

# **National Mental Health Benchmarking Project Forensic**

## **Review of Key Performance Indicators**



A joint Australian, State and  
Territory Government Initiative

**June 2008**

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## Background

During 2006-07 and 2007-08 the National Mental Health Benchmarking Project, a collaborative initiative between State, Territory and Australian Governments, convened benchmarking forums in four program areas (general adult, child and adolescent, older persons and forensic) of public sector mental health services. The project aimed to:

1. promote the sharing of information between organisations to increase understanding and acceptance of benchmarking as a key process to improve service quality.
2. identify the benefits, barriers and issues arising for organisations in the mental health field engaging in benchmarking activities.
3. understand what is required to promote such practices on a wider scale.
4. 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.

To facilitate the evaluation of the suitability of the 13 national indicators for benchmarking mental health services, each forum completed a comprehensive review of the national Key Performance indicators (KPIs) utilising the criteria outlined in Table 1 and made recommendations regarding their definition, specification, targets and appropriateness for benchmarking at the mental health service organisation level. Part one provides an overview of the discussion and recommendations made by the Forensic Forum in relation to the nationally agreed KPIs.

In addition to the 13 national KPIs each forum looked at a range of additional and supplementary performance and contextual indicators. These indicators were reviewed against their relevance, utility, feasibility and interpretability. Recommendations were made in regards to the appropriateness of each indicator for benchmarking and for performance indicators if the indicator should be considered for inclusion within the national indicator set (either in addition to or as replacement for an existing indicator). The outcomes of the discussion from the Forensic Forum are in Part Two of this document.

**Table 1: National Key Performance Indicator Review Criteria**

<ol style="list-style-type: none"> <li>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?</li> <li>2. Does the indicator MEASURE WHAT IS INTENDED within the program area? Is it an appropriate indicator for the nominated performance domain and subdomain? Or is it better mapped to another primary domain? Does it inform about an organisation's performance on the domain?</li> <li>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?</li> <li>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?</li> <li>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 'minimally acceptable' and 'best 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 (who's the best of the group) or ABSOLUTES (based on some standard such as evidence, expert opinion or stakeholder consensus)?</li> <li>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?</li> <li>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?</li> <li>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?</li> <li>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?</li> <li>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).</li> </ol>
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## Key issues

The following section outlines key issues considered relevant to interpretation, utility and comparison of most or all of the indicators and recommendations made by the Forensic Forum. The issues should be considered in conjunction with the information provided in the detailed reviews outlined in parts one and two of this document.

### *No indicator in isolation*

A single indicator cannot provide sufficient information to explain and monitor the performance of a mental health service organisation or the mental health system. It is important to ensure that in the interpretation, utilisation and comparison of performance indicators that other related indicators and contextual information is also considered. The required information may differ depending upon the indicator, the organisational context, program area and so on.

### *Model of Service*

The model of service adopted by organisations is a significant influence on many of the indicators. Differences between organisations with different service models may be an artefact of the model rather than differences in performance.

### *Jurisdictional differences and legislation*

Comparison of forensic services across jurisdictions is difficult due to different legislative requirements and processes. However, it is acknowledged that learning can occur despite the differences.

Across jurisdictions there are small differences in the definitions and protocols used which will potentially impact on the comparability of indicators across. For example, the threshold for registration differs in each jurisdiction which may impact on the number of consumers counted in the construction of the population under care indicator. One service may appear to have with a higher population under care than another service however it could potentially be an artefact of the differences in practices around registration thresholds.

A particular issue for forensic services is the differences in the legislative requirements and processes that guide service models, processes and practices. The output of some indicators may be a result of the legislation rather than a factor of clinical practice. For example, length of stay of a sub-set of consumers may be dictated by legal status rather than clinical need.

Additionally, forensic services provide specialist services. It is not considered appropriate to always compare forensic and general adult services and expect the same level of performance without identifying the contextual elements that will influence output.

### *Available resources*

Organisations generally provide services within the resources available to them. Differences between organisations may be due to differences in available resources rather than differences in performance.

### *Data compliance and quality*

The data required to construct the indicators is primarily drawn from electronic information systems used within each jurisdiction. Although, the systems make the collection of data and construction of indicators more feasible, the accuracy and representativeness of the output is dependent upon service compliance with data entry. This is particularly of significance in relation to contact reporting for ambulatory services. Poor coding practices or poor data entry practices also limit the utility of the data used to construct the indicators.

The quality of expenditure data is a significant issue due to the lack of a consistent costing methodology across health services, within and across jurisdictions. Additionally, different input costs such as wage rates further limit the comparability of expenditure data across jurisdictions.

The Forensic Forum indicated that although these issues are of concern and should be considered when interpreting the indicators, the use and reporting of the data at the service level has the potential to improve both compliance and quality.

### *Defining good practice – ‘good practice targets’*

Further discussion and investigation by stakeholders is required to establish what constitutes ‘good practice’ across forensic mental health services. This will enable the appropriateness of any of the recommended targets to be determined and will assist in the refinement and development of appropriate good practice targets for other indicators as appropriate.

It is important to note that the targets set by the Forensic Mental Health Benchmarking Forum are primarily based on the expert opinion and majority consensus of participants. Where available literature has been utilised to support defined targets.

### *Identifying thresholds for investigations – ‘alert targets’*

The Forensic Forum has set ‘Alert Targets’ for a number of the indicators. These targets are not intended to identify poor practices but rather aim to identify a threshold that could potentially trigger an investigation of a range of factors that may be influencing the output (including data compliance, consumer profiles, service models, clinical practices and so on).

### *Indicator literacy*

A key issue that has both hindered and helped participants in the National Mental Health Benchmarking Project is the issue of indicator literacy. Sufficient understanding of the technical specifications, construction and applicability of the indicators is essential to enable appropriate interpretation and utilisation of the data. The understanding of indicators requires significant investment so that the information can be used to appropriately highlight successes, identify quality improvement needs and inform resources allocation.

### *Representation of services*

The participants in the National Mental Health Benchmarking Forum represent approximately 10 per cent of mental health services in Australia. In the Forensic Forum no organisations from four jurisdictions (Tasmania, South Australia, the Northern Territory and the Australian Capital Territory) participated, noting that not all jurisdictions have specialist forensic services.

The information provided in this review is based upon the considered experience of two years of benchmarking activity. However, 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.

## **Guide for reading review documentation**

Throughout this document, references are made to the *National Specifications* and the *Project Specifications*. The National Specifications refer to the specifications published in the document *Key Performance Indicators for Australian Public Mental Health Services (2005)*. The Project Specifications refer to the detailed specifications developed for the Benchmarking Project (published as Part 3 of the Project Manual). Both specifications are required to interpret the comments and recommendations of each of the forums. These documents are available at [www.mhnocc.org/benchmarking](http://www.mhnocc.org/benchmarking).

Please note these documents were developed for each forum as part of the evaluation process. The feedback from the Forensic Forum provides one source of information and advice around the national indicators. Once there is agreement by all participants these documents will be consolidated.

## **Comments and further information**

Any comments or requests for further information regarding the contents of these documents should be forwarded to the evaluation project officer via email: [kristen\\_breed@health.qld.gov.au](mailto:kristen_breed@health.qld.gov.au).

