## Data quality information — Mental health management, chapter 12

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| Data Quality Information |
| Data quality information (DQI) provides information against the seven Australian Bureau of Statistics (ABS) data quality framework dimensions, for a selection of performance indicators in the Aged care services chapter. DQI for additional indicators will be progressively introduced in future reports.  Technical DQI has been supplied or agreed by relevant data providers. Additional Steering Committee commentary does not necessarily reflect the views of data providers. |
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### New client index

DQI for this indicator has been sourced from the Australian Institute of Health and Welfare (AIHW) and State and Territory health authorities with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Equity — access |
| Indicator | New client index |
| Measure  (computation) | Description:  Proportion of total clients under the care of State or Territory specialised public mental health services who were new clients. A new client is a consumer who has not been seen by a specialised public mental health service in the five years preceding the initial contact with a service in the relevant reference period.  Numerator:  Number of new clients ― clients who had not been seen by a public mental health service in the five years preceding the initial contact with a service in the relevant reference period.  Denominator:  Number of total clients under the care of State or Territory specialised public mental health services in the relevant reference period.  Computation:  Expressed as a proportion: (Numerator ÷ Denominator)\*100. |
| Data source/s | The AIHW using data provided by State and Territory governments from the community mental health care (CMHC), residential mental health and admitted patients mental health collections. |
| Data Quality Framework Dimensions | |
| Institutional environment | The AIHW calculated the indicator based on data supplied by state and territory health authorities.  The State and Territory health authorities provide these data according to specifications agreed under the *National Key Performance Indicators for Australian Public Mental Health Services*. State and Territory health authorities receive these data from specialised mental health organisations/units in psychiatric and acute hospitals, community‑based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation. |
| Relevance | Estimates are based on all ‘in‑scope’ clients (new and total) who are in receipt of services from state and territory public psychiatric inpatient units, residential units and community mental health services. New clients are those who have not been seen by a public specialised mental health service in the five years preceding the initial contact with a service in the relevant reference period. A consumer is not considered to be ‘new’ client if they present with a new condition, but have previously received treatment for other conditions.  Data for all years reflect full financial year activity — that is, all in scope clients from public specialised mental health services between the period 1 July and  30 June for each financial year.  Only state and territory specialised public mental health services are included. New clients may have been treated in the preceding five years outside the state/territory specialised public mental health system in the primary mental health care or the specialist private mental health sector.  States and territories vary in their capacity to accurately track clients across organisations, due to the lack of unique patient identifiers or data matching systems. SA indicated that the data submitted were not based on unique patient identifier or data matching approaches.  Remoteness and socioeconomic status have been allocated using the client’s usual residence, not the location of the service provider. State/territory is reported for the state/territory of the service provider.  For NSW, residential clients are not included because their data is manually collected without a Statewide Unique Patient Identifier (SUPI) assigned, thus making the unique counts of the residential clients together with the inpatient and ambulatory clients not possible.  For WA, the matching of mental health community contacts to inpatient episodes is done for 2012‑13 between two separate data systems and requires the use of record linkage to be able to identify the same person in both systems. There are delays associated in the use of record linkage and these delays can result in not getting a match between a community contact and a separation when there should be one. The number of unique consumers (both total and new) could be over‑estimated as a result. Data before 2012‑13 are based on data submitted for the National Minimum Data Set (NMDS) and have not been revised.  Data are not available for Victoria for 2011‑12 or 2012‑13. All Australian totals for 2011‑12 and 2012‑13 exclude Victoria.  All states except Victoria count triage and referral patients, that is those who are assessed and referred on.  Industrial action in Tasmania in 2011‑12 and 2012‑13 has limited the quality and quantity of community data. |
| Timeliness | State and Territory governments provide data to the AIHW for national collation, approximately twelve months after the reference period. The reference period for the latest data is 2012‑13. |
| Accuracy | State and Territory governments are primarily responsible for the quality of the data they provide. The AIHW analyses the data, but cannot independently verify them.  Data are subject to ongoing historical validation. Due to this ongoing validation, 2009‑10 and 2011‑12 data might differ from previous reports.  States and territories differ in their capacity to accurately track clients across organisations or service types, due to the lack of unique patient identifiers or data matching systems. This has led to over/undercounting of clients in some jurisdictions.   * NSW has implemented a SUPI for mental health care. The identification of prior contacts for mental health clients is dependent upon the SUPI, both in coverage (all clients having a SUPI) and in the resolution of possible duplicates. There are differences in the completeness of coverage between the Local Health Districts/Networks and over time. The average SUPI coverage at a State level is 99.9 per cent for 2012‑13. The numbers provided are a distinct count of individuals using the SUPI (majority) and a count of individuals at the facility level for a small percentage of clients without a SUPI in the reporting period (which may include some duplicates of those who attended multiple facilities). * For NSW, residential clients are not included because their data is manually collected without SUPI assigned, thus making the unique counts of the residential clients together with the inpatient and ambulatory clients not possible. The client base of the NSW mental health residential is very small which will have minimal effect on the final result (total residential MH clients in 2010‑11 is 185 with 59 potential new clients, 243 total residential MH clients with 130 potential new clients in 2011‑12) and 237 total residential MH clients with 131 potential new clients in 2012‑13). * For WA, the matching of mental health community contacts to inpatient episodes for 2012‑13 is done between two separate data systems and requires the use of record linkage to be able to identify the same person in both systems. There are delays associated in the use of record linkage and these delays can result in not getting a match between a community contact and a separation when there should be one. The number of unique consumers (both total and new) could be over‑estimated as a result. * For SA, the client counts are not unique: they are an aggregation of three separate databases with no linkage between them. The impact on the result should be minimal due to populations being relatively stable within the three respective catchments. * For Tasmania, information for years before 2012‑13 were extracted from three different data sources and linked together with a Statistical Linkage Key (SLK) for each individual present in the extracts for the reporting period. While every attempt has been made to reduce any duplication of identified clients, using an SLK will lead to some duplication and can wrongly identify clients as new clients. Tasmania has been progressively implementing a state‑wide patient identification system. Data for 2012‑13 is considered to be the first collection period with this system fully implemented. |
| Coherence | Data are reported for each year from 2009‑10 to 2012‑13. There has been no major change to the methodology used to collect the data across years except as outlined below for WA.  The Australian totals for 2011‑12 and 2012‑13 exclude Victoria and are not comparable to previous years.  Jurisdictions can differ in their approaches to counting clients under care. For example, people who are assessed for a mental health service but do not go on to be treated for a mental illness are included in the data by some jurisdictions but not others. Therefore, comparisons between jurisdictions should be made with caution.  States and territories differ in their capacity to accurately track clients across organisations or service types, this can affect the comparability of the results across jurisdictions (see the accuracy dimension).  For WA, data before 2012‑13 are based on data submitted for the NMDS and have not been revised. |
| Accessibility | Data are also available for this indicator in the:   * National mental health reports www.health.gov.au/internet/main/ publishing.nsf/Content/mental‑data * Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/). |
| Interpretability | Information for understanding this indicator is available:   * the *Key* Performance *Indicators for Australian Public Mental Health Services, Second Edition* at www.health.gov.au/internet/mhsc/publishing.nsf /Content/99A25CC5B3781660CA257A5D000235B3/$File/kpitech.pdf * in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition * from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/). |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * States and territories vary in their capacity to accurately track clients across organisations, due to the lack of unique patient identifiers or data matching systems. * Data are not available for Victoria for 2011‑12 or 2012‑13. All Australian totals for 2011‑12 or 2012‑13 exclude Victoria. * Industrial action in Tasmania in 2011‑12 and 2012‑13 has limited the available data quality and quantity of community data. |

### Mental health service use by special needs groups and total population

DQI for this indicator has been sourced from the AIHW for the National Healthcare Agreement with additional Steering Committee comments.

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| Indicator definition and description |

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| Elements | Equity — Access and Effectiveness — Access |
| Indicators | Mental health service use by special needs groups  Mental health service use by total population |
| Measure (computation) | The *numerator* is the number of people receiving mental health services, separately for three service types.  The *denominator* is the Estimated Resident Population (ERP) as at 30 June.  *Calculation* is 100 × (Numerator ÷ Denominator), presented as a percentage and age‑standardised to the Australian population as at 30 June 2001, using 5‑year age groups to 84 years with ages over 84 years combined. Aboriginal and Torres Strait Islander population data are not available for all data sources for 5‑year age groups beyond 64 years. Where data were not available, Aboriginal and Torres Strait Islander disaggregations were standardised to 64 years with ages over 64 years combined.  These are calculated separately for public, private, Medicare Benefits Scheme‑ and Department of Veterans’ Affairs (DVA)‑funded services. |
| Data source/s | Numerators:  For Public data: State/Territory data, including admitted specialised mental health hospital, residential mental health care and CMHC services.  For Private data: Private Mental Health Alliance (PMHA) Centralised Data Management Service (CDMS) data.  For MBS data: Australian Government Department of Health (Health) MBS Statistics.  For DVA data: Australian Government DVA Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data.  Denominator:  ABS ERP as at 30 June.  ABS Aboriginal and Torres Strait Islander Estimates and Projections Series B. |
| Data Quality Framework Dimensions | |
| Institutional environment | The AIHW prepared the denominator and calculated the indicator based on numerators supplied by other data providers. The AIHW is an independent statutory authority within the Health portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.  Numerators for this indicator were prepared by State and Territory health authorities, the PMHA, Health and DVA and quality‑assessed by the AIHW.  The AIHW drafted the initial data quality statement. The statement was finalised by AIHW following input from State and Territory health authorities, PMHA, Health and DVA. The AIHW does not hold the relevant mandated datasets required to independently verify the data tables for this indicator.  Public data  The State and Territory health authorities receive these data from public sector specialised mental health services. States and territories use these data for service planning, monitoring and internal and public reporting.  Private data  The PMHA’s CDMS provided data submitted by private hospitals with psychiatric beds. The data are used by hospitals for activities such as quality improvement.  Health MBS and DVA TAS data  The Department of Human Services (DHS) processes claims made under the *Medicare Australia Act 1973*. These data are then regularly provided to Health. DHS also processes claims for DVA Treatment Card holders made through the MBS under the *Veterans’ Entitlements Act 1986; Military Rehabilitation and Compensation Act 2004* and *Medicare Australia Act 1973*. All claiming data is regularly provided to DVA as per the Memorandum of Understanding between DHS and DVA. |
| Relevance | Estimates are based on counts of individuals receiving care within the year, by each service type, where each individual is generally counted once regardless of the number of services received. Persons can receive services of more than one type within the year; a count of persons receiving services regardless of type is not available.  Persons receiving mental health treatment are not captured in these data sources include individuals receiving mental health services (other than as admitted patients in private hospitals) funded through other third party funders (eg transport accident insurers, workers compensation insurers) or out of pocket sources.  There is likely to be considerable overlap between the various data sources since it is likely that patients accessing public services and private hospital services would also access MBS services.  Remoteness and socioeconomic status have been allocated using the client’s usual residence, not the location of the service provider. State/territory is reported for the state/territory of the service provider.  Public data  Person counts for State and Territory mental health services are counts of persons receiving one or more service contacts provided by public sector specialised mental health services, including admitted hospital, community and residential services. SA submitted data that were not based on unique patient identifier or data matching approaches.  Private data  Private hospital estimates are counts of individuals receiving admitted patient specialist psychiatric care in private hospitals.  Health MBS and DVA TAS data  Data are counts of individuals receiving mental health‑specific MBS services for which DHS has processed a claim.  Analyses by state/territory, remoteness and socioeconomic status are based on postcode of residence of the client as recorded by DHS at the date of last service processed in the reference period. As clients may receive services in locations other than where they live, these data do not necessarily reflect the location in which services were received.  DVA clients comprised less than 2 per cent of people receiving Australian Government (Medicare Benefits Scheme‑ and DVA‑funded) clinical mental health services. |
| Timeliness | The reference periods for these data are 2007‑08, 2008‑09, 2009‑10, 2010‑11, 2011‑12 and 2012‑13. |
| Accuracy | Cells have been suppressed to protect confidentiality (where the presentation could identify a patient or a single service provider).  Public data  State and Territory jurisdictions differ in their capacity to provide accurate estimates of person receiving services (see above). Additionally, jurisdictions differ in their approaches to counting clients under care. For example, people who are assessed for a mental health service but do not go on to be treated for a mental illness are included in the data by some jurisdictions but not others. Therefore, comparisons between jurisdictions should be made with caution.  The Indigenous status data should be interpreted with caution due to the varying and, in some instances, unknown quality of Aboriginal and Torres Strait Islander identification across jurisdictions. Indigenous status was missing or not reported for around 8 per cent of all clients in 2012‑13.  Private data  Coverage of private hospitals includes all private hospital with designated psychiatric beds and private psychiatric day hospitals.  The data provided are an estimate of overall activity. Actual counts are multiplied by a factor that accounts for the proportion of data missing from the CDMS collection. That adjustment is performed at the level of State and Territory and also financial year, since non‑participation rates varied from state to state and financial year.  Patient counts are unique at the hospital level, therefore, duplication of persons in this data may be possible.  Indigenous status information is not collected for these data.  Health MBS and DVA TAS data  As with any administrative system a small degree of error may be present in the data captured.  Data used for statistical purposes are based on enrolment postcode of the patient. This postcode may not reflect the current postcode of the patient if an address change has not been notified to DHS.  The data provided are based on the date on which the claim was processed by DHS, not when the service was rendered. The use of data based on when the claim was processed, rather than when the service was rendered, produces little difference in the total number of persons included in the numerator for the reference period.  People who received more than one type of service are counted once only in the calculations for this indicator.  Health MBS data presented by Indigenous status have been adjusted for under‑identification in the DHS Voluntary Indigenous Identifier (VII) database. Aboriginal and Torres Strait Islander rates are therefore modelled and should be interpreted with caution. These statistics are not derived from the total Australian Aboriginal and Torres Strait Islander population, but from those Aboriginal and Torres Strait Islander people who have voluntarily identified as Aboriginal and Torres Strait Islander to DHS. The statistics have been adjusted to reflect demographic characteristics of the overall Aboriginal and Torres Strait Islander population, but this adjustment may not address all the differences in the service use patterns of the enrolled population relative to the total Aboriginal and Torres Strait Islander population. The level of VII enrolment (61 per cent nationally as at August 2012) varies across age‑sex‑remoteness‑State/Territory sub‑groups and over time which means that the extent of adjustment required varies across jurisdictions and over time. The methodology for this adjustment was developed and verified by the AIHW and Health for assessment of MBS and PBS service use and expenditure for Aboriginal and Torres Strait Islander Australians. For an explanation of the methodology, see *Expenditure on health for Aboriginal and Torres Strait Islander people 2006‑07*.  DVA TAS data are not available by Indigenous status. |
| Coherence | Following the 2011 Census of Population of Housing, the ABS has rebased the Australian population back to 1991. This rebasing had a significant impact on the population time series, therefore data were resupplied in the previous reporting cycle for previous years using the rebased ERP except for data presented by Indigenous status. Rebased Aboriginal and Torres Strait Islander population data is now available and have been used to re‑calculate all historical data disaggregated by Indigenous status.  In 2011, the ABS updated the standard geography used in Australia for most data collections from the Australian Standard Geographical Classification (ASGC) to the Australian Statistical Geography Standard (ASGS). Also updated at this time were remoteness areas and the Socio‑Economic Indexes for Areas (SEIFA) based on the 2011 ABS Census of Population and Housing. The new remoteness areas will be referred to as RA 2011, and the previous remoteness areas as RA 2006. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006.  Data for 2007‑08 through to 2010‑11 reported by remoteness are reported for RA 2006. Data for 2011‑12 and subsequent years are reported for RA 2011. The AIHW considers the change from RA 2006 to RA 2011 to be a series break when applied to data supplied for this indicator, therefore remoteness data for 2010‑11 and previous years are not directly comparable to remoteness data for 2011‑12 and subsequent years.  Data for 2007‑08 through to 2010‑11 reported for SEIFA deciles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011‑12 are reported using SEIFA 2011 at the SLA level. Data for 2012‑13 and subsequent years are reported using SEIFA 2011 at the Statistical Area (SA) 2 level. The AIHW considers the change from SEIFA 2006 to SEIFA 2011, and the change from SLA to SA2 to be series breaks when applied to data supplied for this indicator. Therefore SEIFA data for 2010‑11 and previous years are not directly comparable with SEIFA data for 2011‑12, and SEIFA data for 2011‑12 and previous years are not directly comparable with SEIFA data for 2012‑13 and subsequent years.  Public data  Public data for all collection periods were re‑supplied by jurisdictions due to an expanded scope that includes all specialised public mental health services. Historical disaggregated data have not been re‑supplied, therefore, comparisons with 2012‑13 for any disaggregated data is not valid. As mentioned above, public historical Aboriginal and Torres Strait Islander data were re‑calculated with the revised Aboriginal and Torres Strait Islander population data, however, as per this coherence issue, historical comparisons with 2012‑13 data are not valid.  For public sector community mental health services, Victorian data is unavailable (for 2011‑12 and 2012‑13) due to service level collection gaps resulting from protected industrial action during this period. Industrial action during the 2011‑12 and 2012‑13 collection periods in Tasmania has limited the available data quality and quantity of data. Australian totals for 2011‑12 and 2012‑13 only include available data and should therefore be interpreted with caution. Australian totals for 2011‑12 and 2012‑13 should not be compared to previous years.  Tasmania has been progressively implementing a state‑wide patient identification system. Data for 2012‑13 is considered to be the first collection period with this system fully implemented. Tasmanian data for 2007‑08 and 2008‑09 include people who received a Helpline services. From 2009‑10 onwards these have been excluded consistent with the indicator definitions. Data for 2007‑08 and 2008‑09 are also limited to people who accessed Community mental health services only. Therefore, Tasmanian data is not comparable across years.  In past years there has been variation in the underlying concept used to allocate remoteness and socioeconomic status across jurisdictions (i.e. location of service provider, location of client or a combination of both). In addition, the underlying concordances used by jurisdictions to allocate remoteness may vary. Since  2009‑10, remoteness and socioeconomic status have been allocated using the SLA of the client at last contact. For 2011‑12 data all jurisdictions have used the same concordance and proportionally allocated records to remoteness and SEIFA categories with the following exception:   * NSW and the NT used postcode concordance (rather than SLA concordance) to allocate records to remoteness and SEIFA. * From 2009‑10 onwards, disaggregation by SEIFA is based on a person’s usual residence, not the location of the service provider, except for the NT for which the majority of the data were based on the location of the service. Due to system‑related issues impacting data quality, Tasmania was unable to provide data by SEIFA for 2008‑09.   Comparisons over time for remoteness and socioeconomic status should therefore be interpreted with caution.  Private data  There has been no change to the methodology used to collect the data in 2012‑13. Therefore, the data are comparable to previous reporting periods.  Health MBS and DVA TAS data  The same methodology to attribute demographic information to the data has been used in 2012‑13 as in previous reporting periods.  For 2010‑11 and previous years, remoteness and socioeconomic status for both Health MBS and DVA TAS data were allocated using a postcode concordance. For 2011‑12 and beyond, DVA TAS data were allocated to remoteness using geocoding, and to socioeconomic status using an SLA/SA2 concordance.  MBS items 81325 and 81355 were added from 1 November 2008. These items relate to mental health or psychological services provided to a person who identified as being of Aboriginal or Torres Strait Islander descent.  On 1 January 2010, a new MBS item (2702) was introduced for patients of GPs who have not undertaken mental health skills training. Changes have been made to the existing MBS item 2710 to allow patients of GPs who have undertaken mental health skills training to access a higher rebate. Both of these items relate to the preparation of a GP mental health treatment plan.  On 1 November 2011, MBS items 2715 and 2717 were introduced to cover preparation of a GP mental health treatment plan by a GP who has undertaken mental health skills training. At the same time MBS items 2700 and 2701 were introduced to cover preparation of a GP mental health treatment plan by a GP who has not undertaken mental health skills training.  On 1 July 2011, MBS item 288 was introduced as a telehealth mental health related item.  MBS item 2719 existed from 1 November 2011 to 30 April 2012.  From 2011‑12 MBS item 20104 is included to align with other national indicators.  Caution should be taken when interpreting Aboriginal and Torres Strait Islander rates over time. All other data can be meaningfully compared across reference periods.  Other publications  The AIHW publication series Mental health services in Australia contains data that is comparable in coverage (using different MBS item splits) and includes a summary of MBS mental health‑related items.  The data used in this indicator is also published in the COAG National Action Plan on Mental Health — final progress report covering implementation to 2010‑11. There may be some differences between the data published in these two sources as:   * rates may be calculated using different ERPs other than the June ERPs used for this indicator, * MBS numbers are extracted using a different methodology. The COAG National Action Plan on Mental Health — final progress report covering implementation to 2010‑11 counts a patient in each state they resided in during the reference period but only once in the total whereas this indicator counts a patient in only one State/Territory.   The indicator specifications and analysis methodology used for this report are equivalent to the Healthcare 2011‑12: comparing performance across Australia. |
| Accessibility | MBS statistics are available at:   * www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics‑1 * www.medicareaustralia.gov.au/statistics/mbs\_item.shtml   Disaggregation of MBS data by SEIFA is not publicly available elsewhere. |
| Interpretability | Information is available for MBS data from:   * www.health.gov.au/internet/mbsonline/publishing.nsf/content/medicare‑benefits‑schedule‑mbs‑1 |

