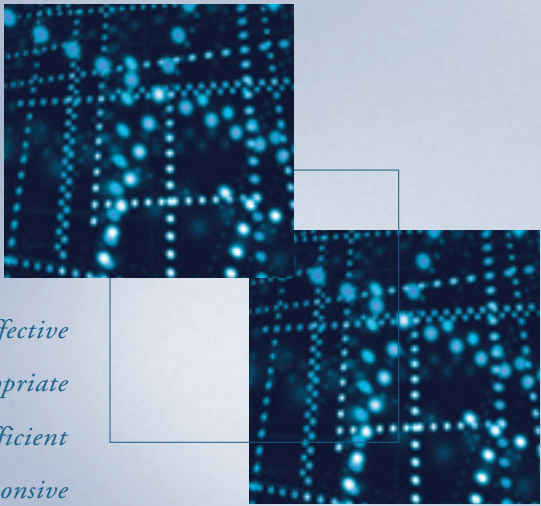


Key Performance Indicators for Australian Public Mental Health Services



effective
appropriate
efficient
responsive
accessible
safe
continuous
capable
sustainable

REPORT OF PERFORMANCE INDICATOR
DRAFTING GROUP

INFORMATION STRATEGY COMMITTEE
AHMAC NATIONAL MENTAL HEALTH WORKING GROUP



Key Performance Indicators for Australian Public Mental Health Services

November 2004

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Previous ISC Discussion Papers

Discussion Paper No. 1 (Out of Print) – Morris-Yates, A & Andrews, G (1997) *Local Area Information Systems for Mental Health Services: General Principles and Guidelines*

Discussion Paper No.2 (Out of Print) – *Report of the National Indigenous Mental Health Data Workshop (1998)*

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

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

All of the above papers are available at www.mentalhealth.gov.au.

Publication Approval Number: 3618

Foreword

The release of this report is an important milestone for mental health services in Australia. Representing the result of several years of collaborative work between the Australian and State and Territory governments, the report describes a new performance indicator framework for evaluating mental health service delivery in the public sector.

Key performance indicators are essential tools for both monitoring and improving the quality of health services. While the use of performance indicators is now well established in the acute health sector and other parts of the health system, mental health services have lagged behind these developments. This has been due, in part, to the unavailability of suitable data, but more to the lack of consensus about how fundamental performance measurement concepts should be applied to mental health care. Under the Second National Mental Health Plan, the Australian Government and States and Territories committed to bridge this gap by developing a specific set of mental health performance indicators, a commitment reiterated in the current National Mental Health Plan and the Australian Health Care Agreements 2003–2008.

This report represents the culmination of that work and presents a way forward. It defines a set of ‘phase one’ indicators that are based on the National Health Performance Framework adopted by all Australian Health Ministers in 2001, and linked to the strategic directions of the National Mental Health Plan 2003–2008. The indicators proposed cover the domains of service efficiency, effectiveness, appropriateness, access, continuity and capability, all central concepts to understanding how a mental health service functions. An important characteristic of the ‘phase one’ indicators is that they are designed to be produced from available datasets, which in turn are the result of the extensive information development that has been undertaken by all States and Territories under the National Mental Health Strategy.

As a first generation set of indicators, it is expected that further refinement will occur as performance measurement is introduced within the mental health sector. The task will be complex, but there is no longer a conceptual or technical basis for the sector to stand aside from the learning that accrues when health services review their performance against a standard set of indicators.

Subsequent to the completion of this report, the proposed framework and initial ‘phase one’ indicators were endorsed by the National Mental Health Working Group of the Australian Health Ministers Advisory Council as providing a suitable basis for beginning the process of performance measurement within public mental health services. All States and Territories have committed to implement the indicators within a timetable that is consistent with each jurisdiction’s capacity, and to continue to work together to build on the foundation that this report provides. To guide the work, a National Mental Health Performance Subcommittee has been established under the Information Strategy Committee, with broad representation of clinical, management and policy expertise.

The concepts outlined in this report were developed through the National Key Performance Indicator Project. Funded by the Australian Government, the project was managed by the Victorian Department

of Human Services and informed by a drafting group with representatives from States and Territories, the Australian Government, the Steering Committee for the Review of Government Service Provision, the National Health Performance Committee and the Australian Institute of Health and Welfare. A list of drafting group members is attached at Appendix K.

It is with great pleasure that, on behalf of the National Mental Health Information Strategy Committee (ISC), I commend this document to readers as a key resource for understanding how performance measurement can be applied in the mental health sector and the directions that will be taken in Australia over the next few years. I also extend our gratitude to the Australian Government for making the funds available, the Victorian Department of Human Services for its skilled management of the project, and to all members of the drafting group for their contributions to this final report.



Dr Aaron Groves
Chair
National Mental Health Information Strategy Committee
Australian Health Ministers' Advisory Council

Acknowledgments



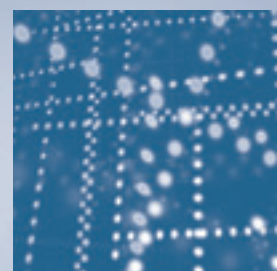
This project was undertaken by the Mental Health Branch, Victorian Department of Human Services, as a component of its Information Development Plan, using funding provided by the Australian Government.

Acknowledgement is given to the contribution made by all States and Territories during the consultation phase of this project. Grateful acknowledgement is also made to the members of the Information Strategy Committee Performance Indicators Drafting Group who advised on all aspects of the project.

This report was compiled on behalf of the Drafting Group by the following members:

- Ms Joy Easton, Senior Project Manager, Mental Health Branch, Victorian Department of Human Services;
- Mr Bill Buckingham, Consultant to Health Priorities and Suicide Prevention Branch, Australian Government Department of Health and Ageing, Canberra; and
- Mr Simon Darlington, Project Officer, Mental Health Branch, Victorian Department of Human Services

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

Eagar et al (2003) *Towards National Benchmarks for Australian Mental Health Services. Information Strategy Committee Discussion Paper No.4,* Commonwealth Department of Health and Ageing, Canberra

Executive summary

This report proposes a set of key performance indicators for use in Australia's public sector mental health services that is based on the National Health Performance Framework (NHPF) and linked to the strategic directions of the National Mental Health Plan 2003-2008.

The indicators are in two categories:

- Phase 1 – indicators for initial trial: Thirteen indicators are proposed as suitable for immediate introduction based on available data collected by all States and Territories.
- Phase 2 – indicators for development: These cover performance sub-domains identified as important for monitoring overall mental health service performance but for which specific indicators are not proposed due to lack of available data.

The figure below summarises the proposed indicator set.

Phase 1 indicators are the primary focus of the current report.

These indicators have been developed using a number of design principles:

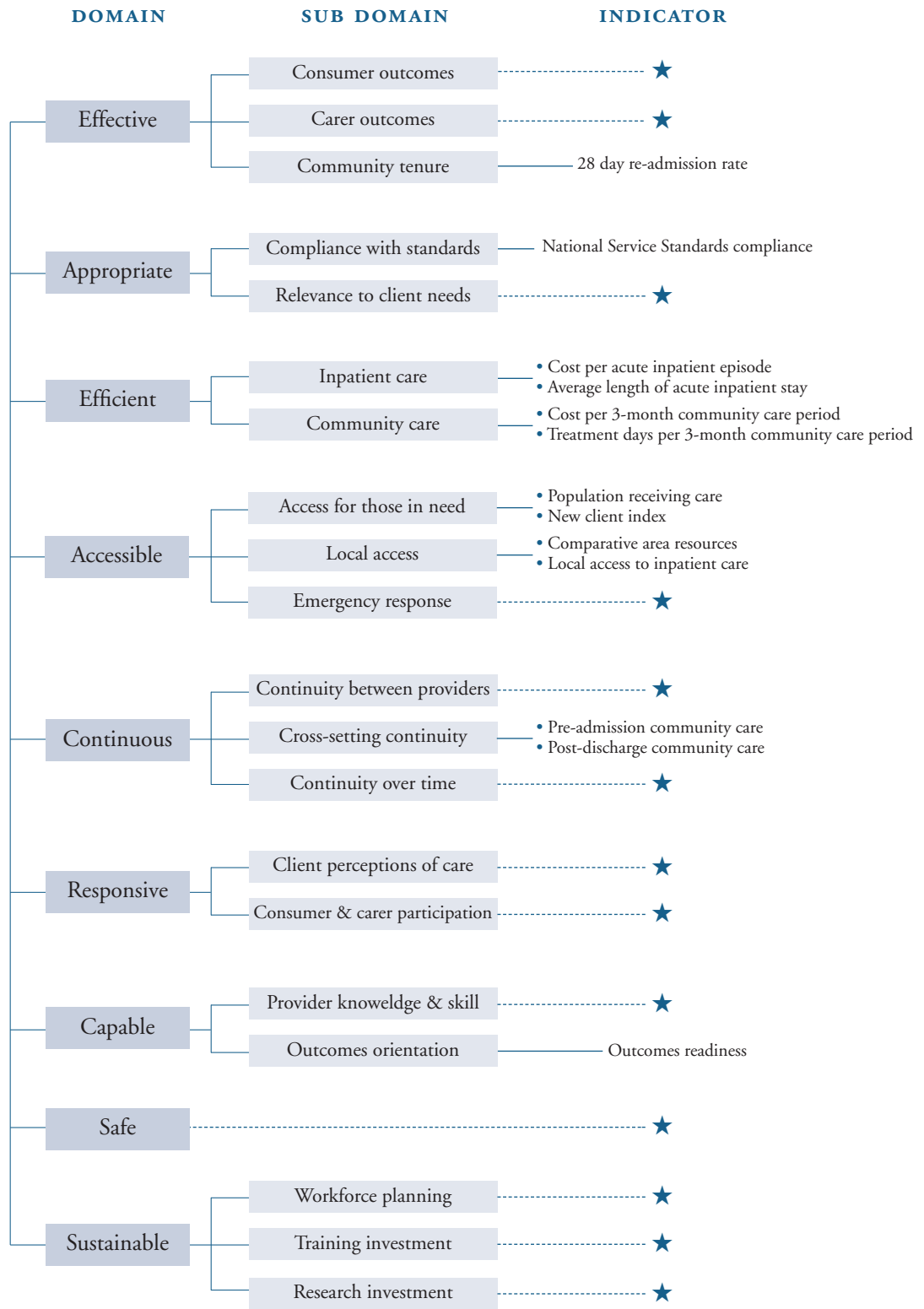
- Their primary purpose is to facilitate collaborative benchmarking between public sector mental health service organisations, with a view to improving service quality.
- The indicators cover the stages of inputs, processes, outputs, and outcomes, depending on the sub-domain being measured.
- While the indicators are targeted at monitoring the performance of mental health service organisations, they are also capable of being aggregated to higher levels of reporting, including comparisons between States and Territories.
- The emphasis is on generic rather than program-specific indicators. Further work will be required to refine the indicators for highly specialist services and develop an agreed approach to the construction of peer groups for such services.

Indicators will require review and development over time as monitoring requirements and availability of data changes. To enable this, the report recommends that a National Mental Health Performance group be established under the Information Strategy Committee with responsibility for advising on indicator development. Extension of the indicator set beyond the public mental health sector is one area of future development.

Trialling indicators is logically a State and Territory responsibility. Consideration needs to be given to engaging stakeholders and supporting the use of indicators for performance benchmarking purposes. Incentives should be considered to encourage the latter.

The Drafting Group did not resolve the issue of indicator reporting at the national level. However, options include local reporting by individual jurisdictions, or publication of a national report by an independent body such as the Australian Institute of Health and Welfare (AIHW) or the Australian Government using data submitted by the States and Territories. A national approach would have advantages in facilitating cross-border benchmarking. This issue should be considered by the proposed National Mental Health Performance group.

**MENTAL HEALTH SERVICE
ORGANISATION PERFORMANCE**



Key ★ = Phase 2 Indicators for development

1. Background and context

Significant advances have been made over the past decade in the development of indicators for the Australian health sector, focusing mainly in the field of acute hospital care. As a result, the language and culture of performance measurement is now well established in the day-to-day life of acute public hospitals.

Ongoing development of performance measures is occurring on multiple fronts, as part of Australian Government and State and Territory initiatives. However, the mental health sector has lagged behind developments in some other sectors, due in part to an historical lack of suitable data sets from which to build indicators but also to lack of agreement within the sector on how to apply fundamental performance measurement concepts to the mental health field.

Under the Second National Mental Health Plan (Australian Health Ministers, 1998), States and Territories agreed to give priority to information development, and to establish an information infrastructure at the service delivery level designed to:

- 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.

Australian Government funding was provided through Information Development Plans to support information developments in States and Territories aimed at achieving these goals.

The strategic direction of the new National Mental Health Plan 2003-2008 encompasses the priority themes of:

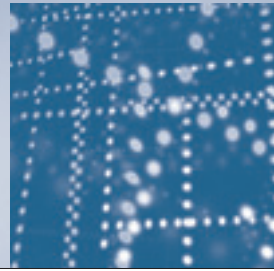
- increasing service responsiveness;
- strengthening quality; and
- fostering research, innovation and sustainability.

To assist in achieving these objectives, as part of the National Mental Health Plan 2003-2008 (Australian Health Ministers, 2003), and the Australian Health Care Agreements 2003-2008 (AHCAs), States and Territories have committed to the development of a national framework to monitor the performance of public mental health services. This framework will incorporate key performance indicators.

This project begins the process of fulfilling AHCA requirements by presenting a set of key performance indicators for use in benchmarking and monitoring mental health services at the national level.

It should be noted that the development of indicators, where the primary dimension is that of safety, has been deferred pending the outcome of work currently being undertaken by the Safety and Quality Partnership Group of the National Mental Health Working Group. However, since performance indicators may have relevance across more than one dimension, this has not excluded the development of those measures where acknowledged secondary dimensional aspects of safety exist.

2. Developments in Australian mental health performance monitoring



Recent developments in the reporting and monitoring of mental health services provide a starting point for the implementation of mental health service performance monitoring at the service provider level.

2.1 National Mental Health Report

In 1993, the *National Mental Health Report* was produced in response to the recognised need to publicly monitor and report against the implementation of the National Mental Health Strategy. A total of eight reports have been published over the course of the Strategy, with the most recent being released in December 2004 (Department of Health & Ageing, 2004).

Each report provides detailed information about the performance of the Australian Government, States, and Territories in implementing the policy directions agreed under the Strategy. However, the report does not inform about outcomes or whether the policy directions are in fact achieving the intended benefits for the community.

The data underpinning each report is collected at the organisational level but, as it is only reported at the jurisdictional level, the report offers limited information for service level performance monitoring or benchmarking purposes.

Nevertheless, the National Mental Health Report was an initial step towards the development of nationally agreed performance standards for mental health services.

2.2 National Minimum Data Sets

By the end of the first National Mental Health Plan, significant work had been undertaken by States and Territories in the collection and analysis of nationally comparable data describing the delivery of mental health services. During the Second National Health Plan, this investment was realised in the establishment of national minimum datasets for both inpatient and community mental health services, and more recently, for residential services.

Three 'patient level' national collections have now been implemented that cover mental health care provided in all treatment settings.

- *National Minimum Data Set – Admitted Patient Mental Health Care* collects information at the national level on consumers admitted to public and private psychiatric hospitals or in designated psychiatric units in general hospitals. Commenced in 1996-97, the collection provides information on approximately 110,000 treatment episodes per year.
- *National Minimum Data Set – Residential Mental Health Care* reports on the care provided to consumers admitted to government-operated, 24-hour staffed residential units. This is a new collection, commencing in 2004-05.

- *National Minimum Data Set – Community Mental Health Care* is designed to collect information on the services provided by public sector mental health services to consumers who are living in the community, external to hospital and residential settings. Commenced in 2000-01, the collection gathers information on an estimated 5 million service contacts provided to approximately 300,000 consumers. It is the largest (and one of few) patient-level collections of community-based care in the Australian health system.

Results from each collection are reported annually by the Australian Institute of Health and Welfare in its publication *Mental Health Services in Australia*.

Together, the mental health national minimum data sets have advanced our understanding of mental health service delivery in Australia and established the building blocks for further work. The availability of consistently defined mental health data items across State and Territory jurisdictions has played a key role in enabling the development and specification of the key performance indicators proposed in this document.

2.3 Australian Health Care Agreement – Annual Performance Reports

The Australian Health Care Agreement (AHCA) Annual Performance Reports, first published for the 1998-1999 financial year, provide high-level measures of the State and Territory health care systems in relation to a limited range of performance measures and priority issues.

Pending the development and implementation of agreed national key performance indicators for mental health service delivery, the information provided in the mental health section of the AHCA Annual Performance Reports is generally based on the National Mental Health Report.

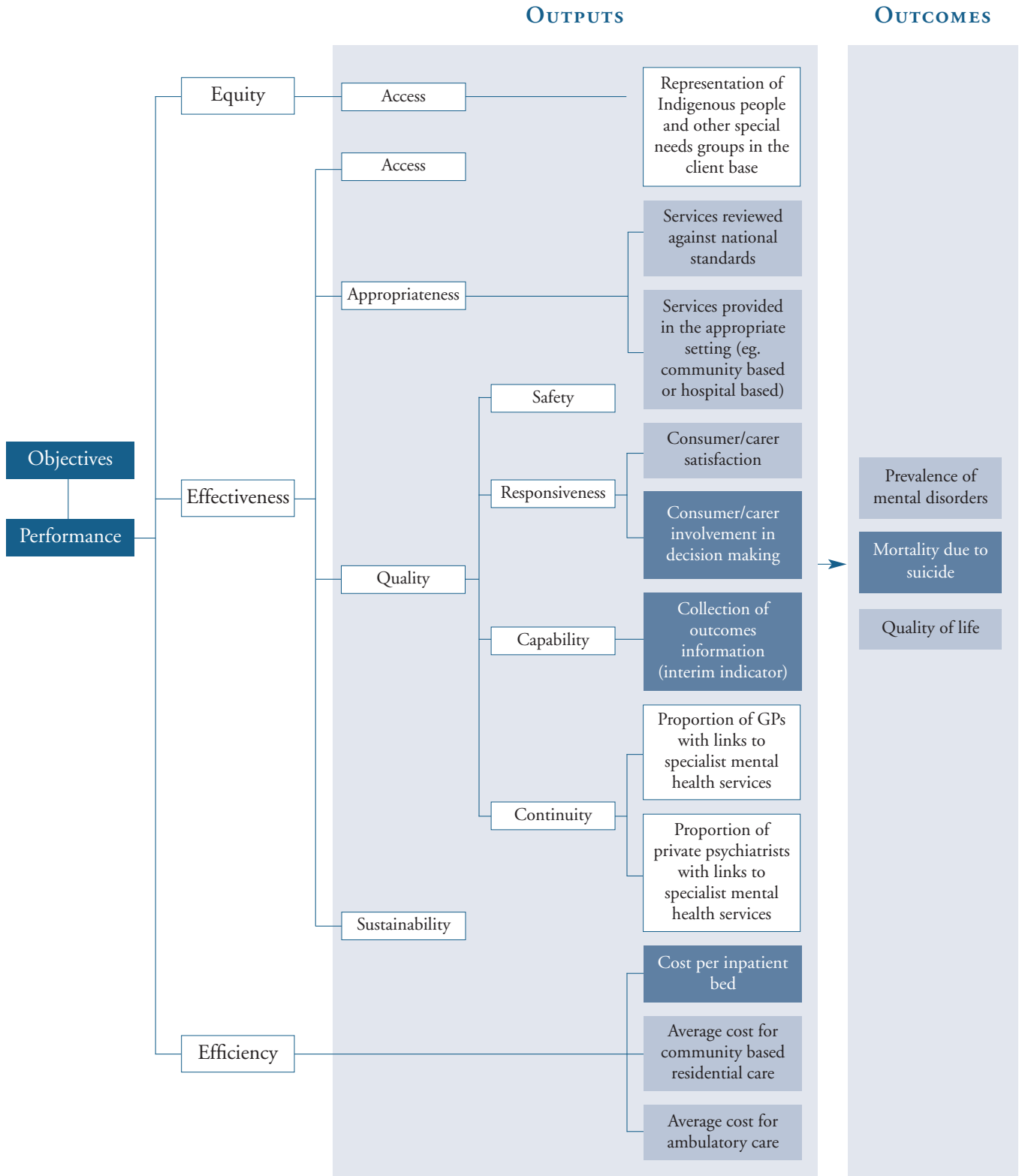
2.4 Report on Government Services

In 1999, the Steering Committee for the Review of Commonwealth/State Service Provision (SCRCSSP), now the Steering Committee for the Review of Government Service Provision (SCRGSP), introduced the separate reporting of mental health service performance in its annual Report on Government Services. Previously, mental health services had been included only within the reporting of acute hospital performance.

The performance monitoring framework adopted in the report followed that previously developed by the then National Health Ministers' Benchmarking Working Group (now replaced by the National Health Performance Committee – see below) and comprised five dimensions of health care (quality, appropriateness, access and equity, outcomes and unit cost), categorised under the broad headings of efficiency and effectiveness. In 2002, the SCRGSP developed a new outcome-oriented performance framework that gives greater emphasis to the importance of equity, as well as efficiency and effectiveness.

Like the AHCA Annual Performance Reports and the National Mental Health Report (NMHR), the *Report on Government Services* provides useful information at the jurisdictional level, but is of limited usefulness for the purposes of performance monitoring and benchmarking at the mental health service organisational level. Figure 1 shows the performance framework and indicators used in the 'mental health chapter' of the 2005 Report on Government Services (Steering Committee for the Review of Government Service Provision, 2005).

Figure 1: Mental health performance indicator framework used in the 2005 Review of Government Services



Key ■ = Provided on a comparable basis for this report subject to caveats in each chart or table
 □ = Information not complete or not directly comparable
 ■ = Yet to be developed or not collected for this report

2.5 National Health Performance Framework

The National Health Performance Committee (NHPC) was formed in August 1999 at the request of the Australian Health Ministers' Conference, in order to develop and maintain a national performance measurement framework for the health system. The mission of the NHPC is to foster the use of benchmarking based on national performance measures and indicators, in order to improve the quality of care of health services.

To develop a broader framework for measuring performance in the Australian health system, a discussion paper was developed by the NHPC in February 2000 and disseminated widely to government and non-government providers and participants and consumers in the health system (National Health Performance Committee, 2000). A workshop was held the following month under the auspices of the National Public Health Partnership to provide advice to the NHPC on population health perspectives for a performance framework, criteria for selection of performance indicators and the development work required, taking into account existing work.

In 2001, the NHPC published its national health performance framework, covering the following three 'tiers' (National Health Performance Committee, 2001):

- health status and outcomes (Tier 1);
- determinants of health (Tier 2); and
- health system performance (Tier 3).

Based on a model developed by the Canadian Institute of Health Information (Canadian Institute for Health Information, 1999), the framework advocates that indicators are needed for all three 'tiers' to provide a comprehensive picture of the population's health and how the health system is performing in meeting health needs. The tiers are not hierarchical in nature, but intended to reflect the fact that health status and health outcomes are influenced by the impacts of health determinants and health system performance. An additional design feature of the framework is that it is intended for use at all levels of the health system – that is, for assessing an individual service or at higher levels of aggregation, such as State and Territory or national.

In August 2001, Australian Health Ministers agreed to this overarching performance framework for use in reporting across all areas of the health system. Subsequently, two national-level reports have been presented to Health Ministers by the National Health Performance Committee. The inclusion of mental health indicators in future reports has been identified as a priority.

The national health performance framework is shown in Figure 2. The relevant tier for the current project is Tier 3 – health system performance. The nine dimensions of this tier are also detailed in Figure 2.

Figure 2: Australia's National Health Performance framework

HEALTH STATUS AND OUTCOMES ('TIER 1')				
How healthy are Australians? Is it the same for everyone? Where is the most opportunity for improvement?				
Health conditions	Life expectancy	Human function and well-being	Deaths	
Prevalence of disease, disorder, injury or trauma or other health-related states.	Alterations to body, structure or function (impairment), activities (activity limitation) and participation (restrictions in participation).		Broad measures of physical, mental, and social well-being of individuals and other derived indicators such as Disability Adjusted Life Expectancy (DALE).	
Age or condition specific mortality rates.				
DETERMINANTS OF HEALTH ('TIER 2')				
Are the factors determining health changing for the better? Is it the same for everyone? Where and for whom are they changing for the worse?				
Environmental factors	Socio-economic capacity	Community factors	Health factors	Person-related
Physical, chemical and biological factors such as air, water, food and soil quality resulting from chemical pollution and waste disposal.	Socio-economic factors such as education, employment per capita expenditure on health, and average weekly earnings.	Characteristics of communities and families such as population density, age distribution, health literacy, housing, community support services and transport.		Attitudes, beliefs, knowledge and behaviours e.g., patterns of eating, physical activity, excess alcohol consumption and smoking.
Genetic related susceptibility to disease and other factors such as blood pressure, cholesterol levels and body weight.				
HEALTH SYSTEM PERFORMANCE ('TIER 3')				
How well is the health system performing in delivering quality health actions to improve the health of all Australians? Is it the same for everyone?				
Effective		Appropriate		Efficient
Care, intervention or action achieves desired outcome.		Care/intervention/action provided is relevant to the client's needs and based on established standards.		Achieving desired results with most cost effective use of resources.
Responsive		Accessible		Safe
Service provides respect for persons and is client orientated: - respect for dignity, confidential, participate in choices, prompt, quality of amenities, access to social support networks, and choice of provider.		Ability of people to obtain health care at the right place and right time irrespective of income, geography and cultural background.		Potential risks of an intervention or the environment are identified and avoided or minimised.
Continuous		Capable		Sustainable
Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.		An individual or service's capacity to provide a health service based on skills and knowledge.		System or organisation's capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring).

