# Mental Health Information Development

## National Mental Health Information Priorities 2nd Edition

June 2005

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ISBN 0-642-82710-9

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Prepared by the Health Priorities and Suicide Prevention Branch, Department of Health and Ageing, Canberra.

Additional copies of the report can be obtained from:

Department of Health and Ageing
GPO Box 9848
Canberra ACT 2602
Phone: 1800 066 247
Facsimile: 1800 634 400

Electronic copies can also be downloaded from:

www.mentalhealth.gov.au
www.mhnocc.org.au

**Suggested citation:**

Department of Health and Ageing (2005) *National Mental Health Information Priorities 2nd Edition.* Commonwealth of Australia, Canberra.

Publications Approval Number: 3676

# Foreword

The availability of information is critical in allowing us to ask, and to answer, the right questions about mental health care in Australia. For this reason, information development was identified as a continuing priority over the life of the National Mental Health Strategy.

The 'first edition' statement of national priorities for mental health information was released in June 1999 and signalled a major investment by all jurisdictions in improving the range and quality of information to support service delivery and planning purposes. A central feature of the directions taken was the introduction of an outcome focus in mental health, through the implementation of a core set of standardised measures for monitoring the progress of consumers in all mental health services. This work has put Australia at the forefront of international developments in this field and impacted on all areas of service delivery. Achieving this progress has required substantial cooperation between all governments and other major parties.

The current document represents an update on the earlier statement and outlines the national priorities for further developing mental health information over the period of the National Mental Health Plan 2003-2008 and beyond. Designed to align with the key themes of the Plan, it recognises that while much has been achieved, the task of building an 'informed mental health system' is far from complete. The central challenge ahead is to apply the various information tools developed in recent years in ways that genuinely improve mental health care in Australia.

The document outlines an extensive work program that will require continued effort by all governments. Developed as a consensus statement between the Australian, State and Territory governments, the work program acknowledges the individual responsibilities of each jurisdiction and also highlights that ongoing collaboration between jurisdictions will be required to make real progress in many of the agreed priority areas.

The release of this document under the auspice of the National Mental Health Strategy reflects the commitment by all governments to continue improving mental health information within the services under their control as well as collaborating in areas where national coordination is required.

Dr Tony Sherbon
Chair
Australian Health Ministers' Advisory Council
National Mental Health Working Group

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# Executive Summary

This document outlines the priorities that will guide the development of national mental health information over the next five years and beyond. Prepared as a consensus statement between the Australian, State and Territory governments under the framework of the National Mental Health Strategy, the document carries forward and extends the work undertaken over the past decade to foster an information culture within the mental health sector.

The priorities described are concerned with 'national information'. This concept is used to refer information that is comparable nationally, national in coverage, or nationally relevant. It also encompasses information that is cross-jurisdictional (Australian and State and Territory governments and other agencies, public and private) and that requires cooperation and coordination between jurisdictions for health information activities to proceed on a coherent basis.

The first edition of national mental health information priorities was released in June 1999 and stimulated major developments by all jurisdictions. In preparing new priorities to move forward under the National Mental Health Plan 2003-2008, it was recognised that the four overarching themes underpinning the 1999 first edition workplan remain relevant to the years ahead and will continue to guide the next phase. They describe a vision for the mental health sector in which information is used to:

- strengthen the focus on consumer outcomes;
- support improvements in service quality;
- shift the focus of concern from cost to value for money; and
- improve our understanding of population needs.

This second edition recognises that much has been achieved in building an information foundation for mental health, but the task is far from complete. Achieving the vision over the next period of the National Mental Health Strategy requires consolidation of the work already underway, as well as extension into new areas of activity that are driven by the requirements of the National Mental Health Plan 2003-2008.

Three key challenges are identified:

- *Moving from information collection to information use*

  The investments made so far by jurisdictions have concentrated primarily on the basic collection aspects of information – putting systems in place, preparing documentation, training the clinical workforce and so forth. However, collection of information has little value unless it is used to support decision making. The next phase of information development will focus on fostering a service delivery culture in which information is used to support decisions at all levels. For this to occur, feedback systems are required that provide timely access to those collecting these data. Additionally, incentives and training need to be in place to facilitate individual service providers and organisations in using information routinely for clinical review, evaluating performance, benchmarking and related activities.

- *From projects to sustainable systems*

  Securing the long-term sustainability of the initiatives that have been taken so far will be a focus over the years ahead. Much of the work has been conducted as special projects or 'research and development' activities, involving time limited funds and appointment of special task groups. While most jurisdictions are progressively incorporating the new initiatives within their recurrent budgets and operational systems, sustainability requires attention to ongoing workforce training issues and longer term planning to keep the work evolving.

- *Responding to new policy drivers*

  The National Mental Health Plan 2003-2008 extends Australia's mental health policy beyond its initial focus on the specialist sector, particularly in the emphasis given to promotion and prevention, and the role of the primary health care sector. National information in relation to each of these is substantially less developed compared to other areas covered by the Plan and will require strategies to chart a future development path.

Within this context, the following ten priority areas are identified for action:

1. Using outcome measurement to improve mental health care.
2. Further development of a mental health casemix classification.
3. Using information to improve safety in mental health care.
4. Establishing performance indicators and benchmarking in mental health services.
5. Strengthening workforce uptake and capacity to use information.
6. Improving national minimum data sets for mental health care.
7. Information to support mental health care provided external to the specialist sector.
8. Monitoring population mental health and wellbeing.
9. Information to support mental health prevention and promotion.
10. Monitoring and reporting of progress under the National Mental Health Strategy.

A number of specific initiatives are identified in each of the ten priority areas. Overall, a total of 42 action items are outlined that will be the focus for mental health information development under the National Mental Health Plan 2003-2008.

PART I

# Future Priorities in Context

# Future Priorities in Context

## 1.1 The central place of information in the National Mental Health Strategy

Information development has been central to National Mental Health Strategy since it began in 1992. There were several factors that made this an imperative.

Firstly, information about mental health services was not readily available to the public, contributing to the stigma commonly associated with mental disorders and their treatment. Making a wide range of information about mental health accessible was seen as an important first step towards tackling community misunderstanding and building trust in the reforms foreshadowed by the Strategy.

Secondly, the absence of a consistent data collection about what services are delivered and who receives them isolated mental health services from the mainstream health system, where significant advances had been made in the use of information over the decade that preceded the National Mental Health Strategy.

Thirdly, building an information base to monitor changes in mental health care was essential to meet the accountability requirements of the National Mental Health Strategy. In endorsing the Strategy, Health Ministers agreed that an important aspect of the reform process was to ensure that progress of all jurisdictions was monitored and reported publicly on a regular basis.

Fourthly, local clinical information systems were not in place in most Australian mental health services at the beginning of the Strategy, limiting the extent to which initiatives to improve service quality could be facilitated by modern information tools.

Each of these factors served as a barrier to the achievement of many of the goals of the Strategy that depended upon an 'informed mental health system', where information is available to guide decisions at all levels – to inform consumers about the services they receive, support clinicians in their treatment decisions, help managers manage, and inform policy makers in planning and funding services.

## 1.2 The first decade of development: 1993-2003

Initiatives were taken early in the National Mental Health Strategy to begin addressing these deficiencies and build the information culture envisaged by the Strategy.

The period of the First National Mental Health Plan, extending between 1993 and 1998, can be described from an information perspective as the 'research and development phase'. Projects were undertaken to trial new measurement concepts, develop consistent data standards and commission specific research that would gather critical data to inform future policy. At the forefront during this period were projects aimed at developing consumer outcome measures for routine use, the design of a casemix classification system for mental health services, and research to quantify the extent of mental disorders in the community. Considerable effort was also given to put in place a national collection that met the accountability requirements of the National Mental Health Strategy and enable progress to be monitored regularly.

The renewal of the Strategy under the Second National Mental Health Plan (1998-2003) introduced new priorities, culminating in the release in June 1999 of the 'first edition' of a national framework for mental health information development.[1] The document signalled a transition from the earlier emphasis on research and development and national-level collections to the important role of clinical information systems in supporting local service delivery and quality improvement activities. The framework outlined the case to develop comprehensive, local clinical information systems within mental health that would:

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

The 1999 national information priorities statement was backed by formal Information Development Agreements between the Australian Government and each of the States and Territories, providing financial assistance for redevelopment of the technical infrastructure and training of the clinical workforce. A central feature of the Agreements was the commitment by all States and Territories to introduce consumer outcome measurement as a component of routine service delivery.

