territory governments in 1996, seeks to focus public attention and health policy on those areas that contribute most to the burden of illness in the community. The NHPA initiative provides a national approach to tackling five agreed priority areas (cardiovascular health, cancer control, injury prevention and control, mental health and diabetes mellitus).

5 Strategies for improving information

- 5.1 Surveys of Low Prevalence Adult Mental Health Disorders and Mental Health of Children and Adolescents: Work initiated under the first National Mental Health Plan will be completed, and further steps determined following a review of findings.
- 5.2 Supplementary analyses of the National Survey of Mental Health and Wellbeing: Ongoing analysis of this data collection is required to improve understanding of specific population mental health issues, including:
 - 5.2.1 The relationship between mental health needs and social indicators.
 - 5.2.2 The level of unmet need for mental health services.
 - 5.2.3 Barriers restricting access to services.
 - 5.2.4 The role of the primary health care sector in responding to mental health need.
- 5.3 Incorporating a mental health dimension in regular and ad hoc national health surveys: Opportunities for the periodic re-assessment of population mental health in the existing ABS survey program and surveys conducted by other organisations will be explored.

- 5.4 Monitoring the mental health needs of culturally and linguistically diverse populations: A range of initiatives will be considered to both establish baseline measures and process for monitoring trends in the mental health of specific populations, with a special on Aboriginal and Torres St Islander people and people from non-English speaking backgrounds. Development of culturally-sensitive measures of mental health will be required as a first step for this work to proceed.
- 5.5 National Health Priority Areas: Further development of mental health indicators and targets will be undertaken in light of the increased range of information available. Biennial publication of progress on mental health priorities will occur, with the first report, focusing on depression with an associated national action plan, due to be finalised during 1999.
- 5.6 Population use of mental health services: Initiatives to improve understanding of the population's use mental health services will be achieved by:
 - 5.6.1 Analysis of service utilisation data provided by specialised mental health services, collected through the NMDS-Mental Health Care.
 - 5.6.2 Analysis of health information collections relating to the role of the primary health care sector as providers of mental health services.
 - 5.6.3 Linking mental health and community sector databases: Work is required to link mental health planning to the knowledge gained from a variety of databases developed in the community services sector. These include information about to be given to disability, housing, and employment.
- 5.7 Publication: Regular publication of data collected through initiatives outlined in this plan is expected to be achieved through:
 - 5.7.1 Publications issued by the AIHW.
 - 5.7.2 Biennial reports published through the National health Priority Areas initiative.
 - 5.7.3 Publications issued by the ABS.
 - 5.7.4 The National Mental Health Report.
 - 5.7.5 Ad hoc research reports.

6 Research and development

- 6.1 Application of population mental health information to improve service quality and effectiveness: A range of initiatives will be considered to translate knowledge gained about population mental health into 'information tools' designed to support improvements in service quality and effectiveness. Initial priority will be given to the following:
 - 6.1.1 Development of population-based funding models to guide the allocation of mental health resources.

- 6.1.2 Methods to assist health organisations identify and respond to unmet need for mental health services.
- 6.1.3 Production of information to support the mental health roles of the primary health care sector, particularly general practitioners.
- 6.1.4 Information to support a focus on people with mental health problems, including those receiving as well as those not receiving assistance.
- 6.1.5 Information to support the Second National Mental Health Plan emphasis on prevention, promotion and early intervention.

Additional Priorities and Strategies

In addition to the new priorities and strategies that are needed to support the Second National Mental Health Plan, further work is required to enhance and develop information priorities that have been developed in the past 5 years.

A major achievement of the first 5 years has been the capacity to inform the mental health community of progress in mental health reform. It is important that these initiatives be consolidated as they form the foundation of much of the work program outlined in this document. These are addressed in the following two modules which cover:

- Continuing development and implementation of the NMDS—Mental Health Care.
- Annual Monitoring and Reporting of Progress Under the Australian Health Care Agreements and the Second National Mental Health Plan.

As outlined above, the proposals contained in this Plan are not exhaustive. As further work occurs in the Promotion and Prevention and Partnerships in Service Reform and Delivery themes under the Second National Mental Health Plan, additional information priorities will be identified.

