National Mental Health Benchmarking Project

Evaluation Report

July 2009

national mental health strategy

A joint Australian, State and Territory Government Initiative

Acknowledgements

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Further information

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PART 1. INTRODUCTION

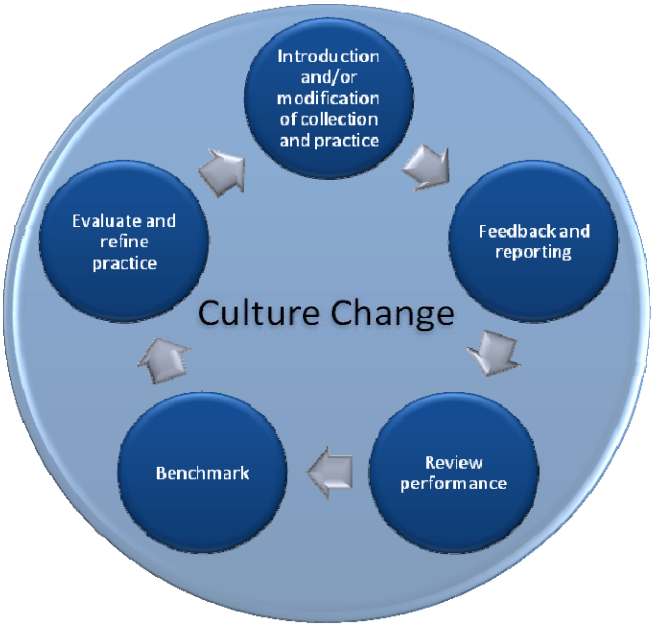
This document outlines the results of the evaluation of the National Mental Health Benchmarking which is primarily sourced from the considered experience of participants of two years of benchmarking activity. Recommendations on appropriate processes and next steps to facilitate continued and enhanced participation by a greater proportion of the sector in benchmarking have been informed by advice from the participating services and the Steering Committee.

Improving service quality has been a theme of the National Mental Health Strategy since it began in 1993. Each of the National Mental Health Plans have strengthened the call for action in this area and placed increasingly significant obligations on both funders and service providers to accelerate efforts to improve outcomes for people affected by mental illness.

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

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

Figure 1: Measurement for quality improvement cycle



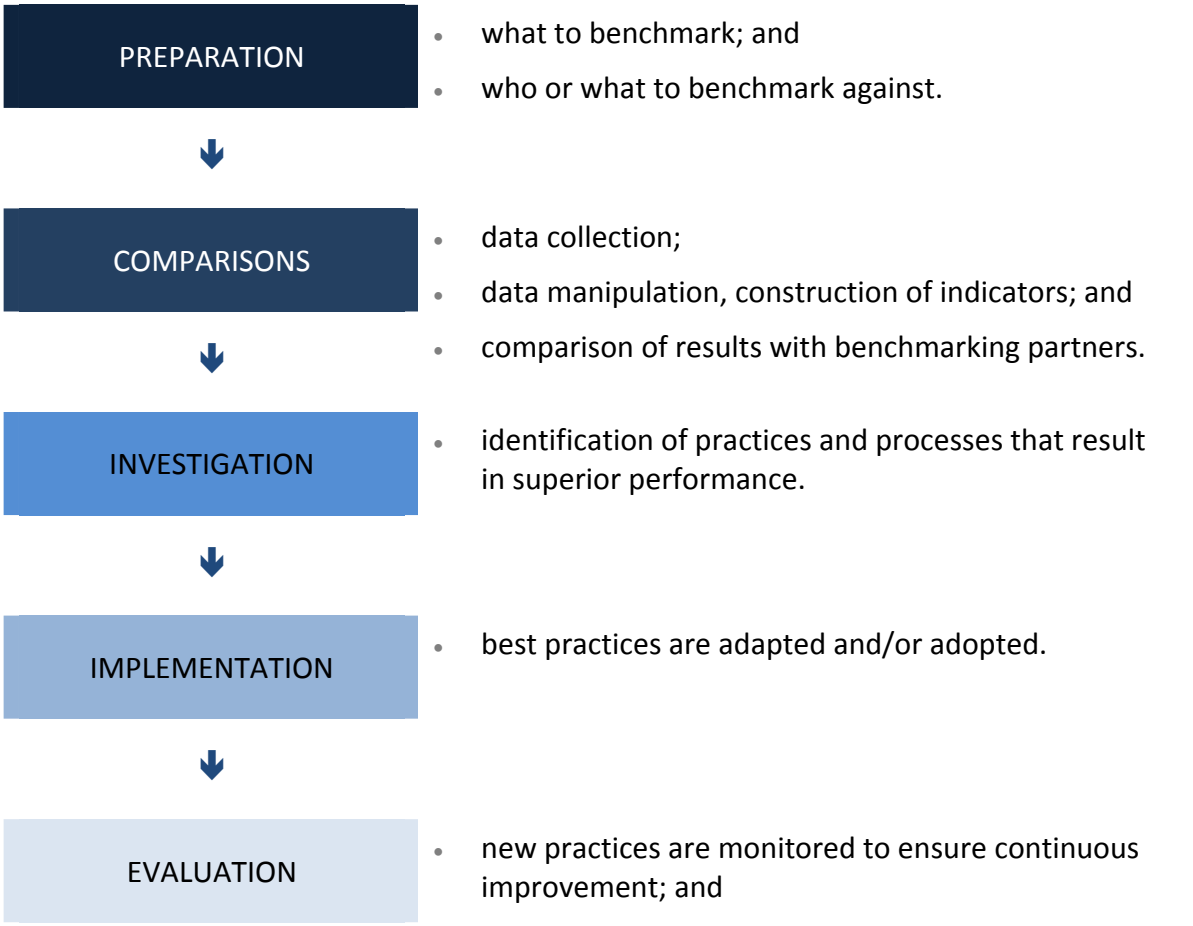
- data is used routinely to contribute to improved clinical practice, service management and policy development; and
- benchmarking is established as the norm with all services having access to regular reports on their performance relative to similar services that can be used in a quality improvement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

Benchmarking defined

A number of definitions of benchmarking have been put forward in the literature. The National Mental Health Plan 2003-2008 adopted the approach taken by Bullivant (1994) who defined benchmarking as "…concerned with the systematic process of searching for and implementing a standard of best practice within an individual service or similar groups of services. Benchmarking activities focus on service excellence, customer/client needs, and concerns about changing organisational culture."

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

Benchmarking generally comprises five basic phases:



Source: National Health Ministers Benchmarking Working Group (1996)

PART 2. NATIONAL MENTAL HEALTH BENCHMARKING PROJECT

The *National Mental Health Benchmarking Project* (the National Project) established demonstration benchmarking forums within the four main program areas of public sector mental health services (general adult, child and adolescent, older persons and forensic). Four core objectives guided the development and implementation of the National Project:

1. To promote the sharing of information between organisations to increase understanding and acceptance of benchmarking as a key process to improve service quality.

2. To identify of the benefits, barriers and issues arising for organisations in the mental health field engaging in benchmarking activities.

3. To understand what is required to promote such practices on a wider scale.

4. To evaluate the suitability of the National Mental Health Performance Framework (domains, sub domains and key performance indicators) as a basis for benchmarking and identifying areas for future improvement of the framework and its implementation.

First conceptualised during the Second National Mental Health Plan, the National Project formally commenced in May 2006 and ceased in November 2008. During this period a range of activities occurred, including the:

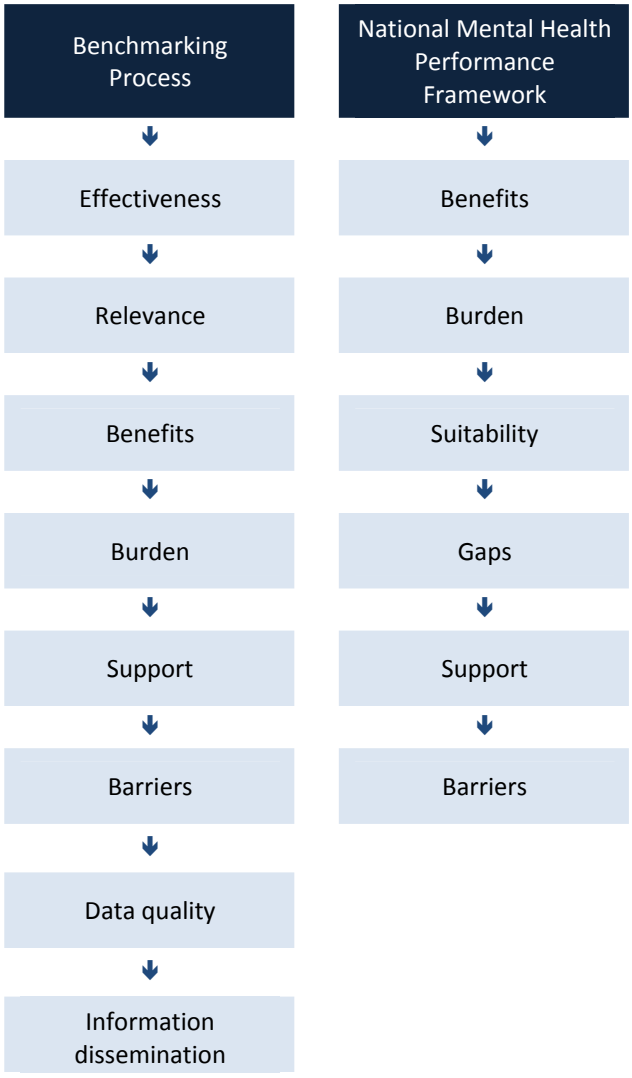
- development and dissemination of a range of resources including the Project Manual, technical specifications (for the national indicators and indicators developed or utilised through-out the project), data-entry workbooks, research reports, and presentations;
- construction, analysis and reporting of indicators, including the 13 phase one national indicators, the 50 plus supplementary indicators included in the initial comparative indicator documents and the varied additional indicators developed throughout the project;
- initiation of special projects developed within each of the forums, such as the good practice guide developed by the adult forum in relation to readmission rates, the staff activity survey and community discharges projects in the child and adolescent forum, the seclusion project in forensic and length of stay activity in the older persons forum;
- provision of support to all participants during and between forums for a range of issues including indicator construction and interpretation and promoting support within organisations;
- dissemination and discussion of outputs within participating organisations to facilitate the sharing of information and gaining of knowledge; and
- convening of two technical specifications workshops held in May and June 2006, two National Mental Health Benchmarking Meetings held in May 2006 and November 2008, and thirty-two benchmarking forums (eight for each program) conducted between August 2006 and July 2008.

PART 3. EVALUATION FRAMEWORK

The evaluation of the National Mental Health Benchmarking Project aims to assess the extent to which the Project met its four core objectives, which can be categorised as relating directly to either:

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

Figure 2: Evaluation Framework



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

The evaluation focuses on issues, learnings and advice from the **mental health service organisation perspective**. It was envisaged outputs and learnings from the evaluation would be considered in conjunction with information gathered from other stakeholders and sources, such as state health authorities, to provide guidance to the Steering Committee and other relevant authorities on future benchmarking activity and indicator development for the mental health sector.

3.1 Methodology

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

Table 1: Evaluation components

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

3.2 Governance

The National Mental Health Performance Subcommittee (NMHPSC) was established to advise on the ongoing development of a national mental health performance framework, to support benchmarking in mental health services and to provide national information on mental health system performance. The NMHPSC acted as the Steering Committee for the National Mental Health Benchmarking Project, including the evaluation component.

3.3 The participants

Services were invited to apply by state and territory central health authorities and the final participants selected by the Steering Committee. The services selected to participate (Appendix 8.2) included a range of metropolitan and regional services of differing size and managing multiple and single service settings. Unfortunately, no organisations from the Northern Territory or Tasmania were able to participate in the National Project.

Approximately ten per cent of mental health service organisations in Australia had at least **one service component** participating in the Project. The defining characteristic for inclusion in each forum was the *target population* served, rather than a requirement for identical service models or consumer casemix. It is important to note that the participants in the Older Persons Mental Health Benchmarking Forum provided specialist older persons services, rather than general mental health services which also provide care to the older population (that is, persons aged 65 years and over).

A bias in the selection of participants, who were generally nominated by jurisdictions as being high performing services, may impact on the results of the indicators, discussion and recommendations made through the evaluation.

3.4 The organisation group

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

The AMHOCN purchased additional expertise to enhance its facilitation and analysis capacity. Furthermore, participating organisations took lead agency in relation to some of the special projects developed during the forums, although AMHOCN continued to play a pivotal role in the coordination of participants.

PART 4. EVALUATION OF THE BENCHMARKING PROCESS

4.1 Expectations of the National Project

The expectations of participants regarding the purpose and perceived benefits of the National Project were generally consistent, although some variation existed. Expectations were primarily related to:

- commencing a conversation around measuring performance, learn from similar services, and develop a national frame of reference about service performance;
- identifying collaborative and individual quality improvement activities that would benefit and improve service and clinical practice;
- learning about benchmarking, constructing and selecting performance indicators; and
- contributing to the national discussion around performance and the development of indicators relevant to program area.