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# **PART ONE**

## **REVIEW OF AGREED NATIONAL KEY PERFORMANCE INDICATORS**

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## 28 day readmission rate

<b>PRIMARY DOMAIN</b>	Effective
<b>SUB-DOMAIN</b>	Community Tenure
<b>SECONDARY DOMAINS</b>	Continuous
<b>INITIAL REVIEW DATE</b>	24 – 25 October 2007

### LEARNINGS

- The 28 day readmission rate for forensic mental health services is very low, particularly in comparison with general adult psychiatric units. This is potentially a factor of access to resources rather than performance. Forensic beds are a scarce commodity 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.
- It is important to note that not all readmissions to psychiatric care are failures of care. Additionally, a lower readmission rate does not necessarily indicate better practices or outcomes than a higher readmission rate.
- A range of factors influence the indicator, 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.
- Analysis and identification of appropriate allied indicators (such as average length of stay and post-discharge community care) and contextual factors is essential to accurately interpret the output, as the same result 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.
- In Forensic services a key factor influencing readmission is the discharge destination. Consumers discharged to the community generally undergo an intensive, step-down discharge process that limits the likelihood of readmission to a forensic unit. Additionally, due to -clinical and resource based reasons (such as bed pressure) consumers who come from prison may be discharged back to prison sooner than the treating team would judge clinically appropriate.
- Although not all factors influencing readmission rates are in the control of service organisations, there is work that can be undertaken locally to impact on readmission rates. Specific action or inaction can be linked to a high or low readmission rate.
- There is the potential to utilise the information gained from the indicator to reinforce arguments regarding factors outside an organisations control (such as resources).
- For forensic services a consumers readmission to any mental health service organisation is more relevant and indicative of performance rather than just the discharging forensic mental health service.
- The Forensic forum investigated readmission rates with varying time periods (28 days, 91 days and 180 days). The data provided different perspective to the issue of readmission however further analysis is required to determine the utility and appropriateness of the varying reference periods.
- The impact of discharge destination warrants further investigation for the forensic mental health sector.

**For the FORENSIC PROGRAM AREA this indicator is RELEVANT**

**YES**

**For the FORENSIC PROGRAM AREA this indicator MEASURES WHAT IS INTENDED**

**NO**

- Although it is a measure of effectiveness as currently defined it does not allow for the specificity of effectiveness that would be relevant for the forensic mental health program area.

**For the FORENSIC PROGRAM AREA the NATIONAL DEFINITION is appropriate** YES

- The distinction between planned and unplanned readmissions is important and should remain within the definition. However, the technical difficulties associated with consistent and reliable collection of planned readmissions is acknowledged and further work is needed to address this issue.

**For the FORENSIC PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate** YES

- Given the current technical inability to accurately and consistently identify planned readmissions, the Forensic Forum agreed that the specifications should continue to look at all readmissions (rather than distinguishing between planned and unplanned readmissions). However, further work should be progressed to address and fix the current technical limitations for the construction of this indicator.
- The forum indicated that the specifications used for the benchmarking project (i.e. admissions to same organisation rather than any organisation within jurisdiction) were less reliable as a measure of efficiency, particularly for metropolitan organisations where there is considerable cross boundary flows. The Forensic Forum agreed that the indicator is best calculated on the basis of readmissions to any hospital within the jurisdiction, although it was acknowledged that this is information difficult for individual organisations to access.

**For the FORENSIC PROGRAM AREA UNIFORM TARGETS can be set** NO

- The legislative factors, outside the control of the mental health service organisation, impact on the organisation's capacity to influence readmissions.
- Planned readmissions are a current practice within many forensic services and given the small number of discharges and admissions could potentially artificially inflate the results.

**The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act** YES

**Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act** YES

**It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis** YES

- For most jurisdictions, individual organisations cannot easily access information regarding readmissions to any mental health service organisation within a jurisdiction and assistance from state and territory health authorities will be required.



**CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator**

- Additional and supplementary indicators:
  - bed occupancy;
  - waiting lists;
  - discharge destination or source of readmission;
  - legal status of consumer.
- Contextual information:
  - service structure, practices and resources (such as FTE);
  - casemix factors (including HoNOS and diagnosis profiles);
  - leave and discharge practices.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	YES	NO
The national definition is meaningful	YES	NO
The national data specifications can be applied without modification	YES	N.A.
The targets set for higher levels are also applicable at this level	N.A.	N.A.

**RECOMMENDATIONS for the FORENSIC PROGRAM AREA**

- The indicator **28 day readmission rate** can be utilised for benchmarking forensic mental health services as nationally defined and specified. However, it is important to note that it is not necessarily a measure of effectiveness due to admission practices and scarcity of forensic resources.
- Although the Forensic Forum agreed that the specifications should continue to look at all readmissions, it was highlighted that further work should be progressed to address and fix the current technical limitations for distinguishing between planned and unplanned readmissions.
- Research into the utility of an additional indicator focusing on readmission within 91 and 180 days should be considered for future investigation.
- The impact of discharge destination (prison versus community) should be considered in the interpretation of the data for forensic mental health services.

### National Service Standards Compliance

<b>PRIMARY DOMAIN</b>	Appropriate
<b>SUB-DOMAIN</b>	Compliance with standards
<b>SECONDARY DOMAIN</b>	Capable
<b>INITIAL REVIEW DATE</b>	24 – 25 October 2007

### LEARNINGS

- The Forensic Forum agreed that compliance with National Service Standards is relevant for mental health services and it is important to acknowledge an external review of processes. 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, there are different exemptions that services can access that may impact comparability of results.
- 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. Additionally, the review process is not necessarily consistent across surveyors or accreditation agencies.
- The indicator as currently specified has limited relevance and utilisation and the service level.
- Further discussion and investigation is required to develop a more appropriate indicator for this domain.

**For the FORENSIC PROGRAM AREA this indicator is RELEVANT** YES

**For the FORENSIC PROGRAM AREA this indicator MEASURES WHAT IS INTENDED** NO

**For the FORENSIC PROGRAM AREA the NATIONAL DEFINITION is appropriate** NO

**For the FORENSIC PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate** NO

**For the FORENSIC PROGRAM AREA UNIFORM TARGETS can be set** NO

**The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act** N.A.

**Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act** N.A.

**It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis** N.A.

**CONTEXTUAL INFORMATION critical to the interpretation of an organisation’s performance on this indicator** N.A.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	NO	NO
The national definition is meaningful	NO	NO
The national data specifications can be applied without modification	N.A.	N.A.
The targets set for higher levels are also applicable at this level	N.A.	N.A.

## **RECOMMENDATIONS for the FORENSIC PROGRAM AREA**

- The indicator **National Service Standards Compliance** should not be used to benchmark the appropriateness of forensic mental health services.
- Future activity should consider the development of a more appropriate indicator for this domain.

### Average length of acute inpatient stay

<b>PRIMARY DOMAIN</b>	Efficient
<b>SUB-DOMAIN</b>	Inpatient
<b>SECONDARY DOMAIN</b>	Appropriate
<b>INITIAL REVIEW DATE</b>	24 – 25 October 2007

### 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. Average length of acute inpatient stay is difficult to utilise within services that provide extended treatment with few discharges over the reference period.
- An indicator of length of stay needs to be interpreted within the context of the service and other indicators as the indicator is susceptible to changes in clinical practices, discharge practices, bed occupancy, community resources (especially accommodation) and prevailing community sensitivities, especially surrounding exit decisions.
- 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.
- Further research should be considered to develop a more appropriate indicator of length of stay or tenure for services providing extended treatment services.