2.6 Summary

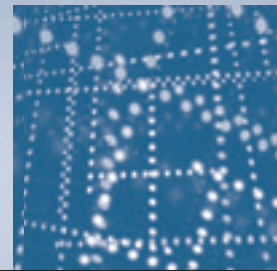
The *National Mental Health Reports*, the Australian Health Care Agreement Annual Performance Reports, and the *Report on Government Services* all represent key achievements in the ongoing development of mental health performance monitoring.

In addition, the continued development and refinement of these reports and information development initiatives under the Second National Mental Health Plan contributed to the improved maturity and availability of mental health data for benchmarking purposes.

However, the primary focus of the reports on overall system performance at a government level renders them unsuitable for the purposes of service level performance monitoring.

This document meets that challenge by proposing a national set of service level key performance indicators based on the National Health Performance Framework and linked to the strategic directions of the National Mental Health Plan 2003-2008.

3. Developments in performance indicators for mental health services



As part of the current project, mental health performance frameworks from a number of sources were reviewed, including Australian States and Territories and selected countries. The main developments are outlined below.

3.1 Australia

Over recent years, Australian jurisdictions have increasingly recognised the need to develop performance indicators to facilitate benchmarking practices within the mental health sector. States and Territories have initiated independent approaches aimed at extending or redeveloping their existing key performance indicator frameworks.

The complexity of mental health services has presented special difficulties for the design of these indicators due to the need to assess performance across both inpatient and community treatment settings.

Existing State and Territory performance indicators share common themes. However, definitions and specifications vary as a result of differing policy contexts, service systems, interpretations of performance requirements, and the level of defined service performance measurement. As a result, there is a strong commitment by States and Territories to move forward on a nationally agreed basis to facilitate benchmarking at a broader level.

Appendix F provides a summary of the indicators in place, or under consideration, by each of the States and Territories at March 2003.

3.2 International overview

The international literature on performance measurement for mental health services has grown extensively over the past decade with a proliferation of frameworks and indicators. Much of the available work is published in the so called 'grey literature' of government reports, commissioned consultancies and reports of committees rather than in peer-reviewed journals.

Driving forces for indicator development are both the need to improve monitoring and accountability of services for government funding purposes, and to improve quality of services for consumers and carers. Approaches differ between countries and between jurisdictions within countries, and there is no internationally agreed standard of mental health performance measurement. Emphases vary from performance systems that focus on traditional areas of policy and management concern (e.g., efficiency and effectiveness) to those that emphasise the pre-eminence of the consumer and carer as 'customer'. While these differences exist there is general acknowledgement of the importance of performance monitoring and the sub-domains selected for monitoring.

3.2.1 United States¹

Extensive development has taken place in the United States over the past ten years to implement performance measures for mental health services. The work has focused on state-funded or operated mental health programs and mental health services offered under managed care arrangements. Multiple state and federal organisations are involved, along with private organisations and accreditation bodies, with considerable cross-fertilisation across seemingly independent initiatives. The University of Washington in its review of developments commented ‘...sorting out what work belongs to whom, and which list of measures is being used or tested by what organization, is nearly impossible... Several published articles try to explain all of the concurrent and interconnected work, and not one of them captures all of the efforts.’ (University of Washington Health Policy Analysis Program, 2000).

Mental Health Statistics Improvement Program

Mental Health Statistics Improvement Program (MHSIP) is a voluntary, collaborative initiative launched in 1976 that includes federal, state, and local governments and other organisations. Funded by the Centre for Mental Health Services of the federal Department of Health and Human Services, the program’s focus is on ‘...mental health data, answering the questions: what needs to be collected, how to collect it, where to find what others have collected, how to understand what has been found, how to report it so other people can understand it, and how to use it to make decisions.’ (Mental Health Statistics Improvement Program, 1993).

MHSIP has been a major player in the United States developments. Commencing in 1993 with the release of its report on performance indicators for mental health care, work began on the development of the ‘consumer oriented mental health report card’. Released in 1996, the emphasis of the report card is centered on the consumer’s perspective on service quality and assesses the performance of mental health services in responding to consumers’ needs (Mental Health Statistics Improvement Program, 1996). It reports on performance across four domains:

- access;
- appropriateness;
- prevention; and
- outcome.

The MHSIP data items capture the consumer’s views on the process of care (e.g., the average length of time from a request for services to the first face-to-face meeting with a mental health professional) and outcomes of care (e.g., consumer’s assessment of being better able to control her or his life). The consumer focus of the report card means that many of the performance indicators included require a direct consumer response. Data are gathered using either a short or long version of a survey completed by consumers.

The MHSIP measures have been widely adopted by most state-based programs and feature in many of the indicators reported publicly by United States jurisdictions.

¹ Recent reviews of developments in the United States have been undertaken by a number of USA jurisdictions and Canadian groups. This section draws on the reviews undertaken by the University of Washington and the Alberta Heritage Foundation in Canada plus additional research for the current project.

National Association of State Mental Health Program Directors (NASMHPD)

In early 1997, the National Association of State Mental Health Program Directors (NASMHPD) initiated a project to develop a standardised approach to performance measurement that would allow state-operated psychiatric hospitals to meet the accreditation requirements under the Joint Commission on Accreditation of Healthcare Organizations. The project recommended 32 initial performance indicators, deemed to be achievable with existing datasets, plus another 14 measures considered to be 'developmental'. Data are drawn primarily from the MHSIP survey and administrative service utilisation datasets. Indicators are organised around the four MHSIP domains, with a fifth domain titled 'Structure/Plan Management' that looks at organisation-wide issues (National Association of State Mental Health Program Directors, 1998).

The NASMHPD indicators have undergone trials and has been implemented to varying degrees throughout the US jurisdictions. A listing of the NASMHPD indicators is provided at Appendix G.

It is worth noting that a number of the indicators draw on data sources outside the mental health sector (e.g., access to supported housing) or require data which are not usually reported through standardised mental health data collection systems (e.g., use of atypical medications), or require identified data matching with other agencies (e.g., contact with the criminal justice system). While such indicators take a more 'whole of person' approach to the performance of the mental health system, they are resource intensive to measure.

The American College of Mental Health Administration

In 2001, a collaboration of national accrediting bodies, working under the auspice of the American College of Mental Health Administration, released a consensus set of indicators for behavioural health, the results of work extending over a four year period (American College of Mental Health Administration, 2001).

The group identified 35 indicators grouped under 15 'topics of concern' as potentially suitable for mental health care, organised under the three 'super groupings' of access, processes and outcomes. Data required to produce the indicators includes consumer self-report via surveys, information extracted from the clinical record and service utilisation data derived from administrative datasets. The indicators are reproduced at Appendix H. Many of the indicators emphasise consumer perceptions of care along the lines of the MHSIP model.

The group suggests that the value of their contribution is in the definition of the detailed domains but acknowledge that '...the greatest challenge in this entire endeavour is the transition from agreement about what is important to measure to agreement about how to actually collect data and calculate measures... there remains much to be done in moving on towards actual implementation of these indicator definitions'.

Individual states

It is beyond the scope of this document to describe the developments in the individual USA jurisdictions, of which there are many. However, it is worth noting that it is at this level where principles need to be translated into practice and indicator systems implemented on the ground. There are many useful examples of how the states are going about the task. Three summary observations are worth noting:

- Indicators developed by most jurisdictions are derived from the MHSIP consumer survey and subsets of the NASMHPD indicators. The type of indicators reported cover service utilisation, consumer perceptions and, in some instances, cost information.

- Many states report publicly on the performance of each funded organisation. Extensive information can be collected about the performance of agencies from a casual hour spent on the internet. Illustrative examples are provided by Oklahoma, South Carolina and Texas (see www.odmhsas.org/statistics/other.htm and <http://www.state.sc.us/dmh> and www.mhmr.state.tx.us).
- The rationale offered by the various state administrations for the collection and use of data is that it aims to serve three purposes: to assess overall system functioning; to examine the results for individual agencies; and to learn what combinations of services work best with identified groups of clients. The Oklahoma website goes further in its explanation of how the information should be used:

‘Collecting information about performance and outcomes helps the Department demonstrate treatment impact and justify requests for federal block grant and state appropriated funding. Service providers use performance and outcome data to make resource allocation decisions and improve service delivery. Consumers and their families use the information to make better choices about the treatment options available to them.’

3.2.2 United Kingdom

The UK National Health Service (NHS) Performance Assessment Framework is designed to assess the performance of the NHS across six domains that ‘... represent outcomes of importance to patients and the public’ (Department of Health, 1999). These include:

- health improvement;
- fair access;
- effective delivery of appropriate health care;
- efficiency;
- patient/carer experience; and
- health outcomes of NHS care.

The intent is that the framework will be applied at local and national level and will be used by Health Authorities, NHS Trusts and Primary Care Groups as well as by the NHS management to support benchmarking, priority setting, and to flag the need for further investigation and action. It incorporates information on diverse population groups, health conditions and client groups and covers a wide range of service types including mental health, population health, acute and chronic care, dental care and primary care.

The UK is at a relatively early stage in rolling these concepts out to the mental health field, although the situation is likely to change rapidly as the performance measurement system for its mental health services evolves. This has been made possible largely through the implementation of an upgraded national minimum data set in 2000. Additionally, the country is in the process of implementing the HoNOS family of measures within its National Health Service funded agencies.

The Healthcare Commission (replacing the Commission for Health Improvement in March 2004, see <http://www.chi.gov.uk/Homepage/fs/en>) carries overall responsibility for the monitoring and measurement of the performance of the Mental Health Trusts. Trusts are rated on a star rating system, based on performance against selected key ‘clinical governance review’ targets and a balanced scorecard.

In 2003-04 the targets were concerned primarily with service development and implementation and covered:

- assertive outcome team implementation;
- community mental health team integration (degree to which teams have integrated health and social care staff);
- effective Care Programme Approach (CPA) systems implementation;
- financial management;
- hospital cleanliness;
- improving working lives (implementation of improved staffing conditions); and
- mental health national minimum data set implementation.

These are supplemented by a broader set of 31 indicators that are used to monitor Trust performance in three areas: clinical focus; patient focus; and capacity and capability focus. The indicators defined for 2003-04 are summarised below in Table 1.

Table 1: United Kingdom indicators used for monitoring Mental Health Trust performance, 2003-04

CLINICAL FOCUS	CAPACITY AND CAPABILITY FOCUS
<ul style="list-style-type: none"> • clinical negligence • CPA systems implementation • psychiatric readmissions (adult) • psychiatric readmissions (older people) • suicide rate 	<ul style="list-style-type: none"> • missed outpatient appointments • crisis resolution team implementation • out of catchment area treatments (adults) • out of catchment area treatments (older people) • CAMHS service mapping • data quality • staff opinion survey • junior doctors' hours • consultant appraisal • sickness absence rate • information governance • fire, health & safety
PATIENT FOCUS	
<ul style="list-style-type: none"> • transition of care between adult services and OPMH • transition of care between CAMHS and adult services • patients with copies of their own care plan • patient complaints procedure • better hospital food • privacy & dignity 	

3.2.3 Canada

The Canadian system of federalism requires federal, provincial and territory government and other stakeholders to collaborate in the development and implementation of a common national approach to health monitoring and performance assessment. To facilitate this, the Canadian Institute for Health Information launched a collaborative 'roadmap initiative' in the late 1990's on health indicators to 'identify the measures that should be used to report on the health of Canadians and the health system' (Canadian Institute for Health Information, 1999).

The performance framework resulting from the work is a four tiered model, and was used as the basis for the Australian National Health Performance Framework described in section 2.5.

Canada is at an early stage in translating the framework to its national-level performance measures for mental health. A small number of indicators confined to hospital care have been published by the Canadian Institute (Canadian Institute for Health Information, 2001). These cover:

- hospital separation rates;
- percentage of all hospital separations for mental illness/addiction services;
- total patient days per 100,000 population;
- average length of stay;
- percentage of total days stay for mental illness/addiction; and
- suicide rates.

Development work is proceeding at the provincial and territorial level. To support this, a highly useful publication was released in 2001, titled *Accountability and Performance Indicators for Mental Health Services and Supports – A Resource Kit*. Prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, the resource kit provides a comprehensive inventory of potential indicators in each of the health system performance domains, but does not address implementation issues (McEwan & Goldner, 2001).

A summary of the indicators listed in this report is presented at Appendix I.

3.2.4 New Zealand

New Zealand has a well established tradition of using performance indicators as accountability tools to guide the interaction between the funder and provider arms of the health system. Commencing with the formation of the Health Funding Authority in the 1980's, performance indicators for health services have been set annually as part of contracting arrangements with the majority of health care providers. These generally were based on inputs (staffing levels, bed numbers) rather than outputs or outcomes. This approach continued following the reorganisation of the health system in 2000 and devolution of the Health Funding Authority's purchasing responsibilities between the Ministry of Health and District Health Boards.

The New Zealand Health Ministry recently signaled its intent to redevelop its monitoring and performance framework to better align system goals at service provider and national levels. As part of this approach, the Ministry foreshadowed its interest in exploring the use of performance indicators for system level accountability purposes as well as tools for driving service quality improvement at the local level (Ministry of Health, 2001).

In the mental health field, performance measurement has been on the agenda since the inception of the New Zealand National Mental Health Strategy in 1994 (Ministry of Health, 2001). As in Australia, the early emphasis was on resource monitoring, using indicators to assess the extent of structural reform and growth in services expected under the Strategy. This reflected both the political reality that policy implementation was the imperative of the day as well as the fact that information infrastructure was not in place that would allow indicators to be produced on what services actually do.

With the creation of the District Health Board (DHB) structure and the introduction of new national mental health datasets, indicators have been added that address access issues (e.g., proportion population receiving services) and examine the extent to which DHBs are meeting population coverage targets. Further development of New Zealand indicators for mental health services is expected over the next few years.

3.2.5 European Union

In 2001, the Commission of the European Communities produced the report *Establishment of a set of mental health indicators for the European Union* (European Commission, 2001). While the emphasis of the report is at the level of international comparison, the report is of interest given the extensive consultative process and piloting of proposed indicators by member states (France, Germany, Greece, Finland and Norway). The proposed indicators were divided into four categories – demographic and socio-economic factors, health status, determinants of health, and health systems. The latter is of the most relevance to the current project.

The performance categories for health systems incorporates aspects of prevention, health protection and promotion, health resources, health care utilisation, expenditure, and health care quality indicators. Indicators are pitched at a high level and include number of inpatient episodes, number of long stay patients, money spent on disability due to mental disorders, and psychiatric beds.

Like indicators from other jurisdictions, some of the proposed European indicators use data collections currently outside the scope of those maintained in some Australian jurisdictions and therefore are not suitable for short term implementation here. The European report concludes that the indicators will be used for future mental health monitoring and should be made available to the public so that international comparisons can be made.

3.2.6 Sweden

In January 2001, the Swedish National Board of Health and Welfare prepared a report *Overall quality indicators in health care and medical services*. This report put forward quality indicators developed with the stated aim of encouraging continuous quality improvement and the provision of good quality health care. The indicators were based on data from medical quality registers. Choice of indicators was based on relevance, validity, measurability, possibility of influencing care, and interpretability and unambiguousness. Indicators were developed in the areas of quality of care, access to care, patient experience, and good health for the whole population.

Indicators selected for psychiatric care included:

- proportion of premature deaths of persons with previous psychiatric diagnosis;
- proportion of suicides among persons previously in institutional care due to mental illness;
- proportion of patients with schizophrenia who have daily meaningful employment; and
- proportion on sick leave for longer than one year with diagnosed depression.

The report noted the inadequacy of critical follow up information in areas operating outside the specialised mental health service system and the problems this posed for provision of information on outcomes indicators for consumers. A similar situation applies in Australia where routine data about an individual's housing status, employment and physical health are either not available or cannot be linked to mental health records.

3.2.7 Summary of international developments

Several observations can be drawn from the international literature:

- Although development is only at an early stage, most Western countries are working towards comprehensive frameworks for measuring performance of their mental health services. There are differences in emphases and terminology but there is also substantial convergence in the domains targeted for performance measurement;
- Performance reporting systems are generally being directly aligned with strategic policy goals and focused on encouraging action by measuring the things that matter to consumers, service providers, health care organisations and funders.
- Most government sponsored mental health indicator initiatives underway recognise the pragmatic reality that investment at this scale needs to serve a number of purposes and users.
- Most frameworks are designed to aggregate information at the level of national and regional populations and for key population groups, and to be used across a range of organisational structures and service categories to enable context specific performance review.
- Indicators for mental health are generally built from multiple data sources and require a combination of service utilisation, consumer survey and clinician-rated outcomes information.
- Whatever performance framework is adopted, emphasis is being given to ensuring that performance dimensions and their associated indicators need to be easily understood by all the stakeholders and should serve as triggers for action.
- Concerns about the safety of mental health care are being given greater focus, as they are more generally in the health industry. This has significant implications for performance measurement because few countries collect the type of data needed to build indicators.
- Long lead times are involved in the development work. There is general recognition that there are few quick solutions and that a long term investment is required.

4. Design issues

This section summarises the approach taken by the Drafting Group in designing a set of ‘first generation’ performance indicators for mental health services.

4.1 ‘Good practice’ in indicator development

Most government sponsored mental health indicator initiatives underway internationally recognise that such an investment needs to serve a number of purposes and users. Data collection and the process of building indicators is costly. As such, the approach generally being taken is to ensure that the cost of indicators developed for funding bodies also translates into useful information for performance measurement and quality improvement at the local service level. Shared information pools are needed that inevitably must be generated from ‘bottom up’ and which conform with an agreed framework. The needs of different groups can be met by ‘slicing’ the information in different ways to meet the varied purposes.

Several ‘good practice’ lessons are evident in the literature that were used by the drafting group in designing indicators for multiple purposes. Foremost amongst these are the need to:

- design indicators as tools for quality improvement not punishment;
- balance the varied interests of stakeholders;
- keep indicators simple, manageable with capacity to evolve with experience;
- build indicators that will promote benchmarking and learning opportunities;
- ensure that systems are in place to maintain control of data integrity; and
- recognise the fact that good indicators require a commitment of resources, in data infrastructure and particularly in time and personnel.

Appendix J summarises the desirable attributes of performance measurement systems that influenced the drafting groups approach to its task.

4.2 Indicators for collaborative benchmarking

‘... for a health system that searches for, compares, learns from the best and improves performance through the adoption of benchmarking practices across all levels of the system.’ (National Health Performance Committee, 2001).

This vision put forward by the National Health Performance Committee in 2001 has underpinned the development of the initial national key performance indicators for public mental health services. The emphasis has been to develop indicators that provide mental health services a set of indicators that serve as tools for improving service quality through collaborative benchmarking.

4.3 Inputs, processes, outputs and outcomes

Measures of inputs, processes, outputs and outcomes are all required to gain a full understanding of the performance of a mental health service system. Debates about the pre-eminence of outcome measures, or arguments that its ‘time to move on from input measures’, ignore the fact that each type of information serves a unique purpose.

Performance indicators may be based on:

- Inputs – the resources used in producing a product or service;
- Processes – actions or processes applied to convert resources into a product or service;
- Outputs – products or services delivered; and
- Outcomes – the outcomes of delivering the product or service. Outcomes may be short, intermediate, or long term.

Measures of input are necessary to understand the capabilities and structural characteristics of the organisation (e.g., staff skills, quality of facilities). Measures of process are needed to determine whether people receive care that is evidenced-based or conforms with consensus expectations about quality (e.g., treatment with dignity, appropriate care). Concerns about processes is particularly important in the mental health field because they reflect the values of the care system. Output measures are needed to understand the quantities of services provided and develop efficiency indicators (e.g., cost per contact). And finally, outcome measures are the basis for understanding whether consumers are improving in their clinical status and wellbeing.

The concept of the ‘balanced scorecard’, developed by the Harvard Business School (Kaplan and Norton, 1992), is based on the recognition that mental health service planners and managers need to balance a range of considerations when improving the quality of care. The delivery of care across the input-process-outcome spectrum needs to be measured at each step. Improvement in inputs may be needed to improve processes, which in turn can lead to better outcomes and prevent adverse events. Improved efficiency can enhance cost effectiveness. Continuous quality improvement activities are specifically premised on these linkages and seek to make changes in the structural and process components of care with the goal of positively influencing outcomes.

The indicators outlined in this report aim to deliver a balance across the input-process-outcome spectrum.

4.4 Service focus

The delivery of mental health services is not the sole domain of the specialised public sector mental health sector. General practitioners, private psychiatrists and hospitals, and psychologists all play an important role in meeting the mental health care needs of Australia’s population.

However, in recent years, the information infrastructure of the specialised public clinical mental health sector has benefited from significant investment by the Australian, State and Territory governments, through the development of nationally agreed data definitions and national minimum datasets, and developments in the area of data collection within jurisdictions.

Universally agreed definitions are a key factor in the utilisation of performance indicators for service level performance monitoring and benchmarking. The focus for the initial development of key performance

indicators for mental health has therefore been on the specialised public clinical mental health sector where these attributes are present.

This initial focus should not be construed as underestimating the key roles other services play in meeting the mental health care needs of Australians. Instead, it is a pragmatic recognition of the need for key performance indicators to be established using nationally defined and collected data items, and the additional development work required to produce these in other sectors.

Future developments aimed at increasing the scope of mental health information within areas such as primary health will facilitate the expansion of this set of key performance indicators to encompass the services provided by these other sectors, thereby contributing to a fuller picture on mental health care in Australia.

4.5 Level of reporting

The performance of specialised public clinical mental health service delivery may be monitored at a variety of levels including, in ascending order of aggregation, the client, the unit/service, the mental health service organisation, regional groups and States/Territories.

Lower levels of aggregation allow for more detailed interpretation and understanding of performance, but also place an increased burden in terms of data collection and reporting.

During the Second National Mental Health Plan and the associated developments in mental health reporting, the concept of the 'mental health service organisation' was adopted as the basis for data collection and reporting (see Appendix B for definition). There are a number of obvious benefits in targeting the key performance indicators at this level.

Firstly, as a key managerial business level, the mental health service organisation provides a natural decision point when assessing opportunities to improve service delivery. In addition, financial and staffing information is readily available at this level for reconciliation against client level data for the development and population of indicators.

Secondly, the mental health service organisation closely aligns with the concept of the integrated mental health service organisation, where client care is not characterised or limited by the notion of care setting but is reflected by a transition between inpatient and community care according to the patient needs, as promoted by the National Mental Health Strategy.

Thirdly, as reporting at this level has been adopted by recent key information development projects such as the National Outcomes and Casemix Collection, it will facilitate future integration of indicators derived from such collections.

In recognition of the above, the initial 13 indicators have been developed and specified at the level of the mental health service organisation, with the capacity for aggregated reporting at higher levels such as regions and States/Territories.

4.6 Generic versus program-specific indicators

There is a wide diversity of programs delivered by mental health service organisations and a need to develop indicators appropriate to each program's objectives. However, by definition, not all indicators can be 'key indicators'.

In developing the 13 initial performance indicators for immediate implementation, the following factors were taken into consideration.

- There should be a sufficient number of key performance indicators to inform about important aspects of program quality, but not so many as to create confusion.
- Although each program type possesses unique characteristics, more important for benchmarking purposes is the presence of fundamental shared concepts of performance that exist across all program types.
- Indicators that measure performance characteristics specific to one particular program type are less useful as key performance indicators where the total number of indicators is limited.
- An indicator cannot be understood in isolation and requires context for interpretation. This additional information is, in the first instance, often provided through other indicators. Indicators therefore need to be viewed as a ‘package’.

In response to these issues, a generic performance measurement framework has been utilised with a focus on indicators that have applicability to the majority of psychiatric services.

The indicators may be implemented within peer group (for example, adult, child and adolescent, and so on) with ongoing refinement as State and Territory mental health datasets continue to develop.

It is recognised that, because the utility of indicators is reliant upon comparing ‘like with like’, services of a highly specialised type may introduce confounding effects when organisations compare their performance on a given set of indicators. For this reason, the detailed indicator specifications proposed in this report (Appendix A) specifically exclude data from highly specialised services.