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| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following issues:   * This is a proxy measure of access to appropriate care. * State and Territory jurisdictions differ in their approaches to counting clients under care, including different thresholds for registering a client. Additionally, they differ in their capacity to provide accurate estimates of individual persons receiving mental health services. Therefore comparisons between jurisdictions need to be made with caution. * The Indigenous status data should be interpreted with caution: * public sector community mental health services (Public) data: There is varying and, in some instances, unknown quality of Aboriginal and Torres Strait Islander identification among jurisdictional data sources. * Medicare Benefits Schedule (MBS) data: have been adjusted for under‑identification of Indigenous status in the Medicare Australia Voluntary Indigenous Identifier (VII) database. * Disaggregation of this indicator by Indigenous status for private patients and those recorded in DVA data is a priority. * Remoteness data for 2010‑11 and previous years are not directly comparable to remoteness data for 2011‑12 and subsequent years. * SEIFA data for 2010‑11 and previous years are not directly comparable with SEIFA data for 2011‑12, and SEIFA data for 2011‑12 and previous years are not directly comparable with SEIFA data for 2012‑13 and subsequent years. * For public sector community mental health services, Victorian data is unavailable (for 2011‑12 and 2012‑13) due to service level collection gaps resulting from protected industrial action during this period. Industrial action during the 2011‑12 and 2012‑13 collection periods in Tasmania has limited the available data quality and quantity of data. Australian totals of public sector community mental health services for 2011‑12 and 2012‑13 only include available data and should therefore be interpreted with caution. Australian totals for 2011‑12 and 2012‑13 should not be compared to previous years. * Public data for all collection periods has been re‑supplied capturing a greater scope. Historical disaggregated data have not been re‑supplied, therefore, comparisons between years for any disaggregated data is not valid. * Historical Aboriginal and Torres Strait Islander data has been re‑calculated with the revised Aboriginal and Torres Strait Islander population data. * Data have been provided according to the State or Territory of service, but at the sub‑state level (remoteness area) have been classified by the client’s place of usual residence. For example, a person who usually resides in a very remote area of the NT and is treated by a service in a major city in Victoria would be classified at the sub‑state level as a very remote area of Victoria (even though Victoria itself has no very remote areas under the ABS remoteness classification). Further work is required to determine whether geographic location for this indicator should be based on usual residence of the client (used for most indicators) or location of the service. * Data linkage work is underway to obtain comprehensive and consistent data on people with mental illness across the full scope of service types. |

### Primary mental health care for children and young people

DQI for this indicator has been sourced from the Australian Government (Department of Health) with additional Steering Committee comments.

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| Indicator definition and description | | |
| Element | Effectiveness — access | |
| Indicator | Primary mental health care for children and young people | |
| Measure  (computation) | Description:  Proportion of young people aged under 25 years who received a primary mental health care services subsidised through the MBS. Data are also reported by four age cohorts: pre‑school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years).  Numerator:  Number of young people aged under 25 years who received a primary mental health care services subsidised through the MBS and by age cohort  (pre‑school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years).  Denominator:  ERP aged under 25 years and by age cohort (pre‑school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years).  Computation:  Expressed as a proportion: (Numerator/s ÷ Denominator/s)\*100.  Calculated for all young people (aged under 25 years) and separately by age cohort, gender, Indigenous status, remoteness, SEIFA and service type. | |
| Data source/s | Numerator:  Department of Health MBS Statistics data.  Denominator:  ABS Australian Demographic Statistics. | |
| Data Quality Framework Dimensions | | |
| Institutional environment | | MBS data are an administrative by‑product of the DHS, Medicare fee‑for‑service payment systems. DHS, Medicare collects MBS data under the *Human Services (Medicare) Act 1973* and regularly provides the data to Department of Health.  The ABS operates within a framework of the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.  For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment at www.abs.gov.au. |
| Relevance | | Includes primary mental health care covered by the MBS only. Other relevant forms of primary mental health care for young people are not incorporated due to a lack of available data, including community health centres, Aboriginal Community Controlled Health Services, school counsellors and health nurses, university and Technical and Further Education counselling services and a component of the mental health care provided by state/territory specialised public mental health services.  MBS data are counts of young people receiving mental health‑specific MBS services for which DHS has processed a claim, excluding those for psychiatrists. The relevant MBS items are as follows:   * GP and other services include MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2700, 2701, 2702, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2715, 2717, 2719, 2721, 2723, 2725, 2727. * Clinical psychologist services include MBS items 80000, 80005, 80010, 80015, 80020. * Other allied health services include MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 81325, 81355, 82000, 82015.   Analyses by state/territory of MBS data is based on postcode of residence of the client as recorded by DHS at the date of last service processed in the reference period. As clients may receive services in locations other than where they live, these data do not necessarily reflect the location in which services were received. The allocation to the state/territory uses a concordance and splits a person where the postcode covers more than one state/territory, therefore the totals may not equal the sum of the individual cells due to rounding.  MBS data are based on the date the claim was processed. Age of the patient is based on their age at the date of the service.  The population data are for the 30 June of the proceeding financial year. For 2013‑14 data, it is June 2013. All ERP data are based on the *2011 Census of Population and Housing* . |
| Timeliness | | MBS claims data are available within 14 days of the end of a month. The reference period for the latest data is 2013‑14. |
| Accuracy | | DVA TAS data are not available.  As with any administrative system a small degree of error may be present in the data captured.  For SEIFA and remoteness reporting, data are excluded for patients whose postcodes do not map to a SEIFA or remoteness area. These patients are reported in a ‘not stated’ category.  Data used for statistical purposes are based on enrolment postcode of the patient. This postcode may not reflect the current postcode of the patient if an address change has not been notified to DHS.  Analyses by age are based on the client’s as recorded by DHS, Medicare at the date the last service that was received in the reference period.  The data provided are based on the date on which the claim was processed by DHS, not when the service was rendered. The use of data based on when the claim was processed, rather than when the service was rendered, produces little difference in the total number of persons included in the numerator for the reference period.  People who received more than one type of service are counted once only in the calculations for this indicator.  Health MBS data presented by Indigenous status have been adjusted for under‑identification in the DHS Voluntary Indigenous Identifier (VII) database. Aboriginal and Torres Strait Islander rates are therefore modelled and should be interpreted with caution. These statistics are not derived from the total Australian Aboriginal and Torres Strait Islander population, but from those Aboriginal and Torres Strait Islander people who have voluntarily identified as Aboriginal and Torres Strait Islander to DHS. The statistics have been adjusted to reflect demographic characteristics of the overall Aboriginal and Torres Strait Islander population, but this adjustment may not address all the differences in the service use patterns of the enrolled population relative to the total Aboriginal and Torres Strait Islander population. The level of VII enrolment (61 per cent nationally as at August 2012) varies across age‑sex‑remoteness‑State/Territory sub‑groups and over time which means that the extent of adjustment required varies across jurisdictions and over time. The methodology for this adjustment was developed and verified by the AIHW and Health for assessment of MBS and PBS service use and expenditure for Aboriginal and Torres Strait Islander Australians. For an explanation of the methodology, see Expenditure on health for Aboriginal and Torres Strait Islander people 2006‑07. |
| Coherence | | Estimates are compiled the same way across jurisdictions and over time.  The MBS items included can change over time, for example 2700, 2701, 2715 and 2719 were included for the later years of data. |
| Accessibility | | MBS statistics are available at:   * www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics‑1 * www.medicareaustralia.gov.au/statistics/mbs\_item.shtml |
| Interpretability | | Information for understanding this indicator is available in the:   * Fourth national mental health plan: measurement strategy, www.health.gov.au/internet/mhsc/publishing.nsf/Content/pub‑plan4‑meas * National mental health reports www.health.gov.au/internet/main /publishing.nsf/Content/mental‑data. |
| Data Gaps/Issues Analysis | | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * Not all relevant forms of primary mental health care for young people are not incorporated due to a lack of available data. * Annual data are available. The most recent data available are for 2013‑14. * The data are consistent and comparable over time. | |