Part 2 of this document describes the status of information development in each of the major areas of activity. In summary, the work has impacted on all areas of service delivery and extended beyond the public sector into private hospital sector. From its relatively undeveloped base in 1993, mental health now leads the health industry in several areas, particularly in its commitment to the use of standardised measures for assessing consumer outcomes and the establishment of a national system for reporting on community care. Achieving this progress has required substantial cooperation between all governments and other major parties.

## 1.3 Purpose of the National Mental Health Information Priorities Second Edition

Much has been achieved over the past decade, but the task is far from complete. As discussed later, the upgrading of outdated systems and development of nationally consistent information collections has created the foundation for an 'informed mental health system'. The potential is there, but new initiatives are required to foster a culture of using and applying information in ways that support and improve service delivery.

Converting the potential to a reality is the primary focus of this 'second edition' statement of national information priorities for mental health. The purpose of the document is to:

- provide a stocktake of progress in information development achieved so far under the National Mental Health Strategy;
- identify the key tasks that lie ahead to promote the application and use of information for improving mental health services; and
- map out the priorities that will guide the ongoing collaboration between all major parties in the further development of mental health information over the period of the National Mental Health Plan 2003-2008 and beyond.

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

The work program outlined represents both a consolidation and logical extension of the directions taken over the course of the Strategy and is aligned with the key themes of the National Mental Health Plan 2003-2008.

## 1.4 National Mental Health Plan 2003-2008

In July 2003, Australian Health Ministers endorsed the National Mental Health Plan 2003-2008, renewing the National Mental Health Strategy for a further five year period.

The Plan acknowledges the long term nature of the reform process and aims to consolidate the achievements of the first and second plans, address the gaps identified in both, and take the Strategy forward with restated and new directions.

The Plan outlines a future framework for policy development and activity in mental health service reform, organised around four priority themes:

- promoting mental health and preventing mental health problems;
- improving service responsiveness;
- strengthening quality; and
- fostering research, innovation and sustainability.

A total of 34 outcomes and 111 'key directions' for progressing these themes are identified in the Plan. The central role of information permeates all aspects of the Plan.

## 1.5 Scope of the National Mental Health Information Priorities

The breadth of the mental health field and the many related developments in health information that are in train throughout Australia make it important to be clear about the scope of this document – that is, about what is covered and what is not.

### 1.5.1 Focus on 'national information'

The priorities outlined are concerned with **national information**. The concept of 'national health information' has been defined previously as *"… information that is comparable nationally, national in coverage, or nationally relevant."* [2]

The concept also encompasses information that is cross-jurisdictional (Australian and State and Territory governments and other agencies, public and private) and that requires cooperation and coordination between jurisdictions for health information activities to proceed on a coherent basis.

Within the mental health context, national information is concerned with a number of domains including:

- mental health interventions and services at the individual and population level, the consumers of those services and their outcomes;
- the mental health of the population generally and of specific groups;

2 National Health Information Management Group (2002). *Health Information Development Priorities.* Australian Institute of Health and Welfare, Canberra.

- the determinants of the population's mental health, including those in the external environment and those internal to individuals; and
- the relationship between these elements.

This document therefore is not a strategic plan on how information systems will be developed, nor is it a prescription that binds each of the parties to the National Mental Health Strategy on how information technology should be managed within their jurisdictions. It is instead a statement of common intent, which pursues agreed directions to the extent that is possible for each of the parties.

This focus on national information, rather than the technical aspects of systems development, is based on a recognition of how responsibilities are distributed across Australia's federated system of governments. Within this, each State and Territory jurisdiction is responsible for the design, funding and organisational arrangements for public sector mental health service delivery, including the information environments in which those services operate.

While differences exist between the jurisdictions in their arrangements for mental health information, the release of this document under the framework of the National Mental Health Strategy reflects the commitment by all parties to:

- implement changes within the services under their control, or influence, in a consistent manner for the purpose of nationally pooling and sharing information in the future; and
- continue the collaboration that has been a feature of the past decade in pursuing the work program outlined in this document.

### 1.5.2 Focus on the mental health service sector

The principal focus of the work foreshadowed by this document is on *specialist mental health services*.[3] Reform of the specialty sector was the original 'core business' of the National Mental Health Strategy and continues to be the area that generates most community attention.

However, the priorities include a recognition of the need to extend information development beyond an exclusive concern with specialist services. The framework advocates a number of initiatives in areas that fall outside the specialist public sector, including:

- private hospital psychiatric services;
- primary mental health care – to address the critical role played by general practitioners; and
- emergency departments within general hospitals – recognising the role played by these services in providing a front line response for many people presenting in psychiatric crises.

Additionally, the work program includes steps to further improve our understanding of mental health and mental disorders in the Australian population and support future promotion and prevention efforts that are advocated by the National Mental Health Plan 2003-2008.

3 Specialised mental health services are defined under the National Mental Health Strategy as those health services where the primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental disorder or psychiatric disability, with this criterion being applicable regardless of the source of funds; and where such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function (Department of Health and Ageing, 2004a).

### 1.5.3 Focus on information use as well as content

Historically, the target of national-level agreements on health information has been on content, emphasising the importance of consistent definitions and standards for data collection and reporting. These concerns also underpin the current statement on national mental health priorities, but are complemented by an equal focus on how information is used. This recognises that the effectiveness of mental health information depends not only on the relevance of its content, but also on the way that information is applied for a range of purposes.

Particular emphasis is given to the application of information to improve the quality of mental health services and outcomes for consumers, as well as to improve our understanding of mental health needs in Australia.

### 1.5.4 Relationship to mental health research

This statement on national priorities incorporates a research and development component but, while recognising the close relationship between the two, does not constitute a mental health research strategy as such. The National Mental Health Plan 2003-2008 includes a separate commitment to a national mental health research and development strategy, which is foreshadowed to 'take a strong, forward-looking approach to research development and sustainability'.[4]

The boundary between an information development strategy and a research and development strategy is not easy to define when it is considered how information is essential to research. However, a national approach to information development is expected to support mental health research.

For example, the promotion of data standards and consistency in routine information collections generates a wide range of data, in significant volumes, that is readily accessible to researchers. Some of this work has already been done, as in the introduction of standardised assessment measures in all Australian mental health services that provides a basis for future research on the outcomes of clinical care.

## 1.6 Linkage to national health information policy context

Directions for mental health cannot be considered in isolation of other developments occurring in Australia to strengthen a national approach to health information. Of particular significance are the following initiatives:

- The establishment by Australian Health Ministers in late 2003 of new governance arrangements to facilitate coordination between jurisdictions in all areas of health information development. The *Australian Health Information Council* and the *National Health Information Group* were created as the new peak bodies to assist in transcending jurisdictional boundaries and take Australia forward in achieving common solutions to shared problems.
- Within these new arrangements, continuation of the *Health Information Action Plan for Australia*, initiated under the *Health Online* program, which is designed to advance the use of online technology and related innovations to develop new ways of delivering health services.

4 Australian Health Ministers (2002). *National Mental Health Plan 2003-2008*. Australian Government, Canberra.

- Continuation of national collaboration, through the *HealthConnect* program, toward an interconnected health system and electronic health records, where information is shared at the clinical 'coalface' in a way that promotes integrated care to benefit the consumer.
- The recent agreement by Australian Health Ministers to create a new national entity (the National E-Health Transition Authority) to accelerate development of information and communications technology infrastructure throughout the health system.
- Ongoing work coordinated through the National Health Information Group in relation to the use of unique patient identifiers and record linkage, along with development of appropriate privacy and security safeguards.
- The establishment of the Australian Council on Safety and Quality in Health Care in 2001, which has set new requirements for national information to be compiled and used for the purpose of improving the quality of health care.
- The National Public Health Information Development Plan prepared by the National Public Health Partnership, which sets priorities for information about population health and related areas.

The mental health sector has a major stake in successfully progressing each of these initiatives but cannot act alone in developing its own solutions. This document therefore does not specifically address a range of requirements that are fundamental to the development of an informed mental health sector, where these need to be advanced as part of the broader development of health information systems across Australia.