In addition, the parameters under which specific initiatives and projects under the Second National Mental Health Plan and the overall reform process should be evaluated have yet to be fully determined. Specific attention will need to be given to an evaluation of promotion and prevention activities, and activities under the partnerships theme addressing links between mental health and other sectors. Once these proposals are agreed, an evaluation strategy will be proposed.

MODULE FIVE

Continuing development and implementation of the National Minimum Data Set—Mental Health Care

Short Title: The National Minimum Data Set

1 Purpose

- 1.1 This module outlines proposals to further develop the NMDS—Mental Health Care to ensure that it supports the future implementation of the Second National Mental Health Plan. The NMDS—Mental Health Care here refers to both the NMDS—Institutional Mental Health Care and the NMDS—Community Mental Health Care as agreed under the National Health Information Agreement.
- 1.2 Development of this module will occur under the auspice of the National Mental Health Information Strategy Committee.

2 Objective

- 2.1 The objectives of the module are to:
 - 2.1.1 Promote and support the development of information infrastructure to enable collection and reporting of the NMDS—Mental Health Care by publicly funded mental health services.
 - 2.1.2 Identify a process for resolving conceptual issues that currently restrict reporting of the patient-level data within the NMDS—Community Mental Health Care.
 - 2.1.3 Facilitate the progressive enhancement of patient-level data through the introduction of new data elements demonstrated to have utility under proposals for outcomes implementation and casemix classification implementation.
 - 2.1.4 Ensure that the future development of the NMDS—Mental Health Care is both incorporated within, and contributes to, mainstream health collections.
 - 2.1.5 Establish processes for ongoing improvements in data quality and integrity.
 - 2.1.6 Develop agreement between relevant parties on the regular analysis and reporting of data collected under the NMDS -Mental Health Care.

3 Rationale

- 3.1 The NMDS—Mental Health Care provides an important vehicle for informing the implementation of the Second National Mental Health Plan.
- 3.2 Structural and conceptual issues currently restrict the extent to which the NMDS—Mental Health Care can deliver the type of information required. Resolving these issues is a precondition to selecting and defining any additional data elements for inclusion in the NMDS.
- 3.3 A major change to NMDS—Mental Health Care for Mental Health Services will involve introduction of new patient-level data items arising from outcomes and casemix classification implementation. A process is necessary to progressively incorporate these items within the NMDS—Mental Health Care.

4 Principles to be followed in the continuing development and implementation of the National Minimum Data Set—Mental Health Care

- 4.1 National Agreements: Further development of the NMDS—Mental Health Care should proceed in the context of two national agreements.
 - 4.1.1 The Second National Mental Health Plan outlines the directions for mental health reform agreed between the Commonwealth, and the States and Territories for the next period 1 July 1998 to 30 June 2003.
 - 4.1.2 The National Health Information Agreement determines the processes and structures for endorsement of national health data collection and reporting agreements by the States and Territories, and priorities for information development.
- 4.2 Developmental aspects of national mental health data: Initiatives designed to further develop the NMDS—Mental Health Care should proceed on the basis that significant trial and development of new concepts is necessary prior to introducing any new data elements into national health information collections. A range of concepts may therefore be trialed without prejudice to their future inclusion in the NMDS—Mental Health Care.
- 4.3 Complementarity with State and Territory developments: Implementation of this Module will be progressed in a manner that complements information development initiatives at the State and Territory level.
- 4.4 Mainstreaming mental health information collections: Further development of the NMDS—Mental Health Care will aim to improve the integration of mental health data within mainstream health collections.

5 Definitions

- 5.1 The term ‘‘Outcomes Data Set’ refers to the data outlined in the Outcomes Implementation Module (Information Development Module One).
- 5.2 The term ‘Casemix Data Set’ refers to the data outlined in the Casemix Information Module (Module Three).