### Services reviewed against the National Standards

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Effectiveness — appropriateness |
| Indicator | Services reviewed against the National Standards for Mental Health Services *(NSMHS)* |
| Measure  (computation) | Description:  Proportion of expenditure on specialised public mental health services that had completed a review by an external accreditation agency against the NSMHS.  Numerator/s:  Expenditure on service units, by assessed level (level 1, level 2, level 3, level 4).  Denominator:  Total expenditure on service units in scope for the NSMHS.  Computation:  Expressed as a proportion: (Numerator/s ÷ Denominator)\*100. Calculated separately by assessed level. |
| Data source/s | AIHW from the Mental Health Establishments (MHE) NMDS |
| Data Quality Framework Dimensions | |
| Institutional environment | The AIHW has provided the data for this indicator.  The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.  The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community‑based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.  States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement. |
| Relevance | The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non‑specialised public mental health inpatient units is not in scope of the MHE NMDS.  The NSMHS were first introduced in 1996 and were adopted by all public specialised mental health services and private psychiatric hospitals. Most non‑government community mental health services found it difficult to apply many of the NSMHS to the context within which they operated[[1]](#footnote-1). Revised standards were endorsed in September 2010 and these are designed to be applied across the broad range of mental health services (where mental health is the main focus of care), including non‑government organisations and private office based services (such as GPs). Coverage of all publicly funded mental health services to which the revised NSMHS now apply would improve the relevance of these data to measurement of this indicator for future reports.  Services were assessed as level 1, level 2, level 3, or level 4 where these levels are defined as:   * *Services at level 1* — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met all NSMHS. * *Services at level 2* — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met some but not all NSMHS. * *Services at level 3* — the number of specialised public mental health services that 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. * *Services at level 4* — the number of specialised public mental health services that do not meet criteria detailed under levels 1 to 3, except those for whom the NSMHS do not apply ― code 8 in the MHE NMDS.   Assessments against the NSMHS are based on periodic reviews, usually conducted every three to five years. Services assigned a level 1 for the 2011‑12 data may have been assessed at this level in a review that was conducted in 2005‑06 and therefore this assessed level may not necessary reflect the quality of the actual services delivered in the 2011‑12 reference period, nor the extent to which the NSMHS are used for ongoing quality improvement.  The data element ‘*National standards for mental health service review status’* is collected at the statistical unit of service unit (admitted patient, ambulatory and residential). Specialised mental health service units relate to units in public psychiatric hospitals, designated psychiatric units in acute care hospitals, public community‑based ambulatory and residential services and publicly funded private hospital and non‑government residential service units. Non‑government operated community residential service units are excluded from the analysis. Aged care community residential services in receipt of funding under the *Aged Care Act 1997* are subject to residential aged care reporting and service standard requirements and are therefore excluded from the NSMHS analysis. Ambulatory services managed by non‑government organisations are not defined as statistical units for the MHE NMDS and therefore data on this element are not available for these service types. |
| Timeliness | State and territory health authorities provide the MHE NMDS data to the AIHW for national collation, on an annual basis approximately nine months after the reference period. The reference period for the most recent data is 2012‑13. |
| Accuracy | Coverage of the MHE NMDS in‑scope services for the ‘*National standards for mental health service review status’* data element is complete across jurisdictions and years.  States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non‑compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re‑submitting improved data files.  The quality of the NSW 2010‑11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010‑11 financial year.  Due to ongoing validation, 2005‑06 to 2011‑12 data could differ from previous reports. |
| Coherence | Data are reported for each year from 2005‑06 to 2012‑13.  The data reported from 2005‑06 to 2009‑10 all relate to specialised mental health services assessed against the old NSMHS. Data from 2010‑11 will progressively include larger proportions of services assessed against the revised NSMHS that were endorsed in September 2010.  External accreditation agencies can undertake accreditation of a parent health organisation (for example, a hospital) that can cover a number of specialised mental health service units. Accreditation of the parent organisation does not currently require an individual service unit (for example, a community‑based ambulatory service managed by the hospital) to be assessed separately against the NSMHS. Assessment against the NSMHS for a service unit must be specifically requested and involves a separate review process. This leads to variation across states and territories in the method used to assign an assessment level (1, 2, 3 or 4) to service units. In some states and territories, if an organisation with multiple service units is assessed at a particular level all the organisation’s units are ‘counted’ at that assessment level. In other jurisdictions, assessments are conducted at the service unit level and the level assigned may or may not be consistent with the other units within the organisation. The approach can also vary across organisations within a single jurisdiction.  The external accreditation agencies such as Australian Council on Healthcare Standards (ACHS) and Quality Improvement Council (QIC) can use differing review methods. In addition, external review is a process of negotiation between a mental health service organisation and the accrediting agency. There may be differences in the extent to which all or some of the NSMHS are considered to be applicable to individual service units. |
| Accessibility | The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:   * Mental Health Services in Australia — annual publication * Australia’s Health — a mental health chapter is included in this biennial publication * National Mental Health Reports * Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/).   Unpublished MHE NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incurred in gaining access. Cell sizes with small numbers may be suppressed. |
| Interpretability | Metadata information for the MHE NMDS are published in the AIHW’s online metadata repository — METeOR and in the National health data dictionary.  Information for understanding this indicator is also available:   * in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition * from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/). |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * There is variation across and within states and territories in the method used to assign an assessment level (1, 2, 3 or 4) to service units. This may affect the comparability of the results across jurisdictions. * Data are not provided for the latest reference period (2013‑14). Further work is required to ensure availability of more timely data. |

### Services provided in an appropriate setting

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Effectiveness — appropriateness |
| Indicator | Services provided in an appropriate setting |
| Measure  (computation) | Description:  Recurrent expenditure on community‑based services as a proportion of total expenditure on mental health services.  Numerator:  Governments’ recurrent expenditure on community‑based specialised mental health services. Community‑based recurrent expenditure for this indicator includes expenditure on ambulatory care, non‑government organisations and adult residential services. Aged residential care expenditure is excluded.  Denominator:  Total government recurrent expenditure on specialised mental health services, excluding aged residential care expenditure and unapportioned indirect expenditure.  Computation:  Expressed as a proportion: (Numerator/Denominator)\*100. |
| Data source/s | Numerator and Denominator: AIHW from the MHE NMDS. |
| Data Quality Framework Dimensions | |
| Institutional environment | The AIHW has provided the data for this indicator.  The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.  The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community‑based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.  States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement. |
| Relevance | The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non‑specialised public mental health inpatient units is not in scope of the MHE NMDS.  The data elements on direct and indirect recurrent expenditure and grants to non‑government organisations are collected at levels in the hierarchy used to capture jurisdiction‑wide information on mental health services (state/territory, region, organisation and service units). Non‑government grants are collected at the regional and state and territory levels. Direct recurrent expenditure comprises salaries and wages and non‑salary expenditure, and is collected at the individual service unit level. Indirect recurrent expenditure is additional expenditure associated with the provision of mental health services not incurred or reported at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The estimates do not include residual indirect expenditure incurred at the state and territory level or that unapportioned from the organisational or regional level.  Certain categories of expenditure collected under the MHE NMDS are excluded to derive this indicator and improve the relevance of these data to its measurement.   * Community aged residential care expenditure is excluded from community‑based expenditure to improve comparability across states and territories. A significant share of jurisdictions do not have this service type. * Indirect expenditure at the State and Territory level and indirect expenditure at the organisational or regional level that cannot be apportioned to individual services is also excluded. This indicator is seeking to measure the service mix by showing the proportion of expenditure that is community‑based relative to the other categories of service expenditure (admitted patients) and not relative to total expenditure, which includes indirect expenditure at the State or Territory level on areas such as program administration and property leasing costs.   Government expenditure on mental health services that are out of scope of the MHE NMDS, such as Medicare‑subsidises for community‑based services provided by GPs or the personal helpers and mentors program is not included in the analysis. |
| Timeliness | State and territory health authorities provide the MHE NMDS data to the AIHW for national collation, on an annual basis approximately nine months after the reference period. The reference period for the most recent data is 2012‑13. |
| Accuracy | Coverage of the MHE NMDS in‑scope mental health services’ recurrent expenditure is essentially complete across jurisdictions and years.  States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non‑compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re‑submitting improved data files.  The quality of the NSW 2010‑11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010‑11 financial year.  Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005‑06 to 2011‑12 data could differ from previous reports. |
| Coherence | Data are reported for each year from 2005‑06 to 2012‑13. There has been no major change to the method used to collect the data or to derive the results across years for the majority of jurisdictions, therefore the data are largely comparable across most jurisdictions and years.  For NSW, Confused and Disturbed Elderly (CADE) residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007‑08 onwards, including expenditure. Comparison of NSW data over time therefore should be approached with caution. |
| Accessibility | The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:   * Mental Health Services in Australia — annual publication * National Mental Health Reports.   Unpublished MHE NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incurred in their provision. Cells may be suppressed for confidentiality reasons or where estimates are based on small numbers, resulting in low reliability. |
| Interpretability | Metadata information for the MHE NMDS are published in the AIHW’s online metadata repository — METeOR and in the National health data dictionary. |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * Data are not provided for the latest reference period (2013‑14). Further work is required to ensure availability of more timely data. |

### Collection of outcomes information

DQI for this indicator has been sourced from the Australian Mental Health Outcomes and Classification Network (AMHOCN), Department of Health, AIHW and State and Territory governments with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Effectiveness — appropriateness |
| Indicator | Collection of information on consumers’ outcomes. This DQI should be considered in conjunction with the DQI for Mental health outcomes of consumers of specialised public mental health services |
| Measure (computation) | Description:  Proportion of specialised public mental health service episodes with completed clinical mental health outcome measures data, by consumer type (people in ongoing community‑based care, people discharged from community‑based care and people discharged from hospital).  Numerator:  Number of specialised public mental health service episodes with completed clinical mental health outcome measures data, by consumer type.  Denominator:  Estimated number of specialised public mental health service episodes, by consumer type.  Computation:  Expressed as a proportion: (Numerator/s ÷ Denominator)\*100. Calculated separately by consumer type. |
| Data source/s | Numerator:  State and territory health authorities’ data reported to the National Outcomes and Casemix Collection (NOCC) and analysed by the AMHOCN.  Denominator:  State and territory health authorities’ data as reported to CMHC NMDS and the Admitted Patient Mental Health Care (APMHC) NMDS and analysed by the Department of Health. |
| Data Quality Framework Dimensions | |
| Institutional environment | Health Ministers adopted the routine measurement of consumer outcomes as a priority under the *National Mental Health Strategy (1992)* and in all subsequent National Mental Health Plans. It is also compatible with State and Territory governments’ documented policy emphasis on high quality health services and increased consumer and carer participation.  The AMHOCN prepared this indicator using the NOCC data on the Health of the Nation Outcome Scales (HoNOS) family of measures. The Australian Government contracts AMHOCN to support the implementation of the NOCC as part of routine clinical practice by undertaking three functions 1) data bureau ― receives and processes information 2) analysis and reporting ― analyses and reports on the submitted data and 3) training and service development ― supports training in the measures and their use for clinical practice, service management and development purposes.  The NOCC was endorsed by all State and Territory governments in 2003, and all jurisdictions have reported data since 2004‑05. The NOCC protocol prescribes a set of standard measures to be collected at particular times (collection occasions) in the clinical process. Under the NOCC protocol, collection of outcomes data is mandatory at admission, review and discharge. Data collected outside of NOCC protocols are excluded from the analysis. |
| Relevance | The scope of the NOCC is all specialised public mental health services managed by, or in receipt of funds from, state or territory health authorities. Australian Government funded aged residential services are excluded.  The purpose of the NOCC is to measure consumer outcomes. This indicator relates only to the collection of data for the HoNOS family of measures (HoNOS; HoNOS for Older People (HoNOS 65+) and HoNOS for Children and Adolescents (HoNOSCA). Other consumer outcomes measures are also collected, including those completed by consumers. For adults and older persons these include: Kessler 10 (K10+), Behavior and Symptom Identification Scales (BASIS‑32); for children and adolescents, the parent and youth versions of the Strengths and Difficulties Questionnaire (SDQ). The uptake of these measures is not captured by this indicator.  For an episode to be counted as one for which consumer outcome measures are collected, a minimum of two data collection occasions with ‘valid’ measures within the reference period are required. ‘Valid’ measures are those with a correctly completed specified number of items, for the:   * HoNOS/HoNOS 65+ ― a minimum of 10 of the 12 items * HoNOSCA ― a minimum of 11 of the first 13 items.   Brief ambulatory and inpatient care episodes (defined as follows) are excluded.   * inpatient care ― episodes 3 days or less. * ambulatory ― episodes where the consumers had a treatment period between 1 and 14 days inclusive.   Ambulatory episodes of mental health care that end because of admission to hospital or residential mental health care are also excluded.  The completion of outcomes data are calculated for three consumer groups. Further, the calculation varies depending on the setting and the duration of the episode of care:   * people discharged from hospital, episodes for people who were admitted and discharged from inpatient care during the reference period (an individual can have two episodes of care so the data represent episode‑counts, rather than person‑counts) — measures need to be ‘valid’ for both the admission and discharge occasions rated during the reference period * people in ongoing community‑based care, episodes for people who received community care for the whole of the reference period or who commenced community care sometime after 1 July (beginning of the period) and continued to receive care for the rest of the reference period — measures need to be ‘valid’ for both the first (either an admission or a review) and last (either an admission or a review) occasions rated during the year * people discharged from community‑based care, episodes for people who were discharged from community care (not including those discharged to hospital) who received an episode of community care that started and ended in the reference period — measures need to be ‘valid’ for both the admission and discharge occasions rated during the reference period.   Outcomes are measured for consumers discharged from residential mental health care also, but there were too few public mental health service episodes with completed clinical mental health outcome measures data to derive coverage estimates.  The number of ‘in‑scope’ specialised public mental health service episodes, for which outcomes data should be collected (the denominator) is not provided directly to the NOCC, but is an estimate based on the CMHC or APMHC NMDSs. For determining the denominators for consumers in ongoing ambulatory care and those discharged from ambulatory care the following distinguishing definitions are used:   * ongoing — the estimated unique count of consumers with CMHC treatment periods of greater than 91 days (that is, from their first service contact date to their last service contact date); LESS the estimated number of consumers whose episodes of care were left censored (that is, commenced in an earlier reporting period by finished within the current reporting periods) * discharged ― the estimated unique count of consumers with CMHC treatment periods of 91 days or less (that is, from their first service contact date to their last service contact date); LESS the estimated number of consumers whose episodes of care resulted in a discharge to an inpatient setting.   Data are not available for Victoria for 2011‑12 or 2012‑13. All Australian totals for 2011‑12 and 2012‑13 exclude Victoria. Industrial action in Tasmania in 2011‑12 and 2012‑13 has affected the quality and quantity of data. |
| Timeliness | State and territory health authorities provide the CMHC and APMHC NMDS data to the AIHW for national collation, on an annual basis approximately six months after the reference period.  State and territory health authorities provide the NOCC data to AMHOCN for national collation, on an annual basis and all data are to be submitted approximately six months after the reference period.  The reference period for the latest data is 2012‑13. |
| Accuracy | States and territories are primarily responsible for the quality of the NOCC data they provide. However, AMHOCN undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage, concerned with ensuring that the data file will load and is structurally compliant. A non‑compliant file is rejected and a new file needs to be submitted. (2) The data validation stage, primarily concerned with identifying inconsistent, anomalous, and exceptional issues in relation to the NOCC protocol as well as flagging invalid domain values and/or missing data.  Change in consumers’ clinical outcomes is not presented for states and territories with less than 200 unique consumer outcomes identifiable within the reference period. States and territories excluded from individual publication are used to calculate the change in consumers’ clinical outcomes for Australia. |
| Coherence | Data are available for 2007‑08 to 2012‑13.  The numerator and denominator are sourced from different data sets. Estimates of the total number of episodes requiring outcomes assessment is not provided directly to the NOCC, so it is indirectly estimated from the NMDSs (CMHC and APMHC).  The Australian totals for 2011‑12 and 2012‑13 are not comparable to other years as they exclude data for Victoria. |
| Accessibility | The AIHW and Department of Health provide a variety of products that draw upon the CMHC and APMHC NMDS. Published products available on the AIHW or Department of Health websites include:   * *Mental Health Services in Australia* — annual publication mhsa.aihw.gov.au/home/ * *Australia’s Health* — a mental health chapter is included in this biennial publication aihw.gov.au/publication‑detail/?id=10737422172 * National mental health reports www.health.gov.au/internet/ main/publishing.nsf/Content/mental‑data * the Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/).   Unpublished NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incurred in gaining access. Cell sizes with small numbers may be suppressed.  NOCC data are available on the AMHOCN website amhocn.org/. The following on‑line products are available:   * web decision support tool * NOCC Standard Reports * NOCC Volume and Percentage Clinical Ratings: Australia * NOCC data are also published in the National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental‑data. |
| Interpretability | Metadata information for the CMHC and APMHC NMDS are published in the AIHW’s online metadata repository — METeOR and in the National health data dictionary.  Metadata information for the NOCC are published on the AMHOCN website amhocn.org/.  Information for understanding this indicator is also available:   * in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition * from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/). |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * The numerator and denominator are sourced from different data sets. Estimates of the total number of episodes requiring outcomes assessment is not provided directly to the NOCC, so it is indirectly estimated from the NMDSs (CMHC and APMHC). |

### Rate of seclusion ― acute inpatient units

DQI for this indicator has been sourced from the AIHW and State and Territory health authorities with additional Steering Committee comments.