These expectations were generally met, particularly in relation to commencing a conversation and learning about benchmarking. However, services identified that their capacity to identify and implement quality improvement activities was impacted on by the time required to understand the indicators. For some forums this resulted in less time devoted to understanding clinical practices and identifying quality improvement activities than originally anticipated. Perceived and actual differences in service models also limited the capacity for some forums to engage in collaborative quality improvement activity. Services identified that they had less influence than they had initially anticipated, particularly in relation to selection of indicators specific to program area.

Additionally, a number of services had limited or low expectations at the commencement of the Project as they were unclear of the intended process and purpose. These services suggested that the distributed documentation and preliminary national meetings could have been clearer in regards to what the process was and what was expected of participants.

Most services also identified that their expectations generally changed throughout the course of the National Project as the process moved from focusing on technical aspects of indicator construction and interpretation to comparing service performance and identifying quality improvement activities. These services identified that their expectations became more realistic in regards to what could be achieved within time frames of the Project, but also provided clarity on the potential utility of benchmarking activity in the future.

Services also identified that although some expectations of benchmarking activity is tied to the identified purpose (such as timelines and direction of change) there was a common theme around learning and collaboration which should be central to any benchmarking process.

4.2 Participating in the National Mental Health Benchmarking Project

4.2.1 Benefits of participation

A number of benefits of participating in benchmarking, consistent with existing literature, were identified by participants. These included the:

- ability to *nationally compare service performance and practices*. This provided services with a greater understanding of their own performance than what could have been gained from internal assessment alone. Additionally, it enabled the identification of similarities and differences between services. For some forums, there were more similarities than initially anticipated, which facilitated identification of collaborative activity. Discussion related to differences also generated a range of investigations and quality improvement activity.
- development of *expertise in the techniques, tools and utility of benchmarking indicators*.
- development and sustainability of *quality leadership* within an organisation as the skills required to effectively participate are the same as those needed to provide leadership to a team or in the management of services.
- identification of *new peers* and development of key *relationships* that will form the basis of *collaboration* for future research and quality improvement activities.

4.2.2 Supporting factors

It was identified that the methodology and structure of the National Project supported service participation through the:

- allocation of *funding* to enable services to dedicate resources for coordination and participation. Services utilised the funding in a variety of ways, although the majority of funding was used to employ project officers, back-fill existing staff and attend the forums. Some services invested in the development of additional resources to support information dissemination and engagement within their services.
- development and provision of detailed *technical specifications*, *data entry workbooks* and convening *workshops* and *web discussions* to build knowledge and understanding about the construction of the indicators. This worked to minimise, but not eliminate, confusion and alternate interpretation of terminology and specifications. Although, the indicators were pre-determined and specified, the capacity to advise and modify specifications (for example, population receiving care) to better reflect service structure encouraged services and facilitated engagement within the process.
- provision of a *safe environment* for sharing information through the endorsement of a clear Code of Conduct (Figure 3). This alleviated some of the apprehension due to issues of privacy and misuse of information. Services also identified that the respect shown by other participants, the facilitator and organisers throughout the National Project contributed to and enhanced the environment and enabled robust discussion.
- *planning and direction provided by the coordinating group*. In the first year of the project additional resources were available to support the project coordination and this

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

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

- the level of support from and involvement of *senior management*. Services who received the support of senior management generally identified that participating in the forums was simpler and that they had more success in initiating quality improvement activities.

Figure 3: Code of Conduct

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

Principle of exchange

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

Principle of confidentiality

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

Principle of use

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

Principle of preparation

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

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

4.2.3 Barriers and challenges

Through the Project a number of barriers and challenges to participation were identified. The key barriers to the benchmarking process were entrenched in issues related to data quality, comparability of service models, service capacity and literacy, leadership, and resources.

Data quality

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

1. **Community activity data:** Issues of the *accuracy and representativeness* were identified in relation to the community activity data, primarily due to: (i) variation in the *completeness* of the data set due to differing compliance with data entry; and (ii) the *comparability* of reported data due to variable protocols, processes and definitions (e.g. when to commence a service episode).
2. **Costing data:** There were highly variable costing practices, both between and within jurisdictions, which limited both the accuracy of the output and the capacity to compare performance on measures which utilised expenditure data. All participants highlighted the need for a national process to address issues related to costing methodology, but acknowledged the issue was broader than the mental health sector.

The capacity of services to *access accurate data* within jurisdictional information systems in a timely manner was varied and presented a range of challenges to participants. Whilst some services were relatively self-sufficient, others were wholly dependent upon the central health authority to provide and interrogate the data. This dependence added a layer of complexity as services were required to explain specifications to an external body, which reduced confidence and ownership of the indicators and limited their ability to identify data quality issues.

A number of services identified significant data quality issues and implemented a number of strategies to address them, including the development of standardised processes for recording, cleansing and auditing data. Other services identified improvements in quality through utilisation of data rather than specific intervention.

Comparability and representativeness of participating services

The services selected to participate in the National Project included a range of metropolitan and regional services of differing size and multiple and single service settings. Subsequently there was variation in the service models and structure. These differences influenced the output and the comparability of indicators and limited the capacity for some forums to engage in collaborative quality improvement activity.

However, most services saw value in investigating the source of variation or performance issues related to most indicators. This investigation process generally commenced with identifying data quality issues before looking at available resources, service models and

casemix profiles. If these factors were not the sole source of variation, then clinical practices and processes were examined.

The discussion within forums clearly highlighted that models of service are **critical** to interpreting indicators and perceived variation in performance. Additionally, it was noted that the learnings and advice provided though the National Project was limited by the service models implemented by participating services. For example, participants in the Older Persons Forum all provided specialist older persons services. Discussion within the forum highlighted that the identified issues, benefits and learnings identified for these services may not necessarily be applicable to general mental health services which also provide care to the older population (that is, persons aged 65 years and over). Further discussion and involvement of the broader sector is required to determine the applicability of learnings and recommendations to different service models.

Participant literacy and capacity

At the commencement of the Project there was considerable variability in the capacity of services to consistently translate national definitions and specifications. The required expertise is not the traditional domain of mental health services and a number of services struggled to access the right skill-set.

Sufficient understanding of the technical specifications, construction and applicability of the indicators is essential to enable appropriate interpretation and utilisation of the data. The persons attending the forums did not always have an understanding of the technical aspects of indicator construction which impacted on the pace and momentum of discussions during forums. The variable levels of indicator literacy presented a range of challenges to the Project. Technical documentation, workshops and discussion on how data could contribute to improved clinical practice and service management were the main strategies utilised to build literacy within the forums. Despite the documentation, training and discussions not every indicator had been constructed in the same way. The differences came to light only when indicators were being compared within the forum environment. Services identified there had been an underestimation of the education and skill development required to participate in the benchmarking process.

Leadership

Services highlighted the need for engaging the broader management, clinical leadership and workforce in the project. The general view was that without engaging these stakeholders the benchmarking process would be seen as a special or time-limited project with little relevance to service delivery. It was identified that leadership was required both within the formal forums as well as within each participating organisation. However, engagement is complicated and takes significant time and resources.

Services employed a range of strategies to meaningfully convey information to persons not attending the forums. These included presentations at meetings, newsletters, posters, and workshops. A key factor to successful engagement within services was the ability to simply explain the indicators and the impact the process could and was having on the service.

Active participation and ownership of the process by participants was a significant challenge to the success of the Project. The level of participation was directly impacted on by the level of support by senior management and the capacity of staff to understand the technical and clinical aspects of the process. The forums which continued to focus on the complexity associated with the differences between the services showed the least engagement with the process.

Although the level of engagement and ownership in the process slowly increased, variability still existed between forums at the cessation of the Project. Through the final evaluation survey a number of services suggested that the Project would have benefited from greater capacity to assist services who struggled (e.g. through lack of management support) or the authority, perhaps through the Code of Conduct, to remove or replace a non-involved with a more willing organisation (a reserve organisation). The development of guidelines outlining processes and potential impact of these options would have been beneficial at the commencement of the Project.

Resources

Benchmarking is a resource intensive process. Although the provision of additional resources facilitated participation there was significant unfunded resources required to effectively participate. This placed additional load on existing resources which impacted on the efficiency and effectiveness of participation, for example, the involvement of senior management was critical but limited by the busy schedules of these staff.

4.2.4 Making it relevant

The different forums of the Project concentrated on different indicators and domains of the performance framework. However, all forums discussed the relevance of benchmarking at various levels of the services and its potential impact on delivery of services. It was recognised that the process for making data and indicators relevant to service and clinical practice was complex. A significant amount of energy was invested in finding relevance in the indicators for all forums. This may have been at the expense of other information or indicators that may have been more useful, particularly for sub-specialist services like the forensic. However, the robust discussions enabled the forums to provide informed advice about the suitability of the individual indicators to their program areas.

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

4.2.5 Developing an understanding of data and performance indicators

As previously identified the understanding of data and performance indicators and their application to practice was critical to the success of the Project. As evidenced by the initial

applications not all organisations have the same level of expertise or understanding around data and performance indicators.

Participants in the benchmarking project required time and the opportunity to develop an understanding of data and performance indicators at two broad levels:

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

4.2.6 Coordination and facilitation

A significant amount of support is required to support benchmarking activities, both during the benchmarking discussions, and the data collation and preparation phase. The Australian Mental Health Outcomes and Classification Network (AMHOCN) undertook two important roles during the project. Firstly, a facilitation role to keep discussions focused and moving towards a consensus or shared way forward. The second was a coordination role in support participating organisations to deliver on the agreed activities, through collation and analysis of data, reminders, teleconferences, data entry mechanisms (spreadsheet and database) and so on.

For some aspects of the project, participating organisations took lead agency in relation to special projects developed during the forums, although AMHOCN continued to play a pivotal role in the coordination of participants.

Overall services were positive about the professional contribution of the facilitation and coordination group, which was seen as essential to making progress both within and between forums. The use of an informed facilitator who was able to both guide discussion and take advice from participants, challenge participants and draw wisdom and direction from the robust discussion was seen as integral to the success of the Project.

4.3 Information dissemination

The sharing of information is essential to successful benchmarking and although participants were happy to share information within forums, there was some hesitancy to disseminate outside of the formal benchmarking forums. The main concern was that the highly contextual nature of the material could lead to inaccurate interpretation, inappropriate action and setting of unrealistic benchmarks (particular in relation to cost indicators). The key risk identified regarding the dissemination of information without context was the creation of a punitive rather than collaborative benchmarking environment.

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

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

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

4.4 The impact of benchmarking

At the mental health service organisation level the impact on a range of business and clinical processes have been identified, including:

- the identification of *data quality* issues and implementation of a range of strategies to improve quality, such as standardised business process and clearer definitions related to data entry.
- utilisation of indicators to *guide and evaluate service improvement activities*, such as change in discharge planning communication led by poor rates of post-discharge community contact, development of guidelines to more effectively balance the safety and efficiency aspects of bed occupancy and processes to better engage consumers and minimise the number of 'do not attend' service contacts.
- an improved *understanding of local business practices* as well as the ability to more effectively link data to practice, enabled services to develop and use indicators for specific, such as evaluation of quality improvement activities regarding referral from emergency department to community mental health services.
- improving the capacity of the service organisation to be *accountable and transparent* in its activities, both internally to its staff as well as consumers, carers and other stakeholders. For example, based on the indicators within the *continuous* domain a service identified a gap within its delivery of services. The service implemented strategies and utilised the information to justify its investment, track progress, and to engage stakeholders who were initially resistant to the change.
- a shift in *organisational culture* where there is less resistance to looking at and using information and indicators to identify and monitor service performance.
- the development of a *knowledge-base and experience* that services are able to access, which provides services with a greater capacity to influence and advocate within the broader organisational and political environment.

The global impact of benchmarking is difficult to measure, with services identifying that success was most often seen through discrete, targeted activity rather than significant change or restructure. The complexity of the mental health system and the time-frames associated with the Project limited the ability to identify the impact on individual consumers.

As previously identified, the expectations of what can be achieved through benchmarking vary depending upon the purpose of the activity. However, a key learning for services regarding the potential impact of benchmarking related to acknowledging the difference between the time required to understand and evaluate their service verus the time required to change the service. The ability to understand the service is a pre-requisite to enabling change within the service and subsequently influences the impact of benchmarking activity, particularly within short time-frames.

4.5 Sustainability

The National Mental Health Benchmarking Project was resource-intensive and expensive and although much has been learnt about benchmarking mental health services it is not a model that can be sustainably replicated. Services and the organising group identified the following key factors that should contribute to sustainable benchmarking within the sector:

The right resources. A commitment of extra or dedicated resources is an advantage as this is not an activity that can be 'added-on' to an already overburdened workload. Dedicated involvement and commitment from a range of stakeholders is required for the service to gain the most benefit from the process. The level of resources determines the feasibility and level of participation within any benchmarking process.