**For the FORENSIC PROGRAM AREA this indicator is RELEVANT** YES

**For the FORENSIC PROGRAM AREA this indicator MEASURES WHAT IS INTENDED** NO

**For the FORENSIC PROGRAM AREA the NATIONAL DEFINITION is appropriate** NO

**For the FORENSIC PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate** NO

**For the FORENSIC PROGRAM AREA UNIFORM TARGETS can be set** N.A.

**The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act?** N.A.

**Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act** N.A.

**It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis** N.A.

**CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator** N.A.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator relevant to understanding performance	NO	NO
The national definition meaningful	NO	NO
The national data specifications be applied without modification	N.A.	N.A.
The targets set for higher levels also applicable at this level	N.A.	N.A.

**RECOMMENDATIONS for the FORENSIC PROGRAM AREA.**

- The indicator **average length of acute inpatient stay** can not be utilised for benchmarking forensic mental health services as nationally defined and specified.
- The development of a more appropriate indicator of efficiency in inpatient care as portrayed through length of stay, tenure or service throughput is required for benchmarking the efficiency of forensic mental health services.

**Average cost per acute inpatient episode**

<b>PRIMARY DOMAIN</b>	Efficient
<b>SUB-DOMAIN</b>	Inpatient
<b>INITIAL REVIEW DATE</b>	27 – 28 February 2008

**LEARNINGS**

- Inpatient episode cost is utilised within the general health sector.
- 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. Legal status has a significant impact on length of stay in forensic settings, and therefore will impact upon costs.
- 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 within the forensic environment (given current service models). There is a need to apportion costs for activity that is out-of-scope or to modify specifications to include statistical discharges where there is a change of care type.
- The forensic forum proposed that clarification was required within the definition of separation to determine how a service should count a consumer who moves from an acute unit to a rehabilitation unit within the same organisation.
- Within forensic services it is not uncommon for a number of consumers to be within the unit for the entire reference period and consideration should be given to developing appropriate methods for including those consumers in the calculation of measures of efficiency (such as statistical discharge at end of reference period).
- 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. Collection of data for sub-acute units within the forensic service would be relevant to assist in the understanding of a unit's efficiency in terms of expenditure.
- The reliability of 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. Consequently there is potential for the indicator to mislead analysis of an organisations efficiency and performance.
- The bed day cost, which is a component of episode costs, and full year costs are generally more relevant at the organisational level.

**For the FORENSIC PROGRAM AREA this indicator is RELEVANT** YES

**For the FORENSIC PROGRAM AREA this indicator MEASURES WHAT IS INTENDED?** NO

**For the FORENSIC PROGRAM AREA the NATIONAL DEFINITION is appropriate** NO

**For the FORENSIC PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate** NO

**For the FORENSIC PROGRAM AREA UNIFORM TARGETS can be set** NO

- Considerable work is required to develop consistent costing methodology across mental health services, both within and across jurisdictions.

**The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act?** N.A.

**Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act** N.A.

**It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis** **N.A.**

**CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator** **N.A.**

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	NO	NO
The national definition is meaningful	NO	NO
The national data specifications can be applied without modification	NO	N.A.
The targets set for higher levels are also applicable at this level	N.A.	N.A.

**RECOMMENDATIONS for the FORENSIC PROGRAM AREA**

- The indicator **average cost per acute inpatient episode** is not appropriate for benchmarking forensic mental health services as currently nationally defined and specified.
- The **bed day cost**, which is a component of episode costs, and full year costs are generally more relevant at the organisational level.
- The development of a more appropriate indicator of the efficiency of costs of inpatient care is required for benchmarking forensic mental health services.

**Average treatment days per three month community care**

<b>PRIMARY DOMAIN</b>	Efficient
<b>SUB-DOMAIN</b>	Community
<b>SECONDARY DOMAINS</b>	Appropriate
<b>INITIAL REVIEW DATE</b>	27 – 28 February 2008

**LEARNINGS**

- 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). However, the output at the organisational level potentially averages out any variation between models utilised by different teams and service models.
- Treatment days can be influenced by a range of factors outside the control of the local services, such as staff experience, service models, rurality, access to inpatient services, access to NGO services.
- The average can be impacted on by extreme outliers, particularly in smaller services.
- The indicator is not a measure of FTE productivity and is not intended to account for how clinicians spend their time. The indicator has the potential to highlight issues at the level of the team or individual clinician.
- 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.
- 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).
- It was noted that utilisation of treatment days is a method to account for reporting variation associated with occasions of service or service contacts, both within and between jurisdictions.
- It was acknowledged that the concept of treatment days was complex and would require education and training of staff to interpret and utilise the information.
- Although the pattern across the three years of data has remained relatively stable, the forum agreed that under-reporting of ambulatory contacts continues to be a significant issue impacting on the interpretability and reliability of the indicator.
- The aggregation of the indicator for all ambulatory services within an organisation limited the utility of the indicator at the organisational level. The forum noted that given the differences in service models within organisations (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.
- The forum found the inclusion of all forms of contacts in the construction of a treatment day to be acceptable as a high-level measure as it accounted for a large proportion of variation in costs and had less variability than contact reporting. However, it was acknowledged that the indicator is not a measure of the quality of the treatment provided as differences between the quality of the services provided cannot be determined without outcomes-based information.
- The Forum suggested that the collection of average contacts per treatment day may be a proxy indicator of intensity of treatment (noting that this does not distinguish between types of contacts or the quality of the service provided). However, it was acknowledged that there was not uniform capacity to collect this information.

**For the FORENSIC PROGRAM AREA this indicator is RELEVANT** YES

**For the FORENSIC PROGRAM AREA this indicator MEASURES WHAT IS INTENDED** YES

**For the FORENSIC PROGRAM AREA the NATIONAL DEFINITION is appropriate** YES



**For the FORENSIC PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate** **NO**

- The aggregation of the indicator for all ambulatory services within an organisation limited the utility of the indicator at the organisational level. The forum noted that given the differences in service models within organisations (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 contacts per treatment day may be a more appropriate measure of the efficiency of forensic ambulatory services. Further investigation of the construction and utility of this indicator is required.

**For the FORENSIC PROGRAM AREA UNIFORM TARGETS can be set** **NO**

**The indicator be INTERPRETED AND UNDERSTOOD by people who need to act** **YES**

**Performance on the indicator be INFLUENCED BY LOCAL DECISIONS by people who have the power to act** **YES**

**It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis** **YES**

**CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator**

- National indicators:
  - average cost per three-month community care period.
- Additional and supplementary indicators:
  - average contacts per treatment day;
  - average duration of contacts.
- Contextual information:
  - service models;
  - available resources (such as FTE per 100,000).

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	YES	YES
The national definition is meaningful	YES	YES
The national data specifications can be applied without modification	NO	NO
The targets set for higher levels are also applicable at this level	N.A.	N.A.

**RECOMMENDATIONS for the FORENSIC PROGRAM AREA**

- The indicator **average treatment days per three month community care period** can be utilised for benchmarking forensic mental health services as nationally defined, however the indicator should be stratified for the different forensic ambulatory service types.
- Consideration should be given to the use of **average contacts per treatment day**, and where possible a **measure of contact duration**, as a proxy indicator of intensity of treatment (noting that this does not distinguish between types of contacts or the quality of the service provided).