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| Indicator definition and description | | |
| Element | Effectiveness—quality—safety | |
| Indicator | Rate of seclusion ― acute inpatient units | |
| Measure (computation) | Definition:  Number of seclusion events per 1000 patient bed days in specialised public mental health acute inpatient units  Numerator:  Number of seclusion events in specialised public mental health acute inpatient units.  Denominator:  Number of accrued mental health care days in specialised public mental health acute inpatient units.  Computation:  Expressed as a rate. Calculation is: (Numerator ÷ Denominator) x 1000. | |
| Data source/s | AIHW 2013, *Mental Health Services in Australia Online*, mhsa.aihw.gov.au/home/.  AIHW publishes data provided by State and Territory governments from their adhoc seclusion data collections. | |
| Data Quality Framework Dimensions | | |
| Institutional environment | | The AIHW is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act 1987* to provide reliable, regular and relevant information and statistics on Australia’s health and welfare. It is an independent corporate Commonwealth entity established in 1987, governed by a management Board, and accountable to the Australian Parliament through the Health portfolio.  The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.  The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non‑government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.  One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.  The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance to the Privacy Act 1988, (Cth) ensures that the data collections managed by the AIHW are kept securely, under the strictest conditions with respect to privacy and confidentiality.  For further information see the AIHW website www.aihw.gov.au  At present there is no formal, routine nationally agreed collection and reporting framework for seclusion events in specialised mental health public acute hospital services. Data are sourced from state and territory seclusion data collections for specialised mental health public acute hospital services via Safety and Quality Partnership Standing Committee (SQPSC) a subcommittee, of the Mental Health, Drug and Alcohol Principal Committee (MHDAPC).  The Australian Health Ministers Advisory Council (AHMAC) mental health committees are in the process of formalising the current ‘ad hoc’ SQPSC seclusion data collection arrangements. The Mental Health Information Strategy Standing Committee (MHISSC) is working with AIHW to develop an aggregate seclusion and restraint Data Set Specification (DSS) to standardise the national collection of both seclusion and restraint data (and provide a more detailed data set) from the 2015‑16 collection period. |
| Relevance | | Seclusion is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. A seclusion event commences when a clinical decision is made to seclude a mental health consumer and ceases when there is a clinical decision to cease seclusion. If a consumer re‑enters seclusion within a short period of time this is considered a new seclusion event. The term ‘seclusion event’ is utilised to differentiate it from the different definitions of ‘seclusion episodes’ used across jurisdictions.  Data on seclusion events relates to all specialised mental health public hospital acute services. Wards or units other than specialised mental health services, such as emergency departments, are out of scope for this data collection. Specialised mental health acute forensic hospital services are in scope, regardless of which department manages the service, for example a health department versus a correctional services department. |
| Timeliness | | State and Territory governments provide the data to the AIHW via SQPSC for national collation, approximately three months after the reference period.  At present, two reports have been published using the SQPSC ‘ad hoc’ seclusion data collection (see below for link to 2013 report). The first seclusion report was released on the Mental health services in Australia website in July 2013 with a reference period of 2011‑12. A second report was released in November 2013 with a reference period of 2012‑13.  It is anticipated that a third report will be published in December 2014 covering the 2013‑14 reference period. |
| Accuracy | | Estimated acute bed coverage for 2013‑14 seclusion data was over 95 per cent based on acute beds reported to the MHE NMDS in 2012‑13.  Data are reported as aggregate seclusion events at the hospital level.  Reported rates are derived from the included services combined total for number of seclusion events divided by their combined total for number of accrued mental health care days. This method provides an accurate indication of combined activity, ensuring that larger services are proportionally represented in the data. Previously, some reported rates were calculated from an average of the reported seclusion rates for each service, which may have utility for benchmarking purposes; however, anomalies from smaller services can disproportionately skew overall rates.  Occasionally, jurisdictions re‑supply data for seclusion events or number of occupied bed days. Data re‑submissions are highlighted in subsequent data supplies, with updated figures reported in the next annual publication. For 2013‑14, historical data were re‑supplied for 2 hospitals resulting in minimal changes.  Integrity of the supplied seclusion data is tested by AIHW via a series of ‘logical’ validation checks. Any missing or unusual data are clarified with the supplying jurisdiction.  Some outliers (i.e. a small number of clients who have an above average number of seclusion events) are apparent in the data and have not been removed, this has the effect of ‘skewing’ the rates of seclusion for some jurisdictions.  A new data element, average time in seclusion was collected for the first time for the 2013‑14 collection period. As the average time in seclusion is significantly higher for forensic units, these units were excluded from average time in seclusion calculations to provide a more realistic estimation of seclusion duration.  The absence of unit record data limits the ability to undertake analysis to provide context around the incidence of seclusion events. For example, the analysis of consumer attributes which may indicate risk factors or a vulnerability to experiencing seclusion and restraint events (i.e., legal status, gender, date of birth, indigenous status, country of birth etc).  In addition, identifying the timing of seclusion events within an episode of admitted patient mental health care may be informative in mitigating/pre‑empting patterns in the use of restrictive practices. Some jurisdictions have the capacity to record and report this information but the lack of cross‑jurisdictional consistency restricts the collection and reporting of unit record data at a national level.  Within the aggregate reporting framework, collection of service unit level data is currently not feasible. Although data are collected at target population, collection at the service unit level would improve consistency and comparability with other mental health collections such as the Mental Health Establishment NMDS.  The use of restrictive practices also includes restraint events. However, no national restraint data are currently reported representing a substantial data gap. The AIHW is currently working with the AHMAC mental health committees and jurisdictional representatives to develop national restraint data standards to facilitate the collection and reporting of national restraint event data. |
| Coherence | | Variations in jurisdictional legislation may result in exceptions to the definition of a seclusion event. Data reported by jurisdictions may not be explicitly comparable, jurisdictional comparisons should therefore be made with caution.  Specific jurisdictional caveats are outlined below:  New South Wales  NSW does not have a centralised database for the collection of seclusion data. Services report seclusion rates regularly to the NSW Ministry of Health. Services are required to maintain local seclusion registers, which may be audited by NSW Official Visitors who function with legislative authority to raise issues in relation to patient safety, care or treatment. Seclusion rates are a Key Performance Indicator in regular performance reporting to NSW Local Health Districts. Importantly, NSW seclusion rates include bed days for some forensic services managed by correctional facilities.  Victoria  Both the National Beacon Projects and the Creating Safety Project supported Victorian services to review their use of seclusion and employ different strategies to support the reduction of seclusion, with targets set in the Statement of Priorities to support health services reduce seclusion events. From 2014‑15 seclusion rates are included in the calculation of a Performance Assessment Score for each health service with a specialised mental health inpatient unit and ultimately the level of monitoring by the Department of Health. It is anticipated that variation between health services will improve over time following the increased emphasis on the target, introduction of a new Mental Health Act and a reduction in the use of restrictive practices.  Victoria has fewer beds per capita than other jurisdictions, and as such, it may be useful to view the rate of seclusion events in a broader population context (rates per capita).  Seclusion events per 10 000 population in Victoria were 7.2 in 2011‑12, 5.8 in 2012‑13 and 5.5 in 2013‑14.  Queensland  Queensland do not report any acute forensic services to the collection, however forensic patients can and do access acute care through general units.  Western Australia  It should be noted that WA does not have a centralised data base for the collection of seclusion data. Services provided seclusion data from their own data bases. From 1 July 2014, the Chief Psychiatrist in WA has requested quarterly reporting of seclusion and restraint rates by all current reporting services.  WA reports occupied bed days rather than accrued mental health care days to the seclusion and restraint DSS. For the purpose of these analyses, occupied bed days are considered to be the same as accrued mental health care days for this jurisdiction.  South Australia  Recent data reporting improvements will impact on SA data. Importantly, bed days used to calculate SA’s seclusion rates are estimated based on 100 per cent occupied bed numbers, which are fluctuating in relation to new infrastructure projects. During 2010‑11, a substantial number of seclusion events in one particular hospital were for a small number of patients with over half of these patient‑requested events. This may have impacted on the overall seclusion rate reported for the state for 2010‑11.  SA was unable to supply seclusion data for 2008‑09. Information on seclusion duration is only available in 4 hour blocks, therefore averages cannot be calculated and seclusion duration figures for SA are not included in national totals.  Tasmania  The increase in the state‑wide Tasmanian seclusion rate for 2012‑13 and 2013‑14 data is due to a small number of clients having an above average number of seclusion events.  Australian Capital Territory  When interpreting these data, the relative small size of the ACT should be noted, with a total of between 60 and 70 acute inpatient beds reported between 2008‑09 and 2013‑14.  ACT was unable to provide the number of mental health‑related admitted patient care episodes with a seclusion event in 2013‑14. Therefore, the proportion of episodes with a seclusion event and the average number of seclusion events per episode could not be calculated for the ACT.  ACT activities initiated as part of the Beacon Site project included the implementation of a clinical review committee inclusive of clinical staff, consumers and carer representation to review episodes of seclusion for systemic issues on a case‑by‑case basis. This has led to a number of reforms over several years that have had a direct impact on the use of seclusion and its reduction to the low levels now reported.  Work is progressive and ongoing as part of a larger process of providing a place of improved safety and security, both for people experiencing an acute episode of mental ill health leading to an inpatient admission, visitors and for the staff who work in this challenging environment.  Northern Territory  The NT was unable to supply seclusion data for 2008‑09.  The NT is unable to segregate Forensic Inpatient Episodes and Events from general events. Therefore all NT totals, wherever stated, are comprised of both General & Forensic Inpatient Episodes and Events. As this may artificially inflate NT data, caution should be used when comparing or interpreting this data.  Due to the low ratio of beds per person in the NT compared with other jurisdictions, the apparent rate of seclusion is inflated when reporting seclusion per patient day compared with reporting on a population basis.  Due to the low number of beds in the NT, high rates of seclusion for a few individuals have a disproportional effect on the rate of seclusion reported.  Due to these variations, NT seclusion data are not directly comparable with other jurisdictions.  At present there is no formal, routine nationally agreed collection and reporting framework for seclusion events in specialised mental health public acute hospital services. Data are sourced from state and territory seclusion data collections for specialised mental health public acute hospital services via SQPSC a subcommittee, of the MHDAPC. |
| Accessibility | | Seclusion data are available at AIHW’s Mental Health Services in Australia — annual publication (https://mhsa.aihw.gov.au/services/admitted‑patient/restrictive‑practices). Additional disaggregation of the seclusion data are in this AIHW publication. |
| Interpretability | | Information is available for interpreting seclusion data from AIHW’s Mental Health Services in Australia — annual publication (mhsa.aihw.gov.au/services/admitted‑patient/restrictive‑practices). |
| Data Gaps/Issues Analysis | | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * The absence of unit record data limits the ability to undertake analysis to provide context around the incidence of seclusion events. For example, the analysis of consumer attributes which may indicate risk factors or a vulnerability to experiencing seclusion and restraint events (for example, legal status, gender, date of birth, Indigenous status, and country of birth). * In addition, identifying the timing of seclusion events within an episode of admitted patient mental health care may be informative in mitigating/pre‑empting patterns in the use of restrictive practices. Some jurisdictions have the capacity to record and report this information but the lack of cross‑jurisdictional consistency restricts the collection and reporting of unit record data at a national level. * Within the aggregate reporting framework, collection of service unit level data is currently not feasible. Collection at this level would improve consistency and comparability with other mental health collections such as the Mental Health Establishment NMDS. * The use of restrictive practices also includes restraint events. However, no national restraint data are currently reported representing a substantial data gap. The AIHW is currently working with the AHMAC mental health committees and jurisdictional representatives to develop national restraint data standards to facilitate the collection and reporting of national restraint event data. | |

### Consumer and carer involvement in decision making

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Effectiveness — Quality — Responsiveness |
| Indicator | Consumer and carer involvement in decision making |
| Measure  (computation) | Description:  Number of paid full time equivalent (FTE) consumer OR carer staff per 1000 FTE direct care, carer and consumer staff  Numerator:  1) Number of paid FTE consumer staff.  2) Number of paid FTE carer staff.  Denominator:  Number of paid FTE direct care, carer and consumer staff.  Computation:  Expressed as a proportion per 1000 FTE. Calculation is:(Numerator/Denominator\*1000). |
| Data source/s | Numerator and Denominator: AIHW from the MHE NMDS. |
| Data Quality Framework Dimensions | |
| Institutional environment | The AIHW has provided the data for this indicator.  The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.  The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community‑based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.  States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement. |
| Relevance | The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non‑specialised public mental health inpatient units is not in scope of the MHE NMDS.  Direct care staff comprise consultant psychiatrists and psychiatrists, psychiatry registrars and trainees, other medical officers, registered nurses, enrolled nurses, occupational therapists, social workers, psychologists, other diagnostic and health professionals and other personal care staff. Other categories of staff who work in mental health services are collected under the MHE NMDS, such as administrative and clerical staff, but are not included.  Mental health consumer and carer workers are individuals who are employed on a paid basis to represent the interests of consumers and carers, respectively, and advocate for their needs. The person must be employed for the expertise developed from their lived experience of mental illness. The person should also receive a salary or contract fee on a regular basis and it excludes individuals who only received reimbursement of expenses or occasional sitting fees for attendance at meetings.  The MHE NMDS does not collect information on the staffing of, or consumer and carer participation in, specialised ambulatory mental health services managed by government‑funded NGOs. |
| Timeliness | State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data are 2012‑13. |
| Accuracy | Coverage of the MHE NMDS in‑scope mental health services for direct care staff and consumer and carer workers may not be complete across jurisdictions and years due to the transition from a count of consumer/carer consultants up to 2009‑10 to a count of mental health consumer/carer workers from 2010‑11.  States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non‑compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re‑submitting improved data files.  Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005‑06 to 2011‑12 data could differ from previous reports.  The quality of the NSW 2010‑11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010‑11 financial year.  WA have advised that data on FTE consumer or carer workers per 1000 direct care, consumer and carer staff do not accurately represent consumer and carer participation strategies used in WA. |
| Coherence | Data are reported for each year from 2005‑06 to 2012‑13. Data up to 2009‑10 were restricted to consumer/carer consultants. In 2010‑11, the definitions were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. These improved definitions should promote greater consistency between jurisdictions. Comparisons between data up to 2009‑10 and data from 2010‑11 should not be made. |
| Accessibility | The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:   * Mental Health Services in Australia — annual publication * Australia’s Health — a mental health chapter is included in this biennial publication * National Mental Health Reports. |
| Interpretability | Metadata information for the MHE NMDS are published in the AIHW’s online metadata repository — METeOR and in the National health data dictionary. |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * From 2010‑11, the definitions of consumer/carer workers were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. These improved definitions should promote greater consistency between jurisdictions. Comparisons between data up to 2009‑10 and data from 2010‑11 should not be made. * Data are not provided for the latest reference period (2013‑14). Further work is required to ensure availability of more timely data. |