Participation in benchmarking requires the development or utilisation of significant organisational capacity, including an understanding of clinical, structural and financial aspects of the service; understanding data and indicators; effective liaison with information personnel; and time to effectively participate and consider the results of the constructed indicators and how they may be explained in terms of local business processes.

- **Commitment**. To succeed organisations have to commit to supporting and participating in the benchmarking process. This includes a commitment to ensure that: staff involved in the project are supported by all levels of the organisation; sufficient investment is made to build the capacity of the organisation and its staff to utilise and apply data, performance indicators and learnings for service improvement activity.
- **Leadership**. Benchmarking is a confronting experience for many participants and without sufficient or strong leadership the benefits will be limited and the exercise has the potential to be passive and uninformative. Changes of leadership during the course of the Project for some services had a significant impact on their capacity and willingness to collaborate and participate.
- **Integrity, transparency and accountability**. These three principles are fundamental to benchmarking as they (i) enable a safe environment to be established to facilitate robust discussion; (ii) ensure participants are clear on purpose and direction; (iii) facilitate engagement with staff as they are able to see that promises are kept and action is taken; and (iv) facilitate ownership of the process. The process needs to commence within a safe environment, such as that established through adherence to a ratified code of conduct, however successful benchmarking will move to broader dissemination of contextualised information in line with the principles of transparency and accountability.
- **Make it normal**. Benchmarking is traditionally seen as outside the norm and, as identified by one participating organisation, the technical skills have not historically been

developed within the mental health sector. However, to be sustainable the process needs to be integrated into normal service structures rather than being seen as a special initiative. The capacity to achieve normalcy is linked to available resources, the level of commitment and the strength of leadership.

- **Differences and similarities**. Mental health service organisations are generally complex organisations with many differences in models of service, casemix profiles, legislative frameworks and so on. However, if stringent criteria were applied the pool of peer organisations would be extremely small, therefore the peer groups need to be similar enough to make benchmarking a useful quality improvement activity. It is important for services to learn from both the similarities and differences between organisations.
- **Facilitation, coordination and support**. Any benchmarking process needs to be coordinated and facilitated. There is no single model for benchmarking and the level of facilitation and coordination will vary according to that utilised. There is a growing expertise within Australian government and private organisations to provide this coordination and facilitation role. Current options include: the provision (such as InforMH in New South Wales) or funding (such as the Mental Health Clinical Collaborative in Queensland) of activity by central health authorities; the purchase of expertise from the general health sector, such as the Health Round Table; and the AMHOCN, which continues to coordinate and facilitate benchmarking activities for the forensic sector.

Services identified that participation in the Project allowed for significant learning and growth within individual services. However it was acknowledged there is still much to be learnt about the indicators and benchmarking mental health services that can only be enhanced through participation by a greater proportion of the sector.

PART 5. EVALUATION OF THE NATIONAL MENTAL HEALTH PERFORMANCE FRAMEWORK

The following section outlines advice in relation to the benefits and suitability of the *National Mental Health Performance Framework* as a basis for benchmarking from the mental health service organisation perspective. This advice should be considered in the context of the issues identified in Section 4.2.3 which are critical to interpretation of performance and setting of targets, including the variable data quality (particularly *community activity* and *expenditure* data) and the differing service models of participating organisations. Informed discussion by stakeholders, including both service providers and funders, is required to consider the implications of this advice and resolve identified issues, such as interpretation of the variable advice provided by participating services and implications of differences between service-level and jurisdiction-wide targets.

5.1 Benefits of using the National Framework

Services clearly identified that the key benefit to utilising the national framework was the common starting point it provided by limiting the debate about what data to collect and enabling the benchmarking process to begin. Although not all indicators were relevant to all programs, the framework opened a dialog and enabled informed discussion. Additional benefits included:

- exposure to an overall framework which encouraged consideration of different domains of performance;
- the existence of technical specifications and the use of existing collections with relatively consistent data definitions, albeit the accuracy and comparability of data was limited for some collections, especially expenditure data.

5.2 Limitations of using the National Framework

The major limitation to the framework that services identified was the high-level and generic nature of the national indicator set which did not adequately capture the complexity of individual services. Additional limitations included the:

- *focus on inpatient and adult models of service*, which limited the application of the all indicators to all forums. However, there were relevant indicators within the framework which guided forum discussion and identification of quality improvement activities.
- *breadth and complexity of the complete comparative indicator* set required considerable energy to interpret took away from the consideration or development of alternate indicators that may be more suitable to the different program areas.
- *quality of and access to data* required for the construction of the indicators. Although the data should have been readily available, it became evident throughout the Project that the access to quality and comparable data was significantly varied between participating organisations.

5.3 Suitability of the national framework and indicator set

There was general agreement by participants that the overall National Mental Health Performance Framework was suitable as a basis for benchmarking, primarily as it encouraged consideration of different domains of performance and facilitated identification of related issues.

A substantial amount of time was invested in a formal review (Table 2) of each of the 13 national indicators to determine their suitability, from the mental health service organisation perspective, for benchmarking activity. The learnings, issues and recommendations from participating organisations on the national indicators, including identification of required contextual information, are summarised in Appendix 8.3.

This process led to identification of potentially appropriate *service-level targets* for some of the indicators. Target identification was based upon the considered debate and judgement of the forums that (i) the indicator was relevant and in the control of services, and (ii) the indicator was understood enough to identify issues related to good practice. The inclusion of these targets in this document should not be considered as their endorsement for national implementation.

Table 3 provides a high-level overview of recommendations and areas of concern (such as relevance of concept, appropriateness of specifications and data quality) from the perspective of each forum.

Table 2: Indicator Review Criteria

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

Table 3: Overview of Forum Review of Key Performance Indicators

Indicator		Adult	Older Persons	Child and Adolescent	Forensic
28 day readmission rate	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target	**GPT**: ≤ 10.0% **AT**: ≥ 20.0%	**GPT**: ≤ 7.0% **AT**: ≥ 10.0%		
National Service Standards Compliance	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target			**GPT**: 100% Level 1	
Average length of acute inpatient stay	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target	**GPT**: ≤ 12 days	**AT**: ≤ 35 days **AT**: ≥ 50 days	**AT**: ≥ 15 days	
Average cost per acute inpatient episode	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target				
Average treatment days per 3-month community care period	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target	**AT**: ≤ 6 days **AT**: ≥ 18 days	**AT**: ≤ 8 days	**AT**: ≤ 3 days	
Average cost per 3-month community care period	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target				

Indicator		Adult	Older Persons	Child and Adolescent	Forensic
Population receiving care: *Ambulatory*	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target	**GPT**: ≥ 2.0%		**GPT**: ≥1.9% - 2.4%	
Population receiving care: *Acute Inpatient*	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target				
Population receiving care: *Residential*	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target				
Local access to acute inpatient care	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target				
New client index	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target		**AT**: ≤ 50.0% **AT**: ≥ 80.0%	**AT**: ≤ 50.0%	
Comparative area resources: *Ambulatory*	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target				

Indicator		Adult	Older Persons	Child and Adolescent	Forensic
Comparative area resources: *Acute Inpatient*	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target				
Comparative area resources: *Residential*	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target				
Pre-admission community contact	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target	**GPT**: ≥ 75.0% **AT**: ≤ 50.0%	**GPT**: ≥ 80.0%	**AT**: ≤ 70.0%	**GPT**: 100.0%
Post-discharge community contact	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target	**GPT**: ≥ 75.0% **AT**: ≤ 50.0%	**GPT**: ≥ 80.0%	**AT**: ≤ 70.0%	**GPT**: 100.0%
Outcomes readiness	**Concept** is relevant				
	Specification is **appropriate**				
	Sufficient **data quality** (numerator)				
	Sufficient **data quality** (denominator)				
	Forum identified target	**GPT**: ≥ 75.0% **AT**: ≤ 50.0%	**GPT**: ≥ 80.0%	**AT**: ≤ 70.0%	**GPT**: 100.0%

NOTES

(i) Targets are the views of participating services from a local perspective.

(ii) Identification of targets should not be considered as their endorsement for national implementation.

(iii) Further work is required to resolve issues at jurisdictional and national levels.

LEGEND

No or few issues with proposition

Minor, but fixable issues, with proposition

Substantial issues and disagreement with proposition

Good Practice Target **GPT** *Alert Target* **AT**

5.3.1 Gaps in the national indicator set

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

- The *lack of measures of consumer outcome*. Services identified that the different perspectives on, and dimensions of, mental health consumer outcomes (e.g., clinical outcomes as measured by clinicians, self-assessed clinical outcomes, social outcomes – housing tenure, employment etc) need to be included in a comprehensive performance measurement framework.
- Despite the majority of service activity occurring in non-admitted services, there *is limited focus on community based indicators*.
- Although through the course of the Project most participants were able to identify at least a sub-set of the indicators relevant to their program area, alternates are necessary to more appropriately represent the varying service models, clinical practices and structural issues associated with the different program areas (for example, measure of throughput or length of stay in extended treatment settings).

5.4 Review of supplementary indicators

In addition to the 13 national indicators, the forums were exposed to a range of additional indicators, either as supplements to the national indicators or additional indicators developed through the forums. Each forum reviewed the supplementary performance and contextual indicators. The review was loosely based on the criteria outlined in Table 2 however given the number of indicators the review was not as comprehensive. Further detail regarding issues and recommendations from participating organisations on the supplementary indicators are summarised in Appendix 8.5.

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

Table 4: Key recommendations of the review of supplementary indicators

Domain(s)	Indicator title	Rationale	Appropriate for:
Efficient	**Community ambulatory mental health services direct care FTE per 100,000 population**	• FTE information is more comparable than financial data as it is less susceptible to different accounting practices and overcomes many of the issues that arise with comparisons of the financials.	• Older Persons • Adult
	Acute beds per 100,000 population	• Bed information is more comparable than financial data as it is less susceptible to different accounting practices. Additionally, the concept of beds has more operational meaning and provides a better basis for jurisdictional comparisons.	• Older Persons • Forensic • Adult

Domain(s)	Indicator title	Rationale	Appropriate for:
Efficient	**Community residential beds per 100,000 population**	• Community residential services often have broad catchments and a mental health service organisation may not be responsible for its functioning but is considered part of its catchment.	• Older Persons
	Proportion of expenditure on salaries and wages	• The proportion of expenditure of salaries and wages provides information on how services are expending their funds. This allows some comparison and understanding of resource availability and allocation.	• Adult • Child & Adolescent
	Average cost per acute inpatient bed day	• This indicator limits the influence of length of stay, has more operational meaning and provides a better basis for jurisdictional comparisons. There was variable advice from the forums as to whether this indicator should replace or be used to complement the indicator average cost per acute inpatient episode.	• Older Persons • Adult • Child & Adolescent
	Average cost per community treatment day	• This indicator limits the influence of number of episodes, has more operational meaning and provides a better basis for jurisdictional comparisons. This information can also be used to identify issues around underreporting of ambulatory collections. • There was variable advice from the forums as to whether this indicator should replace or be used to complement the indicator average cost per 3-month community care period.	• Older Persons • Adult • Child & Adolescent
Safe Efficient	**Bed occupancy**	• Bed occupancy is important in understanding a range of indicators and can have significant impact on a services performance on those indicators, such as readmission rates. • Although there was some divergent views the Adult Forum generally considered that action could be taken to influence performance on bed occupancy, although resource availability was a significant influence.	• Adult • Child & Adolescent • Forensic (context)
Responsive	**Consumer outcomes participation**	• The number of National Outcomes and Casemix Collection (NOCC) ambulatory care setting collection occasions with a valid consumer self-assessment outcome measure during the reference period the number of NOCC ambulatory care setting collection occasions during the reference period.	• Adult
	Average days from referral to assessment	• Wait time is an important measure and can be expressed as referral to assessment or referral to treatment. • This indicator is about the responsiveness of the service to be able to see a client.	• Child & Adolescent
	Average days assessment to discharge	• The length of time a consumer accesses a mental health service is important measure of the capacity and responsiveness of services to meet the needs of consumers.	• Child & Adolescent

PART 6. CONCLUSIONS

The National Mental Health Benchmarking Project was a significant investment which met its four core objectives to varying extents. Overall, the participating organisations were very positive about the experience and eager to contribute to the national discourse about the future of benchmarking.

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

Participants were generally engaged with the process and despite initial reservations there was increased understanding and acceptance of benchmarking as a key process to improve service quality. This acceptance developed in a safe environment, where robust discussion enabled participants to challenge and be challenged in regards to the outputs, models and strategies. Additionally, the opportunity for collaboration with and advice from peers has proven to facilitate acceptance of the process

To identify of the benefits, barriers and issues arising for organisations in the mental health field engaging in benchmarking activities.