4.7 Selecting and assessing the candidate indicators

A large number of candidate indicators was considered by the drafting group, drawn from the published literature and other sources. All candidates were evaluated using the criteria outlined in the National Health Performance Framework, eight of which target the viability of each individual indicator, and five of which relate to the comprehensiveness of the proposed indicator set as a whole (see Table 2). Candidate indicators were also assessed against reliability and validity criteria that are implicit within the framework but were considered of sufficient importance to warrant explicit assessment.

4.8 Statistically derived episodes of care as ‘units of counting’

In measuring service performance it is necessary to define the patient care outputs or ‘units of counting’.

The concept of ‘episode of care’ is used widely throughout the health system to describe patient care products, where episode refers to a period of care with a discrete start and end point.

Most work on defining episodes has been tied to acute hospital settings, where the principle is relatively simple – one episode per patient per hospital at any one time, with the episode beginning at admission and ending at discharge.

Table 2: Criteria used to evaluate candidate indicators

CRITERIA APPLIED TO INDIVIDUAL INDICATORS	CRITERIA TO OVERALL INDICATOR SET
<ul style="list-style-type: none"> • Be worth measuring. • Be measurable for diverse populations. • Be understood by people who need to act. • Galvanise action. • Be relevant to policy and practice. • Measurement over time will reflect results of actions. • Be feasible to collect and report. • Comply with national processes of data definitions. • Reliability. • Validity. 	<ul style="list-style-type: none"> • Cover the spectrum of the health issue. • Reflect a balance of indicators for all appropriate parts of the framework. • Identify and respond to new and emerging issues. • Be capable of leading change. • Provide feedback on where the system is working well, as well as areas for improvement.

As part of the National Outcomes and Casemix Collection, significant work has been undertaken to translate this concept to mental health services and address the issues surrounding multiple service providers, client care over extended periods, and the setting of community care (Department of Health and Ageing, 2003).

This work defined an episode of mental health care to be ‘... a more or less continuous period of contact between a client and a mental health service organisation that occurs within the one mental health service setting’. Three broad episode types based on treatment setting – inpatient, community residential, and ambulatory:

- Inpatient episode (overnight admitted) – a period of care provided to a consumer who is admitted for overnight care to a designated psychiatric inpatient service;
- Community residential episode – a period of care provided to a consumer who is admitted for overnight care to a designated 24-hour community-based residential service; and
- Ambulatory episode – all other types of care provided to consumers of a designated mental health service.

These definitions have formed the basis for the development of *statistically derived episodes of care* which form the units of counting for patient care products within this framework, and are necessary to address the issues raised by those episodes of care which overlap reporting period boundaries.

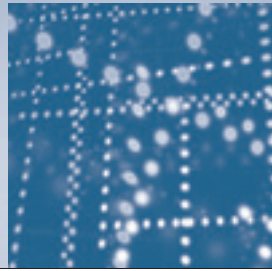
4.9 A staged approach to implementation

A final issue considered in the design of indicators is whether they should be based on currently available data or whether a staged approach should be taken to indicator development.

The risk with adopting a ‘lowest common denominator’ approach is that the resultant indicators will be unable to measure those performance issues identified as being of key significance. Alternatively, if reliable data is not available, the quality and usefulness of the indicator will be compromised.

Rather than compromise indicator development via the use of the lowest level of common data across jurisdictions, candidate indicators have been designed with a view to staged implementation, and in recognition of the commitment by States and Territories to ongoing development and refinement of the mental health data collections and definitions.

5. Measuring mental health across the national health performance domains



The central task for the Drafting Group was to consider the nine ‘Tier 3’ performance domains of the National Health Performance framework in relation to mental health services. This section works through the domains, clarifying definitions and interpretation within a mental health context and proposes indicators for adoption at the national level.

5.1 Preliminary considerations

The Drafting Group undertook an initial review of the performance framework in the context of policy goals set for mental health under the National Mental Health Strategy. It concluded that the framework offered a sufficiently comprehensive model for monitoring the performance of mental health services but, as a preliminary step to defining indicators for each domain, several issues need to be resolved.

- **Domains need to be further specified to the most salient matters of concern (‘sub-domains’)**

Each of the nine domains represents a broad area of concern relevant to health service performance such that, within any domain, it is necessary to specify further levels of detail as a first step towards indicator development. For example, the domain Responsiveness covers the concepts of respect for client dignity and choice, quality of amenities, and promptness. Each of these may be the subject of one or more indicators.

For the majority of domains, we have represented this multidimensionality by identifying key sub-domains relevant to the delivery of mental health services. Each sub-domain can be regarded as describing a topic of concern, or the most salient aspects of organisation performance.

- **Sub-domains considered most relevant may change over time**

Issues considered important within any particular domain are likely to change over time in response to community expectations or specific challenges facing the service delivery system. Decisions about which sub-domains warrant the development of indicators require a judgment about those aspects of service delivery considered most important in the current service delivery and policy climate.

- **The domains and their component sub-domains vary in the extent to which indicators can be constructed from available data**

Technical problems such as lack of data or unreliability of source information limit the extent to which some performance concepts can be translated to practice. The suggested approach is to develop indicators in two phases. The first phase is to identify candidate indicators for which data are immediately available. For convenience, we refer to this group of indicators as ‘Phase 1 indicators for initial trial’ on the basis that, subject to agreement by State and Territory jurisdictions, the logical next step is to model these indicators using the most current available data.

A total of 13 indicators are identified for Phase 1 implementation (see Section 5.3).

The second phase is to develop indicators for those domains or sub-domains for which indicators cannot be derived from currently available data. Three of the nine national performance domains fall into this category (Responsiveness, Safety and Sustainability), as do several key sub-domains within other areas of the NHP framework. We have labelled these areas as *Phase 2 indicators for development* and identified potential candidates for consideration. The majority will require either new data collections or new analyses of existing datasets that have not previously been explored from a performance indicator perspective.

- **Indicators map to multiple domains**

There is considerable overlap between the nine NHP domains. For example, the domain *Appropriateness* includes elements relevant to responsiveness and continuity. The implication is that any one indicator may be relevant to multiple performance dimensions. This point was acknowledged by the National Health Performance Committee in its original report.

The approach taken by the Drafting Group was that consideration of the domains should be used to generate indicators without being bound by notions of conceptual purity. Where a recommended indicator mapped to more than one dimension of the NHP framework, for the purpose of simplicity it has been assigned to a 'primary domain', but cross linkages to secondary dimensions are identified.

5.2 Indicators by domain

The section that follows discusses each of the performance domains, identifying indicators for Phase 1 implementation and areas for Phase 2 development. A summary of the proposed indicator set is provided in section 5.3.

A number of supporting materials are presented in the Appendices:

- Appendix A provides detailed specification of each of the Phase 1 indicators;
- Appendix C summarises the data sources for all indicators; and
- Appendix D provides a hypothetical illustration of how the indicator set can be used to review the performance of a mental health service organisation.

5.2.1 EFFECTIVENESS: 'Care, intervention or action achieves desired outcome in an appropriate timeframe'

National Mental Health Strategy context

Improving mental health service outcomes was a central goal of the National Mental Health Strategy when it was first agreed by all Australian Health Ministers in 1992. The need to improve service effectiveness continued as a theme under the Second National Mental Health Plan (1998-2003) and is further reinforced by the current National Mental Health Plan 2003-2008.

The Strategy emphasises the need for outcomes to be reviewed on a regular basis with particular focus given 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.'

Underdeveloped information systems and lack of suitable measurement tools have acted as obstacles to this goal. To address this, substantial work has been commenced by all States and Territories to establish the information infrastructure and workforce skills needed to embed the measurement of consumer outcomes as a routine part of service delivery. By June 2003, an estimated 56 percent of public mental health services had commenced the process of direct consumer outcome measurement (Department of Health and Ageing, (2004).

Interpretation of the domain

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

- **Multiple levels at which outcome may be measured** – outcomes of mental health care can be described at the level of whole populations (for example, suicide rates), or for service systems (for example, percent of discharges to homeless shelters), or at the level of the individual consumer.
- **Multiple outcome sub domains** – the concept of outcome has multiple dimensions, each of which need to be considered independently. For example, outcomes at the level of the individual consumer may be measured by improvements in functioning (which in turn has multiple aspects covering social, occupational and activities of daily living functioning), clinical status, or quality of life. No single outcome measure can adequately assess all aspects.
- **Multiple perspectives on outcomes** – similarly, assessment of the outcomes of mental health care needs to ask the question ‘according to whom?’. Outcomes as assessed by clinicians may (and often are) different from those made by consumers and carers. The need to consider differing perspectives on health service performance applies across all domains but is particularly critical to the selection of effectiveness indicators.
- **Multiple timeframes – an outcome may be initial, intermediate, or long-term.** Selecting an appropriate timeframe for measurement is especially important for defining a ‘good outcome’ for people with recurrent or continuing mental disorders. Satisfactory results achieved in the short term may be misleading when viewed from a longer term perspective, or vice versa.

The Drafting Group took the approach that a comprehensive set of indicators to address this complexity will need to evolve over an extended period. However, initial indicators are needed and available to begin the process of monitoring the effectiveness of mental health services.

Sub-domains

Three sub-domains are proposed for monitoring the effectiveness of mental health services:

- **Consumer outcomes** – this sub-domain comprises measures of the impact of health care on the consumer’s clinical status and functioning. Indicators of this type are often described as the ‘gold standard’ of service effectiveness indicators on the basis that mental health services must first and foremost be accountable to the populations they serve.
- **Carer outcomes** – this sub-domain is designed to monitor the impact of mental disorders on the quality of life of family members and other carers as they support a person experiencing mental illness.
- **Community tenure** – this sub-domain concerns the extent to which mental health services are effective in maintaining consumers in the community, without unnecessary hospitalisation. Emphasis on the development of community services as alternatives to hospital care is a central platform of the National Mental Health Strategy.

Phase 1 indicator for initial trial: 28 day readmission rates

Of the three proposed sub-domains, only community tenure is suitable for Phase 1 implementation. Substantial scope to complement this indicator with direct measures of consumer outcomes is expected over the next few years.

The indicator 28 day readmission rates is focused on unplanned early returns to hospitals following discharge from acute inpatient services. It provides a useful starting point to assess community tenure for several reasons:

- Psychiatric inpatient services aim to provide treatment that enables individuals to return to the community as soon as possible. Unplanned admissions to hospital following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up community care was inadequate to maintain the person out of hospital. In this sense, high levels of unplanned readmissions potentially point to deficiencies in the functioning of the overall care system.
- Research and clinical literature identifies the period of one month as a reasonable time period for defining clinically avoidable readmissions following discharge from an acute inpatient mental health service.
- Avoidable rapid readmissions place pressure on finite beds.
- International comparative data are readily available. Versions of the 28 day readmission rate indicator are in use and publicly reported by several United States jurisdictions and in the United Kingdom and Canada.

While reporting of 28 day readmission rates is proposed primarily as an indicator of effectiveness, it is important to note that it is also relevant to an organisation's performance in the appropriateness and continuity dimensions of the national framework.

Phase 2 indicators for development

The implementation of consumer outcome measures by Australia's public mental health services lays the foundation for more direct indicators of service effectiveness. These will provide both clinician and consumer perspectives on the extent to which services are effective in achieving improvements in both functioning and clinical status, as summarised in the matrix below.

Table 3: Potential areas for indicator development derived from consumer outcomes measures

EFFECTIVENESS SUB DOMAIN	CLINICIAN PERSPECTIVE	CONSUMER PERSPECTIVE
Improvement in clinical Status	Example: % consumers showing improvement on Health of the Nation Outcomes Scales	Example: % consumers reporting improvement on Behaviour and Symptom Identification Scale
Improvement in functioning	Example: % consumers showing improvement on Life Skills Profile	Example: % consumers reporting improvement on Mental Health Inventory

While the new measures hold great potential, exploratory work is needed before they can be applied within a performance indicator context. As there are few international precedents to guide the work, Australia needs to 'grow the evidence' from which any indicators will emerge. The Drafting Group took the view that it would be premature and possibly counterproductive to specify indicators derived from consumer outcome measurement until this work is completed.

The key task at this stage is to ensure that the introduction of consumer outcome measures is fully implemented across all public sector mental health services. An indicator titled 'outcomes readiness' is proposed under the *Capable* domain to monitor progress in this area (see 5.2.7).

Beyond the work on consumer outcomes, effectiveness indicators need to be extended to the Carer outcomes sub-domain. The need for greater effort in improving outcomes for carers is emphasised in the National Mental Health Plan 2003-2008. Considerable development work will be required to identify suitable measurement tools that are amenable to performance indicator production.

5.2.2 APPROPRIATENESS: 'Care, intervention or action provided is relevant to the client's needs and based on established standards'

National Mental Health Strategy context

Concerns about the appropriateness of care were an original driver of the National Mental Health Strategy. More recently, perceived inadequacies in the way in which mental health care is provided have been the subject of considerable criticism.

Most reform effort in the early years of the Strategy focused on structural reform to reduce Australia's historical reliance on separate psychiatric hospitals and to develop a better mix of community-based and general hospital services. This emphasis on structural change was later complemented by a focus on defining the processes required at the service delivery level to meet international and consensus-based criteria for 'good practice mental health care'. These were endorsed as the National Standards for Mental Health Services and released in 1996 (Department of Health and Family Services, 1996). All States and Territories have agreed to progressively implement the Standards across public sector mental health services.

Interpretation of the domain

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

The *Appropriateness* domain overlaps with the domains of *Responsiveness* and *Continuity* because these are also intrinsically concerned with processes of service delivery. The distinguishing attribute used by the drafting group in assigning indicators to appropriateness as the primary domain is that such indicators require assessment against some external standard.

Sub-domains

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

- **Compliance with established standards** – this sub-domain addresses the question of whether the services provided by the organisation conform with guidelines that are evidence-based or derived from expert consensus on what constitutes 'best practice'.

- **Relevance to client needs** – this sub-domain addresses the question of whether the organisation provides care that is tailored to the individual characteristics and requirements of the consumer.

Phase 1 indicator for initial trial: *National Service Standards Compliance*

One indicator is proposed for Phase 1 implementation and focuses on the application of the National Standards for Mental Health Services within mental health service organisations. The Standards express many of the aspirations entailed in notions of ‘good practice mental health care’ and are expected to be adopted comprehensively across public sector mental health services.

The indicator *National Service Standards Compliance* assesses the degree to which service delivery units (inpatient wards, community teams) managed by an organisation have been judged by an external accreditation body as meeting the National Standards for Mental Health Services. The indicator is expressed as a simple percentage, where the contribution of each service unit to the total score is weighted by its relative size within the organisation’s overall mental health service network (for example, an inpatient ward that accounts for 25 percent of the organisation’s mental health expenditure would contribute 25 percent to the organisation ‘score’).

Recent changes to the annual National Survey of Mental Health Services (NSMHS), collected for monitoring progress of the National Mental Health Strategy, will provide the means for this indicator to be introduced.

Phase 2 indicators for development

Further work and new data collections will be required to develop indicators covering concepts within the *Relevance to client needs* sub-domain. There are many options, depending on the aspects of service delivery, that are the focus of concern. For example, indicators could be designed to monitor the extent to which services provided to indigenous consumers are facilitated by indigenous mental health workers, the rate at which child and adolescents are treated in general adult units, the level of addiction services provided to consumers with substance abuse comorbidity; and so forth.

The Drafting Group concluded that issue-specific indicators of appropriateness would impose a considerable burden on existing data collections if these were expected to be available at the national level. While this is a logical area for development it should not distract from the broader task of establishing a basic set of key performance indicators across the mental health service industry.

5.2.3 EFFICIENCY: ‘Achieving desired results with the most cost effective use of resources’

National Mental Health Strategy context

Concerns about efficiency are less explicit in the various documents that comprise the National Mental Health Strategy than other concepts covered by the NHP framework. While many of the policy directions advocated by the Strategy can be construed from the perspective of allocative efficiency (achieving optimal outcomes using available resources), relatively little has been written at the national level about the technical efficiency of public mental health services (production of outputs for the least cost). This reflects the limited progress made to date on developing nationally agreed costing concepts and benchmarks in the mental health field, as well as highlighting the need for meaningful data to inform such development.

The situation at the State and Territory level is quite different. All jurisdictions are experiencing significant pressures on mental health budgets and increased demands by government to ensure efficient use of resources. State and Territory health departments are also expected to report on a range of efficiency indicators. In the course of the current project all States and Territories expressed a common need for comparable data to be made available at the national level to assist in managing their programs.

Interpretation of the domain

Indicators developed on health sector efficiency have primarily focused on technical efficiency aspects because methodologies to measure allocative efficiency are only in the developmental stages. Consequently, indicators currently reported at the national level for the broader health sector are exclusively concerned with technical efficiency issues, focusing on cost per unit of output. This will also be the case for indicators of mental health sector efficiency.

The key issue for the mental health sector is resolving the unit of output (or 'product') for which efficiency measures are to be developed. Most work in developing indicators within the health system defines the product as the 'treated patient', and measures the product in terms of individual episodes of care. These concepts are well established in the acute hospital sector but have not been extended to the mental health context. The traditional focus of mental health efficiency measures in Australia has been on input-based measures (for example, average cost per worker) or intermediate processes (for example, bed days, occasions of service), rather than final patient care products.

As noted in section 4, recent work to design the National Outcome and Casemix Collection (NOCC) has addressed these issues and defined episodes of care within the mental health context as the units for measurement purposes. This work provides the basis for the unit cost measures proposed below.

Sub-domains

Separate sub categories of efficiency indicators are needed to ensure comparisons are based on similar service or care types. In effect, this involves creating two sub-domains for initial indicator development.

- **Inpatient care** – inpatient services account for approximately 50 percent of national expenditure on public sector mental health services, and have very different unit cost characteristics from community-based care. There is also evidence that the clinical cost drivers (patient characteristics) differ from those operating in community care (Buckingham et al, 1998).
- **Community (ambulatory) care** – ambulatory care services account for approximately 38 percent of mental health services expenditure.

Phase 1 indicators for initial trial:

- Cost per acute inpatient episode.
- Average length of acute inpatient stay.
- Cost per three month community care period.
- Treatment days per three month community care period.

The four indicators proposed – two for each sub-domain – are designed to provide information on average unit costs and the key factors influencing cost variation.

For inpatient care:

- *Cost per acute inpatient episode* will provide a direct measure of the efficiency of a component of the service system that accounts for 70 percent of the total costs of specialised mental health inpatient care and 36 percent of overall delivery costs.
- *Average length of acute inpatient stay* provides supplementary information on the key driver of variation in acute inpatient episode costs and reflects differences between mental health service organisations' practices, casemix, or both. Inclusion of this indicator promotes a fuller understanding of an organisation's episode costs as well as providing a basis for utilisation review. For example, it allows services provided to particular patient groups to be assessed against clinical protocols. Inclusion of the indicator also enables the more traditional efficiency indicator used throughout the mental health sector (average bed day costs) to be derived.

For community care:

- *Cost per three month community care period* is intended to assist the sector in moving beyond its historical concern with 'micro' indicators (for example, cost per occasion of service) to approaches that aggregate individual treatment events to higher level 'care products' more consistent with the measurement concepts used in the broader health sector.
- *Treatment days per three month community care period* gives an indication of the volume of services (measured by the number of days on which contact occurs) to consumers during the course of their care in the community. Previous work has pointed to frequency of servicing as the prime driver of variation in community care costs (Buckingham et al, 1998), making this indicator the community equivalent of length of stay in inpatient services. Like length of stay, this indicator promotes a fuller understanding of an organisation's episode costs, as well as providing a basis for utilisation review.

Technical adjustments will be needed to available data sources to standardise definitions and analysis methodologies in a manner that promotes like-with-like comparisons on each of the indicators. For example, the specifications outlined in Appendix A propose what is effectively a statistically derived concept of community episodes that standardises episodes to three month periods of care in a way that departs from the rules used to guide data collection under the NOCC protocol. Similarly, standardisation is required on how to handle inpatient leave periods and sameday admissions. The specifications outlined in Appendix A begin the process of documenting the technical work required, but further detail will be needed to guide indicator production.

Phase 2 indicators for development

Future work to refine efficiency indicators for the mental health sector falls into two categories.

First and most important is the need to incorporate casemix adjustment. Variations between organisations on efficiency measures will not be properly understood until adjustments are made to take account of differences in the mix of patients treated. This in fact applies to any of the performance indicators but is especially critical to the interpretation of efficiency.

The second category for the future is the extension of the Phase 1 indicators to non acute and residential services. This is necessary to provide a more comprehensive picture of overall mental health sector performance.

5.2.4 ACCESSIBILITY: 'Ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background'

National Mental Health Strategy context

Improving access to services has been a continuing priority theme throughout the history of the National Mental Health Strategy. National objectives to improve access to mental health care have been multifaceted and cover local access to specialist services through decentralisation of resources, increasing access to mainstream health and community support programs for people affected by mental illness, and improving service availability for special needs groups.

Access issues are given prominence in the National Mental Health Plan 2003-2008, featuring in 11 of the 34 'key outcomes' advocated by the Plan. The priority objectives cover both improved access to services (acute care, early intervention, community services, disability support) and for specific populations (Aboriginal and Torres Strait Islanders, consumers with complex needs).

Interpretation of the domain

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

- Access implies that people in need of care in fact actually receive services. The issue of unmet need has become prominent since the publication by the Australian Bureau of Statistics of evidence suggesting that of the 18 percent of adults who are affected by mental illness, two thirds do not receive any form of treatment (Australian Bureau of Statistics, 1998). The implication for performance indicators is that they should monitor population treatment rates and assess these against what is known about the distribution of mental disorders in the community.
- Access also implies geographical proximity so that services are delivered in a way that minimises dislocation of the consumer from family and local supports.
- A third meaning concerns timeliness, or responding to needs when they arise. Timely access to services is a major factor in ensuring that consumers receive needed services. It includes prompt attention to emergencies as well as reasonable wait times for other referrals.

Sub-domains

Three sub-domains are proposed to cover the different aspects of access:

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

Phase 1 indicators for initial trial:

- Population treatment rates.
- New client index.
- Local access to inpatient care.
- Comparative area resources.

Four indicators are recommended for Phase 1 implementation, covering two of the three sub-domains.

For the *Access for those in need* sub-domain, two indicators provide comparative information on population utilisation of public mental health services.

- *Population treatment rates* is intended as a proxy measure of treated prevalence (whether persons with mental illnesses are in fact receiving mental health care), and measures the percentage of the organisation's catchment population that utilises services within a given period.² The indicator provides a basis to compare utilisation rates with data on the prevalence of mental disorders in the community. Stratification of the indicator (for example, by indigenous status or age) can be performed to investigate whether service organisations are responsive to various consumer populations.
- *New client index* examines the relative extent to which the organisation provides services to new cases as opposed to existing clients and is expressed as a simple percentage (new clients as a percentage of total clients). This indicator aims to respond to concerns that mental health services invest a disproportionate level of resources in dealing with existing clients and too little in responding to the needs of new clients as they present.

Indicators of the *local access* sub-domain are derived from utilisation and resource data.

- *Local access to inpatient care* measures the extent to which people living in the organisation's catchment area who require acute inpatient care are in fact treated by the local inpatient service. The indicator is expressed as a percentage ('within area' separations as a percentage of total separations), with higher scores indicating greater area self-sufficiency.
- *Comparative area resources* is an input-based measure and quantifies the level of mental health resources dedicated to the organisation's catchment population, measured in terms of per capita recurrent expenditure. Resource information of this type is essential for interpreting the overall performance data. For example, an organisation may achieve low population treatment rates because it has relatively less resources available to care for its population than similar services.

Phase 2 indicators for development

Indicators to capture the *timeliness* sub-domain need to be developed. A number of options were considered by the Drafting Group (for example, waiting times for urgent referrals), but none were judged to be feasible within current national data collections.

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

National Mental Health Strategy context

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

The National Mental Health Plan 2003-2008 states that 'continuity of care remains a key challenge'. Four of the Plan's 34 'key outcomes' are devoted to improvements in this area.

² Population treatment rates are sometimes referred to as penetration rates.

Interpretation of the domain

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

Sub-domains

Three sub-domains are proposed for development of continuity of care indicators relevant to the mental health sector:

- **Continuity across settings** – indicators developed for this sub-domain should focus on coordination between inpatient and community services as consumers move between treatment settings.
- **Continuity between providers** – this sub-domain concerns the integration of services delivered by multiple providers.
- **Continuity over time** – indicators for this sub-domain would focus on continuity across the course of an illness, recognising that consumers will have different needs at different points in time.

Phase 1 indicators for initial trial:

- Pre-admission community care.
- Post-discharge community care.

Both indicators address continuity of care between inpatient and community services and monitor the extent to which community services are involved with consumers prior to and following hospitalisation. The indicators are based on what is known about admission patterns and risk factors:

- Most admissions to public psychiatric units involve the readmission of consumers known to the local service.
- Many potential admissions may be averted by the involvement of community treatment and support services.
- Where readmission to hospital is necessary, early re-admissions largely reflect failures in the care system. The greatest risk period for re-admission is in the month following discharge.