### Post discharge community care

DQI for this indicator has been sourced from the AIHW for the National Healthcare Agreement with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Quality ― Continuity |
| Indicator | Post discharge care — rate of community follow up within first seven days of discharge from a psychiatric admission. |
| Measure  (computation) | Proportion of separations from the mental health service organisation’s acute psychiatric inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated, was recorded in the seven days following that separation.  The *numerator* is the number of in‑scope separations from the mental health service organisation’s acute psychiatric inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated, was recorded in the seven days following that separation.  The *denominator* is the number of in‑scope separations for the mental health service organisation’s acute psychiatric inpatient unit(s).  Calculation is 100 x (Numerator ÷ Denominator) |
| Data source/s | State/territory admitted patient and CMHC data. |
| Data Quality Framework Dimensions | |
| Institutional environment | The tables for this indicator were prepared by the AIHW based on data supplied by state and territory health authorities. The AIHW is an independent statutory authority within the Health portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.  AIHW drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies) in consultation with State and Territory health authorities.  The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities receive these data from public sector community mental health services and public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. The AIHW does not hold the relevant nationally mandated datasets required to independently verify the data tables for this indicator.  Community mental health services and public hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.  States and territories supplied these data for publication in the RoGS 2015 and for the indicators section of the AIHW’s *Mental health services in Australia website.* |
| Relevance | Estimates are based on all ‘in scope’ separations from state and territory psychiatric acute inpatient units, where ‘in scope’ is defined as those separations for which it is meaningful to examine community follow‑up rates. The following separations were excluded: same day separations; overnight separations that occur through discharge/transfer to another acute hospital; discharge to an(other) psychiatric hospital; statistical discharge – type change; left against medical advice/discharge at own risk; death; separations where the length of stay is one night and a procedure code for ECT is recorded and separations that end by transfer to community residential mental health services.  Data for all years reflect full financial year activity – that is, all in scope separations from public sector acute psychiatric units between the period 1 July and 30 June for each financial year.  Community mental health contacts counted for determining whether follow‑up occurred are restricted to those in which the consumer participated. These may be face‑to‑face or ‘indirect’ (e.g., by telephone), but not contacts delivered ‘on behalf of the client’ in which they did not participate, with the exception of the NT which includes all contacts, but advised that the impact on the indicator is believed to be marginal. Contacts made on the day of discharge are also excluded for all jurisdictions.  Only community mental health contacts made by state and territory public mental health services are included. Where responsibility for clinical follow‑up is managed outside the state/territory mental health system (e.g., by private psychiatrists, general practitioners), these contacts are not included.  States and territories vary in their capacity to accurately track post‑discharge follow up between hospital and CMHC services, due to the lack of unique patient identifiers or data matching systems. SA was the only jurisdiction that indicated that the data submitted were not based on unique patient identifier or data matching approaches for 2012‑13. This factor can contribute to a comparatively lower follow‑up rate for SA.  Tasmania has been progressively implementing a state‑wide patient identification system. Data for 2012‑13 is considered to be the first collection period with this system fully implemented. It is likely that an improved patient identification system will increase the percentage post‑discharge community care reported by Tasmania. Therefore, Tasmanian data are not comparable across years.  WA indicated that submitted data were not based on a unique state‑wide patient identifier system. It is likely that this reduces the rate of post‑discharge community care reported for WA.  In 2011, the ABS updated the standard geography used in Australia for most data collections from the ASGC to the ASGS. Also updated at this time were remoteness areas and the SEIFA. The new remoteness areas are referred to as RA 2011. The new SEIFA are referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006.  Data for 2011‑12 and subsequent years are reported for RA 2011.  Data for 2011‑12 are reported using SEIFA 2011 at the SLA level (an ASGC substate geographical unit). Data for 2012‑13 are reported using SEIFA 2011 at the SA2 level (an ASGS substate geographical unit). The AIHW considers the change from SLA to SA2 to be a series break when applied to data supplied for this indicator. Therefore, SEIFA data for 2011‑12 are not directly comparable with SEIFA data from 2012‑13 and subsequent years.  Remoteness and socioeconomic status have been allocated using the SA2 of the client at last contact. For 2012‑13 data all jurisdictions have used the same concordance and proportionally allocated records to remoteness and SEIFA categories with the following exception:   * NSW, Victoria and Tasmania used postcode concordance (rather than SA2 concordance) to allocate records to remoteness and SEIFA.   Remoteness and socioeconomic status have been allocated using the client’s usual residence, not the location of the service provider except for the NT for which the majority of the data were based on the location of the service. State/territory is reported for the state/territory of the service provider. |
| Timeliness | The latest reference period for these data are 2012‑13. |
| Accuracy | State and territory jurisdictions differ in their capacity to accurately track post‑discharge follow up between hospital and community service organisations (see Relevance section above for further information). |
| Coherence | Specifications for this indicator were revised for the National Healthcare Agreement to align with specifications for the nationally agreed key performance indicators for public mental health services. Specifically, the revised indicator focuses on follow up care for people discharged from acute psychiatric units only, rather than discharges from all psychiatric units.  This indicator is currently reported in the RoGS and in the Indicators section of the AIHW’s Mental health services in Australia website. It is also equivalent to the Key Performance Indicators for Australian Public Mental Health Services: MHS PI 12—Rates of post‑discharge community care (which this new indicator is based on) and the Fourth National Mental Health Plan: NMHP PI 16—Rates of post‑discharge community care.  Clarification of the scope of the separations data was made to the 2012‑13 data specification, however, jurisdictions advised that the impact on the overall data is likely to be minimal. Therefore, data are considered comparable across years in terms of the definitions.  For public sector community mental health services, Victorian data are unavailable (for 2011‑12 and 2012‑13) due to service level collection gaps resulting from protected industrial action during this period.  Industrial action during the 2011‑12 and 2012‑13 collection periods in Tasmania has limited the available data quality and quantity of community data. Australian totals for 2011‑12 and 2012‑13 should therefore be interpreted with caution.  For 2012‑13, the ACT has refined its calculation methodology and as such, comparisons to previous years’ results should be viewed with caution.  All jurisdictions have used the same concordance and proportionally allocated records to remoteness and SEIFA categories.  Source systems vary in terms of whether location data for the patients usual address is SA2 versus postcode. |
| Accessibility | These data are published in the:   * RoGS available at: www.pc.gov.au/rogs. * Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/). |
| Interpretability | Definitions for this indicator are published in the indicator specifications in METeOR. |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * States and territories vary in their capacity to accurately track post‑discharge follow up between hospital and community service organisations, due to the lack of unique patient identifiers or data matching systems. * For public sector community mental health services, Victorian data are unavailable (for 2011‑12 and 2012‑13) due to service level collection gaps resulting from protected industrial action during this period. Industrial action during the 2011‑12 and 2012‑13 collection periods in Tasmania has limited the available data quality and quantity of community data. Australian totals for 2011‑12 and 2012‑13 should therefore be interpreted with caution. * SEIFA data for 2011‑12 are not directly comparable with SEIFA for 2012‑13. |

### Readmissions to hospital within 28 days of discharge

DQI for this indicator has been sourced from state and territory health authorities and AIHW with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Quality― continuity |
| Indicator | Readmissions to hospital within 28 days of discharge |
| Measure (computation) | Description:  Proportion of ‘in‑scope’ admitted patient overnight separations from public psychiatric acute inpatient services that were followed by readmission to public psychiatric acute inpatient services within 28 days of discharge.  Numerator:  Number of ‘in‑scope’ admitted patient overnight separations from public psychiatric acute inpatient services that were followed by readmission to public psychiatric acute inpatient services within 28 days of discharge.  Denominator:  Number of ‘in‑scope’ admitted patient overnight separations from public psychiatric acute inpatient services.  Computation:  Expressed as a proportion: (Numerator ÷ Denominator)\*100. |
| Data source/s | State and territory governments APMHC data set. |
| Data Quality Framework Dimensions | |
| Institutional environment | The AIHW calculated the indicator based on data supplied by state and territory health authorities. The state and territory health authorities receive these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting.  Public hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation. |
| Relevance | Estimates are based on all ‘in scope’ overnight separations from state and territory psychiatric acute inpatient units, where ‘in scope’ is defined as those separations for which it is meaningful to examine readmission after 28 days of discharge rates. The following separations were excluded: same day separations, including index separation and subsequent readmission; statistical and change of care type separations; separations that end by transfer to another acute or psychiatric hospital; separations that end by death, or instances where the person left against medical advice or discharged at own risk, separations where the length of stay is one night only and a procedure code for ECT is recorded.  A readmission for any of the separations identified as ‘in‑scope’ is an admission to any other public acute psychiatric unit within the jurisdiction. For this to occur a system of unique client identifiers needs to be in place that allows individuals to be ‘tracked’ across units. Such systems have been available in all states/territories for the full period (2005‑06 to 2012‑13), with the exception of Tasmania (which introduced such a system in 2007‑08) and SA (which has not yet introduced such a system).  Readmissions across state and territory boundaries or movements between public and private hospitals are not captured.  No distinction is made between planned and unplanned readmissions because data collection systems in most Australian public mental health services do not include a reliable or consistent method to distinguish a planned from an unplanned admission to hospital.  Remoteness and socioeconomic status have been allocated using the client’s usual residence, not the location of the service provider. State/territory is reported for the state/territory of the service provider. |
| Timeliness | State and territory health authorities provide these data to Department of Health for national collation, on an annual basis approximately twelve months after the reference period.  The latest year of data available is 2012‑13. |
| Accuracy | Coverage of the ‘in‑scope’ separations and readmissions is essentially complete across jurisdictions and years.  States and territories are primarily responsible for the quality of these data. The AIHW analyses the data, but cannot independently verify them.  Undercounting of readmissions may have occurred in SA and Tasmania in the years that the system of unique identifiers is not in place (see the relevance dimension). Additional undercounting of readmissions may have occurred in SA as admitted patient reporting systems only identify mental health activity based on the discharging ward. However, this factor is believed to be immaterial as the majority of admissions to mental health wards end in hospital discharge from there.  Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005‑06 to 2011‑12 data could differ from previous reports. |
| Coherence | Data are available from 2005‑06 to 2012‑13. There has been no major change to the method used to collect the data or to derive the results across years for the majority of jurisdictions, therefore the data are largely comparable across most jurisdictions and years.  States and territories differ in their capacity to accurately track clients across organisations or service types, this can affect the comparability of the results across jurisdictions (see the relevance and accuracy dimensions).  For data before 2012‑13, states and territories differed in the overnight separations that they count as ‘in scope’. NSW and Queensland excluded separations where length of stay is one night only and the procedure code for ECT is recorded and the ACT excluded all overnight separations with the procedure code for ECT, whereas the others (Victoria, WA, SA, Tasmania and the NT) included all overnight separations for the procedure code for ECT.  For 2012‑13, the exclusion of overnight stays of one night with an ECT procedure code became a business rule for the calculation of data for this indicator. The change was considered likely to be minimal, therefore, historical data updates were not considered mandatory. The change is also unlikely to alter the interpretability of long term data trends.  Queensland applies in‑scope filtering to the subsequent readmission that matches the counterpart in‑scope filter for index separations. For example, as outlined above, separations that end by transfer to another acute or psychiatric hospital separations are excluded from the denominator (index separation). By the same token, for the subsequent readmission, Queensland excludes separations that are commenced with code indicating they commenced with transfer from another acute or psychiatric hospital. However, these separations may be eligible for consideration as separate index separation if they did not end with a transfer to another facility.  For 2012‑13, the ACT has refined its calculation methodology and as such, comparisons to previous years’ results should be viewed with caution. |
| Accessibility | These data are also published in the:   * COAG national action plan on mental health progress reports available at www.coag.gov.au * National mental health reports available at www.health.gov.au/internet/ main/publishing.nsf/Content/mental‑data * Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/). |
| Interpretability | Further information to understand this indicator are available:   * in the COAG national action plan on mental health — progress report 2010‑11 * in National mental health reports www.health.gov.au/internet/main/ publishing.nsf/Content/mental‑data * in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition * from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/). |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * No distinction is made between planned and unplanned readmissions. * States and territories differ in their capacity to accurately track clients across organisations or service types. * States and territories differ in the overnight separations that they count as ‘in scope’. |

### Cost of inpatient care — average recurrent cost per inpatient bed day

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Efficiency |
| Indicator | Cost for inpatient care — average recurrent cost per inpatient bed day |
| Measure  (computation) | Description:  Average recurrent cost per inpatient bed day.  Numerator:  Expenditure on State and Territory funded specialised mental health admitted patient services, by hospital and program type and by target population and program type.  Denominator:  Number of inpatient bed days in State and Territory funded specialised mental health admitted patient services, by hospital and program type and by target population and program type.  Disaggregations for numerator and denominator are:  By inpatient target population:   * general, by acute and non‑acute * child and adolescent, by acute and non‑acute * older persons’ psychiatry, by acute and non‑acute * forensic psychiatry, by acute and non‑acute   By hospital type:   * psychiatric hospitals, by acute units and non‑acute units * public acute hospital with a psychiatric unit or ward, by acute and  non‑acute units   Computation:  Expressed as $ per bed day. Calculation is Numerator/Denominator.  Real expenditure is reported across years. The general formula for applying the deflator (used in the attachment tables) to convert nominal dollars to real dollars is:  More details can be found within the text surrounding this image.  Where:  More details can be found within the text surrounding this image.is real dollars in year t  More details can be found within the text surrounding this image.is nominal dollars in year t  More details can be found within the text surrounding this image. is the new index based in year t. More details can be found within the text surrounding this image.is sourced from ABS unpublished, government final consumption expenditure on hospitals and nursing homes price deflator for 2012‑13 dollars (2012‑13=100). |
| Data source/s | Numerator and Denominator: AIHW from the MHE NMDS. |
| Data Quality Framework Dimensions | |
| Institutional environment | The AIHW has provided the data for this indicator. The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.  The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community‑based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.  States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement. |
| Relevance | The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non‑specialised public mental health inpatient units is not in scope of the MHE NMDS.  Bed days include those for same day admissions, which are counted as one day. Leave days are excluded. Same day admissions are a confounding issue that require the identification of intent of admission (that is, day care or overnight stay). Leave days also present complexities in the mental health area and further work is required to ensure that it does not distort this indicator.  Expenditure data are for services provided in specialised mental health service units in public psychiatric hospitals, public acute hospitals and publicly funded private hospital units. Expenditure comprises direct and indirect expenditure incurred at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The residual indirect expenditure incurred at the state and territory level and that unapportioned from the organisational or regional level is not included in the estimates.  Cost per inpatient bed day data are not adjusted for differences in the client mix. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. More relevant measures would be casemix adjusted, for which cost is adjusted to take into account the type and complexity of cases. Data for these measures are not yet available, as casemix funding has not been applied to specialised mental health services. |
| Timeliness | State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data are 2012‑13. |
| Accuracy | Coverage of the MHE NMDS in‑scope mental health services for expenditure and bed days is essentially complete across jurisdictions and years.  States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non‑compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re‑submitting improved data files.  Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005‑06 to 2011‑12 data could differ from previous reports.  The quality of the NSW 2010‑11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010‑11 financial year. |
| Coherence | Data are reported for each year from 2005‑06 to 2012‑13. Data should be reported consistently across most jurisdiction and across years within most jurisdictions.  Costs per inpatient bed day may not be comparable across jurisdictions. Classification of expenditure into target populations and program type is based on the classification of services as reported to the MHE NMDS rather than the characteristics of their patient populations. For a service to be classified as providing a child and adolescent, older persons’ or forensic mental health service for example, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services. It is likely that the cost per patient day for general mental health services in a jurisdiction that has separate child and adolescent and older persons services (for example, NSW and Victoria), may not be comparable to the average cost in a jurisdiction that has general services only (for example, NT).  For NSW, CADE residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007‑08 onwards, including expenditure. Comparison of NSW data over time therefore should be approached with caution.  Caution is required when interpreting historical Queensland data, particularly as several services reported as forensic up to 2008‑09 were reclassified as general services in 2009‑10 to more accurately reflect the function of these services. For 2010‑11 and 2011‑12, a small number of Youth services have been included in the General category at the request of Queensland. Queensland public acute hospital data includes costs associated with extended treatment services (campus and non‑campus based) reported as non‑acute admitted patient services in public acute hospitals. Queensland does not provide any acute services in public psychiatric hospitals. Additionally, Queensland provides older persons’ mental health inpatient services using a number of different service models, however the majority of older persons’ acute care is reported through general adult units, which limits comparability with jurisdictions that report these services differently. Queensland does not report any acute forensic services, however forensic patients can and do access acute care through general units.  For 2010‑11 to 2012‑13 data, a small number of Youth services have been included in the General category at the request of Queensland.  For WA data, a review of services resulted in the reclassification of beds between the acute and non‑acute categories for the 2010‑11 collection, to more accurately reflect the function of these services.  ACT average costs for older person’s mental health services during  2006‑07 are based on a new 20 bed unit opened in March 2007, in which only 6–10 beds operated due to issues related to staffing resources. This has artificially inflated the average cost of older persons’ mental health services relative to other jurisdictions and other years for the ACT. |
| Accessibility | The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:   * Mental Health Services in Australia — annual publication * Australia’s Health — a mental health chapter is included in this biennial publication * National Mental Health Reports * the Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/). |
| Interpretability | Metadata information for the MHE NMDS are published in the AIHW’s online metadata repository — METeOR and in the National health data dictionary.  Further information to understand this indicator are available:   * in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition * from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/). |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * The average recurrent cost per inpatient bed day measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency. * Data are not provided for the latest reference period (2013‑14). Further work is required to ensure availability of more timely data. |