## 1.7 Special requirements of the mental health sector that impact on information priorities

The integration of mental health into general health care is not a simple undertaking and raises challenges for information collections. Mental health care differs in its nature and organisation from the conventional image of acute hospital specialities around which much of Australia's information development has been centred. Many of these differences are also characteristic of other specialities, such as the health care of older people or those with chronic illnesses, for example:

- Care may be long term or may occur in shorter but recurring episodes.
- Care is usually provided by multiple treatment teams working across hospital and community settings, including the consumer's home. This poses practical difficulties for clinical staff recording details of their work, and thus has implications for what information can become 'national information'.
- Coordination of the overall care effort can be difficult, and is dependent on modern communication technologies, most of which are not currently available to the typical mental health service provider.
- Outcomes are relatively difficult to study as many facets of consumers' and carers' lives may be affected over long periods of time.

In addition, there are some characteristics that are specific to mental health care:

- Because mental illness may affect all aspects of living, including work, family, and social life, mental health care has significant overlap with the work of the welfare sector, particularly in the areas of housing and disability support services. Capturing information about the mental health-welfare interface within national information collections is especially difficult.
- Services may need to work with consumers who, as a result of their illness, are affected by disorganisation or disinclined to accept treatments that professionals consider important for them to have.
- Special confidentiality and data protection issues arise from working with police and criminal justice agencies.
- The need to record, and report on, the use of the different Mental Health Acts operating within each State and Territory requires specific data collection and reporting.
- Concerns about public safety are high, with a relatively small number of service failures given substantial publicity. As a result, there is considerable public interest in information about the performance of mental health services.

Collectively, these factors impact at all levels of the information development chain. They create special challenges for local system developers, who are required to ensure that the information needed by mental health clinicians is included in general health information systems. Current approaches to health information consist mainly of the collection and analysis of unlinked individual treatment episodes. A more complex data collection model is required that is consistent with the continuity of care and service integration themes of the National Mental Health Strategy.

At the national level, the factors outlined above emphasise the need for a specific focus on the mental health sector that takes account of the whole and not just parts of the service system, that looks at care provided over the longer term, and gives proper consideration to the specific requirements of the National Mental Health Strategy.

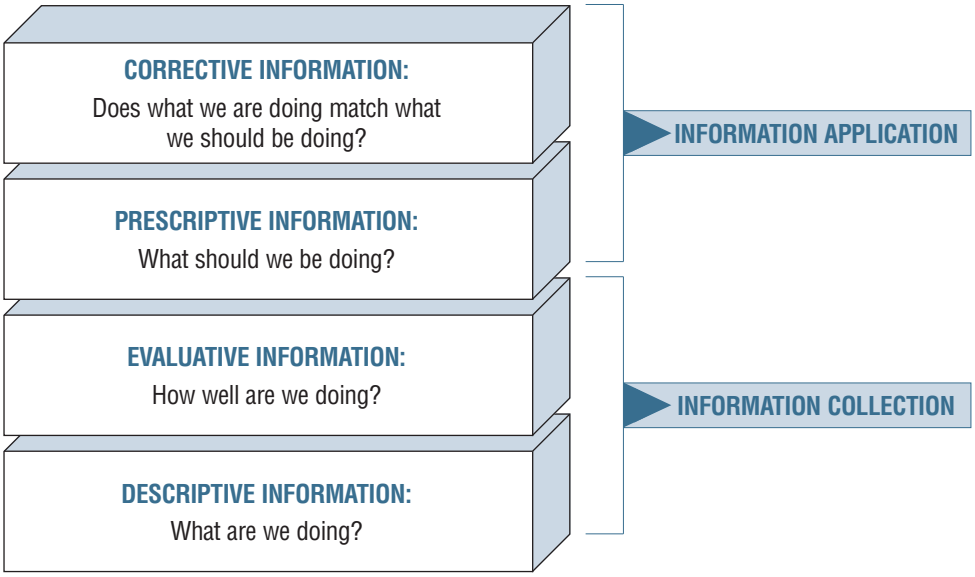
These factors support the development of a national mental health information plan that is progressed concurrently with the higher level system approaches to health information development that are taking place in Australia.

## 1.8 Types of information required

A recent report from the Mental Health Statistics Improvement Program of the United States Centre for Mental Health Services provides a useful framework for classifying the types of information required to support a comprehensive mental health care system.[5] It describes four categories of information, summarised in Figure 1.

5 Centre for Mental Health Services (2000). *Decision Support 2000+: Draft Requirements Analysis*. Centre for Mental Health Services, Maryland.

**Figure 1: Information 'building blocks' required to support a comprehensive mental health system**




*Descriptive information – What are we doing?*

Basic descriptive information is needed to answer questions of the 'who, what and how' kind, including, for example: Who needs services and who receives services? Who provides those services and at what cost?

*Evaluative information – How well are we doing?*

Information in this category is needed to provide feedback on whether intended goals are being met. Evaluative information provides feedback on the outcomes of services and treatments for consumers and indicates how well individual providers, programs, and the system as a whole perform in regard to the provision of accessible, appropriate, high quality, and cost-effective care.

*Prescriptive information – What should we be doing?*

Information in this category is derived from what the research literature or clinical or managerial experience indicate will produce the best results and usually takes the form of service standards or clinical and system guidelines. Prescriptive information is fundamental to evidence-based practice.

*Corrective information – Does what we are doing match what we should be doing?*

Corrective information comprises feedback that compares actual clinical and system practices to those practices recommended in evidence-based guidelines. Typically, corrective information is available in the form of performance indicators or benchmarks that ask the question 'does what we are doing match what we should be doing'. When desired effects are not achieved, the information obtained through these measures provides the focus for quality improvement activities.

Information addressing each of these categories is required to support decisions at all levels of the mental health system.

Initial information development efforts under the National Mental Health Strategy were focused on gathering descriptive information, and were designed to answer the question of *'who receives*

*what services from whom and at what cost …'*.[6] The final part of this question – *'… with what effect'* – has been the focus of more recent work to introduce outcomes data into routine mental health collections and extended the national focus into the evaluative domain.

Information development for prescriptive and corrective purposes – that is, to move from collection of information to using that information to support decision making – has not yet been a focus of national activity. As discussed in Part 3, this is the key challenge ahead. The work plan outlined aims to move the mental health sector closer to the ideal, while recognising that building the full complement of information categories is a long term objective.

## 1.9 Information needs of key stakeholders

The mental health system in Australia comprises a number of key players who all have a legitimate stake in the way that information development is advanced at the national level:

- *Consumers* need information to understand their illnesses better, gain an appreciation of their treatment options and to enable them to participate actively in their treatment. Information needs to be available in a form that provides a structure to guide dialogue with the clinician about treatment planning and personal progress. Consumers also expect the clinicians who are responsible for their care to be engaged in evidence-based practice, using modern information approaches to regularly review their treatment methods and outcomes, and ensure that it meets accepted safety and quality standards.
- *Carers* have similar requirements for information to understand mental illness and be aware of the treatment options so that they are able to care for themselves and the person for whom they are caring.
- *Mental health service providers* need access to information to conduct needs assessments, formulate individual care plans, monitor progress and evaluate outcomes. Mental health clinicians are living in a world of increasing advances in therapies, greater emphasis on evidence based health care, increasing community expectations, and better-informed and more empowered consumers. All of these create demands on service providers to be 'information literate' and apply information in ways that support the services they offer to consumers.
- *Mental health service managers* need information about the services under their control to manage resources, monitor workflows and assess the overall efficiency and effectiveness of the service.
- *Health policy makers* need information to assess the population needs for mental health care, plan and pay for services, determine priorities for the allocation of resources, monitor the achievement of outcomes set by government and enable formal accountability to the public and parliament for resources.
- *Health service researchers* need information to enable them to analyse and report on trends and contribute their expertise on 'cutting edge' issues affecting mental health planning and service delivery.

In combination, these needs present significant demands to collect, collate, analyse and action increasing volumes of mental health data.

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

## 1.10 Benefits of a national approach to mental health information

The approach being pursued under the National Mental Health Strategy is intended to have several benefits:

- It produces economies by reducing duplication of effort by jurisdictions in finding solutions to common issues, while enabling targeting of the remaining resources to other problems.
- It allows for the combined input of all stakeholders to contribute to solving complex issues that are often beyond the capacity of local resources.
- The collection and sharing of uniform data allows comparisons between services and opportunities for benchmarking and related quality improvement activities, within and between jurisdictions.
- The national pooling of data gives greater depth to the analysis of issues and informs debates about mental health and mental health services in Australia.
- A national approach provides a means for issues of national significance, such as the monitoring of population mental health, to be addressed with the combined resources of all parties.
- It provides a basis for international and interstate comparisons that could otherwise not occur. This allows Australia to account for and monitor itself in an international context as well as to monitor various regional subdivisions such as by State and Territory.