A number of benefits and challenges were identified that will support development and utilisation of a variety of models. The major benefits and challenges that were identified included:

Benefits

- the establishment of a national frame of reference;
- a greater understanding of models of service, local processes and their impact on overall performance;
- the development of expertise in the techniques, tools and utility of benchmarking and indicators; and
- collaboration with peers.

Challenges

- data (both access and quality, particularly in relation to costing and community mental health);
- overcoming limitations due to differences in models of service, such as ability to appropriately compare performance and applicability of learnings to broader sector;
- the intensity of resources required (particularly unfunded components such as involvement of senior management); and
- the varying capacity, commitment and engagement of participating services.

To understand what is required to promote such practices on a wider scale.

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

- Commitment and identification of appropriate *organisational and facilitation resources*;
- Commitment and *active participation* by participants;
- *Leadership*, both within any collaborative activity (such as quality improvement projects or meetings) and within the organisations themselves. Without sufficient or strong leadership the benefits will be limited and the exercise has the potential to be passive and uninformative.
- *Integrity, transparency and accountability* are required to (i) enable a safe environment to be established to facilitate robust discussion; (ii) ensure participants are clear on purpose and direction; (iii) facilitate engagement with staff as they are able to see that promises are kept and action is taken; and (iv) facilitate ownership of the process.
- *Incorporating and embedding* the activity as part of service practice (i.e 'make it normal).
- Appropriate identification of *peers* who are similar enough to make benchmarking a useful quality improvement activity, as service models are critical to the interpretation of performance information. It is important for services to learn from both the similarities and differences between organisations.
- *Facilitation, coordination and support*. Any benchmarking process needs to be coordinated and facilitated. There is no single model for benchmarking and the level of facilitation and coordination will vary according to that utilised.
- *Quality data* to support and guide the correction interpretation and utilisation of benchmarking information.

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

The National Project had limited success in promoting benchmarking outside of participating organisations, although through conference presentations and communication vehicles (such as the website) other stakeholders were aware of the Project. Promoting benchmarking on wider scale is complex, particularly as the capacity of services to participate is variable.

Dissemination of learnings from the Project are a key first step but responsibility for development of capacity to participate, support and perpetuate is primarily located at local, area and state levels. A direct output of the Project which will facilitate promotion of benchmarking activity is the potential for participants to publish papers about specific aspects of their forums (such as learnings and quality improvement results).

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

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

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

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

PART 7. RECOMMENDATIONS

7.1 Supporting benchmarking

The outcomes of the Project support benchmarking activity as a mechanism to promote quality improvement, accountability and transparency within the mental health sector. Although there are benefits to national benchmarking, the next stage of benchmarking should be led within jurisdictions where there is greater capacity to implement a sustainable process. Recommendations, based on the advice of participating services and the Steering Committee, identify *action* and the associated *roles and responsibilities* at two levels of the sector: (i) the mental health service organisation; and (ii) the health authority as policy developers and funder (including State, Territory and/or Australian Governments). These recommendations are made on the basis that the contribution from the different levels should complement and enhance not constrain or interfere with benchmarking activity.

7.1.1 Workforce development

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

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

7.1.2 Technological infrastructure

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

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

7.1.3 Leadership, culture and process management

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

	Roles, responsibilities and actions	
	Mental Health Service Organisation	**Health Authority**
Leadership and Culture Change	• Prioritisation and support for benchmarking activity within quality improvement cycle. • Clarification of clinical and corporate governance responsibilities and expectations regarding benchmarking processes and findings. • Allocation and investment of appropriate resources to support service-level understanding and utilisation of benchmarking information.	
	• Inspire aspirations for excellence and good practice, harness pride and healthy competitiveness within staff. • Integration and embedding of benchmarking activity into existing infrastructure, e.g. quality management frameworks and processes, and training initiatives and programs. • Development and support for appropriate literacy and education activity to ensure appropriate understanding and utilisation of performance information. • Utilising benchmarking findings to improve service infrastructure, delivery and outcomes. • Set realistic expectations and goals in the context of timelines and resources.	• Review of approach and identification of potential improvements in the ongoing implementation of benchmarking (e.g. setting process indicators for benchmarking activity). • Set realistic expectations and goals in the context of timelines and resources. • Supporting infrastructure changes in response to benchmarking findings, e.g. service redesign.
Collaboration	• Identification and selection of appropriate peer groups. • Identification and support for mechanisms to enable interactions between peers, including face-to-face, tele-conference, video conference, and web-based technologies. • Support and adherence for rules for collaboration, participation, information sharing and release.	• Creation and facilitation of opportunities for peer group formation. • Trial and develop alternate mechanisms for interaction, such as web-based forums. • Formulation of rules for collaboration, participation, information sharing and release, e.g. Code of Conduct.

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

7.2 Refinement of national Key Performance Indicators

Each forum devoted a significant amount of time and energy to discussing the suitability, relevance and utility of the national indicators at the mental health service organisation level. This advice should be utilised to contribute to the national debate, discussion and activity related to (i) the applicability of the current indicator set to different levels of the mental health sector, (ii) future research and indicator development, particularly in relation to identified gaps and supplementary indicators, and (iii) identification of any national and/or state targets.

PART 8. APPENDICES

8.1 References

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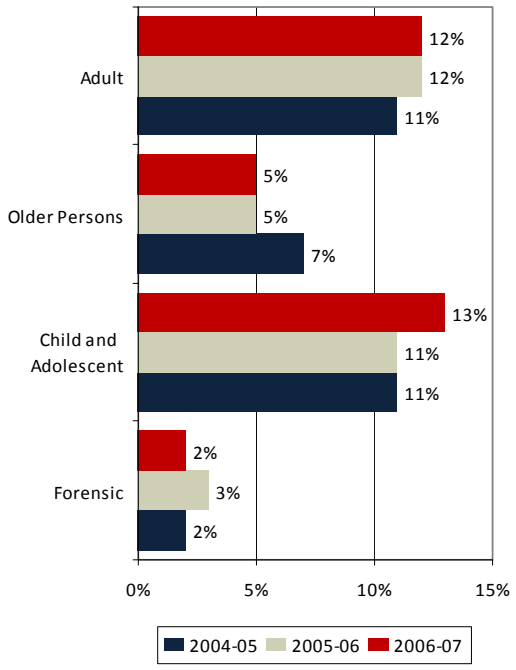
8.2 Participating Services

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

8.3 Key Performance Indicator Output

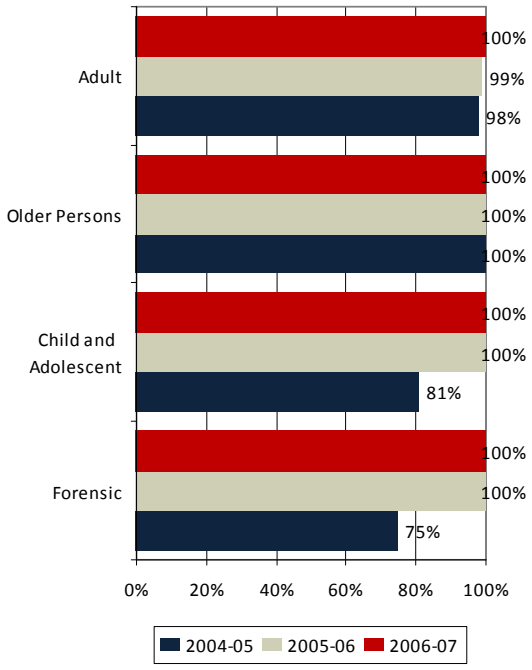
EFFECTIVE

28 day readmission rate



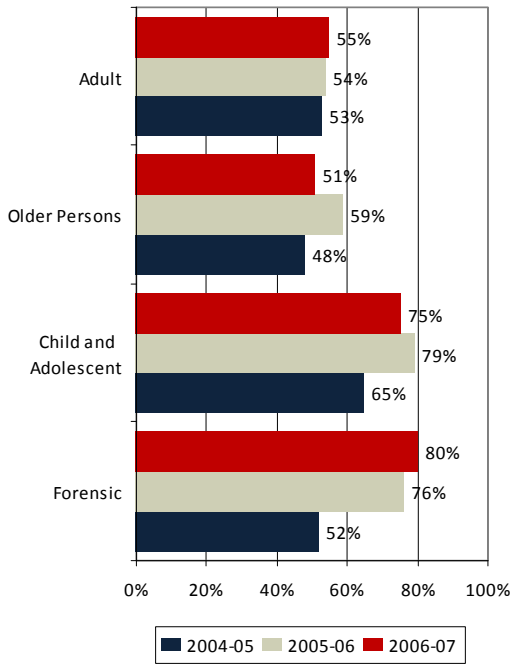
APPROPRIATE

National Service Standards compliance

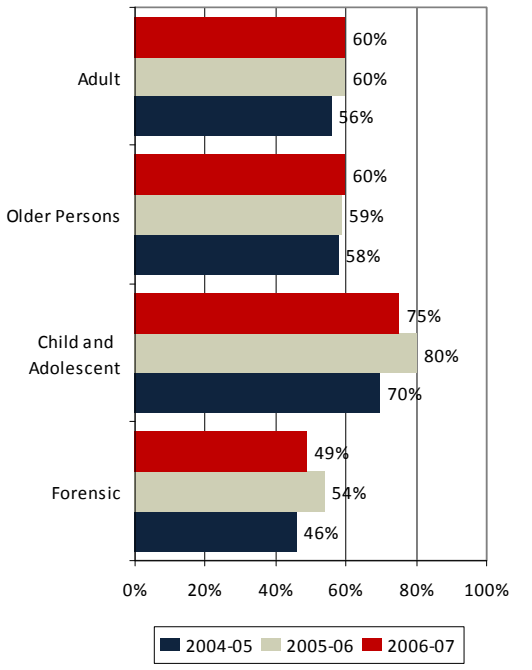


CONTINUOUS

Pre-admission community contact

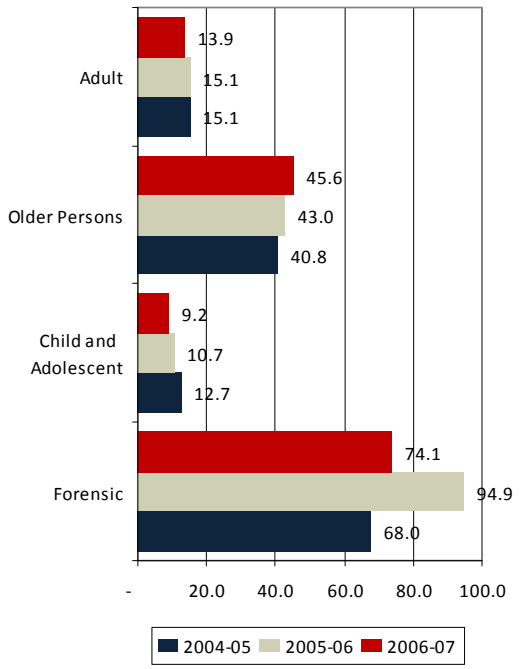


Post-discharge community contact

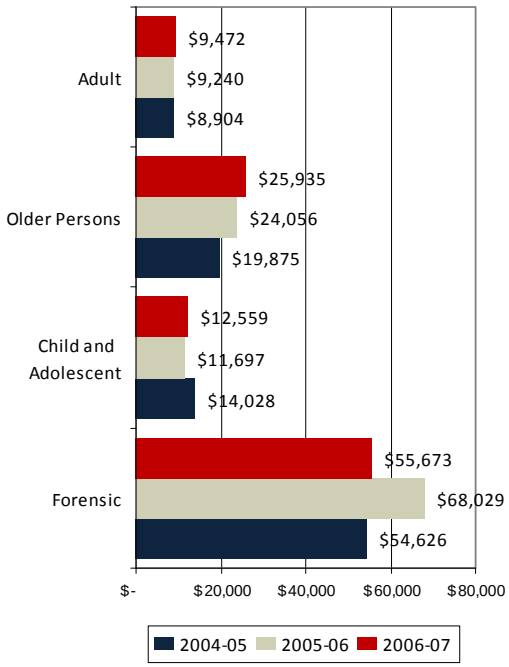


EFFICIENT

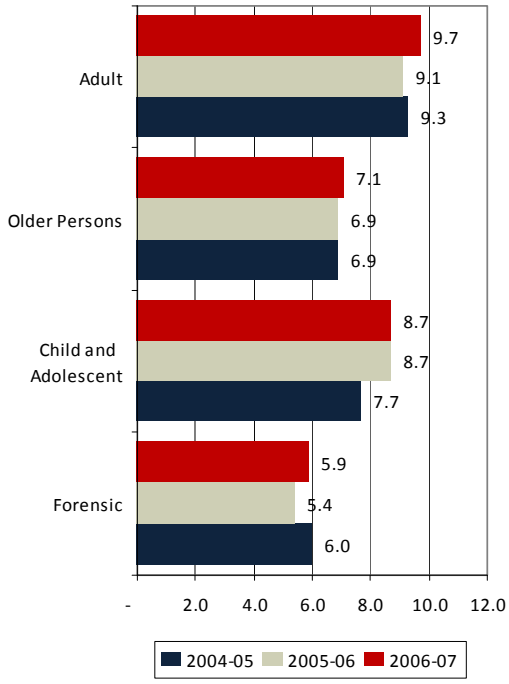
Average length of acute inpatient stay



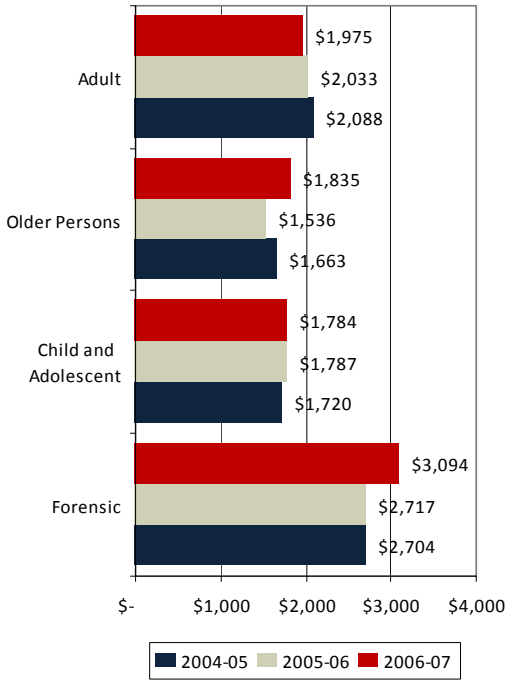
Average cost per acute inpatient episode