### Cost of inpatient care — average length of inpatient stay

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Efficiency |
| Indicator | Cost of inpatient care — average length of inpatient stay |
| Measure  (computation) | Description:  Average length of inpatient stay in acute units, by target population.  Numerator:  Number of inpatient bed days in State and Territory funded specialised mental health admitted patient acute units, by target population.  Denominator:  Number of separations from State and Territory funded specialised mental health admitted patient acute units, by target population.  Disaggregations for numerator and denominator are:  By inpatient target population:   * general acute * child and adolescent acute * older persons’ psychiatry acute * total acute (excluding forensic)   Computation:  Expressed as number of days per stay. Calculation is Numerator/Denominator. |
| Data source/s | Numerator and Denominator: AIHW from the MHE NMDS. |
| Data Quality Framework Dimensions | |
| Institutional environment | The AIHW has provided the data for this indicator.  The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.  The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community‑based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.  States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement. |
| Relevance | The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non‑specialised public mental health inpatient units is not in scope of the MHE NMDS.  Bed days include those for same day admissions, which are counted as one day. Leave days are excluded. Same day admissions are a confounding issue that require the identification of intent of admission (that is, day care or overnight stay). Leave days also present complexities in the mental health area and further work is required to ensure that it does not distort this indicator.  Average length of stay data are not adjusted for differences in the client mix. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. More relevant measures would be relative stay index, for which the length of stay index takes into account the type and complexity of cases. Data for these measures are not yet available, as casemix analysis has not been applied to specialised mental health services.  Patients days for clients who separated in the reference period that were during the previous period (for example, 2009‑10), are excluded. Patient days for clients who remain in hospital (that is, are not included in the separations data) are included.  Average length of stay is not calculated for forensic services as the length of stay is determined by factors outside the control of the specialised mental health service. However, the child and adolescent and older persons’ psychiatry target population services may include a forensic component.  Average length of stay is not calculated for non‑acute inpatient units due to variability across jurisdictions in the models and mix of care (in particular, variability across jurisdiction in mix of non‑acute inpatient and community‑based residential care units) that would significantly affect the comparability of the average length of stay data. |
| Timeliness | State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data are 2012‑13. |
| Accuracy | Coverage of the MHE NMDS in‑scope mental health services bed days and separations is essentially complete across jurisdictions.  States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non‑compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re‑submitting improved data files.  The quality of the separations data used to derive this indicator is variable across jurisdictions. Until recently, these separations data were not subject to the level of in depth scrutiny that has applied to other data elements in the MHE NMDS. Therefore, data are only available from 2010‑11. It is expected that the quality of these data will improve over time.  The quality of the NSW 2010‑11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010‑11 financial year. |
| Coherence | Data are reported for 2010‑11 to 2012‑13.  Average length of stay data may not be comparable across jurisdictions. Classification of inpatient days and separations into target populations and program type is based on the classification of services as reported to the MHE NMDS rather than the characteristics of their patient populations. For a service to be classified as providing a child and adolescent, older persons’ or forensic mental health service for example, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services. It is likely that the average length of stay for a general mental health services in a jurisdiction that has separate child and adolescent and older persons services (for example, NSW and Victoria) may not be comparable to the average length of stay that has general services only (for example, NT).  Queensland provides older persons’ mental health inpatient services using a number of different service models, however the majority of older persons’ acute care is reported through general adult units, which limits comparability with jurisdictions that report these services differently.’  A small number of Youth services have been included in the General category at the request of Queensland. |
| Accessibility | The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:   * Mental Health Services in Australia — annual publication * Australia’s Health — a mental health chapter is included in this biennial publication * National Mental Health Reports * the Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/). |
| Interpretability | Metadata information for the MHE NMDS are published in the AIHW’s online metadata repository — METeOR and in the National health data dictionary.  Further information to understand this indicator are available:   * in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition * from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/). |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * The average length of stay measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency. * The quality of the separations data used to derive this indicator is variable across jurisdictions. * Data are not provided for the latest reference period (2013‑14). Further work is required to ensure availability of more timely data. |

### Cost of community‑based residential care

DQI for this indicator has been sourced from the AIHW and state and territory health authorities with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Efficiency |
| Indicator | Cost of community‑based residential care |
| Measure  (computation) | Description:  Average recurrent cost per patient day for community‑based residential care  Numerator:  Expenditure on community‑based residential care, by target population and staffing provided  Denominator:  Number of patient days in community‑based residential care, by target population and staffing provided.  Disaggregations for the numerator and denominator are:  General adult units   * 24 hour staffed * Non‑24 hour staffed   Older people’s care units   * 24 hour staffed * Non‑24 hour staffed   Computation:  Expressed as $ per bed day. Calculation is Numerator/Denominator.  Real expenditure is reported across years. The general formula for applying the deflator (used in the attachment tables) to convert nominal dollars to real dollars is:  More details can be found within the text surrounding this image.  Where:  More details can be found within the text surrounding this image.is real dollars in year t  More details can be found within the text surrounding this image.is nominal dollars in year t  More details can be found within the text surrounding this image. is the new index based in year t. More details can be found within the text surrounding this image.is sourced from ABS unpublished, government final consumption expenditure on hospitals and nursing homes price deflator for 2012‑13 dollars (2012‑13=100). |
| Data source/s | Numerator and Denominator: AIHW from the MHE NMDS. |
| Data Quality Framework Dimensions | |
| Institutional environment | The AIHW has provided the data for this indicator.  The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.  The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community‑based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.  States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement. |
| Relevance | The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes).  Patient days and expenditure relating to community residential services includes that for publicly funded residential services operated by non‑government organisations.  Expenditure data are for services provided in community residential units. Expenditure comprises direct and indirect expenditure incurred at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The residual indirect expenditure incurred at the state and territory level and that unapportioned from the organisational or regional level is not included in the estimates.  Cost per patient day data are not adjusted for differences in the client mix. The client mix in community residential settings can differ — for example, some jurisdictions treat a higher proportion of more complex patients in community residential services. More relevant measures would be casemix adjusted to take into account the type and complexity of cases. Data for these measures are not yet available, as casemix funding has not been applied to specialised mental health services.  Data for child and adolescent community‑based residential units are included in the data for general acute units for NSW and the ACT. Other jurisdictions do not have these types of units.  For 2011‑12, a small number of Youth services have been included in the General category at the request of WA. For 2012‑13, a small number of Youth services have been included in the General category at the request of Victoria, WA and the ACT.  Queensland does not report any in‑scope government‑operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non‑campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non‑acute admitted patient services. |
| Timeliness | State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data are 2012‑13. |
| Accuracy | Coverage of the MHE NMDS in‑scope mental health services community residential expenditure and bed days is complete across jurisdictions and years.  States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non‑compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re‑submitting improved data files.  Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005‑06 to 2011‑12 data could differ from previous reports.  The quality of the NSW 2010‑11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010‑11 financial year. Delays caused by this change in completing the NSW 2010‑11 MHE NMDS has also meant that the figures provided for the RoGS have not completed full validation and may be different to the finalised data that will be provided for the *National Mental Health Report*. |
| Coherence | Data are reported for each year from 2005‑06 to 2012‑13. Data should be reported consistently across years within most jurisdictions.  Average cost of community‑based residential care may not be comparable across jurisdictions. Classification of expenditure and inpatient days into target populations is based on the classification of services as reported to the MHE NMDS rather than the characteristics of their patient populations. For a service to be classified as providing a general or older persons’ mental health service, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services. For NSW and the ACT, some child and adolescent services are reclassified to general adult to protect agency confidentiality.  For NSW, CADE residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007‑08 onwards, including patient days. Comparison of NSW data over time therefore should be approached with caution.  Several WA residential services reported as 24‑hour staffed services in 2009‑10 transitioned to a non‑24‑hour staffed model of care as of 1 July 2010. |
| Accessibility | The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:   * Mental Health Services in Australia — annual publication * Australia’s Health — a mental health chapter is included in this biennial publication * National Mental Health Reports. |
| Interpretability | Metadata information for the MHE NMDS are published in the AIHW’s online metadata repository — METeOR and in the National health data dictionary. |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * The cost of community‑based residential care measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency. * Data are not provided for the latest reference period (2013‑14). Further work is required to ensure availability of more timely data. |

### Cost of ambulatory care

DQI for this indicator has been sourced from the AIHW, state and territory health authorities and Department of Health with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Efficiency |
| Indicator | Cost of ambulatory care |
| Measure  (computation) | Description:  Average treatment days per episode of ambulatory care.  Average cost per treatment day of ambulatory care  Numerator:  (1) Number of treatment days in ambulatory care.  (2) Adjusted recurrent expenditure on ambulatory care.  Denominator:  (1) Number of statistical episodes of ambulatory care.  (2) Number of treatment days in ambulatory care.  Computation:  Expressed as treatment days per episode OR cost per episode. Calculation is Numerator (1 OR 2)/Denominator (1 OR 2). |
| Data source/s | Numerator (1): AIHW from the CMHC NMDS.  Numerator (2): AIHW from the MHE NMDS  Denominator/s: AIHW from the CMHC NMDS. |
| Data Quality Framework Dimensions | |
| Institutional environment | The AIHW has provided the data for this indicator.  The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.  The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community‑based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.  States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement. |
| Relevance | The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Ambulatory services managed by non‑government organisations are not defined as statistical units for the MHE NMDS and therefore excluded.  The scope of the CMHC NMDS is government‑operated community (also termed ambulatory) mental health services. Data collected includes information relating to each individual service contact provided by an in‑scope mental health service. Examples of data elements are demographic characteristics of patients, such as age and sex, clinical information, such as principal diagnosis and mental health legal status, and service provision information, such as contact duration and session type. Ambulatory services managed by  non‑government organisations are not considered in‑scope for the CMHC NMDS and are therefore excluded.  All activity (treatment days and statistical episodes) and expenditure associated with non‑uniquely identified consumers is excluded.  Expenditure data are for services provided in public specialised mental health ambulatory services. Expenditure comprises direct and indirect expenditure incurred at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The residual indirect expenditure incurred at the state and territory level and that unapportioned from the organisational or regional level is not included in the estimates.  Treatment days per episode or expenditure per treatment day are not adjusted for differences in the client mix. The client mix in ambulatory settings can differ — for example, some jurisdictions treat a higher proportion of more complex patients in ambulatory settings as distinct from treating them in hospitals. More relevant measures would be casemix adjusted to take into account the type and complexity of cases. Data for these measures are not yet available, as casemix funding/analysis has not been applied to specialised mental health services.  Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode. ‘One treatment day’ episodes are included. These episodes are a confounding issue and a method for accounting for ‘one treatment day’ ambulatory episodes might provide more relevant measures.  An episode of ambulatory care is a three month period of ambulatory care for an individual registered patient where the patient was under ‘active care’ (one or more treatment days in the period). Community‑based periods relate to the following four fixed three monthly periods: January to March, April to June, July to September, and October to December. The three month period used in this indicator to define a treatment episode is arbitrary. Further development of episode‑based funding models may enable more meaningful/relevant measures in future.  Data are not available for Victoria for 2012‑13. All Australian totals for  2012‑13 exclude Victoria.  Industrial action in Tasmania in 2011‑12 and 2012‑13 affected the quality and quantity of Tasmania’s CMHC data. |
| Timeliness | State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period.  State and territory health authorities provide the CMHC NMDS data to the AIHW for national collation on an annual basis, approximately six months after the reference period.  The reference period for the most recent data are 2012‑13. |
| Accuracy | Coverage of the MHE NMDS in‑scope expenditure is essentially complete across years. Coverage of the CMHC NMDS in‑scope mental health services contacts is variable among the jurisdictions, with coverage issues for both the services in‑scope for collection and the reporting of service contacts between clinicians and clients. Work is ongoing to clarify coverage for jurisdictions.  States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non‑compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re‑submitting improved data files.  States and territories are primarily responsible for the quality of the CMHC NMDS data they provide. However, the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is concerned with ensuring that the data file supplied is structurally compliant and correctly formatted. A non‑compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is series of edit checks to ensure that the data supplied are consistent, logical and with valid values. Potential validation errors are queried with jurisdictions, and where the priority for correction is considered high, resubmissions are requested in response to these edit queries. A series of additional edit checks are conducted by the AIHW including coverage checks, historical validation and state/territory comparisons. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re‑submitting improved data files.  Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005‑06 to 2011‑12 data could differ from previous reports.  The quality of the NSW 2010‑11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010‑11 financial year. |
| Coherence | Data are reported for each year from 2005‑06 to 2012‑13.  ‘Non‑uniquely identifiable consumers’ are defined as those with service contacts for which a unique person identifier was not recorded. The proportion of contacts attributed to these consumers varies across jurisdictions (for example, from zero to 15 per cent) and can vary in one jurisdiction across time (for example, from 76 to 99 per cent). As all activity (treatment days and statistical episodes) and expenditure associated with non‑uniquely identified consumers are excluded using these proportions, the coherence and comparability of the results across jurisdictions and across time may be affected.  The Australian totals for 2011‑12 and 2012‑13 are not comparable to earlier years as they exclude data for Victoria. |
| Accessibility | The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:   * Mental Health Services in Australia — annual publication * Australia’s Health — a mental health chapter is included in this biennial publication * National Mental Health Reports * the Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/).   Unpublished MHE NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incur in their provision. Cells may be suppressed for confidentiality reasons or where estimates are based on small numbers, resulting in low reliability. |
| Interpretability | Metadata information for the MHE NMDS are published in the AIHW’s online metadata repository — METeOR and in the National health data dictionary.  Further information to understand this indicator are available:   * in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition * from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/). |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * The cost of ambulatory care measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency. * Data are not provided for the latest reference period (2013‑14). Further work is required to ensure availability of more timely data. * The exclusion of activity (treatment days and statistical episodes) and expenditure associated with non‑uniquely identified consumers means that the coherence and comparability of the results across jurisdictions and across time may be affected. |