PART 2

# Stocktake of Progress

# Stocktake of Progress

Information development under the National Mental Health Strategy has to date covered a diverse array of initiatives including national agreement on data standards, establishment of new data collections and specific research and development projects designed to point the way for the future. Aspects of the work undertaken have no international precedent and required considerable innovation.

This section summarises the main elements of the information foundation that has been built over the past decade.

## 2.1 Information to monitor the National Mental Health Strategy

An early priority driving much of the collaborative effort between jurisdictions was the need to monitor progress of the Strategy itself. At the beginning of the Strategy, none of the existing national health collections had the capability for delivering the type and range of information needed within the time frame required. Thus, a separate collection was needed, tied to the national mental health policy objectives, that could be used as the basis for annual monitoring at the national level.

This special purpose data collection, first implemented in 1993, was aimed at building a picture of the range, level and costs of services available in each of the States and Territories and evolved into the annual National Survey of Mental Health Services. The survey covers all specialised mental health services managed or funded by the State and Territory health administrations, and requires the collection of data elements covering activity, expenditure and staffing in admitted patient services, community based services, and a range of 'system level' categories such as research and mental health promotion.

The first National Survey of Mental Health Services was undertaken by the Department of Health and Ageing in 1994 and has been repeated annually for all subsequent years of the Strategy. The data from the survey is reported periodically in the National Mental Health Report series.[7] These reports are widely regarded as presenting the most comprehensive compilation of information about mental health services produced in Australia and have played an important role in informing government policy and resourcing by all governments.

7 For the most recent report at the time of publication, see Department of Health and Ageing (2004a). *National Mental Health Report 2004: Eighth Report. Summary of Changes in Australia's Mental Health Services under the National Mental Health Strategy 1993-2002*. Commonwealth of Australia, Canberra.

## 2.2 Information about Australia's mental health

An accurate estimate of the community's need for mental health care was recognised as critical to planning services, allocating resources and evaluating the overall effectiveness of the Strategy. Estimates made prior to the Strategy pointed to a substantial level of unmet need. However, these estimates were based on a small number of local studies and overseas evidence. A more direct measure was deemed to be required as a base for future planning.

Commencing in 1995, a specific population study was planned to gauge the level of need. Known as the National Survey of Mental Health and Wellbeing, the study was the first major survey of the Australian population aimed at gathering direct measures of mental disorders in Australia. The survey sought to:

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

The study comprised three surveys: one for adult Australians, one for children and adolescents, and one in relation to low prevalence disorders.

The adult survey, conducted by the Australian Bureau of Statistics in 1997, highlighted significant unmet need:

- almost one in five (18%) of Australians experienced a mental disorder at some time in the twelve months prior to the survey; and
- of these, only 38% used a health service over the same period, with about half of this group seeing a mental health professional.

The child and adolescent survey was a household survey conducted by the University of Adelaide in 1998. In general, the study followed the findings from the adult study, finding that approximately 14% of children and adolescents experience mental health problems, but only one out of four receives professional help.

The low prevalence survey was conducted by the University of Western Australia in 1998. The study examined specified catchment areas in four jurisdictions and provided estimates of one-month and one year prevalence of severe mental illness in the community. The study also assessed the personal and social circumstances and the extent of service utilisation of persons with a 'low-prevalence' mental illness. Results highlighted the extensive disability experienced by people affected by such disorders. Despite the fact that specialist mental health services were targeting this group as a priority for treatment and care, the survey found that the health and disability-related needs of many people with a psychotic illness remained unmet.

Overall, the National Survey of Mental Health and Wellbeing was instrumental in highlighting that potential demand for mental health care is high. In particular, it has highlighted the need to take a broader 'whole of community' approach to mental health than was envisaged when the Strategy was drafted in the early 1990s and raised the priority assigned to the Strategy's promotion and prevention themes.

## 2.3 National minimum datasets for mental health services

It was clear at the outset of the National Mental Health Strategy that the structure and content of existing national health data did not provide the framework to guide data collection at the mental health service delivery level, nor to build a national picture of services and the consumers of those services. Little quantitative data were available to answer the question of *'…who receives what services from whom'*.

The main contributing factor was the isolation of mental health service delivery from mainstream health care. The emphasis on developing data standards and investments in information infrastructure that occurred in the acute health sector over the ten years preceding the Strategy largely bypassed mental health services. A critical step for the future was to translate the Strategy's emphasis on 'mainstreaming' to the information aspects of mental health reform and to ensure that any new developments were both tested and incorporated within the broader health information environment.

Consequently, an early priority agreed by all the jurisdictions was the development of a consistent set of data definitions and the establishment of national collections of agreed minimum datasets. Responsibility for this work has been carried by the Australian Institute of Health and Welfare, advised by the Information Strategy Committee of the AHMAC National Mental Health Working Group. Through its national role in health information management, the Institute was best placed to coordinate the development and implementation of mental health collections across both hospital and community settings.

Three 'patient level' national collections have been implemented that cover mental health care provided in hospitals, residential settings and the community:

- *National Minimum Data Set – Admitted Patient Mental Health Care* collects information at the national level on consumers admitted to public and private psychiatric hospitals or in designated psychiatric units in general hospitals. Commenced in 1996-97, the collection provides information on approximately 110,000 treatment episodes per year.
- *National Minimum Data Set – Residential Mental Health Care* reports on the care provided to consumers admitted to government-operated, 24-hour staffed residential units. This is a new collection, commencing in 2004-05.
- *National Minimum Data Set – Community Mental Health Care* is designed to collect information on the services provided by public sector mental health services to consumers who are living in the community, external to hospital and residential settings. Commenced in 2000-01, the collection gathers information on an estimated 5 million service contacts provided to approximately 300,000 consumers. It is the largest (and one of few) patient-level collections of community-based care in the Australian health system.

Data collected in each of these national collections is detailed in Appendix A.

Together, the mental health national minimum data sets have advanced our understanding of mental health service delivery in Australia and established the building blocks for further work. Results from each collection are reported annually by the Australian Institute of Health and Welfare in its publication *Mental Health Services in Australia*.[8]

8 See Australian Institute of Health and Welfare (2005). *Mental Health Services in Australia 2002–03*. Australian Institute of Health and Welfare, Canberra.

## 2.4 Introduction of routine consumer outcome measures

The emphasis on health outcomes and information systems to support service quality improvement has been gaining momentum in the wider health sector for several years. Increasing focus is being given to the responsibility of health care providers to use outcome measures to contribute to the ongoing review and development of clinical practice as well as to inform health service planning, policy development and the broader community.

Within the mental health field, the regular assessment of consumer outcomes has been a priority of the National Mental Health Strategy since it was first agreed by Health Ministers in 1992. The National Mental Health Policy includes as one of its original objectives:

> *"To institute regular review of client outcomes of services provided to persons with serious mental health problems and mental disorders as a central component of mental health service delivery."*[9]

The concept was simple but ambitious in the context of the poor status of information in mental health services in the early 1990s. Most services did not routinely collect basic clinical and service delivery data nor have systems capable of timely analysis and reporting of such data to inform clinical care. Simple and reliable instruments for measuring consumer outcomes were not available at the commencement of the Strategy, nor was a set of candidate measures evident. Perhaps more significantly, there were few precedents to follow as no other country had established routine consumer outcome measures comprehensively across their publicly funded mental health services.

In response, a research and development program was initiated early in the Strategy to identify measures of outcome that were feasible for use in routine clinical practice with adult consumers, resulting in the selection of a small set of standard measures that were put to trial.[10,11] Similar work was undertaken in relation to outcome measures for use in child and adolescent mental health services.[12]

Implementation of the selected measures in public sector mental health services commenced under the Second National Mental Health Plan and was a central objective of the 'first edition' statement of national mental health information priorities released in 1999. All States and Territories prepared comprehensive Information Development Plans to guide their implementation activities. A summary of the outcome measures selected for use in public sector services is shown in Table 1.

Recognising the complexity of the work required and its national significance, the Australian Government contributed substantial funding to assist States and Territories to implement their plans and support a range of related quality and safety initiatives in specialist mental health care. This was made available through bilaterally negotiated 'Information Development Agreements'.