**Average cost per three month community care period**

<b>PRIMARY DOMAIN</b>	Efficient
<b>SUB-DOMAIN</b>	Community
<b>INITIAL REVIEW DATE</b>	27 – 28 February 2008

**LEARNINGS**

- The indicator is susceptible to poor compliance by clinicians with local information reporting requirements, particularly contact reporting (i.e. low reporting rates increases costs).
- The reliability of 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. Consequently there is potential for the indicator to mislead analysis of an organisation’s efficiency and performance.
- 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.
- The Forensic forum noted that efficient use of resources did not always equate to the provision of quality clinical care and that this needed to be considered in the interpretation of all indicators of efficiency..

**For the FORENSIC PROGRAM AREA this indicator is RELEVANT** YES

**For the FORENSIC PROGRAM AREA this indicator MEASURES WHAT IS INTENDED** YES

**For the FORENSIC PROGRAM AREA the NATIONAL DEFINITION is appropriate** YES

**For the FORENSIC PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate** YES

**For the FORENSIC PROGRAM AREA UNIFORM TARGETS can be set** NO

- Considerable work is required to develop consistent costing methodology across mental health services, both within and across jurisdictions.

**The indicator be INTERPRETED AND UNDERSTOOD by people who need to act** YES

**Performance on the indicator be INFLUENCED BY LOCAL DECISIONS by people who have the power to act** YES

**It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis** YES

**CONTEXTUAL INFORMATION critical to the interpretation of an organisation’s performance on this indicator**

- National indicators:
  - average treatment days per three month community care period.
- Additional and supplementary indicators:
  - average cost per treatment day;
  - annual average cost per consumer treated.
- Contextual information:
  - staffing mix.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	YES	NO
The national definition is meaningful	YES	NO
The national data specifications can be applied without modification	YES	N.A.
The targets set for higher levels are also applicable at this level	N.A.	N.A.

**RECOMMENDATIONS for FORENSIC PROGRAM AREA**

- The indicator *cost per three-month community care period* can be utilised for benchmarking at the mental health service organisation level as currently nationally defined and specified.
- Significant work is required to develop consistent costing methodology across health and mental health services, both within and across jurisdictions.

### Population under care

<b>PRIMARY DOMAIN</b>	Accessible
<b>SUB-DOMAIN</b>	Access for those in need
<b>INITIAL REVIEW DATE</b>	24 – 25 October 2007

### LEARNINGS

- Access to mental health services is an ongoing issue for most services and capacity to monitor and improve access (where necessary) is relevant.
- 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, such as catchment size, proportion of vulnerable groups, such as Indigenous populations and the level of available resources.
- 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).
- There is a need to be clear that it is not about the percentage of the catchment population receiving mental health care, but rather the percentage of catchment population receiving mental health care from local services.
- The output is susceptible to inaccuracies caused by different registration activities across community services. To be nationally comparable the data must be consistently recorded and counted. This must be considered in the interpretation and comparison of the indicator.
- It is essential that the indicator be split into the three service settings (acute inpatient, residential and ambulatory) to enable accurate interpretation, analysis and action. However, there are 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.
- Determination of the inpatient catchments for forensic population is also difficult, primarily prison versus general public. The legislation may allow for admission from general public but service models, local policy and bed pressures may dictate that admissions only come from the prisons. For most inpatient services the catchment population is the prison population however, this is variable across the participants and needs to be considered in the analysis and interpretation of this indicator.
- Given that forensic inpatient beds are a scarce resource and difficulties in identifying appropriate population, the focus of this indicator should be on the ambulatory services.

**For the FORENSIC PROGRAM AREA this indicator is RELEVANT** YES

**For the FORENSIC PROGRAM AREA this indicator MEASURES WHAT IS INTENDED** YES

**For the FORENSIC PROGRAM AREA the NATIONAL DEFINITION is appropriate** NO

- The national definition looks at the overall organisation and does not allow for the different catchments between service components.
- The definition utilised as part of the National Mental Health Benchmarking Project is more appropriate and useful, with further stratification by forensic ambulatory service type (Prison Mental Health, Court-Liaison, and Community Forensic)

**For the FORENSIC PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate** **NO**

- The national specifications construct the indicator for the overall organisation and does not allow for the different catchments between service components.
- The specifications utilised as part of the National Mental Health Benchmarking Project is more appropriate and useful, with further stratification by forensic ambulatory service type (Prison Mental Health, Court-Liaison, and Community Forensic)

**For the FORENSIC PROGRAM AREA UNIFORM TARGETS can be set** **NO**

- Targets developed for the forensic program area would vary depending upon the service type (for example, research indicators that between 20 – 25 percent of the prison population require treatment for mental illness, however this figure would be lower in Court Liaison and Community Forensic services). Further epidemiological evidence is required before targets can be set for this program area.

**The indicator be INTERPRETED AND UNDERSTOOD by people who need to act** **YES**

**Performance on the indicator be INFLUENCED BY LOCAL DECISIONS by people who have the power to act** **YES**

**It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis** **YES**

**CONTEXTUAL INFORMATION critical to the interpretation of an organisation’s performance on this indicator**

- Additional and supplementary indicators:
  - FTE per 100,000 population.
- Contextual information:
  - model of service;
  - population characteristics (such as demographic and epidemiological profiles);
  - staffing profile;
  - local prevalence of mental illness.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	YES	NO
The national definition is meaningful	YES	NO
The national data specifications can be applied without modification	N.A.	N.A.
The targets set for higher levels are also applicable at this level	N.A.	N.A.

**RECOMMENDATIONS for FORENSIC PROGRAM AREA**

- The indicator **population under care** can be utilised for benchmarking forensic mental health services as currently defined and specified for the National Mental Health Benchmarking Project, with further stratification by forensic ambulatory service type.
- Focus of analysis and investigation should be on ambulatory population under care as these services undertake the majority of activity within the public sector.

### Local access to inpatient care

<b>PRIMARY DOMAIN</b>	Accessible
<b>SUB-DOMAIN</b>	Local access
<b>INITIAL REVIEW DATE</b>	24 – 25 October 2007

#### 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 and/or clinician may not be 'local'.
- For services whose inpatient catchment stretches a large geographic region, which is the case for most forensic services, the concept of 'local' as defined for this indicator is not meaningful.
- The national definition and specifications currently exclude state-wide services as it was deemed irrelevant for services where there is not a competing non-local service for consumers to access.