The indicator *Pre-admission community care* looks at the pre-admission period and is expressed as the percentage of admissions to acute psychiatric units where the consumer had one or more contacts with a community team in the seven days prior to admission. The standard underlying the indicator is that a characteristic of an integrated service is involvement by community teams in the lives of consumers and families during the highly stressful pre-admission period.

The indicator *Post-discharge community care* looks at the extent to which community services engage with patients in the immediate post-discharge period. Statistically, the indicator is expressed as the percentage of separations from acute units where the consumer had one or more contacts with a community team in the seven days following discharge. The standard underlying this measure is that continuity of care involves prompt community follow-up of consumers in the vulnerable period following discharge from hospital.

Phase 2 indicators for development

Indicators for the remaining two sub-domains (*continuity between providers, continuity over time*) need to be developed. For the former, the drafting group considered that the priority should be given to indicators that focus on linkages between specialist mental health services and the primary health care system. New data items will be required for this to be progressed.

5.2.6 RESPONSIVENESS: ‘Service provides respect for persons and is client orientated. It includes respect for dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks, and choice of provider’

National Mental Health Strategy context

Improving service responsiveness is one of four themes used by the National Mental Health Plan 2003-2008 to organise priorities over the five year period. Consultations conducted in the lead up to the Plan identified problems in this aspect of service delivery as significant concerns for consumers and carers.

Interpretation of the domain

The NHP concept of Responsiveness is closely tied to the *Accessibility* and *Appropriateness* domains. However, a distinguishing feature of responsiveness as defined in the framework is that it looks at service delivery from the perspective of the client’s experience and expectations. Indicators of responsiveness are therefore customer-oriented, with all measures taking the approach of ‘ask the customer first’.

The National Mental Health Plan 2003-2008 takes a different approach, incorporating the NHP dimensions of accessible and continuous within the concept of service responsiveness. For example, the Plan identifies three responsiveness sub-themes – access to care, continuity of care, and support for families and carers.

Sub-domains

Elaboration of responsiveness sub-domains followed the NHP concept on the basis that the broader concepts outlined in the National Mental Health Plan are well covered by other domains. Two sub-domains were identified for indicator development:

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

Phase 1 indicator for initial trial

No indicators for Phase 1 implementation are proposed because existing data collections do not include the type of information needed to assess responsiveness.³

³ Information on consumer and carer participation is collected at the organisational level as a component of the National Survey of Mental Health Services and reported at State and Territory level in the National Mental Health Report. However, the data collected monitors structural arrangements, such as whether consumers and carers are represented on various committees, rather than whether they perceive themselves as influencing decisions about the health care they receive.

Phase 2 indicators for development

Indicators of service responsiveness, suggested in the performance indicator literature, rely on survey methods to capture consumers' and carers' experience of care. For example, national surveys of consumers are conducted regularly in the United States with results reported as the 'consumer-oriented mental health report card', released under the auspice of the Center for Mental Health Services Mental Health Statistics Improvement Program.⁴

Comparable collections are not available in Australia, although steps are being taken by two jurisdictions (New South Wales and Victoria) to develop consumer and carer perceptions instruments. Work along these lines would need to be extended to the national level as a first step to introducing meaningful indicators of responsiveness within the performance monitoring framework.

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

National Mental Health Strategy context

While the National Mental Health Strategy recognises that a competent mental health workforce is a precondition for quality mental health care, lack of standards that define the essential skill and knowledge requirements for practitioners has been a barrier to setting national objectives for workforce development. Work commenced under the Second National Mental Health Plan (1998-2003) to address this gap and culminated in the release in 2002 of the National Practice Standards for the Mental Health Workforce (Department of Health and Ageing, 2002). These are designed to complement the National Service Standards by defining the core competencies expected of individual mental health practitioners in terms of the knowledge, skills, and attitudes.

The Practice Standards propose a two-year timeframe from the time an individual professional begins work in a mental health service during which they can work towards meeting the requirements. A national implementation plan to apply the standards across public sector mental health services is currently being developed.

Interpretation of the domain

The NHP framework notes that, while the primary focus of this domain relates to the training of health professionals, it also concerns the capability of the overall service to do the work that is required in delivering quality mental health care.

Sub-domains

Two sub-domains are proposed to guide development of capability indicators relevant to the mental health sector:

- **Provider knowledge & skill** – this concerns the extent to which the health professional workforce employed by mental health service organisations meet core competencies requirements.
- **Outcomes oriented** – this sub-domain is proposed as an interim concept to reflect the work being undertaken by States and Territories in implementing routine consumer outcome measurement. The logic underpinning the sub-domain is that a capable service is results oriented and has systems in place to regularly monitor client outcomes.

⁴ See www.mentalhealth.samhsa.gov/publications/allpubs/MC96-60/

Phase 1 indicator for initial trial: Outcomes readiness

This indicator is concerned with measuring the progress of organisations in implementing systems that routinely report on consumer outcomes. Statistically, the indicator is expressed as the percentage of total episodes of care within a defined period that have completed outcome assessments.

Given the commitment and investments by all States and Territories to comprehensively implement routine outcome measurement, it is envisaged that this indicator will serve a useful purpose only in the short term (two to three years). As noted earlier, direct indicators of consumer outcomes are expected to be added to the performance framework as experience develops with the data.

Phase 2 Indicators for development

Phase 2 requires indicators to monitor uptake of the National Practice Standards by public sector service organisations. Consideration of these was deferred by the Drafting Group pending finalisation of the National Standards Implementation Strategy.

5.2.8 SAFETY: ‘The avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered’

National Mental Health Strategy context

Safety is a core component of both the National Standards for Mental Health Services and the National Practice Standards for the Mental Health Workforce. In recognition of the importance of safety in mental health care, the National Mental Health Working Group (NMHWG) established the Safety and Quality in Mental Health Partnership Group in 2003 as an expert advisory group.⁵ One of its first priorities is the development of a National Mental Health Safety Policy, Framework and Action Plan.

The Group has identified lack of information as a key issue to be addressed. For example:

- No nationally agreed information is routinely collected or reported on sentinel events in mental health, such as death or deliberate self harm in care, rates of seclusion and restraint, or use of emergency psychiatric treatments.
- No nationally agreed information is recorded that details the safe and quality use of medicines.
- No information is routinely reported across the mental health sector on whether safety protocols exist that make the activities and environment of mental health services safe for consumers, carers, families, staff, and the community.

Work has been commenced by the Group to define the priority areas for a safety agenda in mental health. Although only in the early stages, the following areas are the main priority themes emerging for the Mental Health Safety Action Plan:

- reducing suicide and deliberate self-harm in mental health and related settings;
- reducing adverse events associated with restraint and seclusion and ensuring their appropriate use;
- reducing adverse medication events in mental health services; and
- safe transport of people experiencing mental illness.

⁵ Membership of the Partnership Group comprises the Australian Council on Safety and Quality in Health Care, the Royal Australian and New Zealand College of Psychiatrists Quality Improvement Committee, the Strategic Planning Group for Private Psychiatric Services, the Australian Government, representatives (usually Chief Psychiatrists) from each State and Territory, mental health consumer and carer representatives and a representative from the New Zealand Ministry of Health.

Development of nationally agreed indicators and associated datasets are expected to follow as the group makes further progress. Given this, the Performance Indicators Drafting Group deferred consideration of the Safety domain.

5.2.9 SUSTAINABILITY: ‘System or organisation’s capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs’

National Mental Health Strategy context

‘Fostering research, innovation and sustainability’ is the fourth priority theme outlined in the National Mental Health Plan 2003-2008. It covers a number of aspects of national policy that were relatively ‘silent’ in previous Plans, with a particular emphasis on investing in research and related activities to ensure that innovation found to be effective is translated into mainstream practice.

Interpretation of the domain

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

Sub-domains

Three sub-domains are suggested to guide future indicator development:

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

Phase 1 indicator for initial trial

Lack of suitable data prevents indicators for this domain being feasible for Phase 1 implementation. This parallels the wider health performance framework which is yet to incorporate measures of sustainability.

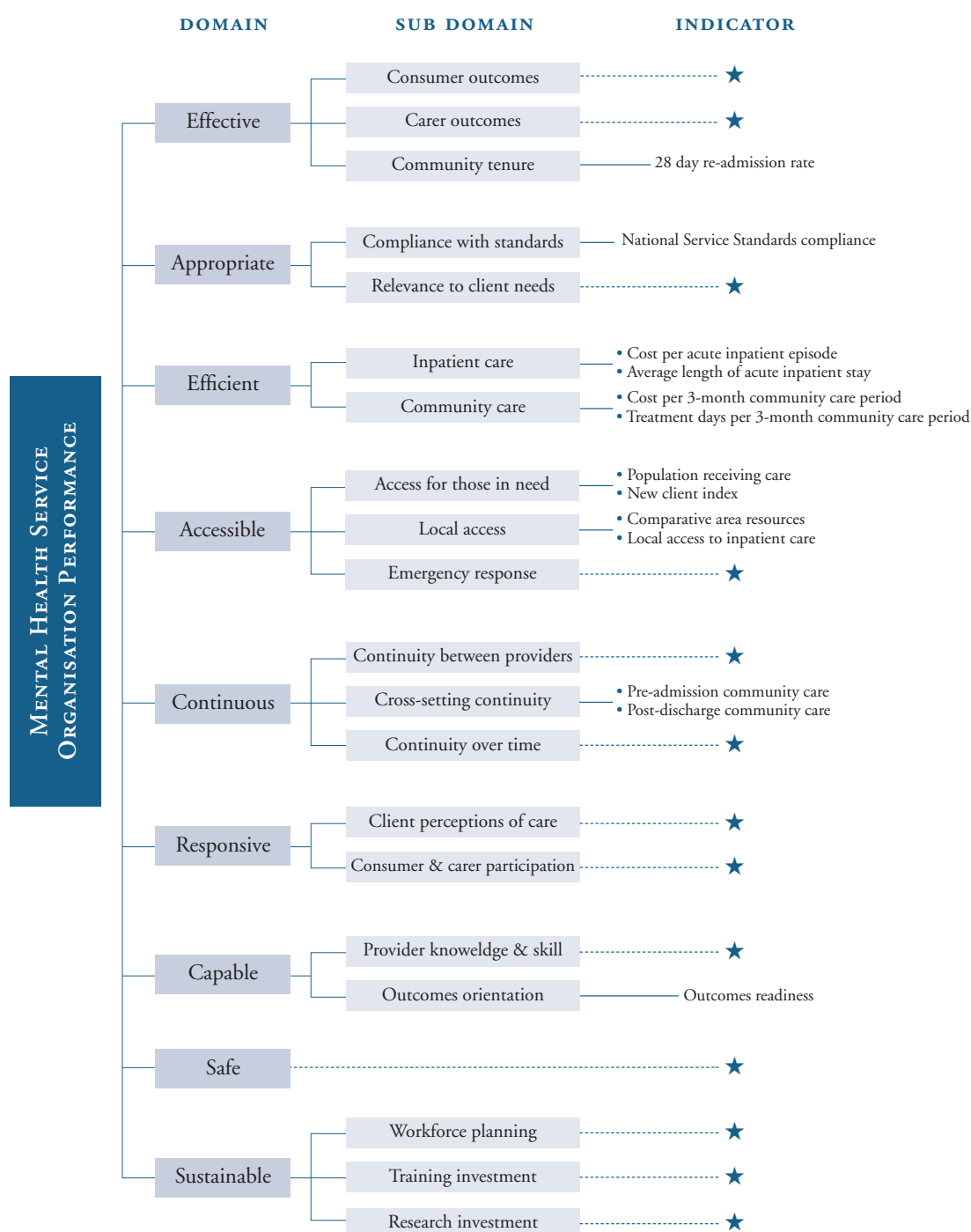
Phase 2 Indicators for development

A range of options is available for future consideration, including, for example, workforce indicators such as average age and recruitment of new graduates. Nursing is the logical area to begin development of such indicators given its overall significance and recent projections of major workforce shortages (Senate Community Affairs Committee, 2002).

5.3 Summary of proposed indicator set

A summary of the performance framework and proposed Phase 1 indicators is shown in Figure 3. Overall, 20 sub-domains are identified as key areas for performance indicator development. A total of 13 indicators is suggested as suitable for early implementation, based on data currently collected and reported by Australian public sector mental health services.

Figure 3: Summary of performance framework and proposed indicators for Australian public sector mental health services



Key ★ = Phase 2 Indicators for development

Table 4 maps each of the 13 indicators to a primary domain of the Australian National Health Performance Framework, also showing secondary linkages to related domains. The initial performance indicators provide primary coverage in seven of the nine dimensions with particular focus on Appropriateness, Efficiency, Accessibility, Continuity, and Effectiveness.

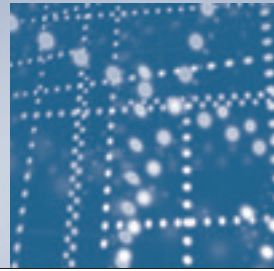
Three of the nine domains (Responsiveness, Sustainability and Safety) have no primary indicator as suitable data sources are not currently available.

Table 4: Phase 1 key performance indicators – primary and secondary coverage of the National Health Performance domains

KEY PERFORMANCE INDICATOR	EFFECTIVE	APPROPRIATE	EFFICIENT	RESPONSIVE	ACCESSIBLE	SUSTAINABLE	CAPABLE	SAFE	CONTINUOUS
28-day readmission rate	▲								■
National Service Standards compliance		▲					■		
Cost per acute inpatient episode			▲						
Average length of acute inpatient stay		■	▲						
Cost per three month community care period			▲						
Treatment days per three month community care period		■	▲						
Population receiving care					▲				
Local access to inpatient care					▲				
New client index					▲				
Comparative area resources					▲	■			
Pre-admission community care					■				▲
Post-discharge community care					■			■	▲
Outcomes readiness	■						▲		

▲ = Primary domain
 ■ = Secondary domain

6. Next steps in implementing performance indicators



The Drafting Group believes that the proposed set of indicators provides a suitable basis for beginning the process of performance measurement and benchmarking in the public mental health sector. However, while agreement on a performance framework is a necessary first step, it will not in itself lead to performance indicators being introduced to public mental health services. A number of issues need to be resolved for this to occur, including how the indicators are produced, how frequently they are reported, and who is responsible for their production.

This final section of the report outlines our views on the steps required to embed performance indicators within public sector mental health services.

6.1 States and Territories responsible for trialing the indicators

As the jurisdictions responsible for the provision of public mental health services, principal responsibility for putting performance indicators in place lies with the States and Territories. This does not imply that any jurisdiction should be bound to implement the proposed indicator set in total, or within a nationally imposed timetable. The proposed indicators have substantial implications from the perspective of data management and analysis and not all jurisdictions will have capacity to proceed at an equal pace. Decisions on how and when to begin should be left to the discretion of individual States and Territories.⁶

The Drafting Group anticipates that momentum will build as States and Territories begin the process of producing the indicators from source data with considerable opportunity for shared learning.

6.2 Detailed technical specifications to be further developed

Although the proposed Phase 1 indicators draw on available data, there are complex technical issues to resolve in indicator production that are best guided by detailed specifications of counting rules and supplementary definitions. The specifications outlined in Appendix A begin the process but the Drafting Group became aware that several issues will need further work to ensure consistency in how the indicator concepts are applied. The complexities of mental health data can result in quite different analysis results when the same question is asked of apparently equivalent data sets.

Agreement is therefore required on how to proceed with the necessary additional technical work necessary. Ideally, this would be conducted at the national level rather than duplicating effort across each individual State and Territory.

⁶ It is important to note there that at least one jurisdiction (Victoria) has commenced the process of building the proposed Phase 1 indicators using 2002-03 datasets.

6.3 Establishing a national process for regular review of indicators

All performance indicators should be considered as potentially having ‘use by’ dates by which they outlive their usefulness and need to be replaced by better measures. The Phase 1 indicators outlined in this report comprise a set of imperfect measures that strive to capture the essence of complex concepts. They will need to be reviewed and refined regularly based on experience.

Similarly, ongoing work is required to expand the indicator set to incorporate domains and sub-domains not covered in the proposed Phase 1 indicator set.

Comparable issues are faced in the design and reporting of those indicators published at the national level under the auspice of the National Health Performance Committee. To address these, procedures have been put in place to ensure that the national indicator set retains its currency by reviewing content and specifications biennially.

The logical step is to establish a national group that is responsible for advising on the ongoing development of key performance indicators for public mental health services. Once the indicators are established, this group should align the review schedule with that followed by NHPC, and report biennially on desirable changes. It is anticipated however that more frequent, annual reports on progress and modifications will be necessary during the first few years of implementation. This will allow scope for amendments to be made based on the experience of States and Territories in the early implementation phases.

While such a national group should have linkage to the National Health Performance Committee, formal auspice arrangements should be through the AHMAC National Mental Health Working Group via the Information Strategy Committee (ISC). The national mental health performance indicators group should be established as a subcommittee of ISC.

6.4 Resolving national reporting issues

Decisions on the production of a national publication need to be considered separately from the processes used by States and Territories to introduce performance reporting across services under their control. National reporting adds value, but in itself is not the end game. If in five years time all that has been produced from this process is a periodic, high level national report on the performance of public sector mental health services then the process has failed.

While acknowledging this, it is also important to recognise that there are clear benefits in publishing indicators of public mental health services performance at the national level. At a minimum, such reports would provide essential benchmark data to support the use of indicators by service organisations while also satisfying accountability expectations under the current Australian Health Care Agreements.

Various options are available to produce the Phase 1 indicators at the national level. For example:

- indicators could be reported as prepared by individual jurisdictions, along the lines of much of the content of the Report on Government Services; or
- indicators could be prepared and published by an independent national agency such as the Australian Institute of Health & Welfare using source data supplied by States and Territories; or

- national indicators could be prepared by the Australian Government Department of Health and Ageing using data submitted by States and Territories as part of the accountability requirements of the Australian Health Care Agreements (AHCAs). This is the model to be used in production of the annual State of Our Public Hospitals report under the current AHCAs and has been used for all previous National Mental Health Reports.

The Drafting Group did not resolve a preferred approach but supports the value of a national publication to complement the development of performance measurement within State and Territory mental health services. Further consideration of this issue should be the responsibility of the proposed national mental health performance indicators group discussed above.

6.5 Supporting the use of performance indicators for benchmarking

Publications of indicators alone will not be sufficient to stimulate a culture of benchmarking throughout the mental health industry. The introduction of performance measurement systems requires attention not only to the technical issues but also the process of building interest and capacity within service organisations to use them creatively.

Consideration needs to be given to creating incentives for organisations to participate in collaborative benchmarking whereby the indicators are used simply as tools for quality improvement. Experience in the acute health sector has highlighted that such activities have start up costs due to them being data intensive. Benchmarking partners need to prepare their data as well as make resources available to investigate differences in performance, encourage changed practices and evaluate results.

The National Mental Health Strategy provides all jurisdictions with discretionary funding that could be dedicated to 'kick starting' benchmarking activities within services under their control.

6.6 Engaging stakeholders

The introduction of performance measurement is not welcomed equally by all stakeholders in the health care system. Mistrust of intent prevails with indicators often interpreted as a prelude to 'funding cuts' or other management interventions. More commonly, there is usually a lack of appreciation of the potential of indicators to be used to achieve shared goals for an improved service delivery system.

Initiatives are required to promote dissemination of performance information and discussion of performance issues throughout both the industry and the wider community. Options include use of State and Territory department websites, special publications, periodic conferences, and incorporation of performance-related items at all meetings of key stakeholder.

Special attention needs to be given to purposeful reporting to consumer and carers. Performance information needs to be presented in ways that integrates consumer defined measures of quality with those of value to providers. It also needs to be presented in a language and format that consumers can understand and readily use.

6.7 Priorities for new data collections

As noted, the proposed Phase 1 indicators leave several gaps that can only be filled with new data collections. Of these, two are priority candidates for data development over the next few years.

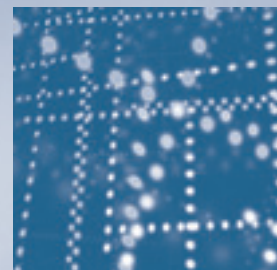
The first concerns data items relating to the safety issues in mental health care. The type of information required to inform the National Mental Health Safety Action Plan is likely to be qualitatively different from existing data collections and introduce new levels of detail.

The second concerns measures of consumer and carer perceptions necessary to develop indicators of service responsiveness. Work being undertaken by New South Wales and Victoria should be used to guide consideration of possible new national collections of this type.

6.8 Expanding indicator coverage beyond the specialist public sector

In order to provide a fuller picture of mental health care, performance measures need to be extended beyond the specialist public sector and incorporate the activities of private providers and the primary mental health sector. This work could be progressed in parallel with the ongoing development of measures targeted at State and Territory managed services.

Appendix A



Phase one indicator specifications

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

Dimensions covered:

Details the relationship of the Key Performance Indicator against the 9 Dimensions of the Third Tier of the National Health Performance Framework. A single indicator may be relevant across several dimensions with the primary dimension appearing in bold font.

Strategic issue:

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

Rationale:

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

Definition:

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

Technical issues:

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

Data sources:

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

Coverage/scope:

Service types within the public mental health sector covered.

Assessment against criteria:

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

Recommendation for implementation:

Specifies timeline for implementation.

Implications for data development:

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

Key stratification options:

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

Issues/notes:

Any other relevant matters not covered by the above.

28 DAY READMISSION RATE

Dimensions covered:

Effective	<input checked="" type="checkbox"/>	Appropriate	<input type="checkbox"/>	Efficient	<input type="checkbox"/>
Responsive	<input type="checkbox"/>	Accessible	<input type="checkbox"/>	Safe	<input type="checkbox"/>
Continuous	<input checked="" type="checkbox"/>	Capable	<input type="checkbox"/>	Sustainable	<input type="checkbox"/>

Strategic issue:

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

Rationale:

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

Definition:

Percentage of separations from the mental health service organisation’s acute psychiatric inpatient units that result in unplanned readmission to the same or to another public sector acute psychiatric inpatient unit within 28 days of discharge.

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

Denominator: All separations from the mental health service organisation’s acute psychiatric inpatient unit(s) occurring within the reference period.

Coverage/scope:

All public mental health acute inpatient services.

- Exclusions:
- Statistical and change of care type separations.
 - Separations that end by transfer.
 - Same day admissions – because it is not possible to specify intent (ie expectation of overnight stay vs day only care).

Technical issues:

- Terminology:
- Same day admissions are defined as inpatient episodes where the admission and separation dates are the same.
 - Where a mental health service organisation has more than one adult unit, for the purposes of this indicator the units should be pooled.
 - Ideally, readmission is considered to have occurred if the person has been admitted to any public sector mental health acute inpatient unit within the State/Territory but this requires statewide unique identifiers to be in place. For consistency between jurisdictions, initial implementation could restrict readmission criteria to within an organisation’s inpatient units.

Methodology: Nil.

Data sources:

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

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

28 DAY READMISSION RATE

Assessment against NHPC criteria:

Worth measuring	<input checked="" type="checkbox"/>	Relevant to policy/practice	<input checked="" type="checkbox"/>	
Diverse populations	<input checked="" type="checkbox"/>	Measurable over time	<input checked="" type="checkbox"/>	Additional criteria
Understood/clear intent	<input checked="" type="checkbox"/>	Feasible	<input checked="" type="checkbox"/>	Reliable <input checked="" type="checkbox"/>
Galvanise action	<input checked="" type="checkbox"/>	Definable	<input checked="" type="checkbox"/>	Valid <input checked="" type="checkbox"/>

Level at which indicator can be applied:

Level		Program type	
Service unit/team	<input checked="" type="checkbox"/>	Adult	<input checked="" type="checkbox"/>
Health service organisation	<input checked="" type="checkbox"/>	Child and adolescent	<input checked="" type="checkbox"/>
Regional group of services	<input checked="" type="checkbox"/>	Older persons care	<input checked="" type="checkbox"/>
State/Territory	<input checked="" type="checkbox"/>	Forensic	<input checked="" type="checkbox"/>

Recommendation for implementation

Given differences in operational and performance expectations of the various program types, Adult Mental Health Services should be the initial focus of implementation.

Key stratification options

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

Implications for data development

Immediate: Nil.

- Short term:
- Development of planned/unplanned readmission flag to indicate at discharge whether readmission within 28 days is planned as part of the treatment process.
 - Same day admissions are a confounding issue that require the identification of intent of admission (ie day care or overnight stay).
 - Need to identify program type by separation in National Minimum Dataset - Admitted Patient Mental Health Care National Minimum Dataset if age is not a suitable proxy.