### Rates of illicit and licit drug use

DQI for this indicator has been sourced from the AIHW with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Outcome |
| Indicator | Rates of illicit and licit drug use |
| Measure (computation) | Description:  Proportion of people aged 14 years or over who use specific licit and illicit drugs in the preceding 12 months — by drug type: alcohol, cannabis, ecstasy, cocaine, meth/amphetamine, hallucinogens, Gamma‑hydroxybutyrate (GHB), inhalants, and heroin.  Numerator:  Number of people aged 14 years or over who use specific licit and illicit drugs in the preceding 12 months — by drug type.  Denominator:  Total population aged 14 years or over.  Computation:  (Numerator ÷ Denominator)\*100  Calculated separately, by drug type. |
| Data source/s | AIHW 2014, *National Drug Strategy Household Survey (NDSHS) detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra.  AIHW 2011, *2010 NDSHS Report*, Drug statistics series no. 25, Cat. no. PHE 145. |
| Data Quality Framework Dimensions | |
| Institutional environment | The NDSHS data were managed, analysed and published by the AIHW. The AIHW is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act 1987* to provide reliable, regular and relevant information and statistics on Australia’s health and welfare. It is an independent statutory authority established in 1987, governed by a management Board, and accountable to the Australian Parliament through the Health and Ageing portfolio.  The NDSHS is one of the key data collections that support the *National Drug Strategy*. The last survey in this program was conducted in 2013, with previous surveys in 1985, 1988, 1991, 1993, 1995, 2001, 2004, 2007 and 2010. The data collected from these surveys have contributed to the development of policies for Australia’s response to drug‑related issues. |
| Relevance | Scope and coverage  The NDSHS collects self‑reported information on tobacco, alcohol and illicit drug use and attitudes from persons aged 12 years and over.  Excluded from sampling were non‑private dwellings (hotels, motels, boarding houses, etc.) and institutional settings (hospitals, nursing homes, other clinical settings such as drug and alcohol rehabilitation centres, prisons, military establishments and university halls of residence). Homeless persons were also excluded as well as the territories of Jervis Bay, Christmas Island and Cocos Island.  The exclusion of people from non‑private dwellings and institutional settings, and the difficulty in reaching marginalised people are likely to have affected estimates.  The 2013 NDSHS was designed to provide reliable estimates at the national level. The survey was not specifically designed to obtain reliable national estimates for Aboriginal and Torres Strait Islander people, as there was no target sample size for Aboriginal and Torres Strait Islander Australians. In 2013, the sample size for Aboriginal and Torres Strait Islander Australians was smaller than anticipated based on population estimates, and so estimates based on this population group should be interpreted with caution.  Reference period  The fieldwork was conducted from 31 July to 1 December 2013. Respondents to the survey were asked questions relating to their beliefs and experiences covering differing time periods, predominantly over the previous 12 months.  Geographic detail  In 2013, data were coded to the census collector’s district level. Data are generally published at the national level with a selection of data published at the State/Territory and Remoteness Area levels.  Statistical standards  Data on alcohol consumption was collected in accordance with World Health Organization standards and alcohol risk data were reported in accordance with the current 2009 National Health and Medical Research Council’s ‘Australian Guidelines to Reduce Health Risks from Drinking Alcohol’. |
| Timeliness | The NDSHS is conducted approximately every three years over a three‑four month period. 2013 data were collected between late‑July and early December 2013.  A preliminary data set was received by the AIHW in late‑January 2014 and initial data checks were completed in early February 2014.  Key findings from the 2013 NDSHS were released on 17 July 2014. |
| Accuracy | Perceptions of behaviour  It is known from past studies of alcohol consumption that respondents tend to underestimate actual consumption levels (Stockwell et al. 2004). There are no equivalent data on the tendencies for under‑ or over‑reporting of actual illicit drug use.  However, illicit drug users, by definition, have committed illegal acts. They are, in part, marginalised and difficult to reach. Accordingly, estimates of illicit drug use and related behaviours are likely to be underestimates of actual practice  Sample design  The 2013 sample was stratified by region (15 strata in total ─ capital city and rest of state for each state and territory, with the exception of the ACT, which operated as one stratum). To produce reliable estimates for the smaller states and territories, sample sizes were boosted in Tasmania, the ACT and the NT.  The over‑sampling of lesser populated states and territories produced a sample that was not proportional to the state/territory distribution of the Australian population aged 12 years or older. Weighting was applied to adjust for imbalances arising from execution of the sampling and differential response rates, and to ensure that the results relate to the Australian population.  Sampling error  The measure used to indicate reliability of individual estimates reported in 2013 was the relative standard error (RSE). Only estimates with RSEs of less than 25 per cent are considered sufficiently reliable for most purposes. Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with RSEs greater than 50 per cent should be considered as unreliable for most practical purposes.  Non‑sampling error  In addition to sampling errors, the estimates are subject to non‑sampling errors. These can arise from errors in reporting of responses (for example, failure of respondents’ memories, incorrect completion of the survey form), the unwillingness of respondents to reveal their true responses and the higher levels of non‑response from certain subgroups of the population.  Reported findings are based on self‑reported data and not empirically verified by blood tests or other screening measures.  Response rates and contact rates  Overall for the 2013 Survey, contact was made with 48 579 in‑scope households, of which 23 855 questionnaires were categorised as being complete and useable, representing a response rate for the 2010 survey of 49.1 per cent, slightly lower than the drop and collect component of the 2010 survey (50.6 per cent).  Some survey respondents did not answer all questions, either because they were unable or unwilling to provide a response. The survey responses for these people were retained in the sample, and the missing values were recorded as not answered. No attempt was made to deduce or impute these missing values.  A low response rate does not necessarily mean that the results are biased. As long as the non‑respondents are not systematically different in terms of how they would have answered the questions, there is no bias. Given the nature of the topics in this survey, some non‑response bias is expected. If non‑response bias in the NDSHS is to be eliminated as far as possible, there would need to be additional work conducted to investigate the demographic profile of the non‑respondents and the answers they may have given had they chosen to respond.  Aboriginal and Torres Strait Islander Data  The survey was not specifically designed to obtain reliable national estimates for Aboriginal and Torres Strait Islander people, as there was no target sample size for Indigenous Australians. In the 2013 NDSHS, 1.9 per cent of the sample (or approximately 461 respondents) identified as being of Aboriginal or Torres Strait Islander origin. The sample size for Indigenous Australians was smaller than anticipated based on population estimates, and so estimates based on this population group should be interpreted with caution.  The total population of Aboriginal and Torres Strait Islander people forms a very small part of the total Australian population. At the August 2011 census, the Aboriginal and Torres Strait Islander population was officially calculated at 670,000 people, or 2.1 per cent of the total Australian population. At that time, about one‑third (35 per cent) of the Aboriginal and Torres Strait Islander population lived in Major cities, 22 per cent in Inner regional areas, 22 per cent in Outer regional areas, 8% in Remote areas and 14 per cent in Very remote areas.  The Aboriginal and Torres Strait Islander population living in Very remote areas shows other differences to populations living in Major cities including in household structure, size and age distribution. The NDSHS sample design is stratified by region and not by remoteness. Due to this sampling design, the NDSHS sample of Indigenous Australians living in Very remote areas comprised of 9 per cent of the population in those regions compared with 14 per cent of Indigenous Australians living in Very remote areas based on the 2011 Census. Therefore, Aboriginal and Torres Strait Islander people in Very remote areas are underrepresented, and it becomes difficult to generalise results from Major cities and regional areas to the whole Indigenous population.  The sampling method employed for the NDSHS invited one participant aged over 12 years to take part in the survey. The sample strategy did not take into account the size of the household selected. This is an issue for respondent selection for Indigenous Australians, as often they live in larger households compared with non‑Indigenous Australians. This selection process means that Aboriginal and Torres Strait Islander people are proportionately less likely to be selected.  The NDSHS uses a self‑completion questionnaire, and requires good comprehension of the English language (as it is not translated into other languages) and the ability to follow instructions. Practicality of the survey design meant that some Aboriginal communities and those with low levels of English literacy may have been excluded. Response rates are reported in the relevant NDSHS reports. |
| Coherence | Surveys in this series commenced in 1985. Over time, modifications have been made to the survey’s methodology and questionnaire design. The 2013 survey differs from previous versions of the survey in some of the questions asked and also used three follow up attempts by interviewers instead of the two used in 2010.  Methodology  The 2013 survey was the second to exclusively use the drop and collect method, the first being 2010. In 2007 and 2004, a combination of computer‑assisted telephone interviews (CATI) and drop and collect methods were used, and in earlier waves, personal interviews were also conducted.  The change in methodology in 2010 does have some impact on time series data, and users should exercise some degree of caution when comparing data over time.  Fieldwork was conducted between July and December 2013, slightly later than in previous wave. The collection period also coincided with the 2013 federal election, although no questionnaires were placed on that day.  Sample  To produce reliable estimates for the smaller states and territories, sample sizes were boosted in Tasmania, the ACT and the NT.  In 2013 and 2010, to improve the geographic coverage of the survey, interviewers were flown to Very remote areas selected in the sample. In previous surveys, some Very remote areas that were initially selected in the sample would have been deemed inaccessible and not included in the final sample.  Questionnaire  The 2013 questionnaire was modelled on the 2010 version, to maintain maximum comparability. However, some refinements were made to ensure the questions remained relevant and useful. For more information on questionnaire changes in 2013 see chapter 1 of the 2013 NDSHS report. |
| Accessibility | Results from the 2013 NDSHS are available on the AIHW website. Key findings can be found in the web compendium: Highlights from the 2013 survey and full published results can be found in the 2013 NDSHS report.  Users can request data not available online or in form the AIHW. Requests that take longer than half an hour to compile are charged for on a cost‑recovery basis.  A confidentialised unit record file is available for third party analysis through the Australian Data Archive. Access to the master unit record file may be requested through the AIHW Ethics Committee.  Data for this indicator are also reported in the National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental‑data |
| Interpretability | Information to aid in interpretation of 2013 NDSHS results may be found in chapter 1 of the 2013 NDSHS report titled ‘Introduction’. In addition, the 2013 Technical Report, code book and other supporting documentation are available through the Australian Data Archive website or may be requested from AIHW  Further information to understand this indicator are available in:   * the COAG national action plan on mental health — progress report 2010‑11 * National mental health reports www.health.gov.au/internet/main/ publishing.nsf/Content/mental‑data. |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * Respondents tend to underestimate actual alcohol consumption levels. * Estimates of illicit drug use are also likely to be underestimates of actual practice. * Reported findings are based on self‑reported data and are not independently verified. * The response rate for the 2013 survey was 49.1 per cent. Some non‑response bias is expected ― this bias has not been measured |

### Prevalence of mental illness

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Outcome |
| Indicator | Prevalence of mental illness |
| Measure (computation) | *Numerator*:  Number of people aged 16–85 years who had a mental health disorder diagnosed by the World Mental Health Composite Interviewing Diagnostic Instrument (CIDI), with symptoms in last 12 months.  *Denominator*:  Total population aged 16–85 years.  *Computation*:  (Numerator ÷ Denominator)\*100  Disaggregated by disorder type and age or sex (national only), State and Territory, by disorder type. |
| Data source/s | ABS unpublished, *2007 National Survey of Mental Health and Wellbeing* (Cat. no. 4326.0). |
| Data Quality Framework Dimensions | |
| Institutional environment | For information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, see ABS Institutional Environment (available www.abs.gov.au). |
| Relevance | The 2007 National Survey of Mental Health and Wellbeing (SMHWB) provides information about the prevalence of selected *high prevalence* mental disorders in the Australian population aged 16–85 years, the level of impairment associated with these disorders, physical conditions, and the use of health services, such as consultations with health practitioners or visits to hospital. The survey also provides information on the strength of social networks, caring responsibilities and a range of socio‑economic and demographic characteristics.  The SMHWB was designed to provide prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders (such as social phobia), affective disorders (such as depression) and substance use disorders (such as harmful alcohol use). The SMHWB was not designed to measure the prevalence of all mental health conditions, therefore some severe mental disorders, such as schizophrenia, were not collected.  The SMHWB is based on an international survey instrument, the CIDI, developed by the World Health Organization (WHO) for use by participants in the World Mental Health Survey Initiative.  The 2007 survey was designed to provide data that were internationally comparable, rather than to provide comparisons with the 1997 survey. The survey was also designed to provide estimates of the prevalence of mental disorders at a national rather than a state/territory level. |
| Timeliness | The SMHWB was conducted in 1997 and 2007.  Results from the 2007 survey were released ten months after the completion of enumeration, in the publication *National Survey of Mental Health and Wellbeing: Summary of Results* (cat. no. 4326.0). |
| Accuracy | Estimates from the 2007 SMHWB are subject to sampling and non‑sampling errors. The RSE is a measure of the size of the sampling error affecting an estimate; that is, the error introduced by basing estimates on a sample of the population rather than the full population. Estimates should be considered with reference to their RSEs. Estimates with an RSE between 25 per cent and 50 per cent should be used with caution, and those with an RSE greater than 50 per cent are considered too unreliable for general use. Non‑sampling errors are inaccuracies that occur because of imperfections in reporting by respondents and interviewers, as well as errors made in coding and processing the data.  The SMHWB was designed primarily to provide estimates at the national level. Due to the higher than expected non‑response rate, RSEs were somewhat larger than originally designed. While broad estimates are available for the larger states, users should exercise caution when using estimates at this level due to relatively high sampling errors. |
| Coherence | The 2007 SMHWB was the second survey of this type conducted by the ABS, with the previous survey conducted in 1997. Care should be exercised when comparing data between surveys as there have been a number of changes to the scope, design, collection, methodology and content.  Supporting documentation released with the survey data can assist in understanding the relationships between data variables within the dataset and in comparisons with data from other sources. |
| Accessibility | The main products available from this survey are:   * National Survey of Mental Health and Wellbeing: Summary of Results, 2007 (Cat. no. 4326.0) * National Survey of Mental Health and Wellbeing: Users’ Guide, 2007 (Cat. no. 4327.0) * Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded Confidentialised Unit Record Files, 2007 (Cat. no. 4326.0.30.001) * Technical Manual: National Survey of Mental Health and Wellbeing, Confidentialised Unit Record Files (Cat. no. 4329.0).   Further information may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level. |
| Interpretability | The *National Survey of Mental Health and Wellbeing: Summary of Results* (Cat. no. 4326.0) includes explanatory material to aid the interpretation of the survey results. More detailed information is available in the *National Survey of Mental Health and Wellbeing: Users’ Guide* (Cat. no. 4327.0). |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following issues:   * The SMHWB was designed to provide estimates at the national level. Broad estimates are available for the larger states, but users should exercise caution when using estimates at this level due to relatively high sampling errors. * The SMHWB was designed to provide prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders (such as social phobia), affective disorders (such as depression) and substance use disorders (such as harmful alcohol use). It does not measure the prevalence of some severe mental disorders, such as schizophrenia (which are the mental illnesses most frequently treated by specialised public mental health services). |

### Mortality due to suicide

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Outcome |
| Indicator | Mortality due to suicide |
| Measure (computation) | *Numerator*:  Number of people who have died by suicide over the relevant reference period:   * five year period (2008–2012) * single reference year (2012)   *Denominator*:  ERP.  *Computation*:  (Numerator ÷ Denominator)\*100 000  Expressed as crude, age‑specific or age standardised rates.  Disaggregated by age and sex (national only), State and territory for all persons, young people (15–24 years), by geographical region and Indigenous status. |
| Data source/s | *Numerator:* ABS *Causes of Death* collection (Cat. no. 3303.0)  *Denominator:* ABS ERP (Cat. no. 3101.0); Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021 (Cat. no. 3238.0); ASGC (Cat. no. 1216.0). |
| Data Quality Framework Dimensions | |
| Institutional environment | Statistics presented in *Causes of Death, Australia, 2012* (Cat. no. 3303.0) are sourced from deaths registrations administered by the various state and territory Registrars of Births, Deaths and Marriages. It is a legal requirement of each state and territory that all deaths are registered. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred on a *Death Registration Form*. As part of the registration process, information on the cause of death is either supplied by the medical practitioner certifying the death on a *Medical Certificate of Cause of Death*, or supplied as a result of a coronial investigation.  Death records are provided electronically to the ABS by individual Registrars on a monthly basis. Each death record contains both demographic data and medical information from the *Medical Certificate of Cause of Death* where available. Information from coronial investigations are provided to the ABS through the National Coroners Information System (NCIS).  For information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, see ABS Institutional Environment (available www.abs.gov.au). |
| Relevance | The ABS Causes of Death collection includes all deaths that occurred and were registered in Australia, including deaths of persons whose usual residence is overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars, but are not included in ABS deaths or causes of death statistics.  From the 2007 reference year, the scope of the collection is:   * all deaths registered in Australia for the reference year and are received by the ABS by the end of the March quarter of the subsequent year; and * deaths registered prior to the reference year but not previously received from the Registrar nor included in any statistics reported for an earlier period.   For example, records received by the ABS during the March quarter of 2011 which were initially registered in 2010 or prior (but not forwarded to the ABS until 2011) are assigned to the 2010 reference year. Any registrations relating to 2010 which are received by the ABS after the end of the March 2011 quarter are assigned to the 2011 reference year.  Data in the Causes of Death collection include demographic items, as well as causes of death information, which is coded according to the International Classification of Diseases (ICD). ICD is the international standard classification for epidemiological purposes and is designed to promote international comparability in the collection, processing, classification, and presentation of causes of death statistics. The classification is used to classify diseases and causes of disease or injury as recorded on many types of medical records as well as death records. The ICD has been revised periodically to incorporate changes in the medical field. The 10th revision of ICD (ICD‑10) has been used since 1997.  Non‑Indigenous data from the Causes of Death collection do not include death registrations with a ‘not stated’ Indigenous status. |
| Timeliness | Causes of death data are published on an annual basis.  There is a focus on fitness for purpose when causes of death statistics are released. To meet user requirements for accurate causes of death data it is necessary to obtain information from other administrative sources before all information for the reference period is available (for example, information from finalisation of coronial proceedings to code an accurate cause of death). A balance therefore needs to be maintained between accuracy (completeness) of data and timeliness. ABS provides the data in a timely manner, ensuring that all coding possible can be undertaken with accuracy prior to publication.  In addition, to address the issues which arise through the publication of causes of death data for open coroners cases, these data are subject to a revisions process. This process enables the use of additional information relating to coroner certified deaths either 12 or 24 months after initial processing. |
| Accuracy | Information on causes of death is obtained from a complete enumeration of deaths registered during a specified period and are not subject to sampling error. However, deaths data sources are subject to non‑sampling error which can arise from inaccuracies in collecting, recording and processing the data. Every effort is made to minimise non‑sample error by working closely with data providers, running quality checks throughout the data processing cycle, training of processing staff, and efficient data processing procedures.  Causes of death data for 2006, 2007, 2008, 2009, 2010 and 2011 have been subject to revision. All coroner certified deaths registered after 1 January 2006 are subject to a revision process. This is a change from previous years where all ABS processing of causes of death data for a particular reference period was finalised approximately 13 months after the end of the reference period. Where insufficient information was available to code a cause of death (for example, a coroner certified death was yet to be finalised by the Coroner), less specific ICD codes were assigned as required by the ICD coding rules. The revision process enables the use of additional information relating to coroner certified deaths as it becomes available over time. This results in increased specificity of the assigned ICD‑10 codes.  For this year’s report, causes of death data for 2010, 2011 were updated as more information became available. Final data for 2006, 2007, 2008, 2009 and revised data for 2010 and 2011 and preliminary data for 2012 have been published in the *2012 Causes of Death* publication, released in March 2014. 2011 and 2012 causes of death will be revised in the 2013 Causes of Death publication due for release in 2015. Revisions will only affect coroner certified deaths, as further information becomes available to the ABS about the causes of these deaths. See *Causes of Death, Australia* (Cat. no. 3303.0).  Some rates are unreliable due to small numbers of deaths over the reference period. Resultant rates could be misleading for example where the non‑Indigenous mortality rate is higher than the Aboriginal and Torres Strait Islander mortality rate. All rates for this indicator must be used with caution.  Non‑Indigenous population estimates are available for census years only. In the intervening years, Aboriginal and Torres Strait Islander population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non‑Indigenous population figures for these years, it is possible to derive denominators for calculating non‑Indigenous rates by subtracting the Aboriginal and Torres Strait Islander population from the total population. Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases. |
| Coherence | The methods used to construct the indicator are consistent and comparable with other collections and with international practice.  The completeness or quality of older (unrevised) versus newer data (subject to a revisions process) can affect comparisons across time. The accuracy dimension contains information pertinent to coroner certified deaths affected by the revision process.  The ERPs used to derived rates differ across years and tables. Some are derived using ERPs based on the 2001 Census, 2006 Census or 2011 Census. See particular tables for details. Rates derived using ERPs based on different Censuses are not comparable. |
| Accessibility | Causes of death data are available in a variety of formats on the ABS website under the 3303.0 product family. ERP data are available in a variety of formats on the ABS website under the 3101.0 and 3201.0 product families. Further information on deaths and mortality may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level. |
| Interpretability | Information on how to interpret and use cause of death data are available from Explanatory Notes in *Causes of Death, Australia* (Cat. no. 3303.0). |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following issue:   * Causes of death data are subject to a revisions process. Final data for 2006, 2007, 2008 and 2009 and revised data for 2010 and 2011 have been published in the 2012 Causes of Death publication. Data for 2011 and 2012 causes of death will be revised in 2015. |