<b>For the FORENSIC PROGRAM AREA this indicator is RELEVANT</b>	<b>NO</b>
<b>For the FORENSIC PROGRAM AREA this indicator is MEASURES WHAT IS INTENDED</b>	<b>NO</b>
<b>For the FORENSIC PROGRAM AREA the NATIONAL DEFINITION is appropriate</b>	<b>N.A.</b>
<b>For the FORENSIC PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate</b>	<b>N.A.</b>
<b>For the FORENSIC PROGRAM AREA UNIFORM TARGETS can be set.</b>	<b>N.A.</b>
<b>The indicator be INTERPRETED AND UNDERSTOOD by people who need to act</b>	<b>N.A.</b>
<b>Performance on the indicator be INFLUENCED BY LOCAL DECISIONS by people who have the power to act</b>	<b>N.A.</b>
<b>It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis</b>	<b>N.A.</b>
<b>CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator</b>	<b>N.A.</b>

	<b>SERVICE UNIT</b>	<b>INDIVIDUAL CLINICIAN</b>
The indicator is relevant to understanding performance	<b>NO</b>	<b>NO</b>
The national definition is meaningful	<b>NO</b>	<b>NO</b>
The national data specifications can be applied without modification	<b>N.A.</b>	<b>N.A.</b>
The targets set for higher levels are also applicable at this level	<b>N.A.</b>	<b>N.A.</b>

#### RECOMMENDATIONS for FORENSIC PROGRAM AREA

- The indicator **local access to acute inpatient care** should not be utilised for benchmarking forensic mental health services as a measure of access as nationally defined and specified.

## New Client Index

<b>PRIMARY DOMAIN</b>	Accessible
<b>SUB-DOMAIN</b>	Access for those in need
<b>INITIAL REVIEW DATE</b>	16 – 17 October 2007

### 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.
- 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'). Additionally, the indicator does not specify that the client needs to be an 'active' or ongoing client of the service (i.e. includes assessment only) as the indicator is about access and getting an assessment is about accessing the service.
- It was acknowledged that the use of 'new' as 365 days prior to first contact with any component of the mental health service organisation is arbitrary and an attempt to deal with information system constraints rather than determining that whether or not a consumer is actually new.
- When constructed for stand-alone or state-wide forensic services this indicator can be interpreted as new to program type rather than new to service organisation. This limits capacity to compare between stand-alone and integrated services.
- Different models of service and legislation make comparison within forensic services problematic (for example, the proportion of *civil regulation* versus *forensic* patients).
- The forensic forum agreed that it may be of use to compare new to program and new to organisation, noting the complexity regarding access to the data. There is value in determining if a forensic consumer has been in contact with general mental health services prior to coming into contact with the forensic services, noting this would require access to jurisdiction-wide data.
- Although the indicator can identify issues associated with access it does not identify the cause of access issues. Further analysis of structural, population and practice issues is required to interpret the indicator.

**For the FORENSIC PROGRAM AREA this indicator is RELEVANT** YES

**For the FORENSIC PROGRAM AREA this indicator MEASURES WHAT IS INTENDED** YES

**For the FORENSIC PROGRAM AREA the NATIONAL DEFINITION is appropriate** YES

**For the FORENSIC PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate** NO

- The specification of 'new' as defined for the National Mental Health Benchmarking Project, i.e. 365 days without contact with the mental health service organisation, is appropriate for benchmarking in the adult program area.

**For the FORENSIC PROGRAM AREA UNIFORM TARGETS can be set** NO

**The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act** YES

**Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act** YES

**It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis** **YES**

- The feasibility of data collection is varied within and across jurisdictions due to system issues and requirement of unique identification at the individual consumer level across organisations.
- There are technical and practical issues that impact on the capacity to collect ‘new’ as ‘new’ rather than ‘new in the last 365 days’.

**CONTEXTUAL INFORMATION critical to the interpretation of an organisation’s performance on this indicator**

- National indicators:
  - population under care.
- Additional and supplementary indicators:
  - new client index (new to mental health care).
- Contextual information:
  - population demographics.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	YES	NO
The national definition is meaningful	YES	NO
The national data specifications can be applied without modification	NO	N.A.
The targets set for higher levels are also applicable at this level	N.A.	N.A.

**RECOMMENDATIONS for the FORENSIC PROGRAM AREA**

- The indicator **new client index** as defined and specified for the National Mental Health Benchmarking Project is appropriate for benchmarking forensic mental health services.
- The forum agreed that it may be of use to compare new to program and new to organisation, noting the complexity regarding access to the data. There is value in determining if a forensic consumer has been in contact with general mental health services prior to coming into contact with the forensic services.



### Comparative area resources

<b>PRIMARY DOMAIN</b>	Accessible
<b>SUB-DOMAIN</b>	Access for those in need
<b>SECONDARY DOMAIN</b>	Sustainable
<b>INITIAL REVIEW DATE</b>	24 – 25 October 2007

### LEARNINGS

- The Forum considered that this was not necessarily an indicator of service performance as funding allocation is not completely 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 indicator is informative as defined for the national project (that is, split between the three settings). There are 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
- Access is impacted on by a range of issues (structural, population and service) that may not be within the control of the service.
- 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.

**For the FORENSIC PROGRAM AREA this indicator is RELEVANT** YES

**For the FORENSIC PROGRAM AREA this indicator MEASURES WHAT IS INTENDED** YES

**For the FORENSIC PROGRAM AREA the NATIONAL DEFINITION is appropriate** NO

- The national definition looks at the overall organisation and does not allow consideration of different catchment populations between service components.
- The definition utilised as part of the National Mental Health Benchmarking Project, further stratified by forensic ambulatory service type, is more appropriate and useful than the national definition.

**For the FORENSIC PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate** NO

- The national specifications look at the overall organisation and do not allow consideration of different catchment populations between service components.
- The specifications utilised as part of the National Mental Health Benchmarking Project, further stratified by forensic ambulatory service type, are more appropriate and useful.

**For the FORENSIC PROGRAM AREA UNIFORM TARGETS can be set** NO

**The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act** YES

**Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act** YES

**It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis** YES

**CONTEXTUAL INFORMATION critical to the interpretation of an organisation’s performance on this indicator**

- Contextual information:
  - staffing mix;
  - population demographics.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	YES	NO
The national definition is meaningful	YES	NO
The national data specifications can be applied without modification	YES	N.A.
The targets set for higher levels are also applicable at this level	N.A.	N.A.

**RECOMMENDATIONS for the FORENSIC PROGRAM AREA**

- The indicator **comparative area resources** can be utilised for benchmarking forensic mental health services as currently defined and specified for the National Mental Health Benchmarking Project, further stratified by forensic ambulatory service type (where possible and appropriate).

## Pre-admission community care

<b>PRIMARY DOMAIN</b>	Continuous
<b>SUB-DOMAIN</b>	Cross-setting continuity
<b>SECONDARY DOMAIN</b>	Accessible
<b>INITIAL REVIEW DATE</b>	24 – 25 October 2007

### 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 (limited evidence-base for this argument), (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 provides information about the mental health service organisation as a whole, not just the inpatient setting or just the community setting.
- 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 is vulnerable to poor community data collection adherence. 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.
- The indicator is sensitive to demographic factors, such as rurality (where consumers may wait longer for admission due to distance and so on) and transient population, and the threshold for admission.
- The indicator is about the mental health service organisation as a whole, not just the inpatient setting or just the community setting.
- The forensic forum suggested that there was utility in constructing the indicator as per the national specifications (pre-admission care anywhere), however it was noted that this requires access to state-wide data.