6 Relative Roles

- 6.1 Under the Second National Mental Health Plan and the National Health Information Agreement, a number of parties have important contributions to make to the further development of the NMDS—Mental Health Care.
 - 6.1.1 The Commonwealth in collaboration with the States and Territories, defines the range of information required for monitoring progress and advancing the Strategy objectives.
 - 6.1.2 The States and Territories work with the Commonwealth in defining the information to be reported annually and are responsible for ensuring that such data are collected by funded agencies within their jurisdictions. States and Territories are also members of the National Health Information Management Group.
 - 6.1.3 The National Health Information Management Group provides the forum for the Commonwealth, the States and Territories, the Australian Institute of Health and Welfare and the Australian Bureau of Statistics to jointly review and monitor the performance of the National Health Information Agreement.
 - 6.1.4 The Australian Institute of Health and Welfare (AIHW) has wide ranging responsibilities in the development, collection, maintenance and analysis of national health collections under the National Health Information Agreement. The AIHW is the organisation with specific responsibility for the development of the NMDS -Mental Health Care.
 - 6.1.5 The AHMAC National Mental Health Working Group provides the forum for joint policy development by the Commonwealth, the States and Territories and advises the Minister on national mental health policy matters.

7 Strategies for Implementation

- 7.1 Infrastructure Development: Under the Second National Mental Health Plan, the Commonwealth will work with the States and Territories to develop appropriate clinical information infrastructure to support the routine collection, use and reporting of the NMDS—Mental Health Care.

- 7.2 Reporting of the NMDS—Community Mental Health Care: The Commonwealth, States and Territories and the AIHW will work together to resolve issues that may compromise the consistent reporting of patient-level data to the NMDS—Community Mental Health Care. Priority issues to resolve include
 - 7.2.1 the interpretation of the concept of ‘establishment’ within multi-agency health organisations, and
 - 7.2.2 agreements on the counting and reporting of patient level service contacts
- 7.3 Introduction of Casemix and Outcomes data: The performance of the new patient-level data elements introduced under the Outcomes Implementation Module and the Casemix Classification Module will be reviewed by the Commonwealth, States, Territories and AIHW, with a view to these being incorporated in the NMDS—Mental Health Care for collection from 1 July 2001.
- 7.4 Review of patient-level data: The National Mental Health Information Strategy Committee will make recommendations annually to the AHMAC National Mental Health Working Group on the performance of the NMDS—Mental Health Care. Where appropriate recommendations on changes to the NMDS will be referred to the National Health Data Committee for agreement and forwarded to the National Health Information Management Group for endorsement.
- 7.5 Publication of National Minimum Data Set—Mental Health Care: Regular publication will occur of the data collected through the National Minimum Data Set – Mental Health Care. This is expected to be achieved through:
 - 7.5.1 Annual release of data by the AIHW
 - 7.5.2 The inclusion of relevant NMDS data in reporting against National Service Quality Indicators outlined in Information Development Plan Three, to be published in the National Mental Health Report.
 - 7.5.3 Ad hoc research reports.

Annual Monitoring and Reporting of Progress Under the Australian Health Care Agreements and the Second National Mental Health Plan

Short Title: Performance Monitoring and Reporting

1 Purpose

- 1.1 This module outlines the processes and timeframes for annual performance monitoring and reporting of progress under the Second National Mental Health Plan.
- 1.2 The data elements to be nationally collected under the Second National Mental Health Plan will be negotiated between the Commonwealth and States and Territories and be endorsed by the AHMAC National Mental Health Working Group.

2 Objectives

- 2.1 The objectives of this module are to:
 - 2.1.1 Allow the continued public reporting of progress and reform under the Second National Mental Health Plan for the period 1998–99 to 2002–03.
 - 2.1.2 Agree on a method and schedule for the reporting of activity under the Second National Mental Health Plan and the Australian Health Care Agreements, including the type of information that should be reported (what), the processes for reporting (how), and the timeframes for reporting (when).
 - 2.1.3 To ensure that the annual monitoring and reporting processes developed under the First National Mental Health Plan are expanded to reflect the further priority areas for reform identified under the Second National Mental Health Plan, namely:
 - 2.1.3.1 promotion and prevention;
 - 2.1.3.2 partnerships in service reform and delivery; and
 - 2.1.3.3 quality and effectiveness.
 - 2.1.4 Promote the development of reporting processes that reflect an expanded focus of mental health service provision within the context of primary health care and increase the focus on the mental health issues of sub-populations.