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

Notes:

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

Allied indicators:

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

NATIONAL SERVICE STANDARDS COMPLIANCE

Dimensions covered:

Effective	<input type="checkbox"/>	Appropriate	<input checked="" type="checkbox"/>	Efficient	<input type="checkbox"/>
Responsive	<input type="checkbox"/>	Accessible	<input type="checkbox"/>	Safe	<input type="checkbox"/>
Continuous	<input type="checkbox"/>	Capable	<input checked="" type="checkbox"/>	Sustainable	<input type="checkbox"/>

Strategic issue:

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

Rationale:

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

Definition:

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

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

Numerator: Total expenditure by mental health service organisations on mental health services that meet the definition of Level X where X is the level at which the indicator is being measured (either Level 1, Level 2, or Level 3 as detailed above).

Denominator: Total mental health service organisation expenditure on mental health services.

Coverage/scope:

All public mental health services.

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

Technical issues:

Terminology: Mapping of Levels to National Survey of Mental Health Services codes as follows:

Level 1 – NSMHS code 1; Level 2 – NSMHS codes 2-4; Level 3 – NSMHS codes 5-7.

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

Data sources:

Numerator: National Survey of Mental Health Services or State/Territory central health administration.

Denominator: National Survey of Mental Health Services or State/Territory central health administration.

Assessment against NHPC criteria:

Worth measuring	<input checked="" type="checkbox"/>	Relevant to policy/practice	<input checked="" type="checkbox"/>	
Diverse populations	<input type="checkbox"/>	Measurable over time	<input checked="" type="checkbox"/>	Additional criteria
Understood/clear intent	<input checked="" type="checkbox"/>	Feasible	<input checked="" type="checkbox"/>	Reliable <input checked="" type="checkbox"/>
Galvanise action	<input checked="" type="checkbox"/>	Definable	<input checked="" type="checkbox"/>	Valid <input checked="" type="checkbox"/>

Level at which indicator can be applied:

Level		Program type	
Service unit/team	<input checked="" type="checkbox"/>	Adult	<input checked="" type="checkbox"/>
Health service organisation	<input checked="" type="checkbox"/>	Child and adolescent	<input checked="" type="checkbox"/>
Regional group of services	<input checked="" type="checkbox"/>	Older persons care	<input checked="" type="checkbox"/>
State/Territory	<input checked="" type="checkbox"/>	Forensic	<input checked="" type="checkbox"/>

NATIONAL SERVICE STANDARDS COMPLIANCE

Recommendation for implementation:

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

Key stratification options:

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

Implications for data development:

Immediate: Revised National Survey of Mental Health Services methodology needs to be extended beyond 2002-2003 or States and Territories need to develop alternative monitoring systems where these do not exist.

Short term: Nil.

Long term: Nil.

Notes:

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

Allied indicators:

- Outcomes readiness.
-

COST PER ACUTE INPATIENT EPISODE

Dimensions covered:

Effective	<input type="checkbox"/>	Appropriate	<input type="checkbox"/>	Efficient	<input checked="" type="checkbox"/>
Responsive	<input type="checkbox"/>	Accessible	<input type="checkbox"/>	Safe	<input type="checkbox"/>
Continuous	<input type="checkbox"/>	Capable	<input type="checkbox"/>	Sustainable	<input type="checkbox"/>

Strategic issue:

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

Rationale:

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

Definition:

Average cost of completed separations from acute psychiatric inpatient units managed by the mental health service organisation.

Numerator: Total recurrent expenditure on completed episodes occurring within the mental health service organisation's acute psychiatric inpatient unit(s) during the reference period.

Denominator: Total number of completed inpatient episodes occurring within the mental health service organisation's acute psychiatric inpatient unit(s) during the reference period.

Coverage/scope:

All public sector acute psychiatric inpatient units.

- Exclusions:
- Same day admissions (because these significantly distort averages).
 - Incomplete inpatient episodes.

Technical issues:

- Terminology:
- Episodes are defined as 'acute' on the basis of the classification of the inpatient unit according to the definitions used in the National Survey of Mental Health Services.
 - Same day admissions are defined as inpatient episodes where the admission and separation dates are the same day.
 - Recurrent costs include costs directly attributable to the unit(s) plus a proportional share of indirect costs. Cost data for this indicator is based on gross recurrent expenditure as compiled by Health Departments according to the specifications of the annual National Survey of Mental Health Services or its replacement. As such, it is subject to the concepts, definitions and costing methodology developed for the National Survey of Mental Health Services.
 - A completed inpatient episode is defined as an episode of care within the organisation's acute inpatient units that started and finished within the reference period. Conversely, an incomplete episode is one where either the admission or discharge date falls outside the reference period.

Methodology: Cost modelling methodology for assigning costs to completed episodes requires further development in supplementary technical specifications. However, in summary form, episode cost is calculated as (Total patient days) × (Average patient day cost) where (Average patient day cost) = (Total recurrent expenditure) / (Total patient days).

Data sources:

Numerator: Expenditure data derived from National Survey of Mental Health Services (or State/Territory equivalent).

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

COST PER ACUTE INPATIENT EPISODE

Assessment against NHPC criteria:

Worth measuring	<input checked="" type="checkbox"/>	Relevant to policy/practice	<input checked="" type="checkbox"/>	
Diverse populations	<input type="checkbox"/>	Measurable over time	<input checked="" type="checkbox"/>	Additional criteria
Understood/clear intent	<input checked="" type="checkbox"/>	Feasible	<input checked="" type="checkbox"/>	Reliable <input checked="" type="checkbox"/>
Galvanise action	<input checked="" type="checkbox"/>	Definable	<input checked="" type="checkbox"/>	Valid <input checked="" type="checkbox"/>

Level at which indicator can be applied:

Level		Program type	
Service unit/team	<input checked="" type="checkbox"/>	Adult	<input checked="" type="checkbox"/>
Health service organisation	<input checked="" type="checkbox"/>	Child and adolescent	<input checked="" type="checkbox"/>
Regional group of services	<input checked="" type="checkbox"/>	Older persons care	<input checked="" type="checkbox"/>
State/Territory	<input checked="" type="checkbox"/>	Forensic	<input checked="" type="checkbox"/>

Recommendation for implementation

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

Key stratification options

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

Implications for data development

Immediate: Nil.

- Short term:
- Need to identify acute units that serve a specialist function within jurisdictions.
 - Need to identify program type in National Minimum Dataset - Admitted Patient Mental Health Care (or State/Territory equivalent) if age is not a suitable proxy.
 - Need to identify incomplete episodes at end of reference period in National Minimum Dataset - Admitted Patient Mental Health Care (or State/Territory equivalent) that is, patients remaining in hospital at close of reporting period.
 - Methodology for casemix adjustment required.

Long term: Comparable efficiency indicators for extended care and residential facilities need to be developed.

Notes:

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

Allied indicators:

- Average length of acute inpatient stay.

AVERAGE LENGTH OF ACUTE INPATIENT STAY

Dimensions covered:

Effective	<input type="checkbox"/>	Appropriate	<input checked="" type="checkbox"/>	Efficient	<input checked="" type="checkbox"/>
Responsive	<input type="checkbox"/>	Accessible	<input type="checkbox"/>	Safe	<input type="checkbox"/>
Continuous	<input type="checkbox"/>	Capable	<input type="checkbox"/>	Sustainable	<input type="checkbox"/>

Strategic issue:

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

Rationale:

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

Definition:

Average length of stay of completed separations from acute psychiatric inpatient units managed by the mental health service organisation.

Numerator: Total number of patient days in the mental health service organisation's acute psychiatric inpatient unit(s) accounted for by completed overnight formal separations during the reference period.

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

Coverage/scope:

All public sector acute psychiatric inpatient units.

- Exclusions:**
- Same day admissions (because these significantly distort averages).
 - Incomplete inpatient episodes.

Technical issues:

- Terminology:**
- Episodes are defined as 'acute' on the basis of the classification of the inpatient unit according to the definitions used in the National Survey of Mental Health Services.
 - Same day admissions are defined as inpatient episodes where the admission and separation dates are the same.
 - A completed inpatient episode is defined as an episode of care within the organisation's acute inpatient units that started and finished within the reference period. Conversely, an incomplete episode is one where either the admission or discharge date falls outside the reference period.

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

Data sources:

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

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

Assessment against NHPC criteria:

Worth measuring	<input checked="" type="checkbox"/>	Relevant to policy/practice	<input checked="" type="checkbox"/>	Additional criteria		
Diverse populations	<input checked="" type="checkbox"/>	Measurable over time	<input checked="" type="checkbox"/>			
Understood/clear intent	<input checked="" type="checkbox"/>	Feasible	<input checked="" type="checkbox"/>		Reliable	<input checked="" type="checkbox"/>
Galvanise action	<input checked="" type="checkbox"/>	Definable	<input checked="" type="checkbox"/>		Valid	<input checked="" type="checkbox"/>

AVERAGE LENGTH OF ACUTE INPATIENT STAY

Level at which indicator can be applied:

Level		Program type	
Service unit/team	<input checked="" type="checkbox"/>	Adult	<input checked="" type="checkbox"/>
Health service organisation	<input checked="" type="checkbox"/>	Child and adolescent	<input checked="" type="checkbox"/>
Regional group of services	<input checked="" type="checkbox"/>	Older persons care	<input checked="" type="checkbox"/>
State/Territory	<input checked="" type="checkbox"/>	Forensic	<input checked="" type="checkbox"/>

Recommendation for implementation:

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

Key stratification options:

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

Implications for data development:

Immediate: Nil.

- Short term:
- Need to identify acute units that serve a specialist function within jurisdictions.
 - Need to identify program type in National Minimum Dataset - Admitted Patient Mental Health Care (or State/Territory equivalent) if age is not a suitable proxy.
 - Need to identify incomplete episodes at end of reference period in National Minimum Dataset - Admitted Patient Mental Health Care (or State/Territory equivalent) - that is, patients remaining in hospital at the close of the reporting period.
 - Methodology for casemix adjustment required.

Long term: • Comparable efficiency indicators for extended care and residential facilities need to be developed.

Notes:

- Casemix adjustment is needed to interpret variation between organisations – to distinguish patient and provider factors.
- Same day admissions are a confounding issue that require the identification of intent of admission (that is, day care or overnight stay).
- Length of stay is usually based on all separations within a given period, including those that started before the beginning of the period. Completed episodes are used in preference to match with the average inpatient episode cost data.
- Leave presents special complexities in the mental health area and further work is required to ensure that it does not distort this indicator.
- Average length of stay estimates do not include very long-stay patients who remain in hospital all year. Based on Victorian data (1998), these patients are considered to account for 0.1 percent of episodes and 3 percent of bed days.

Allied indicators

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

COST PER THREE MONTH COMMUNITY CARE PERIOD

Dimensions covered:

Effective	<input type="checkbox"/>	Appropriate	<input type="checkbox"/>	Efficient	<input checked="" type="checkbox"/>
Responsive	<input type="checkbox"/>	Accessible	<input type="checkbox"/>	Safe	<input type="checkbox"/>
Continuous	<input type="checkbox"/>	Capable	<input type="checkbox"/>	Sustainable	<input type="checkbox"/>

Strategic issue:

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

Rationale:

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

Definition:

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

Numerator: Total mental health service organisation recurrent expenditure on community mental health ambulatory care services within the reference period.

Denominator: Total number of ambulatory care statistical episodes (three month periods) treated by the mental health service organisation within the reference period.

Coverage/scope:

All public sector ambulatory care mental health services.

Exclusions: Activities of public sector community based residential services.

Technical issues:

- Terminology:
- Recurrent costs include costs directly attributable to the unit(s) plus a proportional share of indirect costs. Cost data for this indicator is based on gross recurrent expenditure as compiled by health departments according to the specifications of the annual National Survey of Mental Health Services or its replacement. As such, it is subject to the concepts, definitions and costing methodology developed for the National Survey of Mental Health Services.
 - A statistically derived community episode is defined as each three month period of ambulatory care of an individual registered patient where the patient was under 'active care', defined as one or more treatment days in the period. Each patient is counted uniquely at the mental health service organisation level, regardless of the number of teams or community programs involved in his/her care.
- Methodology:
- Three month episode based datasets to be constructed from contact data at analysis rather than collected as discrete variable.
 - For the purposes of this measure, community care periods will consist of the following fixed three monthly periods; January to March, April to June, July to September, and October to December.

Data sources:

Numerator: National Survey of Mental Health Services (or State/Territory equivalent).

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

COST PER THREE MONTH COMMUNITY CARE PERIOD

Assessment against NHPC criteria:

Worth measuring	<input checked="" type="checkbox"/>	Relevant to policy/practice	<input checked="" type="checkbox"/>	
Diverse populations	<input checked="" type="checkbox"/>	Measurable over time	<input checked="" type="checkbox"/>	Additional criteria
Understood/clear intent	<input checked="" type="checkbox"/>	Feasible	<input checked="" type="checkbox"/>	Reliable <input checked="" type="checkbox"/>
Galvanise action	<input checked="" type="checkbox"/>	Definable	<input checked="" type="checkbox"/>	Valid <input checked="" type="checkbox"/>

Level at which indicator can be applied:

Level		Program type	
Service unit/team	<input checked="" type="checkbox"/>	Adult	<input checked="" type="checkbox"/>
Health service organisation	<input checked="" type="checkbox"/>	Child and adolescent	<input checked="" type="checkbox"/>
Regional group of services	<input checked="" type="checkbox"/>	Older persons care	<input checked="" type="checkbox"/>
State/Territory	<input checked="" type="checkbox"/>	Forensic	<input checked="" type="checkbox"/>

Recommendation for implementation:

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

Key stratification options:

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

Implications for data development:

Immediate: Nil.

- Short term:
- Contact duration data is needed for a more sophisticated cost modelling methodology.
 - Identification of assessment only ambulatory episodes.
 - Need to identify program type in the Community Mental Health Care National Minimum Dataset if age is not a suitable proxy.
 - Methodology for casemix adjustment required.

- Long term:
- Accurate reporting at levels above that of mental health service organisation would benefit from unique statewide patient identifiers.

Notes:

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

Allied indicators:

- Treatment days per three month community care period.

TREATMENT DAYS PER THREE MONTH COMMUNITY CARE PERIOD

Dimensions covered:

Effective	<input type="checkbox"/>	Appropriate	<input checked="" type="checkbox"/>	Efficient	<input checked="" type="checkbox"/>
Responsive	<input type="checkbox"/>	Accessible	<input type="checkbox"/>	Safe	<input type="checkbox"/>
Continuous	<input type="checkbox"/>	Capable	<input type="checkbox"/>	Sustainable	<input type="checkbox"/>

Strategic issue:

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

Rationale:

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

Definition:

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

Numerator: Total number of community treatment days provided by the mental health service organisation's community mental health services within the reference period.

Denominator: The total number of ambulatory care statistical episodes (three month periods) treated by the mental health service organisation's community services within the reference period.

Coverage/scope:

All public sector community mental health services.

Exclusions: Activities of community based residential services

Technical issues:

Terminology: • A statistically derived community episode is defined as each three month period of ambulatory care of an individual registered patient where the patient was under 'active care', defined as one or more treatment days in the period. Each patient is counted uniquely at the mental health service organisation level, regardless of the number of teams or community programs involved in his/her care.

• Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode.

Methodology: • Episode based datasets to be constructed from contact data at analysis rather than collected as discrete variable.

- For the purposes of this measure, community care periods will consist of the following fixed three monthly periods; January to March, April to June, July to September, and October to December.

Data sources:

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

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

TREATMENT DAYS PER THREE MONTH COMMUNITY CARE PERIOD

Assessment against NHPC criteria:

Worth measuring	<input checked="" type="checkbox"/>	Relevant to policy/practice	<input checked="" type="checkbox"/>	
Diverse populations	<input checked="" type="checkbox"/>	Measurable over time	<input checked="" type="checkbox"/>	Additional criteria
Understood/clear intent	<input checked="" type="checkbox"/>	Feasible	<input checked="" type="checkbox"/>	Reliable <input checked="" type="checkbox"/>
Galvanise action	<input checked="" type="checkbox"/>	Definable	<input checked="" type="checkbox"/>	Valid <input checked="" type="checkbox"/>

Level at which indicator can be applied:

Level		Program type	
Service unit/team	<input checked="" type="checkbox"/>	Adult	<input checked="" type="checkbox"/>
Health service organisation	<input checked="" type="checkbox"/>	Child and adolescent	<input checked="" type="checkbox"/>
Regional group of services	<input checked="" type="checkbox"/>	Older persons care	<input checked="" type="checkbox"/>
State/Territory	<input checked="" type="checkbox"/>	Forensic	<input checked="" type="checkbox"/>

Recommendation for implementation:

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

Key stratification options:

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

Implications for data development:

Immediate: Nil.

- Short term:
- Identification of assessment only ambulatory episodes.
 - Need to identify program type in Community Mental Health Care National Minimum Dataset if age is not a suitable proxy.
 - Methodology for casemix adjustment required.

- Long term:
- Accurate reporting at levels above that of mental health service organisation would benefit from unique statewide patient identifiers.

Notes:

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

Allied indicators:

- Cost per Three Month Community Care Period.

POPULATION RECEIVING CARE

Dimensions covered:

Effective	<input type="checkbox"/>	Appropriate	<input type="checkbox"/>	Efficient	<input type="checkbox"/>
Responsive	<input type="checkbox"/>	Accessible	<input checked="" type="checkbox"/>	Safe	<input type="checkbox"/>
Continuous	<input type="checkbox"/>	Capable	<input type="checkbox"/>	Sustainable	<input type="checkbox"/>

Strategic issue:

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

Rationale:

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

Definition:

The percentage of persons resident in the mental health service organisation's defined catchment area who received care from a public sector mental health service.

Numerator: Total number of persons resident in the defined area who are recorded as receiving one or more services from a public sector mental health service in the reference period.

Denominator: Total number of persons resident in the defined area within the reference period.

Coverage/scope:

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

Exclusions: Nil.

Technical issues:

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

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

Data sources:

Numerator: National Minimum Dataset - Community Mental Health Care; National Minimum Dataset - Admitted Patient Mental Health Care; National Minimum Dataset - Community Residential Care (or State/Territory equivalents).

Denominator: Australian Bureau of Statistics (or equivalent).

Assessment against NHPC criteria:

Worth measuring	<input checked="" type="checkbox"/>	Relevant to policy/practice	<input checked="" type="checkbox"/>		
Diverse populations	<input checked="" type="checkbox"/>	Measurable over time	<input checked="" type="checkbox"/>	Additional criteria	
Understood/clear intent	<input checked="" type="checkbox"/>	Feasible	<input checked="" type="checkbox"/>	Reliable	<input checked="" type="checkbox"/>
Galvanise action	<input checked="" type="checkbox"/>	Definable	<input checked="" type="checkbox"/>	Valid	<input checked="" type="checkbox"/>

Level at which indicator can be applied:

Level		Program type	
Service unit/team	<input type="checkbox"/>	Adult	<input checked="" type="checkbox"/>
Health service organisation	<input checked="" type="checkbox"/>	Child and adolescent	<input checked="" type="checkbox"/>
Regional group of services	<input checked="" type="checkbox"/>	Older persons care	<input checked="" type="checkbox"/>
State/Territory	<input checked="" type="checkbox"/>	Forensic	<input checked="" type="checkbox"/>

POPULATION RECEIVING CARE

Recommendation for implementation:

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

Key stratification options:

- By age: Because data indicates differential need for mental health services on an age basis.
 - By remoteness: Because mental health services are perceived to be less available in rural areas.
 - By indigenous status: To measure equity of access by these sectors of the population.
 - By diagnosis groupings: To facilitate the measurement by proxy of treated prevalence.
-

Implications for data development:

Immediate: Statistical local area codes or postcodes recorded at time of community contact and/or admission to hospital need to be mapped to mental health service organisation catchment population boundaries.

Short term: Nil.

Long term: Full implementation of this measure requires unique statewide patient identifiers not currently available in all jurisdictions.

Notes:

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

Allied indicators:

- Comparative Area Resources.
-

LOCAL ACCESS TO INPATIENT CARE

Dimensions covered:

Effective <input type="checkbox"/>	Appropriate <input type="checkbox"/>	Efficient <input type="checkbox"/>
Responsive <input type="checkbox"/>	Accessible <input checked="" type="checkbox"/>	Safe <input type="checkbox"/>
Continuous <input type="checkbox"/>	Capable <input type="checkbox"/>	Sustainable <input type="checkbox"/>

Strategic issue:

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

Rationale:

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

Definition:

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

Numerator: Total number of acute psychiatric inpatient separations in the reference period for residents of the defined area where the person was treated within the local public sector psychiatric inpatient unit.

Denominator: Total number of acute psychiatric inpatient separations in the reference period for residents of the defined area who received the acute inpatient service from any public sector mental health service organisation.

Coverage/scope:

All public sector acute psychiatric inpatient services.

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

Technical issues:

Terminology: Nil.

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

Data sources:

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

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

Assessment against NHPC criteria:

Worth measuring <input checked="" type="checkbox"/>	Relevant to policy/practice <input checked="" type="checkbox"/>	
Diverse populations <input checked="" type="checkbox"/>	Measurable over time <input checked="" type="checkbox"/>	Additional criteria
Understood/clear intent <input checked="" type="checkbox"/>	Feasible <input checked="" type="checkbox"/>	Reliable <input checked="" type="checkbox"/>
Galvanise action <input checked="" type="checkbox"/>	Definable <input checked="" type="checkbox"/>	Valid <input checked="" type="checkbox"/>

Level at which indicator can be applied:

Level	<input type="checkbox"/>	Program type	<input type="checkbox"/>
Service unit/team	<input type="checkbox"/>	Adult	<input checked="" type="checkbox"/>
Health service organisation	<input checked="" type="checkbox"/>	Child and adolescent	<input checked="" type="checkbox"/>
Regional group of services	<input checked="" type="checkbox"/>	Older persons care	<input checked="" type="checkbox"/>
State/Territory	<input checked="" type="checkbox"/>	Forensic	<input type="checkbox"/>

LOCAL ACCESS TO INPATIENT CARE

Recommendation for implementation:

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

Key stratification options:

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

Implications for data development:

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

Short term: Nil.

Long term: Nil.

Notes:

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

Allied indicators:

- Population receiving care.
 - Comparative area resources.
-

NEW CLIENT INDEX

Dimensions covered:

Effective	<input type="checkbox"/>	Appropriate	<input type="checkbox"/>	Efficient	<input type="checkbox"/>
Responsive	<input checked="" type="checkbox"/>	Accessible	<input checked="" type="checkbox"/>	Safe	<input type="checkbox"/>
Continuous	<input type="checkbox"/>	Capable	<input type="checkbox"/>	Sustainable	<input type="checkbox"/>

Strategic issue:

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

Rationale:

- Existing population treatment rates (less than 1 percent) are relatively low.
- There is concern that public sector mental health services invest a disproportionate level of resources in dealing with existing clients and too little in responding to the needs of new clients as they present.

Definition:

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

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

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

Coverage/scope:

All public sector mental health services.

Exclusions: Nil.

Technical issues:

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

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

Data Sources:

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

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

Assessment against NHPC criteria:

Worth measuring	<input checked="" type="checkbox"/>	Relevant to policy/practice	<input checked="" type="checkbox"/>	
Diverse populations	<input checked="" type="checkbox"/>	Measurable over time	<input checked="" type="checkbox"/>	Additional criteria
Understood/clear intent	<input checked="" type="checkbox"/>	Feasible	<input checked="" type="checkbox"/>	Reliable <input checked="" type="checkbox"/>
Galvanise action	<input checked="" type="checkbox"/>	Definable	<input checked="" type="checkbox"/>	Valid <input checked="" type="checkbox"/>

Level at which indicator can be applied:

Level		Program type	
Service unit/team	<input type="checkbox"/>	Adult	<input checked="" type="checkbox"/>
Health service organisation	<input checked="" type="checkbox"/>	Child and adolescent	<input checked="" type="checkbox"/>
Regional group of services	<input checked="" type="checkbox"/>	Older persons care	<input checked="" type="checkbox"/>
State/Territory	<input checked="" type="checkbox"/>	Forensic	<input checked="" type="checkbox"/>

NEW CLIENT INDEX

Recommendation for implementation:

Nil.

Key stratification options:

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

Implications for data development:

Immediate: Nil.

Short term: Collection of 'new client' status at intake/admission would simplify the production of this indicator.

Long term: Statewide identifiers would be required for this indicator to be produced at the regional or State/Territory level.

Notes:

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

Allied indicators

- Population receiving care.

COMPARATIVE AREA RESOURCE

Dimensions covered:

Effective	<input type="checkbox"/>	Appropriate	<input type="checkbox"/>	Efficient	<input type="checkbox"/>
Responsive	<input type="checkbox"/>	Accessible	<input checked="" type="checkbox"/>	Safe	<input type="checkbox"/>
Continuous	<input type="checkbox"/>	Capable	<input type="checkbox"/>	Sustainable	<input checked="" type="checkbox"/>

Strategic issue:

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

Rationale:

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

Definition:

Per capita recurrent expenditure on public sector specialised mental health services within the mental health service organisation's defined catchment area.

Numerator: Recurrent expenditure for the defined area.

Denominator: The population of the defined area.