**For the FORENSIC PROGRAM AREA the indicator is RELEVANT** YES

**For the FORENSIC PROGRAM AREA the indicator MEASURES WHAT IS INTENDED** YES

**For the FORENSIC PROGRAM AREA the NATIONAL DEFINITION is appropriate** YES

**For the FORENSIC PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate** YES

**For the FORENSIC PROGRAM AREA UNIFORM TARGETS can be set** YES

- The capacity to meet a target will be impacted upon by local or organisation factors such as service models, admission procedures. Additionally, responsibility for gate-keeping of beds impacts upon this indicator (e.g. whether the service determines who comes in or whether it is the responsibility of another organisation).
- Limited to the specification of the National Mental Health Benchmarking Project, the Forensic forum agreed a good practice target that given adequate resources, good practice and access to state-wide data a mental health service organisation should be able to achieve **100 percent** on this indicator.

**NOTE:** Any target determined is preliminary and may change as more evidence is available. This absolute target is based upon expert opinion and consensus of participants in the Forensic Mental Health Forum.

**The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act** YES

**Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act** YES

- Decisions regarding a range of factors such as collaboration between service components, partnerships within primary care, private sector or non-government mental health services will impact on performance.

**It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis** YES

- Construction is feasible but difficult as it requires unique identification and/or linkage between inpatient and community systems that is not available in all jurisdictions.

**CONTEXTUAL INFORMATION critical to the interpretation of an organisation’s performance on this indicator**

- Additional and supplementary indicators:
  - pre-admission contact setting (forensic versus general mental health care);
  - bed occupancy.
- Contextual information:
  - service model;
  - admission processes, policies and pathways;
  - community data compliance/coverage.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator relevant to understanding performance	YES	YES
The national definition meaningful	YES	YES
The national data specifications be applied without modification	YES	YES
The targets set for higher levels also applicable at this level	YES	NO

**RECOMMENDATIONS for the FORENSIC PROGRAM AREA**

- The indicator **pre-admission community care** can be utilised for benchmarking forensic mental health services as defined and specified in the National Mental Health Performance Framework.
- Based upon the National Mental Health Benchmarking Project specifications a preliminary good practice target (*100 percent and above*) should be considered for use with forensic mental health services.

## Post-discharge community care

<b>PRIMARY DOMAIN</b>	Continuous
<b>SUB-DOMAIN</b>	Cross-setting continuity
<b>SECONDARY DOMAINS</b>	Accessible, Safe
<b>INITIAL REVIEW DATE</b>	16 – 17 October 2007

### LEARNINGS

- 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.
- It was acknowledged that 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.
- 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.
- As the indicator is currently specified there is no differentiation between people who are not contacted versus those where contact is attempted by service but refused or failed (due to movement from jurisdiction).
- The specifications for the national project assume that the organisation is most likely to follow-up, however this may not be the case with forensic consumers. Consequently, the discharge destination of forensic consumers is important in the interpretation of this indicator.
- For a state-wide service the indicator is about both service and system measurement.
- The indicator is vulnerable to poor ambulatory data collection compliance.

**For the FORENSIC PROGRAM AREA the indicator is RELEVANT** YES

**For the FORENSIC PROGRAM AREA the indicator MEASURES WHAT IS INTENDED** YES

**For the FORENSIC PROGRAM AREA the NATIONAL DEFINITION is appropriate** YES

- Both the definition utilised for the National Mental Health Benchmarking Project, discharge to care of forensic mental health organisation, and the definition of the National Mental Health Performance Framework are relevant, but need to be interpreted very differently as there would be different expectations of performance for consumers discharged to non-forensic services and those expected to be case-managed or overseen by a specialist forensic service.

**For the FORENSIC PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate** NO

- The Forensic Forum agreed that the specifications should be modified to only count follow-up contacts where the consumer participated.

**For the FORENSIC PROGRAM AREA UNIFORM TARGETS can be set** **YES**

- The types of forensic ambulatory services available vary across jurisdictions, and not all forensic services provide case-management services or have primary responsibility for contacting consumers. Access to state-wide data would enable the follow up by other services outside of the forensic mental health system to be identified. The forensic forum suggested that 100 per cent of consumers should be followed up when discharged from a forensic psychiatric inpatient unit.

**Good practice target**

- Utilising the National Mental Health Benchmarking Project specifications **100 percent** of consumers should be contacted in the seven days following discharge from an acute inpatient unit.

*NOTE: Any target determined is preliminary and may change as more evidence is available. This absolute target is based upon expert opinion and consensus of participants in the Forensic Mental Health Forum.*

**The indicator can be INTERPRETED AND UNDERSTOOD by people who need to act** **YES**

**Performance on the indicator can be INFLUENCED BY LOCAL DECISIONS by people who have the power to act** **YES**

**It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis** **YES**

- Construction is feasible but difficult as it requires unique identification and/or linkage between inpatient and community systems that is not available in all jurisdictions.

**CONTEXTUAL INFORMATION critical to the interpretation of an organisation’s performance on this indicator**

- Additional and supplementary indicators:
  - FTE per 100,000 population;
  - referral destination.
- Contextual information:
  - service model;
  - population demographics;
  - consumer profile (demographics, outcomes and diagnosis);
  - community data compliance/coverage.

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	YES	YES
The national definition is meaningful	YES	YES
The national data specifications can be applied without modification	YES	YES
The targets set for higher levels are also applicable at this level	YES	YES

**RECOMMENDATIONS for the FORENSIC PROGRAM AREA**

- The indicator **post-discharge community care** can be utilised for benchmarking forensic mental health services as defined in the National Mental Health Performance Framework, noting refinements to specifications to only include contacts where the consumer participated.
- A preliminary good practice target (*100 per cent*) should be considered for use with forensic mental health services when utilising the National Mental Health Benchmarking Project definition.

### Outcomes readiness

<b>PRIMARY DOMAIN</b>	Capable
<b>SUB-DOMAIN</b>	Outcomes orientation
<b>SECONDARY DOMAIN</b>	Effective
<b>INITIAL REVIEW DATE</b>	19 – 20 February 2008

### 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 causes some difficulty in interpretation and face validity (eg when have 150% participation). In particular, it is skewed in the favour of residential or long-stay services.
- A significant component of forensic ambulatory services is consultation liaison, although some jurisdictions provide comprehensive case management. The service models and protocols may dictate that they are not the service to collect the outcome information.
- The capacity to accurately link mental health clinical outcomes and service activity data is required to limit the significant skewing of the indicator.

**For the FORENSIC PROGRAM AREA this indicator is RELEVANT** YES

**For the FORENSIC PROGRAM AREA this indicator is MEASURES WHAT IS INTENDED** YES

**For the FORENSIC PROGRAM AREA the NATIONAL DEFINITION is appropriate** YES

**For the FORENSIC PROGRAM AREA the NATIONAL DATA SPECIFICATIONS are appropriate** NO

**For the FORENSIC PROGRAM AREA UNIFORM TARGETS can be set.** YES

- The forum noted that the national target for compliance with the protocol is 85 percent. There are issues regarding the collection of consumer self-assessment measures in forensic services which need to be considered in the interpretation of outcomes readiness data.
- Differences in local protocols need to be considered in interpreting achievement against the target.

#### Good practice target

- Forensic mental health services should be able to achieve **85 percent or above** compliance with the *National Outcomes and Casemix Collection* protocol.