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9 Australian Health Ministers (1992). *National Mental Health Policy*. Australian Government Publishing Service, Canberra.

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

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

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

**Table 1: Consumer outcome measures introduced in public sector mental health services**

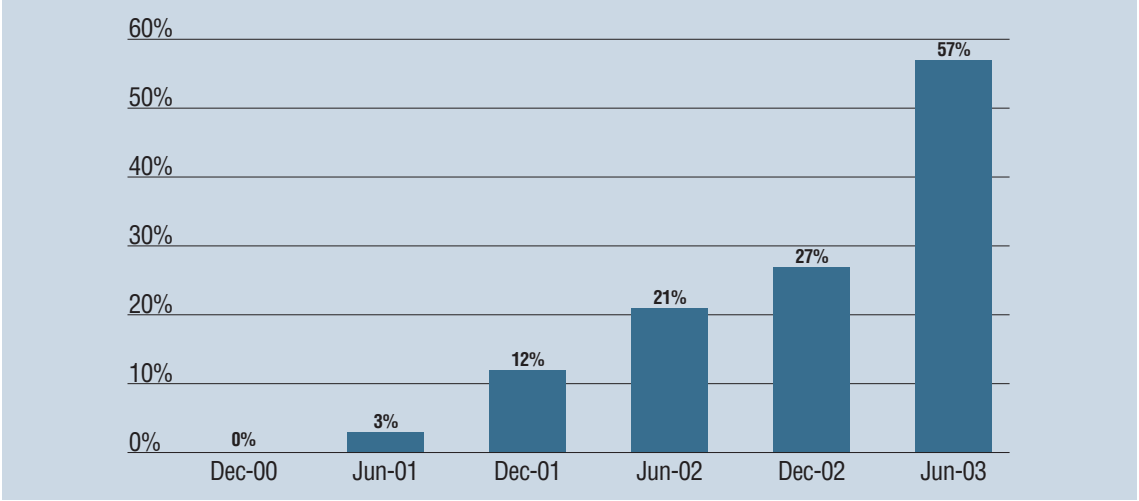
| | Age Group | | |
|---|---|---|---|
| | Child & Adolescent | Adults | Older People |
| **Clinician-rated outcome measurement scales** | | | |
| Health of the Nation Outcome Scales (HoNOS) | | ✓ | |
| Health of the Nation Outcome Scales for Older People (HoNOS 65+) | | | ✓ |
| Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) | ✓ | | |
| Life Skills Profile (abbreviated version) (LSP-16) | | ✓ | ✓ |
| **Consumer self-report outcome scales** | | | |
| Mental Health Inventory (MHI), Behaviour & Symptom Identification Scale (BASIS-32), Kessler-10 (K10) * | | ✓ | ✓ |
| Strengths & Difficulties Questionnaire (SDQ) | ✓ | | |

* One of these three instruments is implemented in each jurisdiction, selected at the jurisdiction's discretion

Implementation of the 'simple concept' articulated in 1992 has taken the mental health sector into a period of major industry re-development and involved all public mental health services. By June 2003:

- approximately 57% of Australian public mental health services had commenced the process of consumer outcome measurement (Figure 2);
- an estimated 10,000 clinicians had participated in training sessions for the collection and use of outcome information, representing approximately 60% of the public sector mental health workforce;
- information systems in all States and Territories had been overhauled, or commenced the upgrade process, to accommodate the new requirements (see 2.8 on page 23); and
- States and Territories began the process of pooling data at the national level, contributing approximately 70,000 de-identified records for which outcome data had been collected.

**Figure 2: National progress of services routinely collecting mental health outcomes**



## 2.5 Developments in the private hospital sector

Services provided by the private sector were not originally considered within the scope of the National Mental Health Strategy but governments have become increasingly aware of the importance of partnerships with private sector services.

Significant information initiatives took place within the sector over the 1998-2003 period, led by the Strategic Planning Group for Private Psychiatric Services (SPGPPS). Comprising representatives drawn from private hospitals, health insurers, the Australian Government, consumer and carer groups, the Royal Australian and New Zealand College of Psychiatrists and the Australian Medical Association, the SPGPPS was established in 1996 to facilitate increased collaboration on issues relevant to the funding of private mental health services. Subsequently, the group's role expanded to encompass a wide range of issues related to private sector development. It is the only group of its kind in the private health sector in Australia that brings together provider, funder and consumer stakeholders to work on developing a common agenda for service development.

The first key development was agreement for the implementation of a national model for the collection and use of data within the psychiatric services provided by private hospitals.[13] Developed following extensive consultation within the industry, the model established systems for the routine collection of information that will enable hospital providers, funders and consumers to compare services and assess the relative effectiveness of various models of care.

The use of standard measures of consumer outcome as an integral part of service delivery is central to the model. The approach taken parallels that being introduced in public mental health services, with measures of outcome completed both by clinicians and consumers at admission and discharge from care. Information collected in this way is pooled subsequently at the national level in de-identified format for analysis and feedback to participating hospitals.

By July 2003, 43 of the 46 Australian private hospitals providing psychiatric care were participating in the collection and reporting of data under the SPGPPS's National Model. This involved the implementation by almost all participating hospitals of a common database application for collecting, submitting and making local use of outcomes and service utilisation data. Concurrently, a centralised data management service was established, providing comprehensive quarterly reports to all participating hospitals and health insurance funds.

## 2.6 Development of casemix for mental health

Alongside the work to put routine outcome measures in place, separate research and development was directed to design a casemix classification suited to the needs of the mental health sector. Recognising that the accepted casemix standard (AR-DRG's or Australian Refined National Diagnosis Related Groups) was not appropriate for describing the 'outputs' of mental health services, the National Mental Health Strategy set as one of its priorities the development of an alternative classification model that could be used for both hospital and community-based care.

13 Morris-Yates, A and The Strategic Planning Group for Private Psychiatric Services Data Collection and Analysis Working Group (2000). *A National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital–based Psychiatric Services.* Commonwealth of Australia, Canberra.

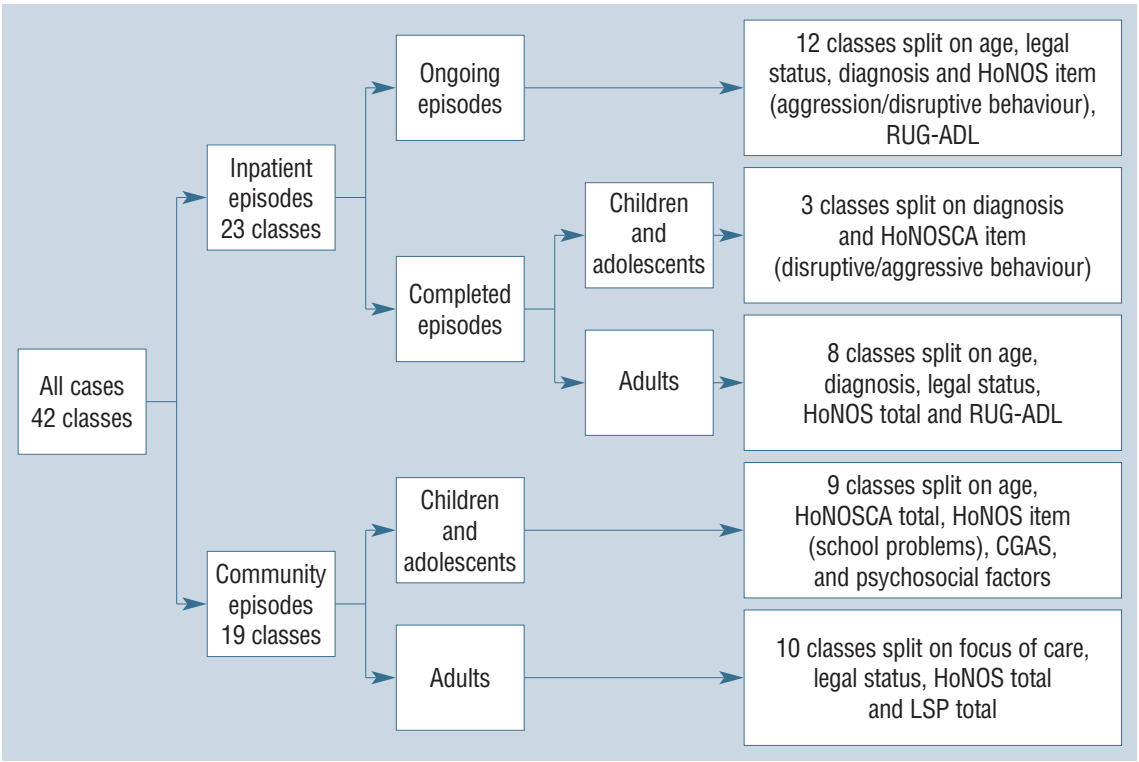
This subsequently became one of the largest investments on any single project funded over the first five years, with significant implications for future data collections. The Mental Health Classification and Service Costs Project (MH-CASC) was commissioned to determine whether clinical factors explained service costs and whether these could be used to build a patient classification that was both clinically meaningful as well as resource homogeneous. Taking three years to complete, the study collected detailed socio-demographic and service use data on approximately 18,000 consumers attending specialised mental health services, covering 25% of Australia's private and public mental health services.[14]