3 Rationale

- 3.1 The provision of agreed data for the National Mental Health Report is a principle condition of funding under the Second National Mental Health Plan.
- 3.2 All State and Territory Health Ministers have endorsed monitoring and accountability provisions as incorporated in the Terms and Conditions of funding for mental health in the Australian Health Care Agreements.
- 3.3 The monitoring and accountability provisions of the First National Mental Health Plan have underpinned and directed the mental health reform agenda and contributed towards ensuring that the mental health needs of the community have a prominent place on the health agenda of Australia.
- 3.4 Agreement is required on the development of specific mental health data processes to adequately monitor activity under the Second National Mental Health Plan, as endorsed by Health Ministers during their meeting of 30 July 1998.
- 3.5 Resolution is required on what constitutes ‘Agreed Data’ under the Second National Mental Health Plan.

4 Principles to be Followed in the Development of Performance Monitoring and Reporting

- 4.1 Maintenance of experience in data collection: Future work should build on the achievements to date and aim to ensure that the valuable information and skills that have been gained are further strengthened.
- 4.2 Focus on key objectives of monitoring and reporting: Historical collections have focussed on monitoring activity in terms of allocations and costs. Attention should shift from monitoring the inputs to a system to monitoring the outputs and outcomes in terms of their impact on processes for care and consumer outcome.
- 4.3 Recognise impact of broader health care sector: An underlying aim is to provide a focus on mental health care issues within routine health service delivery. In support of this, mental health reporting processes should reflect an expanded focus of service provision and incorporate a focus on primary health care and population health outcome monitoring.
- 4.4 Minimise individual effort, maximise collective outcome: Further work should minimise the labour intensive activities of program monitoring and reporting and increase efforts on combining information from a variety of sources into summary resource documents such as the National Mental Health Report.
- 4.5 Adherence to agreed performance targets: The establishment of performance targets should enable comparable monitoring and contribute to a shared approach to mental health system reform. The purpose of reporting should aim to assess performance against agreed targets.

5 Definitions

- 5.1 The term ‘Agreed Data’ refers to the data and performance information which the States and Territories agree to provide annually for monitoring and reporting progress under the Second National Mental Health Plan and the Australian Health Care Agreements.
- 5.2 The term ‘Annual Monitoring and Reporting’ refers to the preparation of the annual National Mental Health Report by the Commonwealth.

6 Information to be included in monitoring and reporting

- 6.1 The following information should be included as part of the annual monitoring and reporting processes.
- 6.2 Information about State and Territory funded mental health services.
 - 6.2.1 Data that reflects the actual resource implications of service activity and provision across all mental health services.
 - 6.2.2 Data that provides information on the type and needs of people who utilise specialised mental health services.
 - 6.2.3 Information that reflects mental health service attainment against the National Standards for Mental Health Services.
 - 6.2.4 Data to that measures consumer outcome and the utility of measures.
 - 6.2.5 Data to be provided and published that informs on consumer and carer satisfaction with mental health services.
 - 6.2.6 Data that reports on activities to include and involve consumers at State and local levels and highlights opportunities for further involvement of consumers.
- 6.3 Information about services funded by the Commonwealth.
 - 6.3.1 Information about Commonwealth funding for mental health service provision.
- 6.4 Information on private sector activities:
 - 6.4.1 Information about private sector mental health activities, including private hospitals and Consultant Psychiatrists funded under the Medicare Benefits Schedule.
- 6.5 Other information:
 - 6.5.1 Information from other sources relevant to mental health services.

7 Strategies for implementation

- 7.1 Final agreement on the data elements and processes for collection and reporting are to be endorsed by the AHMAC National Mental Health Working Group.
- 7.2 Where appropriate, information for annual reporting will be derived from the activities initiated under the other modules of this plan.
- 7.3 The Commonwealth will continue to be responsible for publishing an annual National Mental Health Report.