**The indicator be INTERPRETED AND UNDERSTOOD by people who need to act** YES

**Performance on the indicator be INFLUENCED BY LOCAL DECISIONS by people who have the power to act** YES

**It is FEASIBLE to collect the required data and report this indicator at an organisational level on a regular basis** YES

**CONTEXTUAL INFORMATION critical to the interpretation of an organisation's performance on this indicator** NO

	SERVICE UNIT	INDIVIDUAL CLINICIAN
The indicator is relevant to understanding performance	YES	YES
The national definition is meaningful	YES	YES
The national data specifications can be applied without modification	YES	YES
The targets set for higher levels are also applicable at this level	YES	YES

**RECOMMENDATIONS for FORENSIC PROGRAM AREA**

- The indicator **outcomes readiness** can be utilised for benchmarking forensic mental health services as nationally defined and specified.
- A preliminary good practice target (*85 per cent and above*) should be considered for use with forensic mental health services.
- An indicator utilising mental health clinical outcomes (such as change scores over time) should be developed to measure the effectiveness of mental health services.



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# **PART TWO**

## **REVIEW OF ADDITIONAL AND SUPPLEMENTARY PERFORMANCE AND CONTEXTUAL INDICATORS**

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## SUPPLEMENTARY CONTEXTUAL INDICATORS

The following section briefly summarises the recommendations and key comments made by the Forensic Forum regarding the supplementary contextual indicators used within the National Mental Health Benchmarking Forum. These indicators were considered to provide **context** to the service and other indicators but were not deemed to be a measure of a service's performance (that is, services would not necessarily be able to influence the results due to changes in clinical or administrative practices).

The Forum considered whether or not the information was relevant and useful for benchmarking forensic mental health services, and whether or not it was feasible to collect the data and construct the indicator.

INDICATOR	DEFINITION and SPECIFICATIONS	RELEVANT, USEFUL and FEASIBLE	NATIONAL INDICATOR
<b>Total in-scope expenditure</b>	Sum of all in-scope expenditure during the reference period.	<b>YES</b> <ul style="list-style-type: none"> <li>Although there are considerable differences in costing methodologies which impact on the comparability of this data it was informative in estimated overall size of resource bucket.</li> </ul>	<b>NO</b>
<b>Inpatient expenditure and funding per capita differentials</b>	<ul style="list-style-type: none"> <li>Total inpatient expenditure <b>over</b> total catchment population (KPI#10).</li> <li>Total inpatient funding <b>over</b> total catchment population.</li> </ul>	<b>YES</b> <ul style="list-style-type: none"> <li>There are considerable differences in costing methodologies which impact on the comparability of this data, particularly in relation to funding sources.</li> </ul>	<b>NO</b>
<b>Ambulatory expenditure and funding per capita differentials</b>	<ul style="list-style-type: none"> <li>Total ambulatory expenditure <b>over</b> total catchment population (KPI#10).</li> <li>Total ambulatory mental health funding <b>over</b> total catchment population.</li> </ul>	<b>YES</b> <ul style="list-style-type: none"> <li>There are considerable differences in costing methodologies which impact on the comparability of this data, particularly in relation to funding sources.</li> </ul>	<b>NO</b>
<b>Community ambulatory mental health services direct care FTE per 100,000 population</b>	Number of community ambulatory mental health services direct care FTE within the reference period <b>over</b> the total catchment population for in-scope community ambulatory mental health services during the reference period.	<b>YES</b> <ul style="list-style-type: none"> <li>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.</li> <li>This indicator provides more information about expenditure rather than basic financial information.</li> </ul>	<b>NO</b>
<b>Acute beds per 100,000 population</b>	Number of in-scope acute inpatient psychiatric beds available during the reference period <b>over</b> the total catchment population for in-scope acute inpatient mental health services during the reference period.	<b>YES</b> <ul style="list-style-type: none"> <li>Bed information is more comparable than financial data as it is less susceptible to different accounting practices. Although there are potential differences in counting what is considered a</li> </ul>	<b>YES</b>

INDICATOR	DEFINITION and SPECIFICATIONS	RELEVANT, USEFUL and FEASIBLE	NATIONAL INDICATOR
		'bed'.	
<b>Non-acute beds per 100,000 population</b>	Number of in-scope non-acute psychiatric beds available during the reference period <b>over</b> the total catchment population for in-scope community residential mental health services during the reference period.	<b>YES</b>	<b>NO</b>
<b>Proportion of indirect expenditure</b>	Total indirect expenditure for all in-scope services during the reference period <b>over</b> the total expenditure for all in-scope services during the reference period.	<b>YES</b>	<b>NO</b>
<b>Proportion of expenditure on salaries and wages</b>	Total salaries and wages expenditure for all in-scope services during the reference period <b>over</b> the total expenditure for all in-scope services during the reference period.	<b>YES</b> <ul style="list-style-type: none"> <li>Although there are limitations on comparison of actual expenditure, 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.</li> </ul>	<b>YES</b>
<b>Full year cost per acute inpatient bed</b>	Total expenditure for all in-scope acute psychiatric inpatient units during the reference period <b>over</b> the number of in-scope acute psychiatric inpatient beds available during the reference period.	<ul style="list-style-type: none"> <li>YES</li> <li>This information complements the indicator <i>cost per acute inpatient episode</i>.</li> </ul>	<b>NO</b>
<b>Proportion of 'assessment only' ambulatory episodes</b>	Number of consumers receiving only one treatment day within a three month period of community care <b>over</b> the total number of three month periods of community care during the reference period.	<ul style="list-style-type: none"> <li>YES</li> </ul>	<b>NO</b>
<b>Full year cost per community ambulatory direct care FTE</b>	Total expenditure for in-scope community ambulatory services within the reference period <b>over</b> the total community ambulatory mental health direct care FTE within the reference period.	<b>YES</b>	<b>NO</b>
<b>Proportion of consumers who reside outside community ambulatory catchment</b>	Number of people receiving one or more community ambulatory service contacts who resided outside of the community ambulatory mental health services designated catchment during the reference period <b>over</b> the number of people receiving one or more community ambulatory service contacts from the community ambulatory mental health service during the reference period.	<b>NO</b>	<b>NO</b>
<b>Proportion of acute inpatient separations where the consumer</b>	Number of separations from the acute inpatient psychiatric unit for people who reside outside the designated acute psychiatric inpatient unit's catchment during the reference	<b>NO</b>	<b>NO</b>

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<b>resides outside acute inpatient catchment</b>	period <b>over</b> the total number of separations during the reference period.		
<b>Diagnosis Profile</b>	Diagnosis (at separation for inpatient, and 'most recent' for ambulatory settings) at separation grouped as percentage within each of the major diagnostic groupings (using ICD-10-AM codes) during the reference period.	<b>YES</b> <ul style="list-style-type: none"> <li>The data should be identified as primary diagnostic profile as it does not identify co-morbidities.</li> </ul>	<b>NO</b>
<b>Mental Health Outcomes Profile (HoNOS)</b>	The Forensic Forum considered the following HoNOS information: <ul style="list-style-type: none"> <li>Total HoNOS Score (Admission for Inpatient, Review for Ambulatory settings).</li> <li>Average HoNOS Item Score by Item (Admission for Inpatient, Review for Ambulatory settings).</li> <li>Percentage of clinically significant items by item (Admission for Inpatient, Review for Ambulatory settings).</li> <li>Proportion of overnight separations with HoNOS data.</li> </ul>	<b>YES</b>	<b>NO</b>
<b>Proportion of out-of-scope overnight separations</b>	Number of overnight separations deemed out-of-scope from acute psychiatric inpatient units within the reference period <b>over</b> the total number of overnight separations from acute psychiatric inpatient units during the reference period.	<b>YES</b>	<b>NO</b>
<b>Acute bed occupancy</b>	Total accrued mental health patient days for in-scope acute psychiatric units during the reference period <b>over</b> the number of available beds days during the reference period.	<b>YES</b>	<b>YES</b>

## SUPPLEMENTARY PERFORMANCE INDICATORS

The following section briefly summarises the recommendations and key comments made by the Forensic Forum regarding the additional and supplementary **performance** indicators used within the National Mental Health Benchmarking Forum.