The project found that there is an underlying episode classification, not just in inpatient care but also in the community. The volume and type of services (and thus cost) provided to patients was found to have a clinically and statistically logical relationship to the patient's clinical status. The project recommended a first version casemix classification model to be introduced within mental health services that includes 42 patient classes – 19 for community episodes and 23 for inpatient episodes. A summary of the classification is provided in Figure 3.

Adoption of the classification requires routine use of a small number of clinical scales, drawn mainly from the same family of instruments used for measuring consumer outcomes and applied at periodic intervals.

National collection and reporting of these data required for the classification began during the Second National Mental Health Plan, in parallel with the introduction of outcome measures. All States and Territories committed under their various Information Development Agreements to pool their data nationally as a resource for the further development of the classification.

**Figure 3: Summary of MH-CASC classification**




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

## 2.7 National mental health outcomes and casemix protocol

The introduction of outcomes and casemix concepts within routine data collections requires a set of nationally agreed rules that guide clinicians as to what is expected of them in the collection and reporting of data. The protocol used for outcomes data is, in many ways, the most critical aspect of the process. Andrews et al (1994) summed this up simply by stating that 'a measure is not a method'.[15]

Consumer outcomes presume a change over time in the person's health status and functioning. Gathering information about consumer outcomes therefore requires the measures to be used at regular intervals in the cycle of care. It is important that the information is collected at times that make sense to both the clinician and the consumer, for example: at entry or re-entry to the service; at case review; and at discharge or case closure. In conjunction with this requirement, there is a need to have some standard to help understand the outcome data and enable reasonable comparisons to be made between, for example, different agencies or different groups of consumers.

This is a difficult issue in the mental health field because there is no 'standard' care cycle. Some people require only a brief period of treatment, while others are under the ongoing care of the mental health services for many years. For this latter group, we need to distinguish between short and long term outcomes – that is, to use the measures to review progress at defined intervals, as well as to assess the overall change between the beginning and end of treatment.

Because many of the concepts and definitions used in Australia's standard health collections are centred on hospital care only, the development of a comprehensive reporting protocol for mental health services was unable to draw on established precedents. To resolve these issues, all States and Territories collaborated in the development of a data collection protocol for what has become known as the 'National Outcomes and Casemix Collection' or 'NOCC'. Released in August 2002, the protocol defines the counting rules to be used and establishes the basis for the new outcomes and casemix data to be reported in consistent ways.[16]

## 2.8 Upgrading of information systems

The collection of minimum data sets, outcomes and casemix measures and their incorporation into routine clinical practice require functional clinical information systems at the local service delivery level. Lack of progress in this area was identified as a major obstacle at the close of the First National Mental Health Plan. An independent evaluation of the Plan concluded:

> *"Information in mental health is grossly undeveloped … A precondition to the changes proposed … is the existence of an information infrastructure built from the clinical services level that contributes to individual consumer care and service quality improvements as well as feeding into higher level planning and policy review. …Putting such systems in place needs to be identified as an imperative for the next Strategy period".*[17]

15 Andrews et al (1994) *ibid*

16 Department of Health and Ageing (2002). *National Outcomes and Casemix Collection: Technical Specification of State and Territory Reporting Requirements for the Outcomes and Casemix Components of 'Agreed Data' under National Mental Health Information Development Funding Agreements*. Department of Health and Ageing, Canberra.

17 National Mental Health Strategy Evaluation Steering Committee, for the Australian Health Ministers Advisory Council, Evaluation of the National Mental Health Strategy: Final Report, Mental Health Branch, Commonwealth Department of Health and Family Services, December 1997.

Each jurisdiction faced unique challenges, as well as issues that were common across all States and Territories. Starting from different points, the major challenges for all has been to incorporate the new mental health data within 'mainstream' hospital-based systems.

The solutions pursued differ across jurisdictions, with choices driven by local preferences and the need to interface with wider corporate systems operating across their health portfolios. At the end of the Second National Mental Health Plan, the extent of implementation of upgraded systems differed significantly across jurisdictions, with all foreshadowing further work being needed to complete the task. Table 2 summarises the development phases within each jurisdiction.

**Table 2: Summary of the development of mental health information systems in each of the States and Territories and the private hospital sector**

| | Pre-National Mental Health Strategy | Key system developments 1993-2003 | Future direction/ Next steps |
|---|---|---|---|
| NSW | • Limited participation by psychiatric inpatient services in mainstream inpatient data.<br>• No systems for community mental health services. Proliferation of local developments but no requirements for state reporting of unit records, only aggregate counts of occasions of service.<br>• No standard for unique patient identifiers.<br>• No systems in place to promote information sharing between service provider agencies. | • All mental health inpatient data reported from mainstream hospital systems.<br>• Major investment in development of enterprise-wide community health information system 'CHIME'.<br>• Pilot process for unique patient identifiers trialed.<br>• Introduction of interim local systems to collect ambulatory and outcome data.<br>• Area and State data warehouses configured to accept mental health admitted and ambulatory data with unique patient identifiers. | • Possible inclusion of outcome data in hospital systems.<br>• Migration from interim local systems to CHIME for non admitted and outcome data where permitted by dept/Area.<br>• Inclusion of non admitted and outcome data in strategic systems (eg CERNER) in some Areas<br>• Strategic State wide Unique identifier process established.<br>• Implement multilevel integrated reporting from data warehouses with 'Business Objects'.<br>• Warehouses used as repository of all mental health data from disparate systems. |
| VIC | • Comprehensive information system for mental health services (PRISM) covering inpatient and community services. Developed separately from mainstream health collections as a reporting system, with limited functionality for service providers.<br>• Statewide unique patient identifiers in place.<br>• Inpatient and community systems shared information through 'live' statewide network. | • Major investment in replacement of PRISM by new 'RAPID' system, designed to modernise the statewide network. | • Developing functionality in RAPID to improve access to information to support and assist in decision-making by services. |

**Table 2: Summary of the development of mental health information systems in each of the States and Territories and the private hospital sector** *(continued)*

| | Pre-National Mental Health Strategy | Key system developments 1993-2003 | Future direction/ Next steps |
|---|---|---|---|
| QLD | • No systems for community mental health services.<br>• Paper-based reporting to head office of patient registrations in community mental health care, partial coverage only.<br>• No standard for unique patient identifiers.<br>• Specific mental health requirements in hospital-based systems not addressed. | • Development of CESA system for community mental health services, comprehensive statewide rollout. Operated as a series of stand alone systems.<br>• Development of separate 'add on' systems for collection of outcomes data.<br>• Unique patient identifiers established at district level.<br>• Mental health admitted patient collection mainstreamed into hospital-based systems. | • Replacement of CESA by a integrated patient management system for community mental health care as part of, or linking to, enterprise system.<br>• Development of single State-wide identifier.<br>• Development of hospital system to incorporate mental health requirements with linkages to the community system(s).<br>• Development of reporting and decision support tools. |
| WA | • No systems established for community mental health services. Paper-based reporting arrangements for community patient registrations and service use.<br>• Statewide case register covering inpatient and community services bringing together mental health activity data from paper-based and electronic sources.<br>• Statewide unique patient identifiers for research purposes in place, managed through central allocation within statewide case register. | • Development of LAMHIS as stand alone electronic system for community mental health services.<br>• Redevelopment of LAMHIS to a new centralised mental health clinical information system (PSOLIS), covering all services within the State across all service settings (inpatient, community and community residential). | • Further development of PSOLIS to:<br>– build in reporting and clinical decision support tools to improve utility of information at service delivery level; and<br>– establish a framework for a comprehensive Electronic Patient Record system. |
| SA | • Several local sites with information systems established for community mental health services and data reported centrally.<br>• Collection of limited Child & Adolescent community information.<br>• Registration of adult & older persons by metropolitan services to create a limited unique patient identifier (community & inpatient). | • Implementation of CMS system to collect community mental health information.<br>• Upgrade of systems, multi user access and extended collection of Child & Adolescent community information.<br>• Country community systems (stand alone, incorporating mental health) implemented.<br>• Central data consolidation for reporting & analysis purposes. | • Replacement of CMS and CAMHS metropolitan mental health community systems with a new CBIS system.<br>• CBIS to collect both community and inpatient NOCC data.<br>• Consolidation of stand alone Country community information systems.<br>• Development of reporting & decision support tools to improve utility of information. |