Average treatment days per 3-month community care period

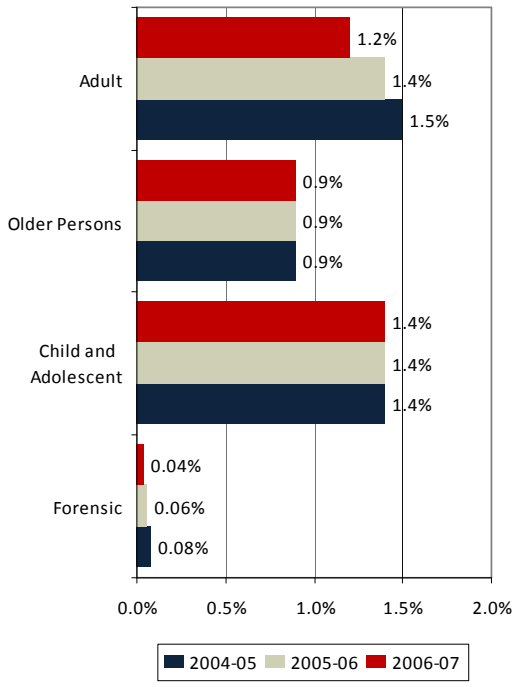


Average cost per 3-month community care period

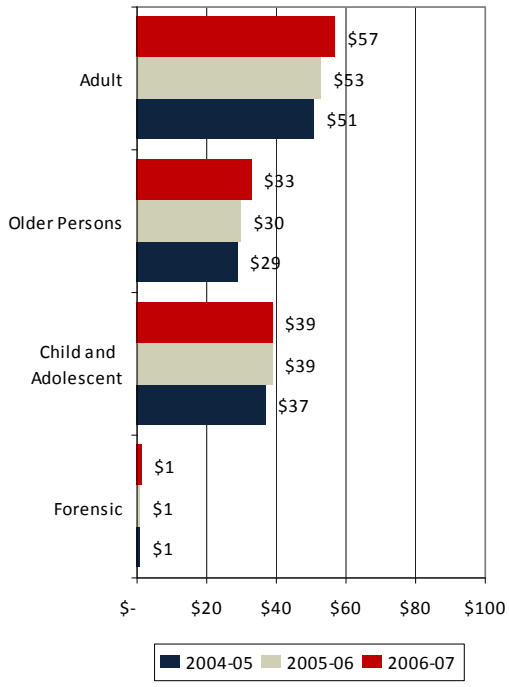


ACCESS

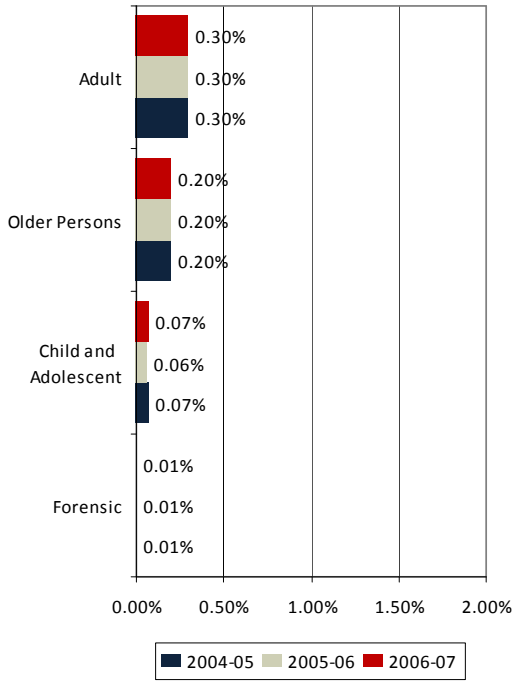
Population receiving care
Ambulatory



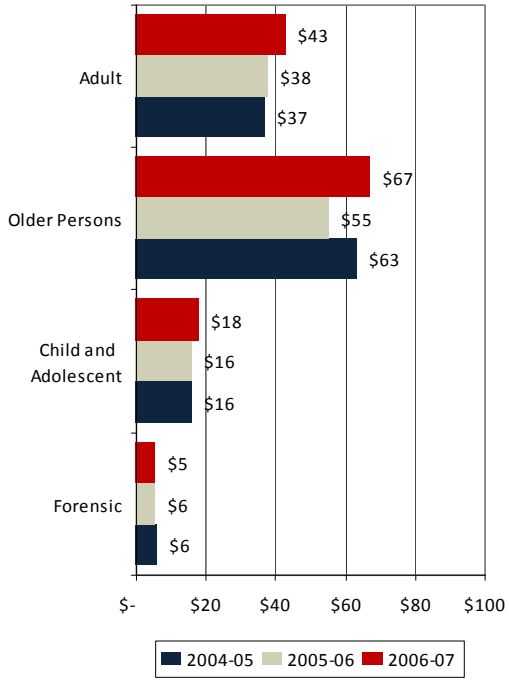
Comparative area resources
Ambulatory



Population receiving care
Inpatient

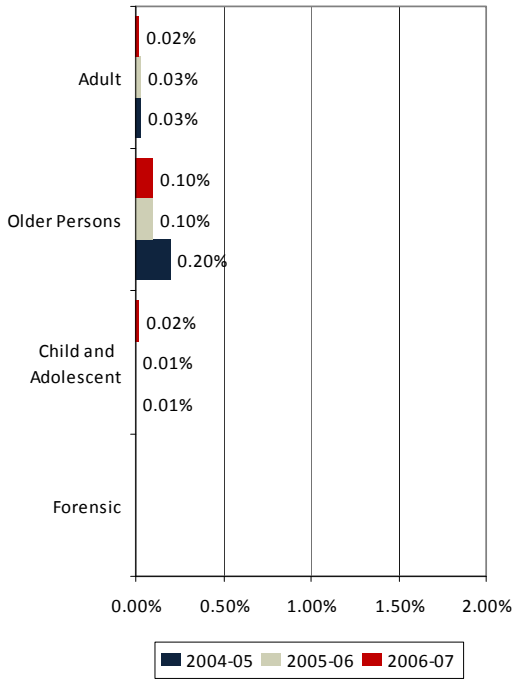


Comparative area resources
Inpatient

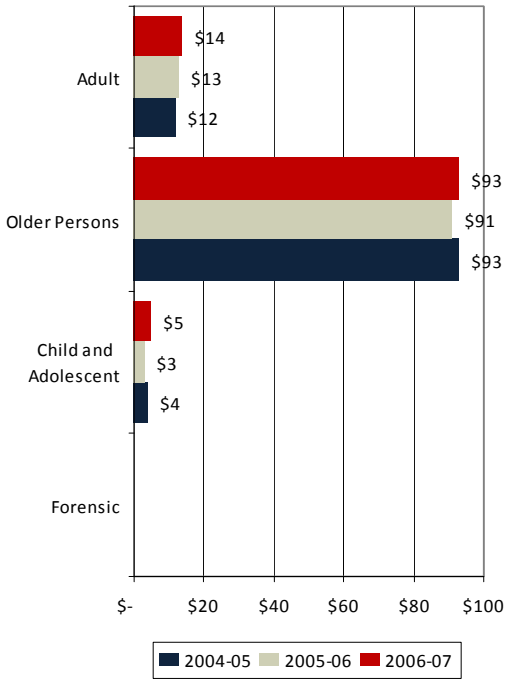


ACCESS

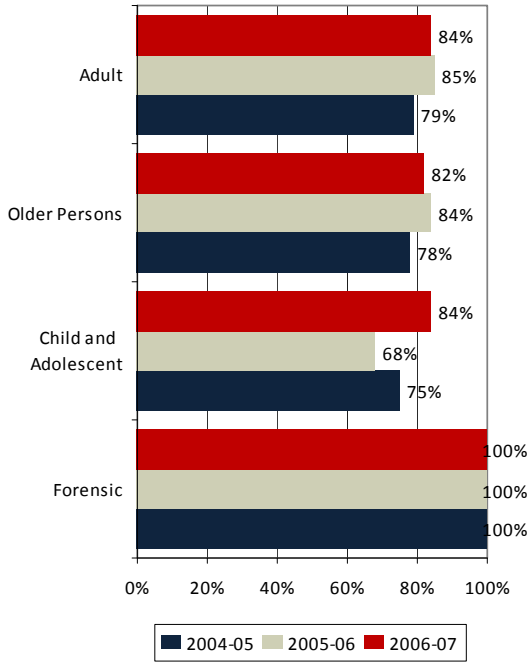
Population receiving care
Residential



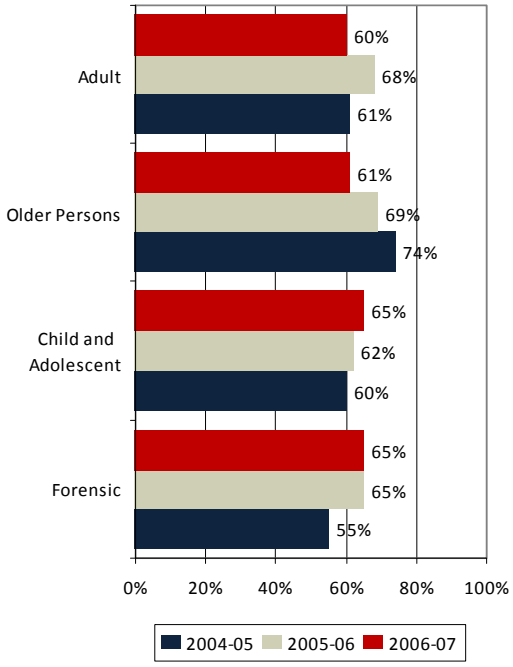
Comparative area resources
Residential



Local access to acute inpatient care

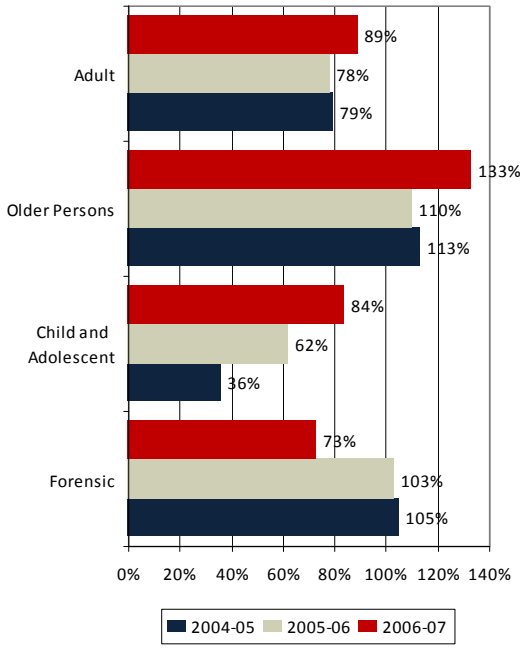


New client index

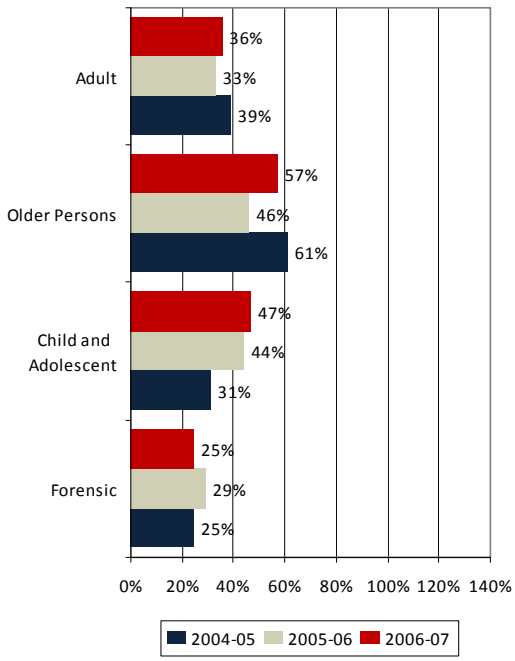


CAPABLE

Outcomes readiness Inpatient



Outcomes readiness Ambulatory



8.4 Review of national indicators

28 day readmission rate

Percentage of separations from the mental health service organisation's acute psychiatric inpatient unit(s) that result in unplanned readmission to the organisation's acute psychiatric inpatient services within 28 day of discharge.