Coverage/scope:

All public sector mental health services.

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

Technical issues:

Terminology: Recurrent costs include costs directly attributable to the unit(s) plus a proportional share of indirect costs. Cost data for this measure is based on gross recurrent expenditure as reported to health departments by mental health service organisations through the annual National Survey of Mental Health Services. As such, it is subject to the concepts, definitions and costing methodology developed for the Survey, as well as variations among the mental health service organisations in costing.

Methodology: Estimates of expenditure for defined populations are based on expenditure reported by the mental health service organisation with specific catchment responsibility for the population, adjusted to remove any cross-regional and statewide services included in the organisation's expenditure.

See Notes for issues to be resolved in further development of this indicator.

- Defined populations should match with catchment areas of the mental health service organisations.

Data sources:

Numerator: National Survey of Mental Health Services.

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

Assessment against NHPC criteria:

Worth measuring	<input checked="" type="checkbox"/>	Relevant to policy/practice	<input checked="" type="checkbox"/>	Additional criteria	
Diverse populations	<input checked="" type="checkbox"/>	Measurable over time	<input checked="" type="checkbox"/>		
Understood/clear intent	<input checked="" type="checkbox"/>	Feasible	<input checked="" type="checkbox"/>		Reliable <input checked="" type="checkbox"/>
Galvanise action	<input checked="" type="checkbox"/>	Definable	<input checked="" type="checkbox"/>		Valid <input checked="" type="checkbox"/>

Level at which indicator can be applied:

Level		Program type	
Service unit/team	<input type="checkbox"/>	Adult	<input checked="" type="checkbox"/>
Health service organisation	<input checked="" type="checkbox"/>	Child and adolescent	<input checked="" type="checkbox"/>
Regional group of services	<input checked="" type="checkbox"/>	Older persons care	<input checked="" type="checkbox"/>
State/Territory	<input checked="" type="checkbox"/>	Forensic	<input type="checkbox"/>

COMPARATIVE AREA RESOURCE

Recommendation for implementation:

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

Key stratification options:

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

Implications for data development:

Immediate: Population catchments for public sector mental health services to be defined.

Short term: Nil.

Long term: Nil.

Notes:

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

Allied indicators

- Population receiving care.
-

PRE-ADMISSION COMMUNITY CARE

Dimensions covered:

Effective	<input type="checkbox"/>	Appropriate	<input type="checkbox"/>	Efficient	<input type="checkbox"/>
Responsive	<input type="checkbox"/>	Accessible	<input checked="" type="checkbox"/>	Safe	<input type="checkbox"/>
Continuous	<input checked="" type="checkbox"/>	Capable	<input type="checkbox"/>	Sustainable	<input type="checkbox"/>

Strategic issue:

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

Rationale:

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

Definition:

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

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

Denominator: Total number of admissions to the mental health service organisation's acute inpatient unit(s).

Coverage/scope:

All public sector mental health acute inpatient units.

- Exclusions:
- Community contacts occurring on the day of admission.
 - Same day admissions as unable to specify intent (that is, expectation of overnight stay versus day care).
 - Admissions by inter-hospital transfer or between programs (for example, acute to rehabilitation).

Technical issues:

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

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

Data sources:

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

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

Assessment against NHPC criteria:

Worth measuring	<input checked="" type="checkbox"/>	Relevant to policy/practice	<input checked="" type="checkbox"/>	Additional criteria	
Diverse populations	<input checked="" type="checkbox"/>	Measurable over time	<input checked="" type="checkbox"/>		
Understood/clear intent	<input checked="" type="checkbox"/>	Feasible	<input checked="" type="checkbox"/>		Reliable <input checked="" type="checkbox"/>
Galvanise action	<input checked="" type="checkbox"/>	Definable	<input checked="" type="checkbox"/>		Valid <input checked="" type="checkbox"/>

PRE-ADMISSION COMMUNITY CARE

Level at which indicator can be applied:

Level		Program type	
Service unit/team	<input type="checkbox"/>	Adult	<input checked="" type="checkbox"/>
Health service organisation	<input checked="" type="checkbox"/>	Child and adolescent	<input checked="" type="checkbox"/>
Regional group of services	<input checked="" type="checkbox"/>	Older persons care	<input checked="" type="checkbox"/>
State/Territory	<input checked="" type="checkbox"/>	Forensic	<input checked="" type="checkbox"/>

Recommendation for implementation:

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

Key stratification options:

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

Implications for data development:

Immediate: Nil.

Short term: Nil.

Long term: Full implementation of this measure requires unique statewide patient identifiers not currently available in all jurisdictions.

Notes:

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

Allied indicators:

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

POST-DISCHARGE COMMUNITY CARE

Dimensions covered:

Effective	<input type="checkbox"/>	Appropriate	<input type="checkbox"/>	Efficient	<input type="checkbox"/>
Responsive	<input type="checkbox"/>	Accessible	<input checked="" type="checkbox"/>	Safe	<input checked="" type="checkbox"/>
Continuous	<input checked="" type="checkbox"/>	Capable	<input type="checkbox"/>	Sustainable	<input type="checkbox"/>

Strategic issue:

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

Rationale:

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

Definition:

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

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

Denominator: Total number of separations for the mental health service organisation's acute inpatient unit(s).

Coverage/scope:

All public acute inpatient mental health services.

- Exclusions:
- Same day separations.
 - Separations due to death.
 - Separations where the patient left against medical advice.
 - Statistical and change of care type separations.
 - Separations that end by transfer.

Technical issues:

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

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

Data sources:

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

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

Assessment against NHPC criteria:

Worth measuring	<input checked="" type="checkbox"/>	Relevant to policy/practice	<input checked="" type="checkbox"/>	Additional criteria	
Diverse populations	<input checked="" type="checkbox"/>	Measurable over time	<input checked="" type="checkbox"/>		
Understood/clear intent	<input checked="" type="checkbox"/>	Feasible	<input checked="" type="checkbox"/>		Reliable <input checked="" type="checkbox"/>
Galvanise action	<input checked="" type="checkbox"/>	Definable	<input checked="" type="checkbox"/>		Valid <input checked="" type="checkbox"/>

POST-DISCHARGE COMMUNITY CARE

Level at which indicator can be applied:

Level		Program type	
Service unit/team	<input type="checkbox"/>	Adult	<input checked="" type="checkbox"/>
Health service organisation	<input checked="" type="checkbox"/>	Child and adolescent	<input checked="" type="checkbox"/>
Regional group of services	<input checked="" type="checkbox"/>	Older persons care	<input checked="" type="checkbox"/>
State/Territory	<input checked="" type="checkbox"/>	Forensic	<input checked="" type="checkbox"/>

Recommendation for implementation:

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

Key stratification options:

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

Implications for data development:

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

Notes:

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

Allied indicators:

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

OUTCOMES READINESS

Dimensions covered:

Effective	<input checked="" type="checkbox"/>	Appropriate	<input type="checkbox"/>	Efficient	<input type="checkbox"/>
Responsive	<input type="checkbox"/>	Accessible	<input type="checkbox"/>	Safe	<input type="checkbox"/>
Continuous	<input type="checkbox"/>	Capable	<input checked="" type="checkbox"/>	Sustainable	<input type="checkbox"/>

Strategic issue:

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

Rationale:

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

Definition:

Percentage of mental health episodes with outcome assessments completed.

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

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

Coverage/scope:

All public mental health services.

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

Technical issues:

Terminology: Assessments occur at commencement of care and at maximum intervals of 91 days thereafter until completion of care, at which point an exit assessment is made.

Completed assessment defined as all required clinical items entered (see Notes).

Methodology: See Notes for methodological issues to be resolved.

Data sources:

Numerator: National Outcome Casemix Collection Dataset.

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

Assessment against NHPC criteria:

Worth measuring	<input checked="" type="checkbox"/>	Relevant to policy/practice	<input checked="" type="checkbox"/>	
Diverse populations	<input checked="" type="checkbox"/>	Measurable over time	<input checked="" type="checkbox"/>	Additional criteria
Understood/clear intent	<input checked="" type="checkbox"/>	Feasible	<input checked="" type="checkbox"/>	Reliable <input checked="" type="checkbox"/>
Galvanise action	<input checked="" type="checkbox"/>	Definable	<input checked="" type="checkbox"/>	Valid <input checked="" type="checkbox"/>

OUTCOMES READINESS

Level at which indicator can be applied:

Level		Program type	
Service unit/team	<input checked="" type="checkbox"/>	Adult	<input checked="" type="checkbox"/>
Health service organisation	<input checked="" type="checkbox"/>	Child and adolescent	<input checked="" type="checkbox"/>
Regional group of services	<input checked="" type="checkbox"/>	Older persons care	<input checked="" type="checkbox"/>
State/Territory	<input checked="" type="checkbox"/>	Forensic	<input checked="" type="checkbox"/>

Recommendation for implementation:

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

Key stratification options:

By collection occasion.

Implications for data development

Immediate: Requires completed implementation of outcome measurement.

Short Term: Nil.

Long Term: Nil.

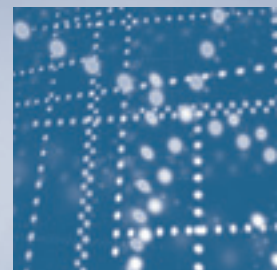
Notes:

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

Allied indicators:

Nil.

Appendix B



Definition of ‘Specialised Mental Health Service Organisation’

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

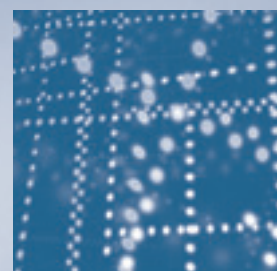
For example, a specialised mental health service organisation may consist of several hospitals or two or more community centres. Where the specialised mental health service organisation consists of multiple service units, those units can be considered to be components of the same organisation where they:

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

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

Source: *Australian Institute of Health and Welfare, National Minimum Data Set – Mental Health Establishments.*

Appendix C

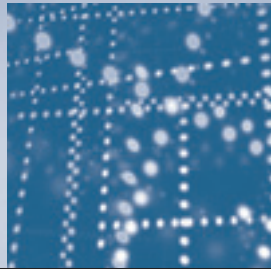


Sources and availability of data for Phase one performance indicators

INDICATOR	DATA SOURCE(S)	AVAILABLE SINCE
28-day readmission rate	National Minimum Dataset - Admitted Patient Mental Health Care or State/Territory equivalent	1996-97
National Service Standards Compliance	National Survey of Mental Health Services or State/Territory Central Health Administration	2002-03
Cost per acute inpatient episode	National Survey of Mental Health Services or State/Territory equivalent National Minimum Dataset - Admitted Patient Mental Health Care or State/Territory equivalent	1993-94 1996-97
Average length of acute inpatient stay	National Minimum Dataset - Admitted Patient Mental Health Care or State/Territory equivalent	1996-97
Cost per three month community care period	National Survey of Mental Health Services or State/Territory equivalent National Minimum Dataset - Community Mental Health Care or State/Territory equivalent	1993-94 2000-01
Treatment days per three month community care period	National Minimum Dataset - Community Mental Health Care or State/Territory equivalent	2000-01
Population under care	National Minimum Dataset - Community Mental Health Care or State/Territory equivalent National Minimum Dataset - Admitted Patient Mental Health Care or State/Territory equivalent ABS Population data by Area	1993-94 1996-97
Local access to inpatient care	National Minimum Dataset - Admitted Patient Mental Health Care or State/Territory equivalent	1996-97
New client index	National Minimum Dataset - Community Mental Health Care or State/Territory equivalent National Minimum Dataset - Admitted Patient Mental Health Care or State/Territory equivalent	2000-01 1996-97
Comparative area resources	National Survey of Mental Health Services ABS Population data by area	1993-94 Ongoing availability
Pre-admission community assessment	National Minimum Dataset - Community Mental Health Care or State/Territory equivalent National Minimum Dataset - Admitted Patient Mental Health Care or State/Territory equivalent	2000-01 1996-97

INDICATOR	DATA SOURCE(S)	AVAILABLE SINCE
Post-discharge community care	National Minimum Dataset - Community Mental Health Care or State/Territory equivalent	2000-01
	National Minimum Dataset - Admitted Patient Mental Health Care or State/Territory equivalent	1996-97
Outcomes readiness	National Outcome Casemix Collection Dataset	Variable by jurisdictions but generally 2002-03
	National Minimum Dataset - Community Mental Health Care or State/Territory equivalent	2000-01
	National Minimum Dataset - Admitted Patient Mental Health Care or State/Territory equivalent	1996-97

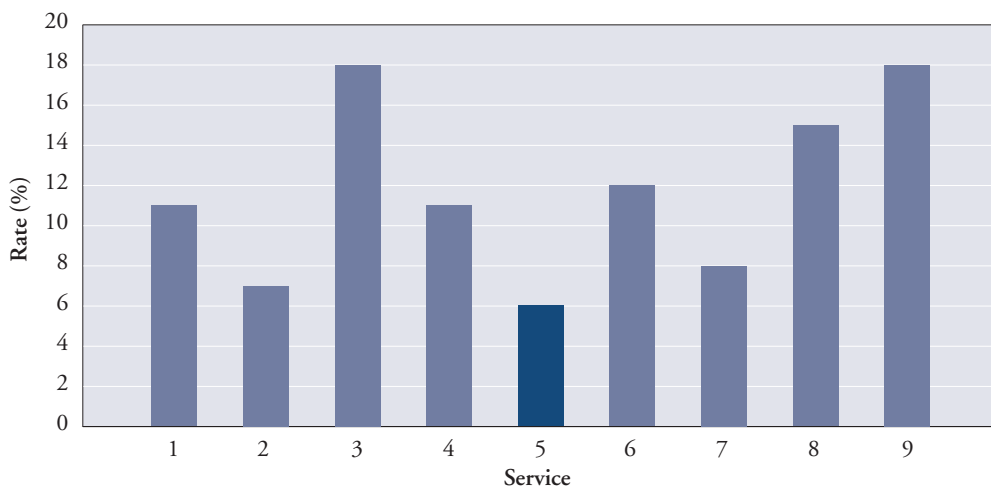
Appendix D



Demonstration of Phase One indicators for a hypothetical organisation

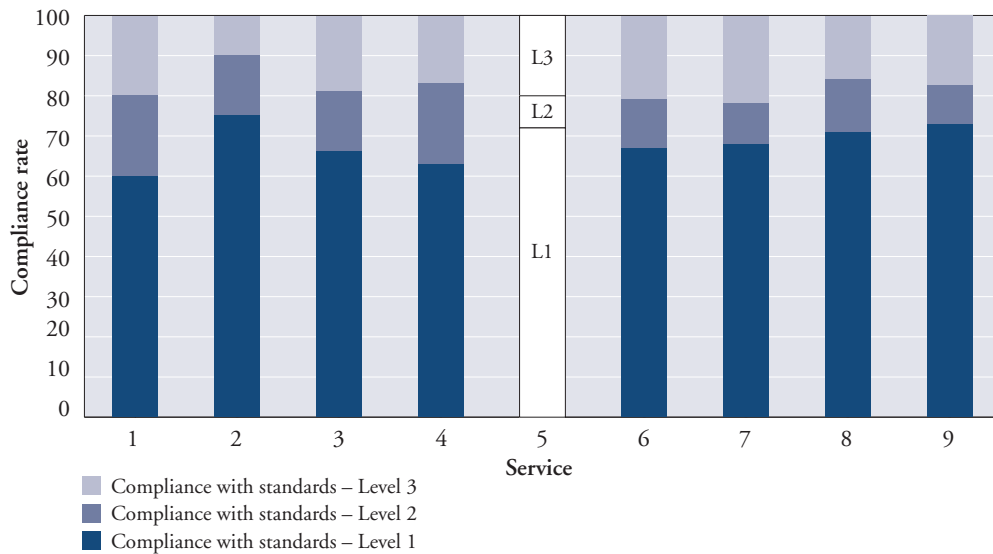
This Appendix provides a brief demonstration of how the indicators can be applied to understanding the performance of an individual service organisation relative to its peers. The hypothetical scenario outlined in the following charts focuses on ‘Organisation 5’, a comprehensive Area Mental Health Service, and compares its performance on each of the indicators against eight other Area Mental Health Service organisations drawn from the same jurisdiction.

28 day readmission rate



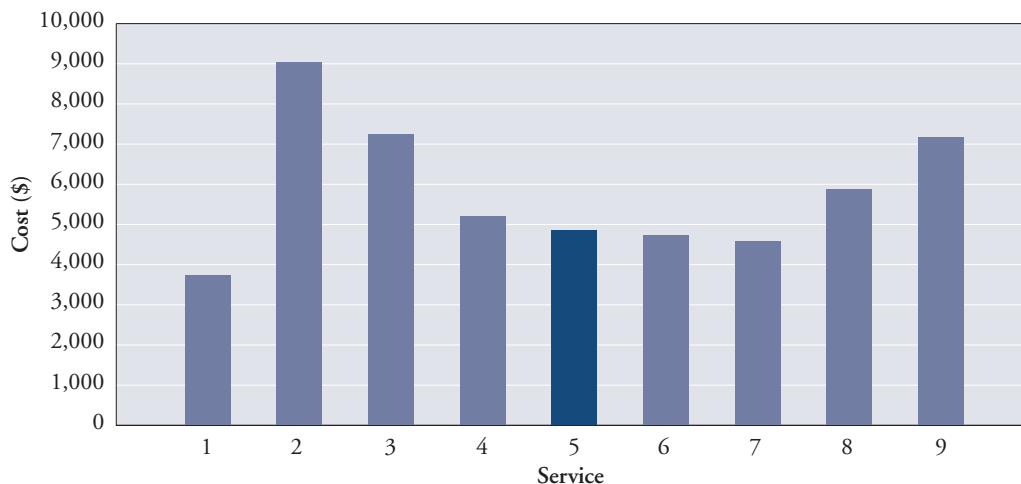
Organisation 5 has a low readmission rate compared with other organisations. By contrast, readmission rates for Organisations 3 and 9 are quite high. This may be due to differences in patient characteristics, clinical practice or availability of community services.

Compliance with standards



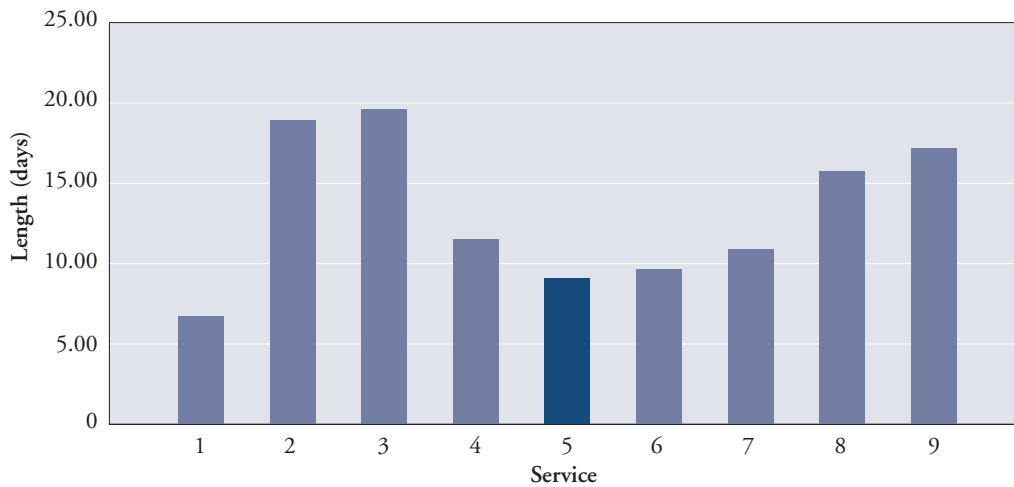
Compliance with the National Standards is similar across the peer group. Organisation 5 has relatively good compliance with the National Standards with approximately 70% of its services meeting Level 1 criteria. This suggests good commitment by the organisation to promoting appropriate practice across its mental health service network. As this indicator provides a static 'snap shot', the next step in understanding the organisation's approach to quality improvement would be to investigate how the Standards are used in driving ongoing service improvements.

Cost per acute inpatient episode



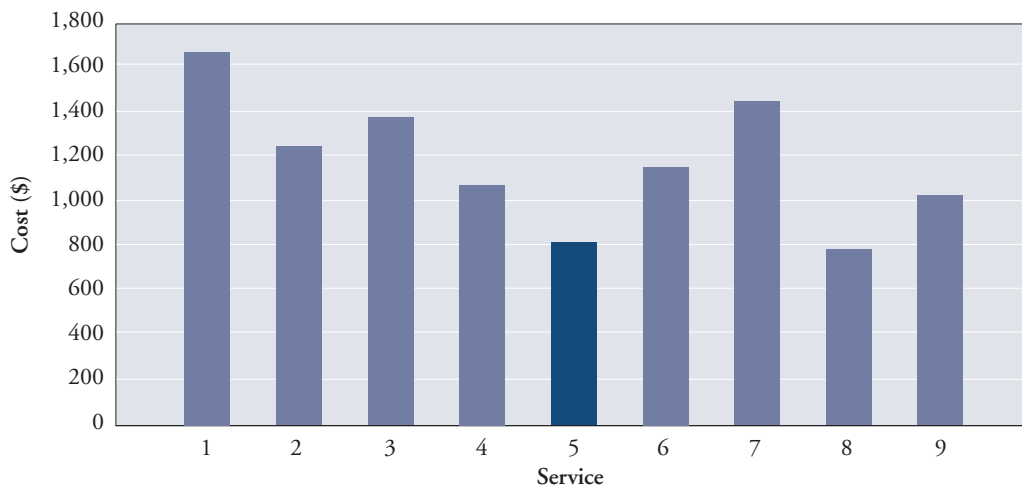
Low readmission rates can be attained through providing intensive and prolonged inpatient care. Despite its low readmission rates, Organisation 5 also has a comparatively low cost per acute inpatient episode, indicating that the relatively good community tenure experienced by consumers following discharge is not a function of them receiving more costly inpatient care compared with consumers of peer organisations. This perspective is supported by Organisation 3 which has the converse of organisation 5 - a high readmission rate in the context of a high cost per acute inpatient episode. Further comparison between the two organisations on patient and provider practice differences has potential to reveal considerable learning for both organisations.

Average length of acute inpatient stay



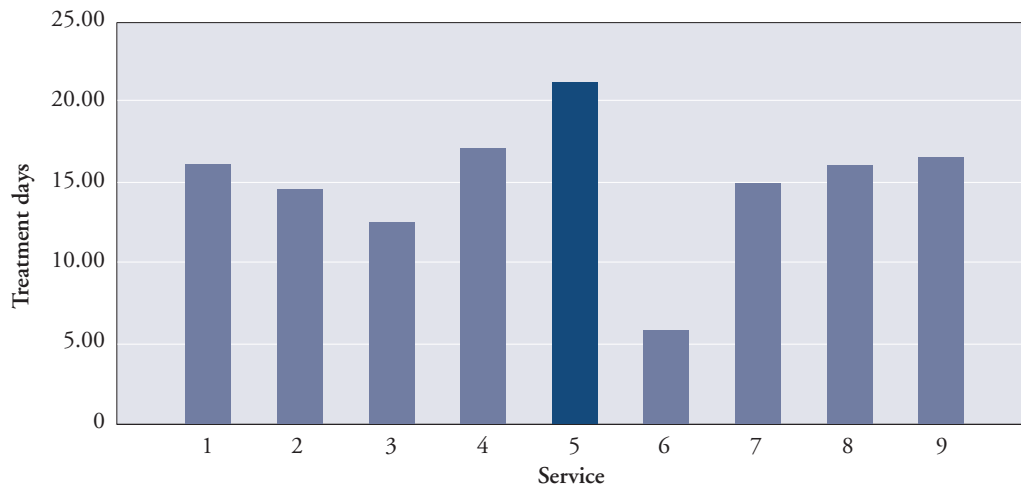
Organisation 5 also has a low average length of inpatient stay, which is the major driver of lower cost per episode. This indicates relative efficiency in inpatient services, differences in casemix, or clinical practice. Of most significance, despite the relatively lower length of stay, Organisation 5’s readmission rate is also low as noted above. This combination is counter to the general view, supported by research literature, that high readmission rates are, in part, a function of reduced inpatient care. The indicator points to a useful area for further investigation.