**Table 2: Summary of the development of mental health information systems in each of the States and Territories and the private hospital sector** *(continued)*

| | Pre-National Mental Health Strategy | Key system developments 1993-2003 | Future direction/ Next steps |
|---|---|---|---|
| TAS | • No systems established for community mental health services. Paper-based collections submitted to central office.<br>• Statewide unique patient identifiers in place, but allocated manually, managed through central allocation, not full coverage of all services. | • Implementation of paper-based OARS information collection and reporting system for community mental health services.<br>• Reviewed options for community system development. | • Establishment of local clinical information systems for community mental health services.<br>• Redevelopment of hospital systems to incorporate mental health requirements.<br>• Statewide unique patient identifiers incorporated with new information system. |
| ACT | • No organised mental health information system in place. | • Initial development of locally designed database (OSCAR), deployed as separate standalone system in each centre.<br>• Subsequent development of the Mental Health Assessment Generation and Information Collection (MHAGIC) system, a networked electronic medical record which makes clinical information available in real time.<br>• Implementation of Territory-wide Health Identifier. | • Increase the use of MHAGIC in bed-based services.<br>• Develop and deploy subsets of MHAGIC on hand-held devices.<br>• Improve linkages with mainstream health collections.<br>• Improve data quality and aggregate reporting. |
| NT | • General Hospital information system in place (Caresys), used by mental health services covering inpatient services only.<br>• Statewide unique patient identifiers in place (community and inpatient).<br>• Separate stand alone community statistical collection systems (FormOHSt) in major centres.<br>• Community mental health data collection performed indirectly by administrative staff. No effective clinical reporting output.<br>• Data accuracy and validation difficulties, no central coordination of information requirements. | • Major investment in development of a corporate Community Care Information System (CCIS), deployed across the Territory.<br>• Client Master Index (CMI) fully integrated across NT community and inpatient information systems.<br>• Generic aggregate service activity reporting available to all users.<br>• Direct clinical data input and on-line access to individual consumer records available in real time and across all service settings and NT service locations. | • Development of reporting and decision support tools to improve utility of information at service delivery, management and program levels.<br>• Seamless integration of patient/client management system across hospital and community mental health services.<br>• Integrated information development workforce training and support systems provided within MH Program. |

**Table 2: Summary of the development of mental health information systems in each of the States and Territories and the private hospital sector** *(continued)*

| | Pre-National Mental Health Strategy | Key system developments 1993-2003 | Future direction/ Next steps |
|---|---|---|---|
| Private Hospital Sector | • Hospital data collections based on jurisdictional requirements. Quality of data was variable.<br>• A small number of hospitals engaged in the routine collection of outcome measures. However there was no general agreement as to what measures were appropriate in the sector and no standard systems for their collection. | • Commencing 1995, implementation of standard data collection requirements under the Hospital Casemix Protocol, a collection maintained by the Australian Government.<br>• During this period, private Hospitals were also required to meet their jurisdiction's increasingly sophisticated data submission requirements.<br>• Implementation of the SPGPPS's National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services was completed in over 95% of the private hospitals with psychiatric beds throughout Australia. | • Maintain and improve adherence with nationally agreed data protocols.<br>• Continuous improvement of the utility of information derived from these data collected.<br>• Resolve problems with the uniform collection of service utilisation data in ambulatory care (same day, hospital outpatient, and community-based) services provided by private hospitals.<br>• Refine the statistical reporting functions of the centralised data management service to improve their utility for both clinical and service management purposes, including benchmarking. |

## 2.9 National infrastructure to support an outcomes focus

To complement the work of States and Territories, the Australian Government established the Australian Mental Health Outcomes and Classification Network (AMHOCN) in 2003, as a focus for national activity in the development of outcomes and casemix concepts in mental health. AMHOCN comprises three components:

- a 'data bureau' centre to receive and process the mental health outcomes and casemix data submitted by States and Territories;
- a specialist research and development centre for the analysis, reporting and ongoing development of mental health outcomes and casemix information at a national level; and
- a national training and service development resource centre for the ongoing use of outcomes and casemix measures, designed to both inform and improve practice through workforce training, benchmarking and related activities.

The AMHOCN network represents a milestone in the development of collaborative work between the Australian Government and States and Territories, being based on sharing of information to advance the national interest in improving mental health services. Over the years ahead it is expected that the network will increasingly provide a resource that supports parallel developments at the State and Territory level while also producing national information to guide judgements about value for money in publicly funded mental health care.

Three national advisory groups were also set up late into the Second National Mental Health Plan period to provide forums for clinician, consumer, carer and other experts to contribute to future mental health information developments. Specifically focused on outcome measurement but with a wider brief to advise on other areas, separate groups were established to cover adult, child and adolescent and older persons mental health services with responsibility for advising on:

- the measures introduced within the National Outcomes and Casemix Collection including future modifications;
- the use of routine outcome measurement to improve clinical practice and service quality; and
- the training and support implications of routine outcome measurement.

Representatives from each Australian jurisdiction and New Zealand participate in the national forums, reflecting both countries commitment to promote outcome measurement concepts in mental health practice.

## 2.10 Performance indicator framework for mental health services

Significant advances have been made over the past decade in the development of indicators for the Australian health industry, focusing mainly in the field of acute hospital care. Mental health services have lagged behind – due, in part, to the lack of suitable data sets, but more to the lack of consensus within the sector on how to apply performance measurement concepts to the mental health field. As a result, little national information has been available to provide stakeholders with insights into how services compare, or which allow normative expectations to be formed about how the mental health system should perform.

The development of performance indicators for mental health services was foreshadowed by the Second National Mental Health Plan and is emphasised further in the current Plan. The context for development is now set by a broader framework, the National Health Performance Framework, agreed to by all Health Ministers in 2001 for monitoring the performance of the health system.[18]

The framework identifies three 'tiers' across which indicators are needed to provide a comprehensive picture of the population's health and how the health system is performing in meeting health needs. The National Health Performance Framework is shown in Figure 4.

An important design feature of the framework is that it is intended for use at all levels of the health system – that is, for assessing an individual service or at higher levels of aggregation, such as State and Territory or national. Since the adoption of the framework, two national-level reports have been presented to Health Ministers by the National Health Performance Committee.[19] The inclusion of mental health indicators in future reports has been identified as a priority.

18 National Health Performance Committee (2001). *National Health Performance Framework Report: A report to the Australian Health Ministers' Conference,* Brisbane

19 National Health Performance Committee (2004). *National report on health sector performance Indicators 2003.* AIHW cat. no. HWI 78. Australian Institute of Health and Welfare, Canberra.