### Social and economic inclusion of people with a mental illness — participation in employment of working age population

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Outcome |
| Indicator | Social and economic inclusion of people with a mental illness — participation in employment of working age population. |
| Measure (computation) | *Numerator*:  Number of people aged 16‑64 years who are employed (by mental health status)  *Denominator*:  Number of people aged 16‑64 years in the population (by mental health status)  *Computation*:  (Numerator ÷ Denominator)\*100  Note: People with a mental health condition are defined as having a self‑reported mental or behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more. |
| Data source/s | ABS unpublished, Australian Health Survey (AHS) 2011‑13 (2011‑12 National Health Survey component). |
| Data Quality Framework Dimensions | |
| Institutional environment | The AHS was collected, processed, and published by the ABS. The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.  For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment at www.abs.gov.au. |
| Relevance | Long‑term health conditions described in this publication are classified to a classification developed for use in the NHS (or variants of that classification), based on the ICD. The 2011‑12 AHS collected data on self‑reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Estimates for people with ‘mental illness’ will differ to those that are derived under the SMHWB using the CIDI.  The definitions of employment, unemployment and the labour force are consistent with those used in ABS labour force surveys. |
| Timeliness | The AHS is conducted every three years over a 12 month period. Results from the 2011‑12 NHS component of the AHS were released in October 2012. |
| Accuracy | The AHS is conducted in all States and Territories, excluding very remote areas. Non‑private dwellings such as hotels, motels, hospitals, nursing homes and short‑stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the NT, where such persons make up a relatively large proportion of the population. The response rate for the 2011‑12 NHS component was 85 per cent. Results are weighted to account for non‑response.  As it is drawn from a sample survey, the indicator is subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their RSE. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use. The attachment tables identify those estimates with RSEs between 25 per cent and 50 per cent.  For information on AHS survey design, see the Australian Health Survey: Users’ Guide on the ABS website. |
| Coherence | The methods used to construct the indicator are consistent and comparable with other collections and with international practise. |
| Accessibility | See *Australian Health Survey: First Results (cat. no. 4364.0.55.001)* for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.  Further information may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level. |
| Interpretability | Information to aid interpretation of the data are available from the Australian Health Survey: Users’ Guide on the ABS website.  Many health‑related issues are closely associated with age; therefore data for this indicator have been age‑standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population. |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following issues:   * The AHS collects data on self‑reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. The data may not be as reliable as or comparable with the data collected under the SMHWB that uses a diagnostic tool to identify mental illnesses. |

### Social and economic inclusion of people with a mental illness — participation in education and employment by young people

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Outcome |
| Indicator | Social and economic inclusion of people with a mental illness — participation in education and employment by young people. |
| Measure (computation) | *Numerator*:  Number of people aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (studying full or part‑time) (by mental health status).  *Denominator*:  Number of people in aged 16–30 years in the population (by mental health status).  *Computation*:  (Numerator ÷ Denominator)\*100  Note: People with a mental health condition are defined as having a self‑reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. |
| Data source/s | ABS unpublished, *AHS 2011‑13* (2011‑12 National Health Survey component)*.* |
| Data Quality Framework Dimensions | |
| Institutional environment | The AHS was collected, processed, and published by the ABS. The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.  For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment at www.abs.gov.au. |
| Relevance | Long‑term health conditions described in this publication are classified to a classification developed for use in the NHS (or variants of that classification), based on the ICD. The 2011‑12 AHS collected data on self‑reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Estimates for people with ‘mental illness’ will differ to those that are derived under the SMHWB using the CIDI.  The definitions of employment are consistent with those used in ABS labour force surveys. |
| Timeliness | The AHS is conducted every three years over a 12 month period. Results from the 2011‑12 NHS component of the AHS were released in October 2012. |
| Accuracy | The AHS is conducted in all states and territories, excluding very remote areas. Non‑private dwellings such as hotels, motels, hospitals, nursing homes and short‑stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the NT, where such persons make up a relatively large proportion of the population. The response rate for the 2011‑12 NHS component was 85 per cent. Results are weighted to account for non‑response.  As it is drawn from a sample survey, the indicator is subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their RSE. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use. The attachment tables identify those estimates with RSEs between 25 per cent and 50 per cent.  For information on AHS survey design, see the Australian Health Survey: Users’ Guide on the ABS website. |
| Coherence | The methods used to construct the indicator are consistent and comparable with other collections and with international practise. |
| Accessibility | See *Australian Health Survey: First Results (cat. no. 4364.0.55.001)* for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.  Further information may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level. |
| Interpretability | Information to aid interpretation of the data are available from the Australian Health Survey: Users’ Guide on the ABS website.  Many health‑related issues are closely associated with age; therefore data for this indicator have been age‑standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population. |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following issues:   * The AHS collects data on self‑reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. The data may not be as reliable as or comparable with the data collected under the National Survey of Mental Health and Wellbeing that uses a diagnostic tool to identify mental illnesses. |

### Mental health outcomes of consumers of specialised public mental health services

DQI for this indicator has been sourced from the AMHOCN and Australian, State and Territory governments with additional Steering Committee comments.

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| Indicator definition and description | |
| Element | Outcome |
| Indicator | Mental health outcomes of consumers of specialised public mental health services. This DQI should be considered in conjunction with DQI for Collection of information on consumers’ outcomes. |
| Measure (computation) | Description:  Proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes. Data are also reported on the proportion who experienced no significant change or a significant deterioration in their mental health outcomes. Data are reported by consumer type: people in ongoing community‑based care, people discharged from community‑based care and people discharged from a hospital psychiatric inpatient unit.  Numerator/s:  Number of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes, by consumer type.  Number of people receiving care in specialised public mental health services who had no significant change in their clinical mental health outcomes, by consumer type.  Number of people receiving care in specialised public mental health services who had a significant deterioration in their clinical mental health outcomes, by consumer type.  Denominator:  Number of specialised public mental health service episodes with completed clinical mental health outcome measures data, by consumer type.  Computation:  Expressed as a proportion: (Numerator ÷ Denominator)\*100. Calculated separately by consumer type. |
| Data source/s | State and Territory data reported to NOCC and analysed by AMHOCN. |
| Data Quality Framework Dimensions | |
| Institutional environment | Health Ministers adopted the routine measurement of consumer outcomes as a priority under the *National Mental Health Strategy (1992)* and in all subsequent National Mental Health Plans. It is also compatible with State and Territory governments’ documented policy emphasis on high quality health services and increased consumer and carer participation.  The AMHOCN prepared this indicator using the NOCC data on HoNOS family of measures. The Australian Government (Department of Health) contracts AMHOCN to support the implementation of the NOCC as part of routine clinical practice by undertaking three functions 1) data bureau ― receives and processes information 2) analysis and reporting ― analyses and reports on the submitted data and 3) training and service development ― supports training in the measures and their use for clinical practice, service management and development purposes.  The NOCC 1.50 was endorsed by all State and Territory governments in 2003, and all jurisdictions have reported data since 2004‑05. The NOCC Technical Specification was revised to 1.60 in 2009. All jurisdictions have supplied, or resupplied NOCC data according to 1.60 from 2007‑08. The NOCC protocol prescribes a set of standard measures to be collected at particular times (collection occasions) in the clinical process. Under the NOCC protocol, collection of outcomes data is mandatory at admission, review and discharge. Data collected outside of NOCC protocols are excluded from the analysis. |
| Relevance | The scope of the NOCC is all specialised public mental health services managed by, or in receipt of funds from, state or territory health authorities Australian Government funded aged residential services are excluded.  The purpose of the NOCC is to measure consumer outcomes. This indicator relates only to consumer outcomes data collected through the HoNOS family of measures (HoNOS; HoNOS for Older People (HoNOS 65+) and HoNOS for Children and Adolescents (HoNOSCA). Other consumer outcome measures are also collected. For adults and older persons these include: Kessler 10 (K10+), Behavior and Symptom Identification Scales (BASIS‑32), or Mental Health Inventory (MHI‑38); for children and adolescents, the parent and youth versions of the SDQ. The uptake of these measures is not captured by this indicator.  Only episodes that have valid measures for two specified data collection occasions are included. ‘Valid’ measures are those with a correctly completed specified number of items, for the:   * HoNOS/HoNOS 65+ ― a minimum of 10 of the 12 items * HoNOSCA ― a minimum of 11 of the first 13 items.   Brief ambulatory care episodes are excluded from this indicator.  The denominator for the ‘completed inpatient’ group excludes those episodes that were partially completed within the year and had a length of less than 3 days. The denominator for the ‘completed ambulatory’ group is made up of those episodes that started and finished within the year. The denominator for the ‘ongoing ambulatory’ group is made up of those ambulatory episodes that started within the reference year and were still open at 30 June or were open at the start and end of the reference year.  Outcome scores are classified based on effect size — a statistic used to assess the magnitude of a treatment effect. The effect size is the ratio of the difference between the pre‑ and post‑ scores to the standard deviation of the pre‑score. Individual episodes are classified as ‘significant improvement’ if the effect size index is greater than or equal to positive 0.5; ‘no change’ if the index is between ‑0.5 and 0.5; and ‘significant deterioration’ if the effect size index is less than or equal to ‑0.5.  Outcomes are calculated for each of the following three consumer groups and the calculation varies depending on the setting and the duration of the episode of care:   * people discharged from hospital, episodes for people who were admitted and discharged from inpatient care during the reference period (an individual can have two episodes of care so the data represent episode‑counts, rather than person‑counts) — the admission and discharge occasions rated during the reference period are used * people in ongoing community‑based care, episodes for people who received community care for the whole of the reference period or who commenced community care sometime after 1 July (beginning of the period) and continued to receive care for the rest of the reference period — the first and last occasions rated during the reference period are used * people discharged from community‑based care, episodes for people who were discharged from community care (not including those discharged to hospital) and who received an episode of community care that started and ended in the reference period — the admission and discharge occasions rated during the reference period are used.   Outcomes are measured for consumers discharged from residential mental health care, but there were too few episodes with completed clinical mental health to derive outcome results.  A single ‘average score’ by consumer type does not reflect the complex service system in which services are delivered across multiple settings (inpatient, community and residential) and provided as both discrete, short term episodes of care and prolonged care over indefinite periods. The approach separates a consumer’s care into segments (hospital versus the community) rather than tracking the person’s overall outcomes across treatment settings. In addition, consumers’ outcomes are measured from the clinician’s perspective and not as the ‘lived experience’ from the consumer’s viewpoint.  Data are not available for Victoria for 2011‑12 and 2012‑13. All Australian totals for  2011‑12 and 2012‑13 exclude Victoria.  Tasmanian data for 2009‑10 are considered unreliable and not reported. As a result, 2008‑09 data are used in the calculation of the 2009‑10 Australian coverage estimates. |
| Timeliness | State and territory health authorities provide the NOCC data to AMHOCN for national collation on an quarterly/annual basis and all data are to be submitted approximately six months after the reference period.  The latest reference period for this data set is 2012‑13. |
| Accuracy | States and territories are primarily responsible for the quality of the NOCC data they provide. However, AMHOCN undertakes extensive validation. Validation is conducted in two stages: (1) The compliance stage, concerned with ensuring that the data file will load and is structurally compliant. A non‑compliant file is rejected and a new file needs to be submitted. (2) The data validation stage, primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues in relation to the NOCC protocol as well as flagging , including invalid domain values and/or, missing data.  The proportion of episodes for which ‘valid’ outcomes data are collected is less than 50 per cent of expected coverage. It is not known if the results for those for whom data are collected are representative of the consumer population. |
| Coherence | Data are available for 2007‑08 to 2012‑13. The comparability of the outcomes data across jurisdictions and years may be affected by the relatively low proportion of episodes for which ‘valid’ outcomes data are collected and the degree to which this proportion varies across jurisdictions and years.  The Australian totals for 2011‑12 and 2012‑13 are not comparable to earlier years as they exclude data for Victoria. |
| Accessibility | Data for this indicator are published in the National mental health reports: www.health.gov.au/internet/main/publishing.nsf/Content/mental‑data and in the Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/).  NOCC data are available on the AMHOCN website amhocn.org/. The following on‑line products are available:   * web decision support tool * NOCC Standard Reports * NOCC Volume and Percentage Clinical Ratings: Australia |
| Interpretability | Metadata information for the NOCC are published on the AMHOCN website amhocn.org/.  Further information to understand this indicator are available:   * in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition * from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/). |
| Data Gaps/Issues Analysis | |
| Key data gaps/issues | The Steering Committee notes the following key data gaps/issues:   * There are differences in the relative proportions of ‘matched pair’ HoNOS/CA/65+ ratings. * NOCC completion rates are for people discharged from hospital and people on ongoing community based care are approximately 85 per cent. * NOCC completion rates for people discharged from community based care, are lower, at approximately 65 per cent. This pattern has been stable over time and generally consistent for all consumer age groups and jurisdictions, with the exception of ACT where technical issues have not enabled linkage of admission and discharge ratings for this consumer group. It is likely that the overall lower completion rate for this consumer group arises when consumers are administratively discharged from care following a period of no active care in the preceding period. |

1. DoHA 2010, *National Standards for Mental Health Services: Implementation guidelines for   
   Non-government Community Services,* Australian Government, Canberra. [↑](#footnote-ref-1)