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

- Same day separations and separations due to transfer, statistical discharge, left against medical advice (including absconding) and death were excluded.
- The national specifications count any readmission regardless of the organisation that manages the impatient unit. The specifications for the project limited the count to readmissions to the same mental health service organisation. Additionally, the national project utilised age as a parameter (Child and Adolescent < 18 years, Adult 18 < 65 years, Older Persons 65+ years and Forensic 18+ years).

Learnings

Utility

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

Specification

- Variable lengths of time between discharge and readmission require different perspectives to the issue of readmission however further analysis is required to determine the utility and appropriateness of the varying reference periods.
- Evolving models of service, such as Psychiatric Emergency Care Centres (PECCs) and Prevention and Recovery Care (PARC) services will impact on the interpretation of readmission rates. The inclusion or exclusion of these services needs to be transparent to ensure that the readmissions are not being hidden due to the specifications utilised.

Interpretation

- A range of factors influence readmission including: bed availability; experience and skill mix of staff (inpatient and community); bed demand, degree of social integration; service practices, such as use and reporting of leave, discharge planning; service context such as structural issues, resources and so on.
- Not all readmissions to inpatient mental health units are failures of care. Analysis and identification of allied indicators (such as average length of stay and post-discharge community care) and contextual factors (such as clinical outcomes, casemix, model of care) is essential to accurately interpret the output.
- The same output may have different causes across organisations. For example, a low readmission rate may be a factor of lack of access to beds, poor community resources, or the geographic location of discharge destination in one organisation but due to concerted action to lower rates or improve staff skill base in another organisation.
- Specialist child and adolescent, older persons and forensic beds are scarce commodities and the capacity to readmit and re-refer consumers within a short period of time is limited. Therefore a lower readmission rate may not be indicative of effectiveness but rather service models and resource limitations. The

28 day readmission rate

capacity to identify psychiatric admissions to non-specialised units with which there is an interface, such as paediatric units or general medical wards, would further enhance the utility of the indicator.

- The number of separations and readmissions in some programs are generally small, which inturn impacts of the stability of the indicator (one or two additional readmissions can significantly increase the readmission rate). Additionally, the indicator can be driven by a small number of consumers who are more regularly admitted to inpatient care. The number of consumers contributing to the result should also be considered in any analysis of this indicator.
- The Adult forum researched current literature and interrogated a range of factors that have the potential to impact on readmission rates to determine the capacity of organisations to influence performance. Further details can be found within the 'Good Practice Guidelines' developed by the forum.

Contextual information

National indicators	*Supplementary indicators:*	*Contextual information:*
• Average length of acute inpatient stay. • Post-discharge community contact.	• Bed occupancy. • Number of persons contributing to readmissions. • Waiting lists. • Discharge destination or source of readmission. • Legal status (*Forensic*). • Readmission to acute medical unit (*Older Persons*).	• Community and inpatient service structures, practices (such as leave and discharge) and resources (such as FTE). • Casemix factors (including HoNOS and diagnosis profiles). • Availability of non-mental health community support (*Older Persons*).

Recommendations

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

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

Targets

• Good practice target: *10 percent or below.* • Alert target: *20 percent or above*.	• Good practice target: *7 percent or below.* • Alert target: *10 percent or above*.	• No target identified.	• No target identified.

- These targets are based upon expert opinion and consensus of participants within the national project. Any target determined is preliminary and may change as more evidence becomes available. Proposed targets for the older persons program only apply to sub-specialist services and may not be applicable for the 65+ population receiving inpatient care in general adult mental health services.
- **Good practice performance targets** are based on the premise that adequate resources are available and the mental health service organisation utilises good practice.
- **Alert targets** identify a threshold that should trigger an investigation of factors that may be influencing performance to ensure the model of clinical care and consumer outcomes are not adversely affected. They **do not** identify poor practice.

National Service Standards compliance

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

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

Numerator Total mental health service organisation expenditure, during the reference period, on mental health services that meet the definition of Level X where X is the level at which the indicator is being measured (either Level 1, Level 2, Level 3 or Level 4 as detailed above)

Denominator Total mental health service organisation expenditure on services during the reference period.

- The national project utilised age as a parameter (Child and Adolescent < 18 years, Adult 18 < 65 years, Older Persons 65+ years and Forensic 18+ years).

Learnings

Utility

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

Specification

- The use of expenditure to distribute compliance across the service complicates understanding of the indicator and the increasing trend for services to be accredited as a 'whole' rather than as individual units or settings further diminishes the utility of the indicator at the service level.
- The *adult forum* briefly discussed options for revision of the definition and specification, such as number of recommendations and length of time accreditation was granted, however it was noted that a range of factors other than service appropriateness potentially had greater influence over the result.

Interpretation

- At the organisational level this indicator has a tendency to produce a 'Yes' or 'No' output and as such does not provide information about incremental improvement by an organisation.

Recommendations

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

Adult			Older Persons			Child and Adolescent			Forensic		
2004-05	*2005-06*	*2006-07*	*2004-05*	*2005-06*	*2006-07*	*2004-05*	*2005-06*	*2006-07*	*2004-05*	*2005-06*	*2006-07*
98%	99%	100%	100%	100%	100%	81%	100%	100%	75%	100%	100%

Targets

- No target identified.
- No target identified.
- Good practice target: *100% at Level 1*.
- No target identified.
- These targets are based upon expert opinion and consensus of participants within the national project. Any target determined is preliminary and may change as more evidence becomes available.

Average length of acute inpatient stay

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

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

- Same day separations and separations due to transfer, statistical discharge, left against medical advice (including absconding) and death were excluded.
- The national project utilised age as a parameter (Child and Adolescent < 18 years, Adult 18 < 65 years, Older Persons 65+ years and Forensic 18+ years).

Learnings

- Performance on this indicator may be a factor of resources and model of service rather than the failure of the service to perform appropriately or to provide efficient services. This indicator must be interpreted within the context of the service and other indicators as it is susceptible to a range of clinical and non-clinical factors including as changes in medical and nursing leadership and practice, discharge practices, bed occupancy, access to alternate admitted patient services, community resources and so on.
- Additionally, there are a number of factors unique to each program area which impacts on length of stay, such as the profile of consumers (for example, consumers with dementia and behavioural issues that cannot be adequately cared for at home or in a nursing home), different models of service, prevalence of physical co-morbidities and so on.
- The mean is impacted on by extreme outliers (e.g. consumer needing extended treatment care receiving care within acute unit as no beds available). It was noted that the greater the difference between the mean and median, the more the average length of stay is affected by outliers. Subsequently, the median and mode will provide additional contextual information to enable more accurate description of the typical length of stay of most consumers.
- Small numbers of 'in-scope' discharges from smaller acute units impacts on the stability of the indicator and analysis of the trend-series.
- Although the average length of stay is influenced by a range of factors (including demographics, casemix, clinical care / processes, rurality, or staff / service philosophies (e.g. discharge as soon as risk is minimised)), there are range of activities can be undertaken to influence performance, such as patient flow practices. Ideally measures of consumer outcomes should also be considered in the interpretation of average length of acute inpatient stay.

Forensic mental health services

- Average length of acute inpatient stay is difficult to utilise within services that provide extended treatment with few discharges over the reference period.
- Efficiency, as measured through average length of stay, is misleading in a forensic environment where length of stay is impacted on legal status and procedures rather than a need for high-level clinical care.

Contextual information

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

Average length of acute inpatient stay

Recommendations

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

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

Targets

- Good practice target: *12 days or less*.
- Alert target: *50 days or more*.
- Alert target: 35 days or less.
- Alert target: *15 days or more*.
- No target identified.

- These targets are based upon expert opinion and consensus of participants within the national project. Any target determined is preliminary and may change as more evidence becomes available. Proposed targets for the older persons program only apply to sub-specialist services and may not be applicable for the 65+ population receiving inpatient care in general adult mental health services.
- **Good practice performance targets** are based on the premise that adequate resources are available and the mental health service organisation utilises good practice.
- **Alert targets** identify a threshold that should trigger an investigation of factors that may be influencing performance to ensure the model of clinical care and consumer outcomes are not adversely affected. They do not identify poor practice.

Average cost per acute inpatient episode

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

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

- Same day separations and separations due to transfer, statistical discharge, left against medical advice (including absconding) and death were excluded.
- The national project utilised age as a parameter (Child and Adolescent < 18 years, Adult 18 < 65 years, Older Persons 65+ years and Forensic 18+ years).

Learnings

- Inpatient episode costs are largely driven by the number of episodes and length of stay, therefore the influences on length of stay also impact on the costs. For example, legal status has a significant impact on length of stay in forensic settings, and therefore will impact upon costs.
- The concept of efficiency should not be viewed in isolation of the context and what factors influence an indicator.
- At the organisational level there is a need to unpack costs and identify associated issues (such as staff hours per day) to enable understanding of efficiency.

Cost methodology and data

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

Specifications

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

Average cost per acute inpatient episode

Contextual information

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

Recommendations

- The indicator **average cost per acute inpatient episode** can be utilised for benchmarking *child and adolescent* mental health services as currently nationally defined and specified. However, the inclusion and utilisation of **average cost per acute bed day** as a supplementary indicator should be considered when benchmarking child and adolescent mental health services.
- The indicator **average cost per acute inpatient episode** is not appropriate for benchmarking *forensic, older persons or adult* mental health services as currently nationally defined and specified.
- The inclusion and utilisation of **average cost per bed day** should be considered for benchmarking *older persons* and *adult* mental health services.
- The development of a more appropriate indicator of the efficiency of costs of inpatient care is required for benchmarking *forensic* mental health services.

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

Targets

• No target identified.	• No target identified.	• No target identified.	• No target identified.

Average treatment days per three-month community care period

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

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

- The national project utilised age as a parameter (Child and Adolescent < 18 years, Adult 18 < 65 years, Older Persons 65+ years and Forensic 18+ years).

Learnings

Interpretation

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

Specification

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

Average treatment days per three-month community care period

Contextual information

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

Recommendations

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

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

Targets

• Alert Target: *Less than or equal to six treatment days*. • Alert Target: *Equal to or more than 18 treatment days*.	• Alert Target: *Less than or equal to eight treatment days*.	• Alert Target: *Less than or equal to three treatment days*.	• No target identified.

- These targets are based upon expert opinion and consensus of participants within the national project. Any target determined is preliminary and may change as more evidence becomes available. Proposed targets for the older persons program only apply to sub-specialist services and may not be applicable for the 65+ population receiving inpatient care in general adult mental health services.
- **Alert targets** identify a threshold that should trigger an investigation of factors that may be influencing performance to ensure the model of clinical care and consumer outcomes are not adversely affected. They do not identify poor practice.

Average cost per three-month community care period

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

Numerator	Total mental health service organisation recurrent expenditure on community mental health ambulatory care services within the reference period.
Denominator	Total number of ambulatory care statistical episodes (three month periods) treated by the mental health service organisation within the reference period.

- A statistically derived community episode is defined as each three month period of ambulatory care of an individual identified patient where the patient was under 'active care', defined as one or more treatment days in the period.
- The national project utilised age as a parameter (Child and Adolescent < 18 years, Adult 18 < 65 years, Older Persons 65+ years and Forensic 18+ years).

Learnings

Interpretation

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

Cost data

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

Average cost per three-month community care period

Contextual information

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

Recommendations

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

Adult			Older Persons			Child and Adolescent			Forensic		
2004-05	*2005-06*	*2006-07*	*2004-05*	*2005-06*	*2006-07*	*2004-05*	*2005-06*	*2006-07*	*2004-05*	*2005-06*	*2006-07*
$2,088	$2,033	$1,975	$1,663	$1,536	$1,835	$1,720	$1,787	$1,784	$2,704	$2,717	$3,094

Targets

• No target identified.	• No target identified.	• No target identified.	• No target identified.