The Forum considered whether or not the information was relevant and useful for benchmarking forensic mental health services, whether or not it was feasible to collect and construct and if the indicator should be considered for inclusion in the *National Mental Health Performance Framework*, either in addition to or as a replacement for an existing indicator.

INDICATOR	DOMAIN	DEFINITION and SPECIFICATIONS	RELEVANT, USEFUL and FEASIBLE	NATIONAL INDICATOR
<b>Average length of acute inpatient stay (stratified)</b>	Efficient	Total accrued patient days during the reference period <b>over</b> all separations from the acute psychiatric inpatient unit stratified by: <ul style="list-style-type: none"> <li>all separations;</li> <li>legal status.</li> </ul>	<b>NO</b> <ul style="list-style-type: none"> <li>The forensic forum identified a range of issues related to separation based indicators of tenure. Although stratification provides useful contextual information for length of stay of consumers within the acute units of organisation.</li> <li>It is difficult to consistently capture legal status.</li> <li>Length of Stay is a poor measure of efficiency for services that provide extended treatment.</li> </ul>	<b>NO</b>
<b>Cost per acute inpatient episode (stratified)</b>	Efficient	Total inpatient expenditure <b>over</b> the number of acute inpatient episodes (all separations) during the reference period	<b>NO</b> <ul style="list-style-type: none"> <li>The total cost of a bed over a 12 month period is more informative for forensic mental health services.</li> </ul>	<b>NO</b>
<b>Proportion of overnight separations with acute length of stay ≥ 180 days</b>	Efficient	Number of in-scope overnight separations with length of stay ≥ 180 days during the reference period <b>over</b> the number of in-scope overnight separations during the reference period.	<b>YES</b> <ul style="list-style-type: none"> <li>This information helps to explain some of the variability between services.</li> <li>Length of stay is often dictated by legal status rather than the performance of the organisation.</li> </ul>	<b>NO</b>
<b>Cost per acute inpatient bed day</b>	Efficient	Total expenditure for in-scope acute psychiatric inpatient units during the reference period <b>over the</b> total accrued mental health patient days for in-scope acute psychiatric units during the reference period.	<b>YES</b> <ul style="list-style-type: none"> <li>This information complements rather than replaces the indicator <i>cost per acute inpatient episode</i>.</li> </ul>	<b>NO</b>
<b>Average cost per community</b>	Efficient	Total expenditure on community ambulatory mental health services	<b>YES</b> <ul style="list-style-type: none"> <li>This information</li> </ul>	<b>NO</b>

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treatment day		during the reference period. Total number of treatment days during the reference period.	complements rather than replaces the indicator <i>average cost per three month community care period</i> .	
Average weekly contacts per direct care FTE	Efficient	Total community ambulatory service contacts within the reference period <b>over</b> the total number of community ambulatory direct care FTE within the reference period multiplied by 44 (assuming annual reporting period).	<b>YES</b> <ul style="list-style-type: none"> <li>This information is more informative when stratified by forensic ambulatory service type.</li> </ul>	<b>NO</b>
Average weekly treatment days per direct care FTE	Efficient	Total community treatment days within the reference period <b>over</b> the total number of community ambulatory direct care FTE within the reference period multiplied by 44 (assuming annual reporting period).	<b>YES</b> <ul style="list-style-type: none"> <li>This information is more informative when stratified by forensic ambulatory service type.</li> <li>When used with other contact indicators help to identify variation across services.</li> </ul>	<b>NO</b>
Average number of persons seen per year per ambulatory direct care FTE	Efficient	Number of persons receiving one or more service contacts from in-scope community ambulatory services during the reference period <b>over</b> the total number of community ambulatory direct care FTE during the reference period.	<b>YES</b> <ul style="list-style-type: none"> <li>This information is more informative when stratified by forensic ambulatory service type.</li> </ul>	<b>NO</b>
Average contacts per three month community care period	Efficient	Total community ambulatory service contacts within the reference period <b>over the</b> total 3-month community care periods during the reference period.	<b>NO</b>	<b>NO</b>
Overnight separations per 100,000 population	Efficient	Total number of overnight separations from acute psychiatric inpatient units during the reference period <b>over the</b> total population of acute psychiatric inpatient units designated catchment during the reference period.	<b>NO</b>	<b>NO</b>
Overnight acute separations per 100,000 population	Efficient	The number of separations from the acute psychiatric inpatient unit <b>over</b> the total catchment population (multiplied by 100,000)	<b>NO</b>	<b>NO</b>
Proportion of same day separations from acute psychiatric inpatient		Number of same day separations from acute psychiatric inpatient units within the reference period <b>over the</b> total number of separations from acute	<b>NO</b>	<b>NO</b>

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units		psychiatric inpatient units during the reference period.		
Proportion of consumers with at least one seclusion event	Safe	The number of consumers within the acute psychiatric inpatient unit at least one event of seclusion during the reference period <b>over</b> the number of consumers within the acute psychiatric inpatient unit during the reference period.	YES	NO
Proportion of consumers with at least two events of seclusion	Safe	The number of consumers within the acute psychiatric inpatient unit at least two events of seclusion during the reference period <b>over</b> the number of consumers within the acute psychiatric inpatient unit during the reference period.	YES	NO
Proportion of seclusion events that are four or more hours in duration	Safe	The number of seclusion events within the acute psychiatric inpatient unit that were at least four hours in duration during the reference period <b>over</b> the number of seclusion events within the acute psychiatric inpatient unit during the reference period.	YES	NO
Proportion of consumers who assault at least one	Safe	The number of consumers of the acute psychiatric inpatient unit who assault at least once during the reference period <b>over</b> the number of consumers within the acute psychiatric inpatient unit during the reference period.	YES	NO
Proportion of consumers who assault at least twice	Safe	The number of consumers of the acute psychiatric inpatient unit who assault at least twice during the reference period <b>over</b> the number of consumers within the acute psychiatric inpatient unit during the reference period.	YES	NO
Population receiving care (Prison)	Access	The number of unique consumers receiving care from Prison Mental Health Service <b>over</b> the total prison population of the catchment.	YES	NO
Population receiving care (Forensic community)	Access	The number of unique consumers receiving care from the Forensic Community Mental Health Service <b>over</b> the total catchment population.	YES	NO

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<b>Population receiving care (Court Liaison)</b>	Access	The number of unique consumers receiving care from Court Liaison Mental Health Service <b>over</b> the total number of court lodgements.	<b>YES</b>	<b>NO</b>
<b>Readmission Rate (91 and 182 days)</b>	Effective	The number of separations from acute psychiatric inpatient units that are followed by a readmission within 91/182 days following that separation during the reference period <b>over</b> the total number of in-scope separations during the reference period.	<b>YES</b>	<b>NO</b>