Cost of three month community care period



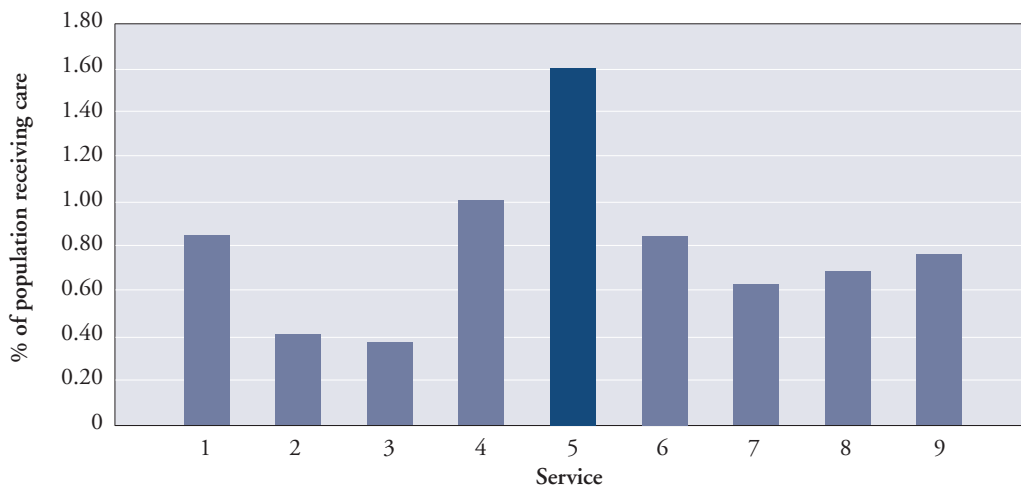
As well as having low inpatient episode costs, Organisation 5 has relatively low community care costs, suggesting efficiency in the delivery of ambulatory care. This indicator however is insufficient to make such a judgement as further information is required on the overall number of clients treated and the frequency of services provided. But it raises an important question when counter-posed against the organisation’s low readmission rates – how does the organisation assist people to remain in the community following discharge when it appears to be providing less costly services?

Treatment days per three month community care period



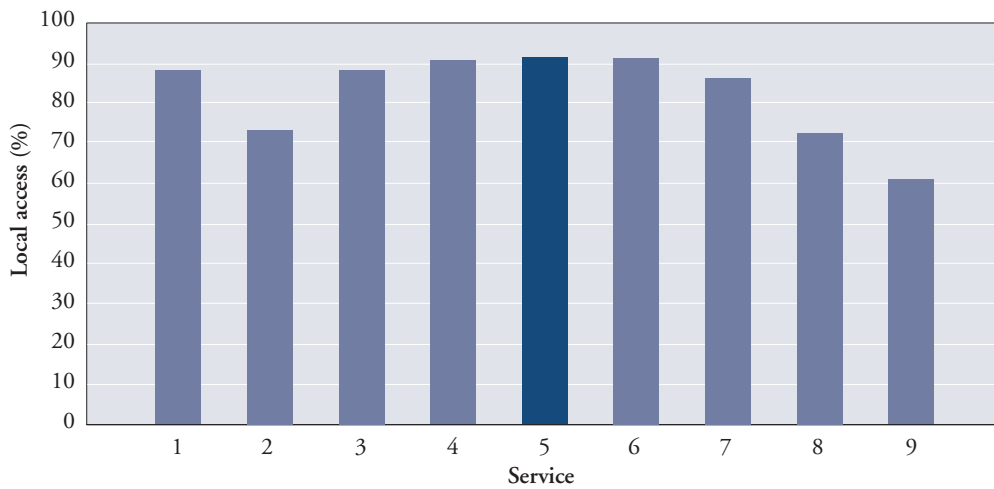
This indicator adds further information by showing that Organisation 5 makes contact with its consumers under community care more frequently than peer organisations. It suggests the following pattern: consumers treated by Organisation 5 are seen more frequently in the community but at a lower overall cost than consumers of similar organisations. It points to lower cost per occasion of service, achieved possibly through one or more of a variety of efficiency factors, including lower staff costs, briefer contacts, or higher contact output per clinical provider. Organisation 5’s greater frequency of servicing of consumers in the community may in part explain its lower readmission rates.

Population receiving care



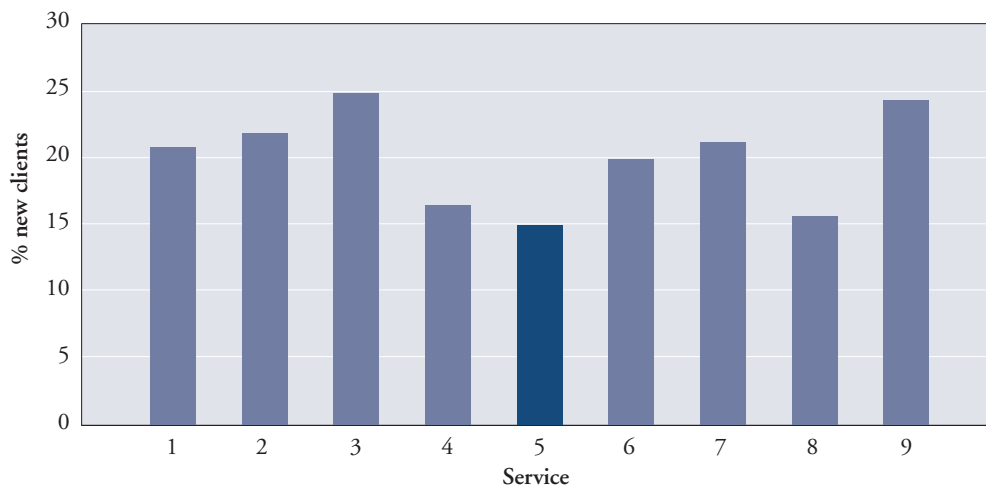
A considerably higher proportion of the population in the area covered by Organisation 5 receive mental health services, pointing to better access to mental health care for the population than all other organisations in the peer group. The picture emerging is one of an organisation that provides services to a greater number of people, at higher servicing rates but lower overall cost.

Local access to inpatient care



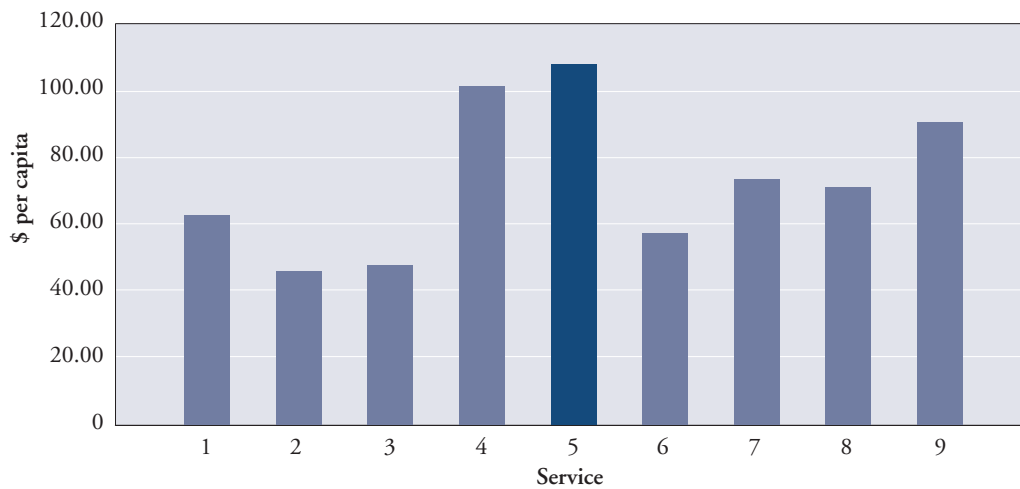
Additionally, when inpatient care is required by people living in Organisation 5's catchment, that care is provided by the local inpatient unit in approximately 90% of occasions, the equal best 'local access' rate of the peer group. By contrast, 40% of hospital admissions for people living in Organisation 9's catchment are transferred to 'out of area' services.

New client index



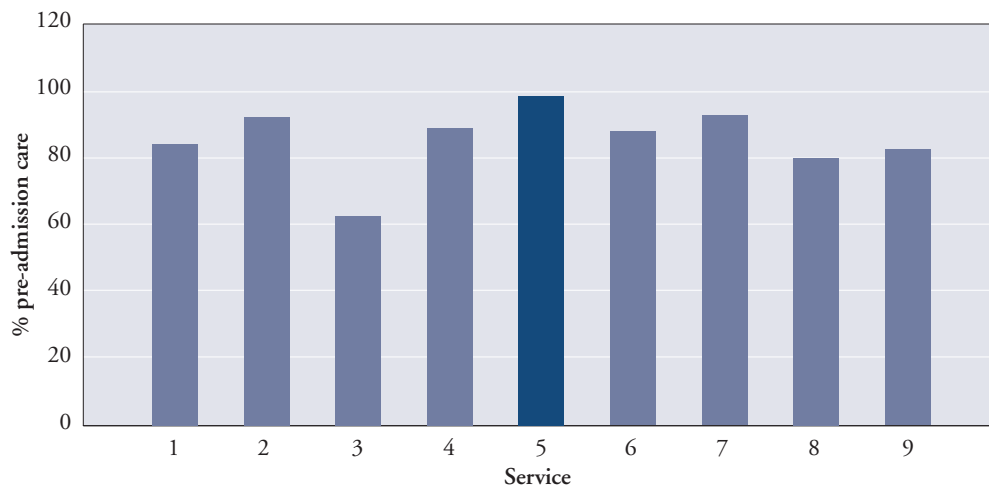
Interestingly, however, Organisation 5 has a relatively low proportion of new clients compared with other services. There is some ambiguity in this indicator that would benefit from further inquiry. On the one hand, it may indicate that some of the efficiencies shown by the organisation are being achieved by conducting fewer intake assessments and other resource-intensive activities associated with client entry. Alternatively, it may indicate that the organisation has achieved good coverage of its target population – that is, through its high population coverage over the years, it has engaged with a large proportion of its target population so that the rate of 'new case accumulation' is relatively low.

Comparative area resources

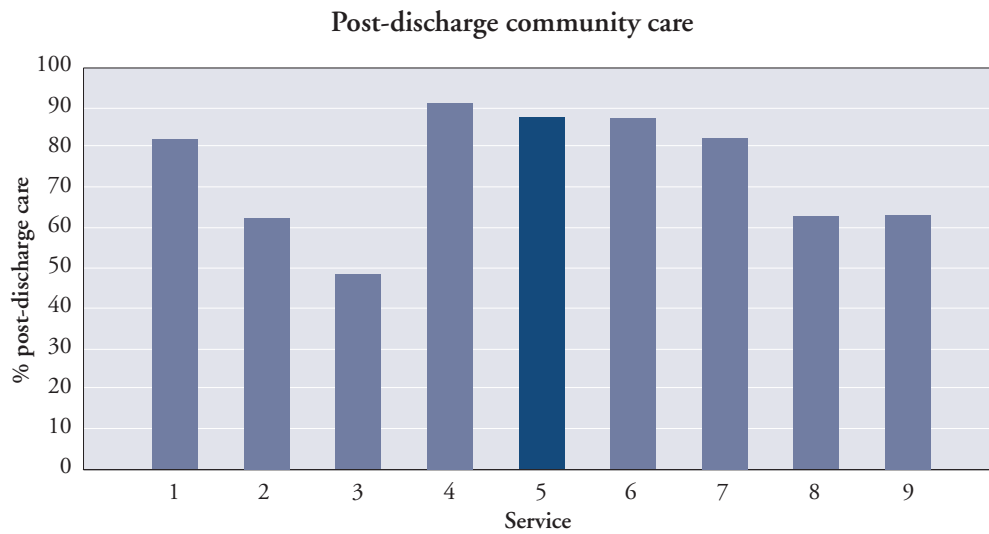


This indicator shows that Organisation 5 is relatively well resourced in comparison with most of its peers. This is an important ingredient for understanding comparative performance and, arguably, one that peer organisations would want to know in any benchmarking exercise. However, the pattern of the previous indicators suggests that higher resource levels cannot fully explain the performance differences between the organisations. Organisation 5 appears to be using the resources at its disposal differently from most of its peers.

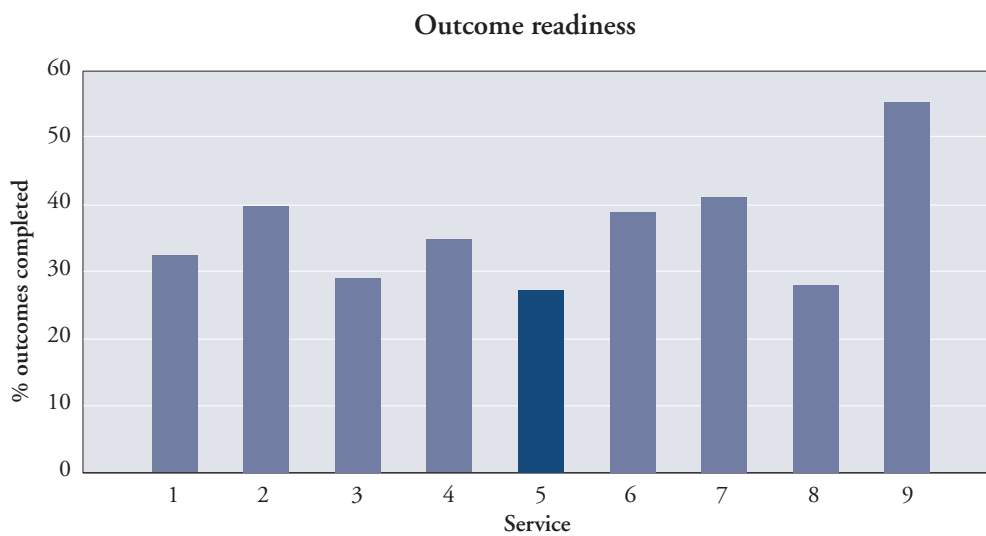
Pre-admission community care



Organisation 5's relatively higher use of community services is also reflected in this indicator. Community services managed by the organisation are involved with 98% of people who require admission to hospital in the 7 days prior to admission. By contrast, only 61% of admissions from Organisation 3's catchment area have community teams involved in the week preceding admission. Given that 85% of the clients treated by Organisation 5 are existing clients, it is reasonable to expect that community teams should be aware of, and involved in a consumer's life during the period of distress that typically preceded admission to psychiatric care.



This indicator looks at the other side of the hospital admission process and monitors the percentage of people seen by community services in the week following discharge. Organisation 5's community teams see 88% of people in that period, the equal second highest rate of the peer group. Early post-discharge contact is hypothesised in the clinical and research literature to be an important intervention to minimise the risk of unplanned readmission.



While Organisation 5 performs well on most of the performance indicators, it has a low compliance with outcome measurement. Only 25% of episodes of care have completed outcome assessments. This compromises the capacity of the organisation to learn about the extent to which it is assisting its consumers.

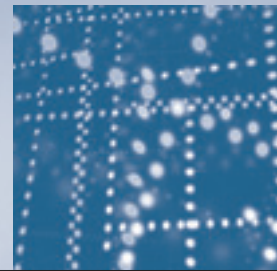
Summary

Within a benchmarking forum, Organisation 5's indicators would likely attract considerable attention, achieving better than average results on all but one of the measures. On the basis of the indicators, the organisation appears to be more effective and efficient and provide better service access to its catchment population than its peers. Provision of continuity of care across inpatient-community boundaries exceeds most of its counterparts. Additionally, the organisation matches its peers in promoting appropriate services as measured by its implementation of the national standards for mental health services.

There are many bits missing to the 'puzzle'. In particular, the Phase 1 indicator set does not contain information on consumer outcomes, consumer and carer perceptions of care or the extent to which services promote safety. These are important directions for future development.

While the indicators do not allow us to judge that Organisation 5 provides the 'best' mental health services, they play the important role of focusing the questions to be raised in learning about 'best practice'. This role of performance indicators in stimulating informed inquiry is widely recognised as their key contribution to quality improvement.

Appendix E



Selection criteria for health performance indicators

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

1. Be worth measuring

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

2. Be measurable for diverse populations

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

3. Be understood by people who need to act

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

4. Galvanise action

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

5. Be relevant to policy and practice

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

6. Measurement over time will reflect results of actions

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

7. Be feasible to collect and report

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

8. Comply with national processes of data definitions

Selection criteria for sets of performance indicators

Criteria related to sets of indicators or composite indices should:

1. Cover the spectrum of the health issue;
2. Reflect a balance of indicators for all appropriate parts of the framework;
3. Identify and respond to new and emerging issues; and
4. Be capable of leading change.
5. Provide feedback on where the system is working well, as well as areas for improvement.

Additional selection criteria specific to NHPC reporting

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

- facilitate the use of data at the health industry service unit level for benchmarking purposes; and
- be consistent and use established and existing indicators where possible.

Appendix F

Existing and developmental State and Territory key performance indicators (as at March 2003)

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NMHR	SCRGSP
EFFECTIVE										
Proportion of services accredited	●	●		●		●				
Services meeting 4 priority areas of the national mental health standards	●	●		●						
Proportion of services participating in an accreditation program	●		●			●				
Percentage and number of unplanned inpatient re-admissions within 28 days of discharge	●						●	●		
Percent of specialised public mental health services reviewed against the national standards for mental health services									●	
Percent of specialised mental health services that have introduced routine consumer outcome measurement									●	
Percentage of mental health presentations that do not lead to a re-presentation for the same complaint within 48 hours					●					
APPROPRIATE										
Percentage of clients whose focus of care matches purpose of treating unit						●				
Percentage change and number of involuntary admissions		●								
Number of community care clients referred to or from inpatient services						●				
Number of clients receiving psychiatric disability support services							●			
Percentage of psychiatric disability support services individual program plans completed within two months							●			
Consumer and carer participation in decision making. The proportion of organisations operating at each level where the levels are:									●	
<ul style="list-style-type: none"> • level 1 – appointment of a person to represent the interests of consumers and carers on the organisation management committee or a specific consumer and carer advisory group to advise on all aspects of service delivery; • level 2 – a specific consumer and carer advisory group to advise on some aspects of service delivery; • level 3 – participation of consumers and carers in broadly based committees; and • level 4 – other/no arrangements. 										

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NMHR	SCRGSP
Proportion of recurrent expenditure on stand alone psychiatric hospitals as a proportion of total spending on mental health services; and									●	
Acute patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals									●	
Service mix										●
• % total service expenditure – non-inpatient services										
• % total service expenditure – co-located units										
• % total service expenditure – sep. psych hospitals										
• % total service expenditure – ambulatory care										
• % total service expenditure – non-government organisations										
• % total service expenditure – 24 hour residential services										
Percentage of acute beds co-locate										●
Stand alone beds as a percentage of total beds										●
Percentage of mental health presentations that require a restraint of any kind					●					
Percentage of mental health presentations who were admitted under the Mental Health Act					●					
Percentage of people under 17 years of age treated in mental health ICU facilities					●					
Percentage of ICU separations or transfers which are greater than 2 days' duration					●					
EFFICIENT										
ALOS inpatients		●				●				
ALOS inpatients (acute)				●						
ALOS residential						●				
Average duration of occasions of service (community)						●				
Cost per inpatient day						●			●	
Cost per residential patient day						●			●	
Cost per hour of occasions of service						●				
Average costs for ambulatory (non-admitted) services									●	
Per capita expenditure										
• Statewide										
• Inpatient services										
• Ambulatory care										
• Non-government organisations										
• 24 hour residential services										●
MBS funded consultant psychiatric services – benefits paid per capita										●
Average mental health presentation cost per mental health clinical FTE					●					

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NMHR	SCRGSP
Average mental health presentation cost					●					
RESPONSIVE										
Consumer and care involvement in decision making	●					●				
ACCESSIBLE										
Proportion of clients from a culturally and linguistically diverse background (NESB)		●				●				
Proportion of Indigenous clients (ATSI)	●	●				●				
Proportion of clients in receipt of a pension		●				●				
Proportion of veterans		●				●				
Percentage of mental health inpatient episodes of care provided locally		●						●		
Median bed days for persons under mental health community management who were admitted to hospital								●		
Median length of stay per episode of care (days) for people with mental illness by DRG		●						●		
Percentage of consumers who are admitted (receive treatment) within 4 wks (28 days) of referral to a community mental health service	●							●		
Percentage of clinical inpatient clients who have contact with clinical community care service providers during the 7 days prior to admission							●			
Percentage of clinical inpatient clients who have contact with clinical community care service providers within 7 days of post-discharge							●			
Number of youth suicide prevention networks established				●						
Beds per 100,000										
• Total inpatient										
• Acute inpatient										
• Non-acute inpatient										
• Total 24 hour residential										
• Adult 24 hour residential										
• Psycho-geriatric 24 hour residential										●
Percentage of population seen by MBS funded consultant psychiatrists										●
Attendances to MBS funded consultant psychiatrists per 100 population										●
Percentage of mental health presentations delivered to health unit catchment area residents					●					
Percentage of mental health presentations seen within NTS agreed times; and > 12 hour waits					●					
Number of contingency plan notifications to MHU in a 3 month period					●					

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NMHR	SCRGSP
Average mental health presentations per mental health clinical FTE					●					
SAFE										
Suicide rate among mental health clients						●				
Seclusion rates						●				
Adverse drug effects						●				
Percentage change and number of accident incident reports		●								
Suicide per 100,000 population										
• All person										
• Persons aged 15-24										
• Capital city/other urban/rural									●	
Suicide and self inflicted injury rates by indigenous status									●	
Percentage of mental health presentations that cause a critical incident or sentinel event to be initiated					●					
Percentage of mental health presentations requiring admission that take longer than 12 hours to be admitted					●					
The proportion of all transports which are retrievals					●					
CONTINUOUS										
% of inpatient admissions and separations referred to mainstream services		●				●				
CAPABLE										
Percentage of clinical positions occupied						●				
FTE per 100,000 population										
• Total										
• Non-inpatient										
• Ambulatory services										●
SUSTAINABLE										
Total inpatient separations	●	●	●			●	●			
Total inpatient episodes of care	●			●						
Total inpatient bed days (acute)	●		●	●						
Total residential separations						●				
Number of patients treated in the community			●	●			●			
Total community client time						●				
Proportion of managers engaging in frontline management training						●				

Appendix G

United States National Association of State Mental Health Program Directors (NASMHPD) Standardised Framework

DOMAIN: ACCESS

- A1 Penetration/utilization rates (age, sex, race, setting)
- A2 Consumer perception of access

Indicators under development:

- A3d Average time to first service
- A4d Denial of care
- A5d Homeless and rural access

DOMAIN: QUALITY/APPROPRIATENESS

- Q1 Participation in treatment planning (adults)
- Q2 Consumers linked to primary health services
- Q3 Contact within seven days following hospital discharge
- Q4 Consumer perception of quality/appropriateness

Adults with SMI receiving effective services:

- Q5 Adults receiving assertive community treatment 'ACT'
- Q6 Adults in supported employment
- Q7 Adults in supported housing
- Q8 Adults receiving new generation 'atypical' medications

Children receiving 'best practices':

- Q9 For example, children receiving in-home services
- Q10 Family involvement in treatment for children/adolescents
- Q11 Readmissions within 30 days
- Q12 Seclusion
- Q13 Restraint
- Q14 Medication errors

Indicators under development:

- Q15d Follow-up after emergency services
- Q16d Family involvement in treatment
- Q17d Screening for TB, HIV, etc.

DOMAIN: OUTCOMES

- O1 Consumer perception of outcomes
- O2 School improvement (children)
- O3 Employment (adults)/school improvement (children)
- O4 Functioning
- O5 Symptom relief

Adverse outcomes:

- O6 Consumer injuries
- O7 Elopement
- O8 Out of home placements
- O9 Health status: mortality
- O10 Recovery/hope/personhood (surrogate measures)
- O11 Reduced substance abuse impairment
- O12 Living situation
- O13 Criminal Justice

Indicators under development:

- O14d Recovery/personhood/hope
- O15d Abnormal involuntary movements (AIMs)

DOMAIN: STRUCTURE/PLAN MANAGEMENT

- S1 Consumer/family member involvement in policy development, quality assurance and planning
- S2 Proportion of expenditures on administration
- S3 Per member per month/average resources spent for mental health

Indicators under development:

- S4d Stakeholder satisfaction
- S5d Cultural competence

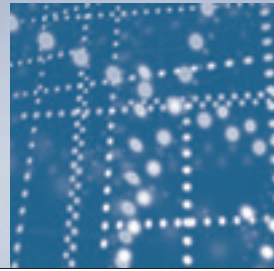
DOMAIN: EARLY INTERVENTION/PREVENTION

None.

Indicators under development:

- P1d Substance abuse screening
- P2d Use of self-help/self-management
- P3d Identification of high-risk populations
- P4d Psycho-educational programs

Appendix H



Consensus indicators developed under the American College of Mental Health Administration

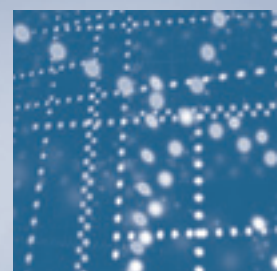
DOMAIN: ACCESS... GETTING INTO SERVICES		
Topic	Concept or concern	Things to count
1. Services are available	Persons served perceive and experience services as available.	<ul style="list-style-type: none"> a. The rate of persons served reporting that they receive services they need. b. The rates of utilization of services as compared to the identified needs of the community.
2. Services are convenient	Persons served perceive and experience services as convenient (i.e., available services are well located, offered at convenient hours, etc.)	<ul style="list-style-type: none"> a. The rate of persons served reporting that transportation is not a barrier to recovery. b. Geographic analysis of population-to-provider rates and travel times for behavioral health professionals.
3. Services are timely	Persons served perceive and experience services as timely.	<ul style="list-style-type: none"> a. The rate of persons reporting timely response from first request for service to first face-to-face meeting with a mental health professional. b. The rate of persons reporting timeliness from a first appointment to a second appointment. c. The average number of days from first request for service to first face-to-face meeting with a behavioral health professional. d. The average number of days from a first appointment to a second appointment.
4. Services are provided	Services are available and provided to people like me.	<ul style="list-style-type: none"> a. The rate of utilization of services at each available level of care described by meaningful groupings of persons served.