Population receiving care

The percentage of persons resident in the mental health service organisation's defined catchment area who received care from the organisation's mental health (inpatient/ambulatory/residential) services.

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

- The national project utilised age as a parameter (Child and Adolescent < 18 years, Adult 18 < 65 years, Older Persons 65+ years and Forensic 18+ years).

Learnings

- Access to mental health services is an ongoing issue for most services and capacity to monitor and improve access (where necessary) is relevant. However, it is not able to account for population demand for services. Additionally, services may restrict access to care to manage the capacity of its resources to provide appropriate clinical care.
- The model of service, particularly where some components of the service are provided outside of the organisations (such as external or shared triage model), will impact on the interpretability and comparability of the indicator.
- There are a range of issues (structural, population and service) that impact on this indicator that are not necessarily in the direct control of the mental health service organisation, including:
- inaccuracies caused by different registration activities across community services. To be nationally comparable the data must be consistently counted;
- catchment size, number and size of vulnerable populations, changes in boundaries and how the catchment population is counted (particularly in the interpretation of the trend series);
- the level of available resources, such as the amount of productive versus unproductive FTE.
- As a measure of performance this indicator cannot be looked at in isolation of other initiatives, such as those funded through Commonwealth of Australian Government (COAG) National Action Plan on Mental Health. These initiatives have the potential to reduce the output without it being an indication of service performance (e.g. more people contact General Practitioners or psychologists rather than the local mental health service).

Forensic mental health services

- There are differences in the target population for the different forensic ambulatory services (Prison Mental Health, Court Liaison, Community Forensic). To enable accurate interpretation, analysis and action for the forensic program area the indicator should be further stratified by ambulatory service types.

Contextual information

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

Population receiving care

Recommendations

- The indicator **population under care** can be utilised for benchmarking *adult, older persons, forensic* and *child and adolescent* mental health services as nationally defined and specified. However, further stratification is required to enable accurate interpretation, analysis and action for the forensic program.
- The focus of analysis and investigation should be on ambulatory population under care as these services undertake the majority of activity within the public sector.

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

Targets

- Good practice target: *2.0 percent or higher of the ambulatory catchment population.*
- No target identified.
- Good practice target: *Between 1.9 – 2.4 percent of the ambulatory catchment population.*
- No target identified.

- These targets are based upon expert opinion and consensus of participants within the national project. Any target determined is preliminary and may change as more evidence becomes available.
- **Good practice performance targets** are based on the premise that adequate resources are available and the mental health service organisation utilises good practice.
- Epidemiological evidence suggests *2.4 percent* of the child and adolescent population have a serious mental illness that would require access to tier three public sector child and adolescent mental health services (Kurtz 1996; NSW Health 2001).
- Epidemiological evidence suggests *2.6 percent* of the adult population have a serious mental illness that would require access to mental health services (NSW Health 2001).

Local access to acute inpatient care

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

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

- The national project utilised age as a parameter (Child and Adolescent < 18 years, Adult 18 < 65 years, Older Persons 65+ years and Forensic 18+ years).

Learnings

- The concept of 'local' is difficult to define, therefore the indicator looks at local as being within the defined catchment area of the service, which from the perspective of the consumer, carer, clinician and/or service may not be 'local'. Catchments are generally defined at a broader level than mental health service organisation and may include a large geographic region (for example, Northern Queensland) and changes to catchment boundaries through jurisdictional and organisational restructuring impact on trend analysis.
- The utility of the indicator is limited as acute mental health inpatient services for all program areas are not available in all areas. Subsequently, services, particularly child and adolescent and forensic, have broad 'local' catchments.
- Additionally, proximity to alternative acute inpatient service services and arrangements (such as general aged care beds with input from the mental health service or access to general adult psychiatric inpatient service) impacts on how this indicator can be interpreted and compared. There may be a benefit in specifying the indicator for different programs and stakeholders, for instance older person mental health services would benefit from the capacity to identify mental health patients in aged care wards.

Recommendations

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

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

Targets

- No target identified.
- No target identified.
- No target identified.
- No target identified.

New client index

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

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

- The national indicator does not specify a time period for determining 'new'. However, the methodology for identifying new clients requires further development. The definition to be used in the national benchmarking project represents an initial approach that is expected to be achievable within the resources available to participating organisations.
- The national project utilised age as a parameter (Child and Adolescent < 18 years, Adult 18 < 65 years, Older Persons 65+ years and Forensic 18+ years).

Learnings

- Access (or lack thereof) to mental health services is an ongoing issue for most services and capacity to monitor and improve access (where necessary) is relevant. The proportion of 'new' clients enables the first part of an organisations throughput to be considered. The point of entry (that is the setting where the consumer first contacted the organisation) is important supplementary information that needs to be considered in the interpretation of the indicator.
- This is a conceptually complex indicator, primarily because defining 'new' has many interpretations and definitional approaches, such as new to service versus new to setting versus new to program versus new to diagnostic group and so on. The indicator looks at who is new to an organisation, regardless of setting or program (i.e. if come from other program not considered 'new').

Interpretation

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

Specification

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

New client index

Contextual information

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

Recommendations

- The indicator **new client index** can be used for benchmarking *adult, older persons, forensic* and *child and adolescent* mental health services as defined and specified for the *National Mental Health Benchmarking Project*.
- Where possible, the new client index as defined within the National Mental Health Performance Framework should be utilised as a supplementary indicator for benchmarking mental health services as it provides a more comprehensive picture of service through-put.
- Consideration should be given to supplementary indicators of new to setting (acute inpatient or ambulatory mental health care) and new to program (transition adult to older persons, or new to forensic mental health).

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

Targets

• No target identified.	• Alert target: *50 percent or less* • Alert target: *80 percent or more*.	• Alert target: *50 percent or less*.	• No target identified.

- These targets are based upon expert opinion and consensus of participants within the national project. Any target determined is preliminary and may change as more evidence becomes available. Proposed targets for the older persons program only apply to sub-specialist services and may not be applicable for the 65+ population receiving inpatient care in general adult mental health services.
- **Alert targets** identify a threshold that should trigger an investigation of factors that may be influencing performance to ensure the model of clinical care and consumer outcomes are not adversely affected. They do not identify poor practice.

Comparative area resources

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

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

- The national project utilised age as a parameter (Child and Adolescent < 18 years, Adult 18 < 65 years, Older Persons 65+ years and Forensic 18+ years).

Learnings

- Comparative area resources is not necessarily an indicator of service performance as funding allocation is generally not within the control of individual mental health service organisations. However, it has the potential to provide: (i) significant leverage for influencing policy and funding decisions; and, (ii) information to service managers to assist in the interpretation of other indicators.
- The reliability of output is dependent upon good quality, accurate and consistent financial reporting (especially regarding organisational overheads). Considerable work is required to develop consistent costing methodology across mental health services, both within and across jurisdictions.
- Differences in the catchments of the different forensic ambulatory services (Prison Mental Health, Court Liaison, Community Forensic). To enable accurate interpretation, analysis and action for the forensic program area the indicator should be further stratified by ambulatory service types
- The interface with between mental health and other services (such as the interface with aged care services) is important when identifying relevant resources for mental health services.

Forensic mental health services

- There are differences in the target population for the different forensic ambulatory services (Prison Mental Health, Court Liaison, Community Forensic). To enable accurate interpretation, analysis and action for the forensic program area the indicator should be further stratified by ambulatory service types.

Contextual information

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

Recommendations

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

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

Targets

• No target identified.	• No target identified.	• No target identified.	• No target identified.

Pre-admission community contact

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

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

- The national indicator specifications require that all pre-admission contacts be counted not just those conducted by mental health service organisation's ambulatory service.
- The national project utilised age as a parameter (Child and Adolescent < 18 years, Adult 18 < 65 years, Older Persons 65+ years and Forensic 18+ years).

Learnings

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

Interpretation

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

Pre-admission community contact

Contextual information

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

Recommendations

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

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

Targets

• Good practice target: *75 percent and above*. • Alert target: *50 percent or less*.	• Good practice target: *80 percent and above*.	• Alert target: *70 percent or less*.	• Good practice target: *100 percent and above*. *Note this target is based on the definition used in the National Mental Health Benchmarking Project.*

- These targets are based upon expert opinion and consensus of participants within the national project. Any target determined is preliminary and may change as more evidence becomes available. Proposed targets for the older persons program only apply to sub-specialist services and may not be applicable for the 65+ population receiving inpatient care in general adult mental health services.
- **Good practice performance targets** are based on the premise that adequate resources are available and the mental health service organisation utilises good practice.
- **Alert targets** identify a threshold that should trigger an investigation of factors that may be influencing performance to ensure the model of clinical care and consumer outcomes are not adversely affected. They do not identify poor practice.

Post-discharge community contact

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

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

- The national indicator specifications require that all pre-admission contacts be counted not just those conducted by mental health service organisation's ambulatory service.
- The national project utilised age as a parameter (Child and Adolescent < 18 years, Adult 18 < 65 years, Older Persons 65+ years and Forensic 18+ years).

Learnings

Interpretation

- The indicator is a direct measure of good clinical practice. It has clinical meaning and relevance at the individual clinician level and can drive practice improvement and change. Further analysis and stratification by client participation, diagnosis groups and so on, may be of use to individual services.
- Public mental health services cannot be expected to see everyone discharged from public inpatient units as some consumers are appropriately followed up by GPs, private psychiatrists or other services.
- The indicator is vulnerable to poor community data collection adherence and variation in practice used to record contacts.
- The indicator is sensitive to a range of factors, including: demography, such as rurality and transient population; discharge destination; models of service; clinical practice and service procedures (such as the threshold for discharge); collaboration between service components; partnerships within primary care, private sector or non-government mental health services.
- The indicator provides information about the mental health service organisation as a whole, not just the inpatient setting or just the community setting. For instance, an increase in emergency admissions could be an indication of poor resources in the community. For state-wides service the indicator is about both service and system measurement.

Specification

- As currently specified there is no differentiation between people who are not contacted versus those where contact is attempted by service but refused or failed. However, this is due to limitation of current information systems to capture the appropriate data.
- Older persons and child and adolescent mental health services agreed that the inclusion of all service contacts as follow-up contact was appropriate as these services often co-ordinate of post-discharge care in collaboration with other services, for example, the most appropriate follow-up for a consumer with a low mental status may be with the residential aged care facility.
- Adult and forensic mental health services agreed that the indicator should only count those contacts in which the consumer participated.
- The seven day parameter was chosen due to substantial literature indicating increased risk of suicide within the first seven days following discharge from acute care. However, there is less evidence that follow-up within seven days makes a difference for the consumer in regards to community tenure. Further analysis of different reference periods should be considered to determine the appropriateness of this period for each program area.

Post-discharge community contact

Contextual information

National indicators	*Supplementary indicators:*	*Contextual information:*
	• Bed occupancy. • Referral destination.	• Available resources (e.g. FTE per 100,000, collaboration with other service providers). • Model of service. • Casemix factors (including HoNOS and diagnosis profiles). • Ambulatory data coverage and data collection protocols.

Recommendations

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

Adult			Older Persons			Child and Adolescent			Forensic		
2004-05	*2005-06*	*2006-07*	*2004-05*	*2005-06*	*2006-07*	*2004-05*	*2005-06*	*2006-07*	*2004-05*	*2005-06*	*2006-07*
56%	60%	60%	58%	59%	60%	70%	80%	75%	46%	54%	49%

Targets

• Good practice target: *90 percent and above.*	• Good practice target: *80 percent and above.*	• Good practice target: *90 percent and above.*	• Good practice target: *100 percent and above*. *Note this target is based on the definition used in the National Mental Health Benchmarking Project.*

- These targets are based upon expert opinion and consensus of participants within the national project. Any target determined is preliminary and may change as more evidence becomes available. Proposed targets for the older persons program only apply to sub-specialist services and may not be applicable for the 65+ population receiving inpatient care in general adult mental health services.
- **Good practice performance targets** are based on the premise that adequate resources are available and the mental health service organisation utilises good practice.

Outcomes readiness

Percentage of expected collection occasions with a valid HoNOS/HoNOS65+/HoNOSCA recorded.

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

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

Learnings

- Compliance with data collection protocols is not an indication of data quality.
- As currently defined and specified, this is not a measure of capability.
- The indicator is overly generous in its calculation of participation, which limits interpretation and face validity (eg when services can have 150% participation). In particular, it is skewed in the favour of residential or long-stay services. The capacity to link between the outcomes and activity collections to accurately identify episodes of care will improve the appropriateness and utility of this indicator.
- The national specifications do not allow for compliance with specific measures to be identified and are unclear on whether consumer self-assessment measures are included in the construction of compliance. Given the significant low rate of offering and completion of these measures inclusion would significantly impact on the output and utility of the indicator.
- Compliance with offering consumer self-assessment measures should be constructed separately.
- Differences in service models and protocols may dictate that not all services collect the outcome information, for example, forensic consultation-liaison services supporting case-management services.

Contextual information

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

Recommendations

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

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

Targets

• No target identified.	• No target identified.	• Good practice target: *85 percent and above.*	• Good practice target: *85 percent and above.*

- These targets are based upon expert opinion and consensus of participants within the national project. Any target determined is preliminary and may change as more evidence becomes available.
- **Good practice performance targets** are based on the premise that adequate resources are available and the mental health service organisation utilises good practice.

8.5 Review of supplementary indicators

A range of supplementary indicators were identified by participants as useful when benchmarking mental health service organisations. These indicators included both **performance** indicators and **contextual** indicators, which were considered to provide **context** to the service and other indicators but were not deemed to be a measure of a service's performance. Not all forums used all indicators and only indicators which were deemed to be relevant and useful for at least one forum are included. Issues outlined in the main report, such as the impact of data quality (particularly expenditure data) and service models on comparability of data, apply to the advice provided in regards to supplementary indicators.

Contextual indicators		
Indicator	**Comments**	**Forums**
Total in-scope expenditure *Sum of all in-scope expenditure during the reference period*.	• Although there is considerable differences in costing methodologies which impact on the comparability of this data some forums identified it was informative in estimating the overall size of available resources.	• Child and Adolescent • Adult • Older Persons • Forensic
Proportion of indirect expenditure	• This information is useful at local level to explain expenditure variation, particularly in regard to information obtained from local finance staff.	• Child and Adolescent • Older Persons • Forensic
Proportion of expenditure on salaries and wages	• This provides information on how services are expending their funds. This allows some comparison and understanding of resource availability and allocation, rather than focusing on actual numbers.	• Child and Adolescent • Adult • Older Persons • Forensic
Inpatient expenditure and funding per capita differentials	• This involved a comparison of total inpatient expenditure over total catchment population (KPI#10) with total inpatient funding over total catchment population.	• Child and Adolescent • Forensic
Ambulatory expenditure and funding per capita differentials	• This involved a comparison of total ambulatory expenditure over total catchment population (KPI#10) with total ambulatory funding over total catchment population.	• Child and Adolescent • Forensic
Full year cost per acute inpatient bed	• It was considered that this information **complements** the indicator *average cost per acute inpatient episode*.	• Child and Adolescent • Adult • Older Persons • Forensic

Contextual indicators		
Indicator	**Comments**	**Forums**
Full year cost per community ambulatory direct care FTE	• It was considered that this information **complements** the indicator *average cost per three-month community care period*.	• Child and Adolescent • Adult • Older Persons • Forensic
Bed-based services as a percentage of total expenditure	• This provides information on how services are expending their funds. This allows some comparison and understanding of resource availability and allocation, rather than focusing on actual numbers.	• Child and Adolescent
Acute beds per 100,000 population	• Indicators utilising bed data are useful for understanding resources as it overcomes many of the issues that arise with the different costing methodologies of financial data and the concept has more operational meaning and provides a better basis for jurisdictional comparisons.	• Child and Adolescent • Adult • Older Persons • Forensic
Non-acute beds per 100,000 population	• Indicators utilising bed data are useful for understanding resources as it overcomes many of the issues that arise with the different costing methodologies of financial data and the concept has more operational meaning and provides a better basis for jurisdictional comparisons.	• Forensic
Community residential beds per 100,000 population	• Community residential services often have broad catchments and a mental health service organisation may not be responsible for its management but may be a user of the service as part of its catchment. • This information was considered useful to advocate for additional resources in relation to these types of services.	• Older Persons
Community ambulatory mental health services direct care FTE per 100,000 population	• Indicators utilising FTE data are useful for understanding resources as it overcomes many of the issues that arise with the different costing methodologies of financial data and the concept has more operational meaning and provides a better basis for jurisdictional comparisons. • Variations in staffing mix will impact on the indicator, eg medical staff are more expensive which may lower FTE for same level of expenditure as another service with less medical staff. • Productive and unproductive (that is, paid but not working) FTE impact on the utility of FTE information.	• Child and Adolescent • Adult • Older Persons • Forensic

Contextual indicators		
Indicator	**Comments**	**Forums**
Staffing mix per acute patient day	• Indicators utilising FTE data are useful for understanding resources as it overcomes many of the issues that arise with the difference costing methodologies of financial data the concept has more operational meaning and provides a better basis for jurisdictional comparisons. • However, staffing mix is not completely under the control of each organisation as the overall mix of the different disciplines can be dictated by industry requirements which may differ across jurisdictions.	• Child and Adolescent • Adult
Proportion of consumers who reside outside community ambulatory catchment	• This gives an indication of the impact of catchment boundary issues.	• Adult • Older Persons
Proportion of assessment only ambulatory episodes	• This gives an indication of the amount of assessment activity undertaken by the services.	• Forensic
Proportion of acute inpatient separations where the consumer resides outside acute inpatient catchment	• This gives an indication of the impact of catchment boundary issues.	• Adult • Older Persons
Proportion of out-of-scope overnight separations	• This provides context to the representativeness of bed-based indicators to the majority of inpatient activity.	• Adult • Older Persons • Forensic
Diagnosis Profile	• Forms part of casemix profile required to unpack variation in performance.	• Child and Adolescent • Adult • Older Persons • Forensic
Mental Health Outcomes Profile	• Forms part of casemix profile required to unpack variation in performance.	• Child and Adolescent • Adult • Older Persons • Forensic
Stratification of key indicators by diagnosis groups	• The stratification of a range of information by diagnostic groupings can facilitate more targeted investigation of performance.	• Older Persons

Performance indicators			
Domain(s)	**Indicator**	**Comments**	**Forums**
Efficient	**Average cost per acute inpatient bed day**	• This indicator limits the influence of length of stay, has more operational meaning and provides a better basis for jurisdictional comparisons. • There was variable advice from the forums as to whether this indicator should **replace** or be used to **complement** the indicator average cost per acute inpatient episode.	• Child and Adolescent • Adult • Older Persons • Forensic
	Average annual cost per community residential bed	• This indicator is relevant to facilitating understanding of costs associated with residential services.	• Adult
	Average cost per contact hour	• This limits the influence of number of episodes, has more operational meaning and provides a better basis for jurisdictional comparisons. • This information can also be used to identify issues around the extended of underreporting of ambulatory collections.	• Child and Adolescent
	Average cost per community treatment day	• This limits the influence of number of episodes, has more operational meaning and provides a better basis for jurisdictional comparisons. • This information can also be used to identify issues around the extended of underreporting of ambulatory collections.	• Child and Adolescent • Adult • Older Persons • Forensic
	Median Length of Stay	• The median provides additional information that is important in understanding the average length of acute inpatient stay.	• Child and Adolescent • Adult • Older Persons
	Proportion of overnight separations with acute length of stay ≥ XX days	• Child and Adolescent ≥ 35 days • Older Persons ≥ 60 days • Forensic ≥ 180 days	• Child and Adolescent • Older Persons • Forensic
	Average direct care staff hours per acute inpatient day	• This information will provide greater understanding to Length of Stay information.	• Child and Adolescent • Adult • Older Persons
	Average weekly contacts per direct care FTE	• This information provides some clarity on issues related to case loads, underreporting and non-consumer related activity.	• Child and Adolescent • Adult • Older Persons • Forensic
	Average weekly contact hours per direct care FTE	• This information provides some clarity on issues related to case loads, underreporting and non-consumer related activity.	• Child and Adolescent

Performance indicators			
Domain(s)	**Indicator**	**Comments**	**Forums**
Efficient	**Average weekly treatment days per direct care FTE**	• This information provides some clarity on issues related to case loads, underreporting and non-consumer related activity.	• Child and Adolescent • Adult • Older Persons • Forensic
	Average contacts per treatment day	• This information unpacks potential sources of variation in relation to treatment days.	• Child and Adolescent • Adult
	Average contacts per three month community care period	• This information unpacks potential sources of variation in relation to treatment days.	• Child and Adolescent
	Proportion of single treatment day consumers per three month community care period	• This information unpacks potential sources of variation in relation to treatment days.	• Child and Adolescent • Adult Older Persons
	Average number of persons seen per year per ambulatory direct care FTE	• This information provides some clarity on issues related to case loads, underreporting and non-consumer related activity.	• Child and Adolescent • Adult • Older Persons • Forensic
Safe Efficient	**Bed occupancy**	• Bed occupancy is important in understanding a range of indicators and can have significant impact on a services performance on those indicators, such as readmission rates. • Although there was divergent views it was generally considered that action could be taken to influence performance on bed occupancy, although resource availability was a significant influence. • For forensic services this was seen to be contextual rather than a measure of performance.	• Child and Adolescent • Adult • Older Persons • Forensic
Efficient Responsive	**'Did Not Attend' as a proportion of total contact**	• The impact of 'Did Not Attend' service contacts can be significant on the interpretation of community indicators. • Additionally, this indicator may also be a measure of capacity of service to appropriately engage with target population.	• Child and Adolescent
Efficient Effective	**Open Clients per Direct Care FTE**	• This describes the case load of a clinician which is operationally important to identify what is happening within a service. However, is interpretation is dependent on the model of service.	• Child and Adolescent

Performance indicators			
Domain(s)	**Indicator**	**Comments**	**Forums**
Efficient Effective	**Staff activity survey**	• Proportion of direct care FTE time spent on direct clinical care, indirect clinical care, non-clinical activity and other. • The activity of mental health clinicians in the community is broader than direct clinical care. Understanding of other activity is important to understanding the efficiency and effectiveness of a service.	• Child and Adolescent
Safe	**Rate of falls per consumer (Inpatient)**	• Falls in the elderly is a significant indicator to increased length of stay. • A fall is defined as an event that results in a consumer coming to rest inadvertently on the ground or floor or other lower level. Including staff finding the consumer on the floor but did not witness the event. Falls in the elderly is a significant indicator to increased length of stay.	• Older Persons
	Proportion of inpatient consumers who fall		• Older Persons
	Proportion of inpatient consumers who fall three or more times		• Older Persons
	Proportion of consumers with at least one seclusion event	• The reduction of seclusion is being driven through a number of national and state initiatives. • Seclusion has the potential to negatively impact on consumers and the effectiveness of care.	• Forensic
	Proportion of consumers with at least two events of seclusion		• Forensic
	Proportion of seclusion events that are four or more hours in duration		• Forensic
	Proportion of consumers who assault at least once	• Critical incidents, such as assaults, can negatively impact on the operation of an organisation. • Literature suggests that this information will facilitate understanding of other issues, including seclusion practices.	• Forensic
	Proportion of consumers who assault at least twice		• Forensic
Effective	**Readmission Rate (91 and 182 days)**	• Readmission following a longer interval from care was seen as important to identify issues related to casemix, resources and organisational structure.	• Forensic

Performance indicators			
Domain(s)	**Indicator**	**Comments**	**Forums**
Effective	**Community Tenure**	• Refers to the number of consumers registered in the mental health service organisations community ambulatory mental health service with no admissions to acute psychiatric inpatient care (following registration with ambulatory service) during the reference period over the number of consumers registered in the mental health service organisations community ambulatory mental health service during the reference period. • Further work is required on the definition and specification of this indicator	Older Persons
Responsive	**Average number of contacts (consumer present)** **Average number of contacts (consumer not present)** **Average Total Contact Time (consumer present)** **Average Total Contact Time (consumer not present)**	• These indicators provide a profile of aspects of service delivery which can be used to better understand the responsiveness of a service.	• Child and Adolescent
	Average days from referral to assessment	• Wait time is an important measure and can be expressed as referral to assessment or referral to treatment. • This indicator is about the responsiveness of the service to be able to see a client.	• Child and Adolescent
	Average days assessment to discharge **Average days referral to treatment**	• The length of time a consumer accesses a mental health service is important measure of the capacity and responsiveness of services to meet the needs of consumers.	• Child and Adolescent
	Consumer outcomes participation	• The proportion of episodes with consumer self-assessment outcome measures.	• Adult
Access	**Proportion of same day separations from acute psychiatric inpatient units**		• Adult • Older Persons
Access	**New Client Index**	• The number of people in contact	• Child and Adolescent

Performance indicators			
Domain(s)	**Indicator**	**Comments**	**Forums**
	(Alternate)	with the mental health service organisation who have never been seen by the organisation prior to the first contact during the reference period over the total number of people in contact with the mental health service organisation during the reference period.	
	Population receiving care (Prison Mental Health Services) **Population receiving care** (Forensic community services) **Population receiving care** (Court Liaison Services)	• The ambulatory catchment population for forensic services is complicated, as they do not necessarily align with general concept of catchment. The capacity to more accurately identify population receiving care for the distinct populations it serves will enhance understanding of access issues.	• Forensic

8.6 National Mental Health Performance Subcommittee Membership

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

At 30 June 2009