PROCESS... WHAT HAPPENS DURING SERVICES

Topic	Concept or concern	Things to count
1. Treatment decisions	Persons served (and families of children and adolescents) participate meaningfully in treatment decisions.	<ul style="list-style-type: none"> a. The rate at which persons served report they received useful information to make informed choices about their treatment. b. The rate of participation in decisions regarding treatment by persons served. c. The rate of participation in decisions regarding treatment by families of children and adolescents when indicated.
2. Responsiveness	Services are responsive to the clinical status of the person served.	<ul style="list-style-type: none"> a. The rate of persons served who receive timely face-to-face follow up care after leaving a 24 hour care setting. b. The rate of persons served who receive a timely course of treatment following diagnosis of a behavioral health disorder.
3. Non-coercive treatment	Whenever possible, treatment should be voluntary and non-coercive.	<ul style="list-style-type: none"> a. The rate of persons served who report experiencing treatment as non-coercive. b. The rate of involuntary treatments. c. The rate of seclusion and restraint.
4. Experience of care	Persons served perceive and service providers as responsive and sensitive.	<ul style="list-style-type: none"> a. The rate at which persons served report they were treated with politeness, respect, and dignity by staff. b. The rate at which persons served report feeling hopeful about their recovery. c. The rate at which persons served report they were treated with.
5. Co-occurring illness	Co-occurring mental illness and substance abuse is recognized and treated.	<ul style="list-style-type: none"> a. The rate of persons served diagnosed with co-occurring mental illness and substance abuse disorders.
6. Safe	Persons served are safe in treatment.	<ul style="list-style-type: none"> a. The rate at which persons served report that they feel safe in treatment. b. The rate at which persons served report that they feel safe in the community. c. The rate of suicide, homicide and unexpected deaths.

OUTCOME... RESULTS OF SERVICES		
Topic	Concept or concern	Things to count
1. Well being	Persons served experience an improvement in health and psychological well being as a result of treatment	<ul style="list-style-type: none"> a. The rate of persons served who are better, worse or unchanged at the termination of treatment compared to the initiation of treatment. b. The rate of persons served who are better, worse or unchanged at a standard interval following the termination of treatment compared to the termination of treatment.
2. Work and school	Persons served are productively involved in work and school.	<ul style="list-style-type: none"> a. For adults: the rate of employed/unemployed adults counted at the termination of treatment and at a standard interval following the termination of treatment. b. For employed adults: the average number of days not worked counted at a standard interval following the termination of treatment. c. For children: the average number of missed class days counted at a standard interval following the termination of treatment.
3. Safety	Treatment improves the safety of persons served.	<ul style="list-style-type: none"> a. The rate of episodes of victimization reported at a standard interval following the termination of treatment. b. For persons served who identify victimisation or vulnerability as a concern at the initiation of treatment: the rate of perceived vulnerability reported at the termination of treatment and at a standard interval following the termination of treatment.
4. Legal involvement	Persons served should be out of trouble with the law.	<ul style="list-style-type: none"> a. For persons served who identify problems with the law as a concern at the initiation of treatment: the rate of arrests, detentions and/or incarcerations counted at a standard interval following the termination of treatment.
5. Housing	Housing needs are resolved.	<ul style="list-style-type: none"> a. The rate of domiciled/homeless persons at the termination of treatment and at a standard interval following the termination of treatment. b. For adults who identify housing as a concern at the initiation of treatment: the rate who report improvement, worsening or no change in their satisfaction with housing at the termination of treatment and at a standard interval following the termination of treatment. c. For children: the rate of children at home at the termination of treatment and at a standard interval following the termination of treatment.

Appendix I



Summary of performance measures listed by Canadian Federal/Provincial/Territorial Advisory Network on Mental Health

DOMAIN/INDICATOR	PERFORMANCE MEASURE
1. Acceptability	Care/service provided meets expectations of client, community, providers and paying organizations.
1.1 Consumer satisfaction	1. Percentage of consumers/families satisfied with services as measured by valid method.
1.2 Formal complaints	2. Existence of a clear process for filing complaints. 3. Number of complaints received by Complaints Commissioner, Mental Health Advocate, Ombudsperson (or equivalent offices), consumer advocacy associations, regional health authority, etc. concerning mental health services and supports. (Nature of complaints received should also be reported). 4. Average time between receipt of complaint and satisfactory resolution. 5. Percentage of consumer (and families) satisfied with resolution of complaints.
1.3 Charter of rights	6. Existence of a consumer/family charter of rights that has been endorsed by the appropriate health authority and/or government body.
1.4 Involvement of consumers and families in treatment decisions and plans	7. Proportion of consumers and families within a service provider population of persons with serious mental illness who actively participate in decisions concerning their treatment.
1.5 Involvement of consumers in service planning and delivery	8. Proportion of communities within region with established regional consumer advisory groups. 9. Total amount of resources allocated to support consumer advisory structures and their activities as a percentage of total mental health budget. 10. Proportion of regional health authorities within province/territory that have a designated person at the management level to facilitate partnerships and involvement of consumers and families. 11. Number of consumer/family self-directed initiatives.
1.6 Cultural sensitivity	12. Proportion of consumers within service provider population of persons with serious mental illness who report that staff are sensitive to their language and ethnic/cultural background. 13. Proportion of service staff who are culturally 'literate'; ie. knowledgeable about the history, traditions and beliefs of ethno-cultural minorities.

DOMAIN/INDICATOR	PERFORMANCE MEASURE
2. Accessibility	Ability of clients/patients to obtain care/service at the right place and right time based on needs.
2.1 Service reach to adults with serious mental illness (SMI)	<p>14. Treated prevalence of serious mental illness (proportion of individuals receiving at least one insured health service compared to the estimated number of persons with SMI in the region, or</p> <p>15. Treated prevalence of schizophrenia (proportion of individuals receiving at least one insured health service for this diagnosis compared to estimated number of individuals in the region with this disorder), or</p> <p>16. Treated prevalence of bipolar disorder (proportion of individuals receiving at least one insured health service for this diagnosis compared to estimated number of individuals in the region with this disorder).</p>
2.2 Service reach to homeless	17. Number of homeless clients receiving assertive community treatment as a proportion of the estimated number of homeless people with SMI.
2.3 Access to psychiatrists	<p>18. Dollars spent per 10,000 population on psychiatry services including fee-for-service, sessional services, outreach services by local health region.</p> <p>19. Services per 10,000 population by region.</p>
2.4 Access to primary care	<p>20. Proportion of persons with SMI who had at least one physician visit for non-psychiatric reasons during the last year.</p> <p>21. Proportion of persons with SMI registered with a primary care physician.</p> <p>22. Number of primary care outreach services provided to persons with SMI.</p> <p>23. Proportion of consumers within a mental health service provider population of persons with SMI who are screened for physical health problems.</p> <p>24. Number of emergency room presentations for medical problems which could be managed in primary care setting.</p>
2.5 Wait-time for needed services	<p>25. Average time (in days) from expression of desire for service by the client, or referral from another provider, to first face-to-face contact by mental health provider.</p> <p>26. Average wait-time (in days) from referral to admission to inpatient facility (acute and tertiary care).</p> <p>27. Proportion of urgent referrals that are assessed within 48-hours.</p>
2.6 Availability of after-hours care and transportation	<p>28. Proportion of communities within a region with 24-hour mental health coverage.</p> <p>29. Proportion of communities within a region with extended hours (evenings, weekends) mental health coverage.</p> <p>30. Services that arrange transportation for clients and their families.</p>
2.7 Denial of service	<p>31. Number of persons with SMI requesting community mental health service who are refused service.</p> <p>32. Reasons why clients are refused service documented and addressed at a planning level.</p>
2.8 Early intervention	<p>33. Duration of untreated symptoms (self and/or family defined).</p> <p>34. Mean age at first treatment contact for persons with psychotic disorders.</p> <p>35. Proportion of clients whose first contact with the system is through emergency departments.</p> <p>36. Dissemination of information to public about symptoms of mental illness and available resources.</p>
2.9 Consumer perception of access	37. Proportion of consumers with SMI satisfied with access to services and supports. (May be measured as one component of client satisfaction).

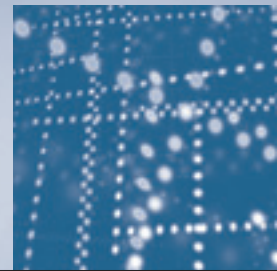
DOMAIN/INDICATOR	PERFORMANCE MEASURE
3. Appropriateness	Care/service provided is relevant to client/patient needs and based on established standards.
3.1 Existence of best practice core programs	38. Existence of, or access to (if unavailable in smaller communities), the following continuum of core programs: Case management/assertive community treatment; Crisis response/emergency services; Housing; Inpatient/outpatient care; Supported consumer initiatives; Family self-help programs; Vocational/educational programs; Early intervention; Primary care.
3.2 Fidelity of best practices to established model	39. Evidence of a process for establishing, adopting, and maintaining best practice core programs and system strategies. 40. Program audit against established criteria.
3.3 Receipt of best practices services/supports among people with SMI	41. Percentage of persons with SMI (or selected diagnoses) receiving assertive community treatment. 42. Percentage of persons with SMI (or selected diagnoses) receiving supported housing. 43. Percentage of persons with SMI (or selected diagnoses) in receipt of paid employment, supported employment, or other vocational/educational support.
3.4 Treatment protocol for co-morbidity	44. Number of community mental health programs that screen for substance use disorders and have an appropriate protocol for treatment and/or referral. 45. Proportion of SMI patients with identified substance misuse receiving addictions treatment.
3.5 Hospital readmission rate	46. Number of acute-care readmissions occurring within 30 days of discharge as a proportion of the total number of psychiatric separations per year.
3.6 Involuntary committal rate	47. Rate of involuntary committals as a percentage of all hospitalisations per annum. 48. Proportion of involuntary committals with extended leave provision.
3.7 Average length of stay in acute-care	49. Average length of stay for separations with a primary mental health diagnosis by region.
3.8 Use of seclusion/restraints	50. Percentage of clients admitted for inpatient psychiatric care who were restrained at least once per facility per year. 51. Hours of seclusion as a percent of total client hours during admission per facility per year. 52. Percentage of clients admitted for inpatient psychiatric care who were restrained at least once per facility per year. 53. Hours spent in restraint as a percent of total client hours during admission per facility per year.
3.9 Least restrictive setting	54. Ratio served in inpatient care to outpatient care.
3.10 Appropriate spending	<ul style="list-style-type: none"> • Proportion of total expenditures on service recipients with SMI relative to total expenditures on all persons who have received any insured health service for a mental health problem. • Proportion of funds spent on preventing crises to funds spent on reacting to crises. • Proportion of investment in informal and consumer-run supports to the investment in formal supports. • Proportion of mental health sector expenditures on best practice programs to total sector expenditures needs. May be measured as one component of client satisfaction.
3.11 Consumer perception of appropriateness	55. Proportion of consumers with SMI who believe the service and supports provided are appropriate to their needs. May be measured as one component of client satisfaction.

DOMAIN/INDICATOR	PERFORMANCE MEASURE
4. Competence	Individual's knowledge skills are appropriate to care/service provided.
	<ul style="list-style-type: none"> No indicators specified. Text reads: 'While appraisal of competencies among mental health practitioners is a critical aspect of ensuring quality mental health care, the state of definition and measurement within this performance domain is very much at a developmental stage. Given this, it is not possible to identify precise indicators reflecting measurable knowledge, skills, and abilities in this section. Instead we list some of the required key competencies and/or desirable attributes for direct care staff. Note that these are generic, not discipline-specific, competencies.'
5. Continuity	Ability to provide uninterrupted, coordinated care/ services across programs, practitioners, organizations, and levels of care/service, over time.
5.1 Continuity mechanisms	56. Percentage of persons with SMI in contact with health care system in receipt of some form of case management.
5.2 Emergency room use	57. Number of emergency service contacts for persons with SMI per annum.
5.3 Community follow-up after hospitalisation	58. Percentage of hospital separations for primary mental diagnoses who have received at least one community mental health service contact within 30 days of discharge. 59. Percentage of hospital separations for primary mental diagnoses who have received at least one psychiatry service contact within 30 days of discharge. 60. Average number of days between hospital discharge and service contact for primary mental health separations.
5.4 Physician reimbursement mechanism for case consultation	61. Existence of a fee-item within the fee-for-service schedule that reimburses physicians for case consultation/case management activities. 62. Proportion of physicians reimbursed through non-fee-for-service mechanisms.
5.5 Documented discharge plans on hospital separation	63. Percentage of patients discharged from acute-care facilities (excluding those discharged against medical advice) who have a documented discharge plan.
5.6 Cases lost to follow-up	64. Proportion of persons with SMI lost to follow-up by community mental health services at six months and one year.
5.7 Repatriation of SMI clients	65. Percentage of clients transferred out of region for acute or tertiary care who return to home community upon discharge.
5.8 Single point of accountability	66. Existence of single mental health authority at local level.
6. Effectiveness	Care/services, intervention or action that achieve desired results.
6.1 Community tenure	67. Aggregated number of days hospitalized for psychiatric reasons plus number of days in custody or incarcerated for service recipients with SMI per annum subtracted from 365. 68. Number of persons with SMI removed from the community for more than 90 days.
6.2 Mortality	69. Crude mortality rate for persons with SMI (or specific diagnostic groups). 70. Standardized mortality ratio for persons with SMI (or specific diagnostic group). 71. Average number of years of life lost for persons with SMI who died in the past year, defined as the difference between age at death and current life expectancy.

DOMAIN/INDICATOR	PERFORMANCE MEASURE
6.3 Criminal justice system involvement	72. Rate of service provider population with SMI apprehended or incarcerated compared to rate for general population. 73. Change in number of arrests within 30 days prior to admission to number of arrests at six and twelve months post-admission. 74. Number of mental health related police calls.
6.4 Clinical status	75. Percentage of service recipients with SMI experiencing reductions in the number and severity of symptoms between admission and follow-up. There are a wide range of clinical instruments available for the measurement of symptomatology.
6.5 Functional status (Global)	76. Percentage of service recipients with improved (or maintained) functioning as measured by a standardised global functioning instrument.
6.6 Employment status	77. Percentage breakdown of service recipients with SMI classified according to employment status categories defined by the IAPSRS Toolkit. 78. Percent of service recipients with SMI attaining independent competitive (paid) employment.
6.7 Housing status	79. Percentage breakdown of service recipient with SMI classified according to residential status categories defined by IAPSRS PSR Toolkit. 80. Percent of service recipients with SMI in independent or supported housing. 81. Number of persons with SMI on housing wait lists.
6.8 Financial status	82. Percentage of service recipients with SMI living above the poverty line. 83. Percentage of service recipients with SMI receiving disability benefits.
6.9 Quality of life	84. Percent of service recipients with SMI reporting improvements in quality of life as determined by a valid measure (Lehman, 1988).
6.10 Patients not diagnosed	85. Percent of active clients of community mental health clinics with a formal psychiatric diagnosis recorded in the administrative and clinical record.
7. Efficiency	Achieving desired results with the most cost-effective use of resources.
7.1 Mental health spending per capita spending	86. Total sector costs (including all health services: physician services, drug benefit plan costs, community mental health services and supports, and inpatient care) divided by the current total population of the region.
7.2 Labour overhead	87. Proportion of dollars spent on administrative and support full-time employees (FTEs) to dollars spent on total FTEs.
7.3 Needs-based resource allocation strategy	88. Existence of a regional mental health funding formula reflecting a needs-based resource allocation strategy.
7.4 Community/institutional spending balance	89. Ratio of spending on community mental health services to institutional mental health services.
7.5 Resource intensity planning tool	90. Evidence of an explicit process for systematically incorporating client population levels of need into resource intensity estimates.
7.6 Unit costs and costs per client	91. Total costs divided by total units of service by program. 92. Total costs divided by the total number of clients served by program.

DOMAIN/INDICATOR	PERFORMANCE MEASURE
7.7 Annualised budget for performance monitoring	93. Percentage of mental health sector budget devoted to supporting the organization capacity to conduct performance monitoring.
8. Safety	Potential risks of the intervention or the environment are avoided or minimised. For the purposes of this report, the concept is extended to the safety of mental health staff and public safety.
8.1 Complications associated with ECT	94. Percentage of patient undergoing ECT who experience a major medical complication.
8.2 Medication errors/side effects	95. Number of medication errors/adverse effects reported by clients with SMI to case managers. 96. Number of medical services and/or hospital services required as a direct result of psychotropic medication problems.
8.3 Incidence of Critical Incidents Involving Inpatients	97. Incidence of any physical injury requiring medical attention to psychiatric patients and staff by inpatient facility per year. 98. Incidence of substantiated reports of sexual assaults on inpatients.
8.4 Suicides	99. Suicide rate per 1000 for general population by age and sex. 100. Suicide rate per 1000 for persons with SMI (or specific diagnostic groups). 101. Suicide rate per 1000 for aboriginal persons. 102. Parasuicide rate from emergency service contact data.
8.5 Homicides	103. Number of homicides committed by persons with SMI.

Appendix J



Desirable attributes of performance measurement systems

Extract from *Key Performance Indicators for New Zealand's Mental Health Services*, Background paper prepared for the New Zealand Ministry of Health, Buckingham & Associates, June 2004

Design indicators as tools for quality improvement not punishment

The strongest message emerging from recent health performance literature is that an effective, accepted, and respected performance measurement system is one that is used for quality improvement, not for punishment.¹ This is not to deny the absolute need of government and its administrative entities to be informed about the workings of funded organisations. Rather, it emphasises that clarification is required at the outset about how indicators are to be used.

The experience of most health organisations implementing a new performance measurement initiative is that this is often met with misunderstanding, suspicion and overt resistance on the part of many stakeholders. In the absence of unambiguous communication of intent, people frequently conclude that performance measurement will be used to reduce jobs, cut funds or publicly 'name, blame and shame' if the results show that a program was not meeting its objectives.

Writing from a different perspective based on the United Kingdom's experience in the education field, Goldstein and Myers argue for a 'code of ethics' for performance indicators that aim to prevent abuse of information. They argue that many adverse, unintended consequences arise when information that is developmental in nature with significant uncertainties is promoted as absolute truth.²

These cautions hold particular relevance for the mental health field because of the extensive knowledge gaps about causality between treatment programs and outcomes, under-developed practice protocols and multiple influences outside the control of the service provider that impact on the mental health status of consumers. The experience of other countries shows that there is no simple roadmap for 'getting it right' and that caution is required.

Successful initiatives are described as those that aim to help organisations learn about what works. The key is to use performance information to promote a culture of inquiry and learning in which indicators are seen as just tools to aid in unravelling the complexity. Because they require information derived from the clinical interface, effort is required to enlist clinician collaboration in the endeavour.

There are important messages here for funders who are seeking performance information to guide their allocations. Alternative, incentive-based funding systems rather than systems based on sanctions, need to be considered as the best funding approaches for supporting quality improvement.

Involve stakeholders from the beginning, balance their varied interests

A second and equally strong message coming from the mental health performance literature is that all stakeholder groups need to be involved from the outset in the design and implementation of any new performance measurement system. Effective performance measurement systems are described as those that incorporate and balance the interests of all stakeholders and perspectives. For example, the audit of Washington's performance indicators concluded that: *'Different people bring different interests to the table. Consumers and other external stakeholders are more interested in health outcomes ... At the same time, public mental health program staff want to know how well some of the processes they use to purchase and manage services are working, in addition to their more recent focus on understanding the outcomes associated with their work'*.³

The general medical literature offers numerous examples of failures that have followed when clinicians are isolated from the process.^{4,5} Recent initiatives have emphasised the powerful contribution that consumers and carers make to the values underpinning the design of performance measurement in mental health. Incorporating each of these groups along with other stakeholders in an exercise that builds the indicator set from bottom up is not the typical path taken by bureaucracies when developing performance reporting arrangements but is necessary to ensure credibility in the mental health field.

Balanced emphasis on inputs, processes, outputs and outcomes

Measures of inputs, processes, outputs and outcomes are all required to gain a full understanding of the performance of a mental health service organisation. Debates about the pre-eminence of outcome measures, or arguments that its 'time to move on from input measures', ignore the fact that each type of information serves a unique purpose.

Measures of input are necessary to understand the capabilities and structural characteristics of the organisation (e.g., staff skills, quality of facilities). Measures of process are needed to determine whether people receive care that is evidenced-based or conforms with consensus expectations about quality (e.g., treatment with dignity, appropriate care). Concern about processes is particularly important in the mental health field because they reflect the values of the care system. Output measures are needed to understand the quantities of services provided and develop efficiency indicators (e.g., cost per contact). And finally, outcome measures are the basis for understanding whether consumers are improving in their clinical status and well being.

The concept of the 'balanced scorecard', developed by the Harvard Business School, is based on the recognition that mental health service planners and managers need to balance a range of considerations when improving the quality of care.⁶ The delivery of care across the input-process-outcome spectrum needs to be measured at each step because each step relates to the other. Improvement in inputs may be needed to improve processes, which in turn can lead to better outcomes and prevent adverse events. Improved efficiency can enhance cost effectiveness. Continuous quality improvement activities are specifically premised on these linkages and seek to make changes in the structural and process components of care with the goal of positively influencing outcomes.

Keep it simple, manageable and able to evolve with experience

Experienced indicator practitioners argue that any performance measurement system should start out as simple and easy-to-use as possible. Organisations should begin with achievable measurement goals and processes and let the system evolve as experience is gained and resources become available. The aim should be to choose carefully what to measure and then make it important to people who can make a

difference. A common mistake is to include too much information in the early stages which distracts decision makers from acting on the important information.⁷

One author summed this up as follows: *'Our experience is that too fast a start with too large a bite can be destructive. My usual advice is that facilities not take on 'world peace' in the beginning of the quality journey.'*⁸

Keeping performance measurement simple is easier said than done, given the need for a balanced scorecard approach that covers multiple domains. Nevertheless, it is a principle that needs to constantly guide the early development work.

Promote benchmarking and learning opportunities

Publications of indicators alone is not sufficient to stimulate a culture of quality improvement and benchmarking throughout the mental health industry. The introduction of performance measurement systems requires attention not only to the technical issues but also the process of building interest, capacity and leadership within service organisations to use them creatively.

A recent Australian report reviewed the status of benchmarking in mental health and concluded that much work was needed to make this a reality: *'The challenge for the mental health sector is clear. The use of performance indicators and the movement towards benchmarking is becoming routine in the Australian health care system. The challenge for the mental health sector is to develop a set of meaningful performance measures and to develop the culture and the processes so that benchmarking becomes the norm'*.

Lessons from the acute health sector have shown the benefits of applying roundtable and related methods to the health field. The engagement of organisations in learning about their performance through comparison with peer organisations grounds performance measurement in practice and provides the means for the vision to be realised. When the information provided by the system matters to the stakeholders, then they will actively contribute to its development over time through a process of trial, feedback and enhancement

Maintain control of data integrity

Indicators are only as useful as the data from which they are built and the validity of the assumptions used for their production. A key challenge in achieving an effective performance measurement system is to ensure the integrity and comparability of data. Without this, organisations lose trust in the process and are unwilling to take action on the basis of results that are regarded as dubious.

How this is done will depend on the administrative arrangements within each jurisdiction. The most common approach is to centralise data management and indicator production functions so that organisations can be confident in the impartiality of the process. Centralised data management and reporting functions also has the advantage of creating economies of scale and expertise.

Resource the technical work

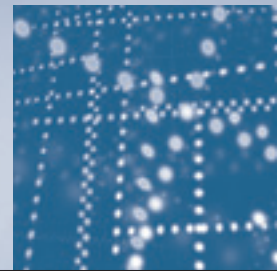
One clear lesson from performance measurement practice arising from performance measurement in the health field is that the processes involved in indicator production and development are typically more complex and costly than anticipated. Developing good indicators requires a commitment of resources – in data infrastructure and particularly in time and personnel.

On a related issue, it is important to ensure that appropriate technical expertise is included early in the work. Many indicator development projects have failed because they have not given adequate consideration to issues concerning technical feasibility and produced sets of non achievable indicators.

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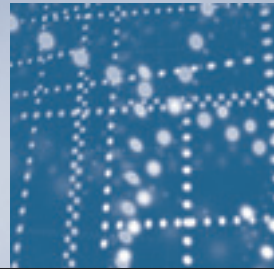
Appendix K



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Appendix L



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