**Figure 4: Australia's National Health Performance Framework**

| HEALTH STATUS AND OUTCOMES ('TIER 1')<br>How healthy are Australians? Is it the same for everyone? Where is the most opportunity for improvement? | | | |
|---|---|---|---|
| **Health conditions** | **Human function** | **Life expectancy and well-being** | **Deaths** |
| Prevalence of disease, disorder, injury or trauma or other health-related states. | Alterations to body, structure or function (impairment), activities (activity limitation) and participation (restrictions in participation). | Broad measures of physical, mental, and social well-being of individuals and other derived indicators such as Disability Adjusted Life Expectancy (DALE). | Age or condition specific mortality rates. |

| DETERMINANTS OF HEALTH ('TIER 2')<br>Are the factors determining health changing for the better? Is it the same for everyone? Where and for whom are they changing for the worse? | | | | |
|---|---|---|---|---|
| **Environmental factors** | **Socio-economic factors** | **Community capacity** | **Health behaviours** | **Person-related factors** |
| Physical, chemical and biological factors such as air, water, food and soil quality resulting from chemical pollution and waste disposal. | Socio-economic factors such as education, employment per capita expenditure on health, and average weekly earnings. | Characteristics of communities and families such as population density, age distribution, health literacy, housing, community support services and transport. | Attitudes, beliefs, knowledge and behaviours e.g., patterns of eating, physical activity, excess alcohol consumption and smoking. | Genetic related susceptibility to disease and other factors such as blood pressure, cholesterol levels and body weight. |

| HEALTH SYSTEM PERFORMANCE ('TIER 3')<br>How well is the health system performing in delivering quality health actions to improve the health of all Australians? Is it the same for everyone? | | |
|---|---|---|
| **Effective** | **Appropriate** | **Efficient** |
| Care, intervention or action achieves desired outcome. | Care/intervention/action provided is relevant to the client's needs and based on established standards. | Achieving desired results with most cost effective use of resources. |
| **Responsive** | **Accessible** | **Safe** |
| Service provides respect for persons and is client orientated: - respect for dignity, confidential, participate in choices, prompt, quality of amenities, access to social support networks, and choice of provider. | Ability of people to obtain health care at the right place and right time irrespective of income, geography and cultural background. | Potential risks of an intervention or the environment are identified and avoided or minimised. |
| **Continuous** | **Capable** | **Sustainable** |
| Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time. | An individual or service's capacity to provide a health service based on skills and knowledge. | System or organisation's capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring). |

A formal work program to apply the framework to the mental health sector was undertaken in the final year of the Second National Mental Health Plan, focused on indicators of health service performance (Tier 3). Arising from this work, a set of 'stage one' performance indicators has been agreed to by the National Mental Health Working Group for progressive implementation over the period of the National Mental Health Plan 2003-2008.[20] Figure 5 summarises the new mental health indicator framework.

## 2.11 Developments in primary mental health care

The primary health and community care sector is the most commonly used part of the health system, being accessed by 85% of Australians each year. General practitioners play the central role and provide the first point of contact for people seeking help for mental health problems. Recent data suggest that mental health problems account for approximately 7% of all problems managed by general practitioners and are a presenting feature in about 10% of all attendances.[21]

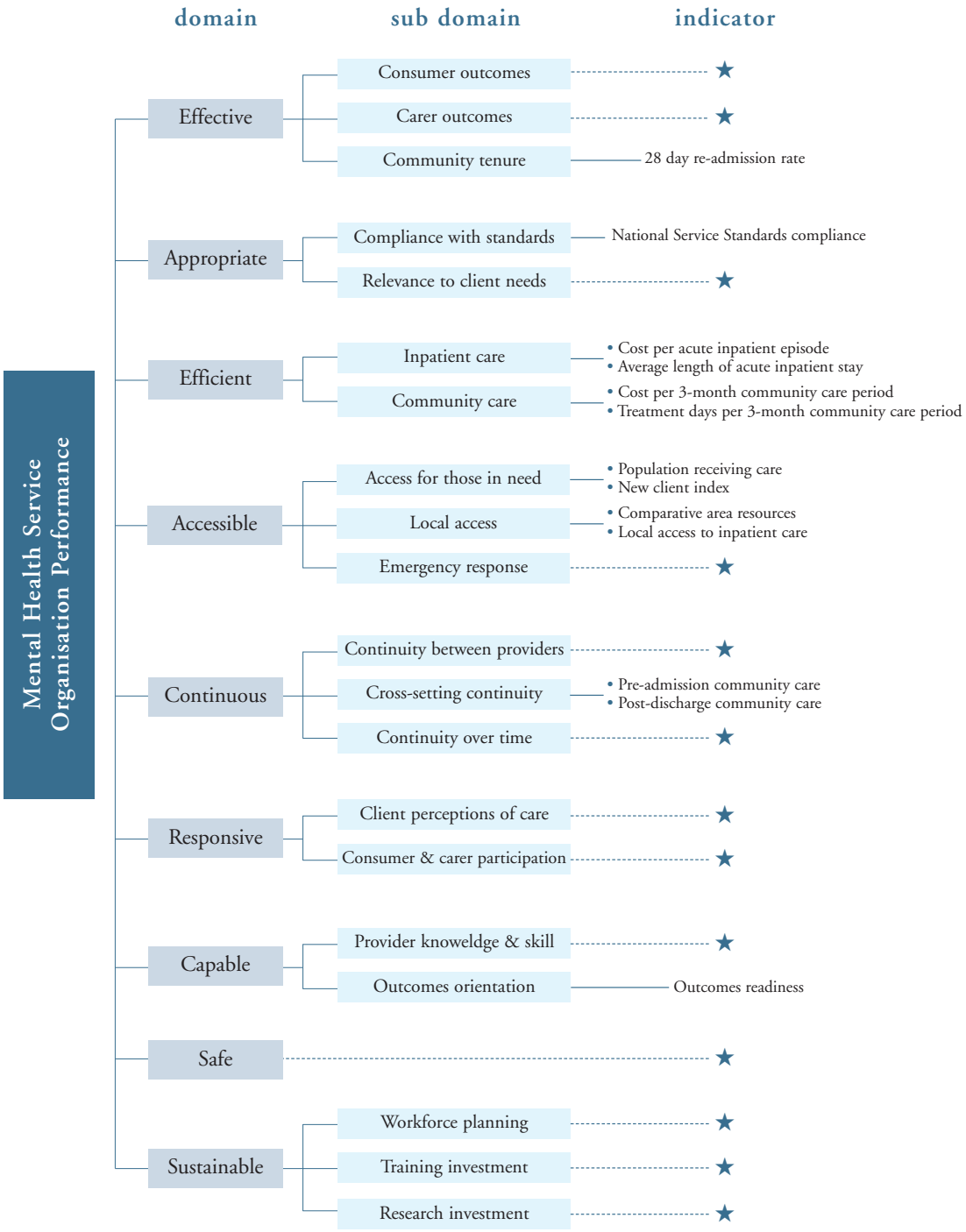
A series of financial incentives, training programs and other initiatives were taken under the Second National Mental Health Plan to strengthen the capacity of general practitioners to respond to common mental health problems in the community. In particular, the *Better Outcomes in Mental Health Care* program, introduced in 2001, established new arrangements designed to expand treatment choices in general practice, increase access to psychological therapies, improve the integration of primary and secondary care mental health services, and strengthen the provision of more evidence based treatments. Incentives include new reimbursement arrangements under the Medicare Benefits Schedule that remove financial barriers that previously acted to discourage general practitioners from providing mental health care. Additionally, funds have been made available for general practitioners to refer patients to allied health professionals. By June 2003, an estimated 15% of general practitioners had 'signed up' to participate in the new arrangements.

An important feature of the new approach is the requirement for participating general practitioners to use standardised measures of consumer outcome in monitoring individual progress. While specific arrangements have not been made for pooling these data at national level, the introduction of an outcomes focus in primary mental health care provides a foundation to develop the use of these measures for evaluation, decision support and related purposes.

20 National Mental Health Information Strategy Committee (2005). *Key Performance Indicators for Australian Public Mental Health Services*. Information Strategy Committee Discussion Paper No. 5. Commonwealth Department of Health and Ageing, Canberra.

21 Australian Institute of Health and Welfare (2004). *ibid*.

**Figure 5: 'Tier 3' performance framework and indicators for Australian public sector mental health services**




Key ★ = Phase 2 Indicators for development

PART 3

# The Challenges Ahead

# The Challenges Ahead

The past decade has laid the foundation for a comprehensive set of information about the cost, quality and outcomes of Australia's mental health services that is rich by national and international standards. The potential for an 'informed mental health sector' exists, but continued effort is needed to make this a reality.

The first edition of the national information priorities statement, released in 1999, mapped out an ambitious agenda that is likely to take ten years to complete. The four overarching themes underpinning the 1999 first edition workplan remain relevant to the years ahead and will continue to guide the next phase. They describe a vision for the mental health sector in which information is used to:

- strengthen the focus on consumer outcomes;
- support improvements in service quality;
- shift the focus of concern from cost to value for money; and
- improve our understanding of population needs.

Achieving the vision over the next period of the National Mental Health Strategy requires consolidation of the work already underway, as well as extension into new areas of activity that are driven by the requirements of the National Mental Health Plan 2003-2008.

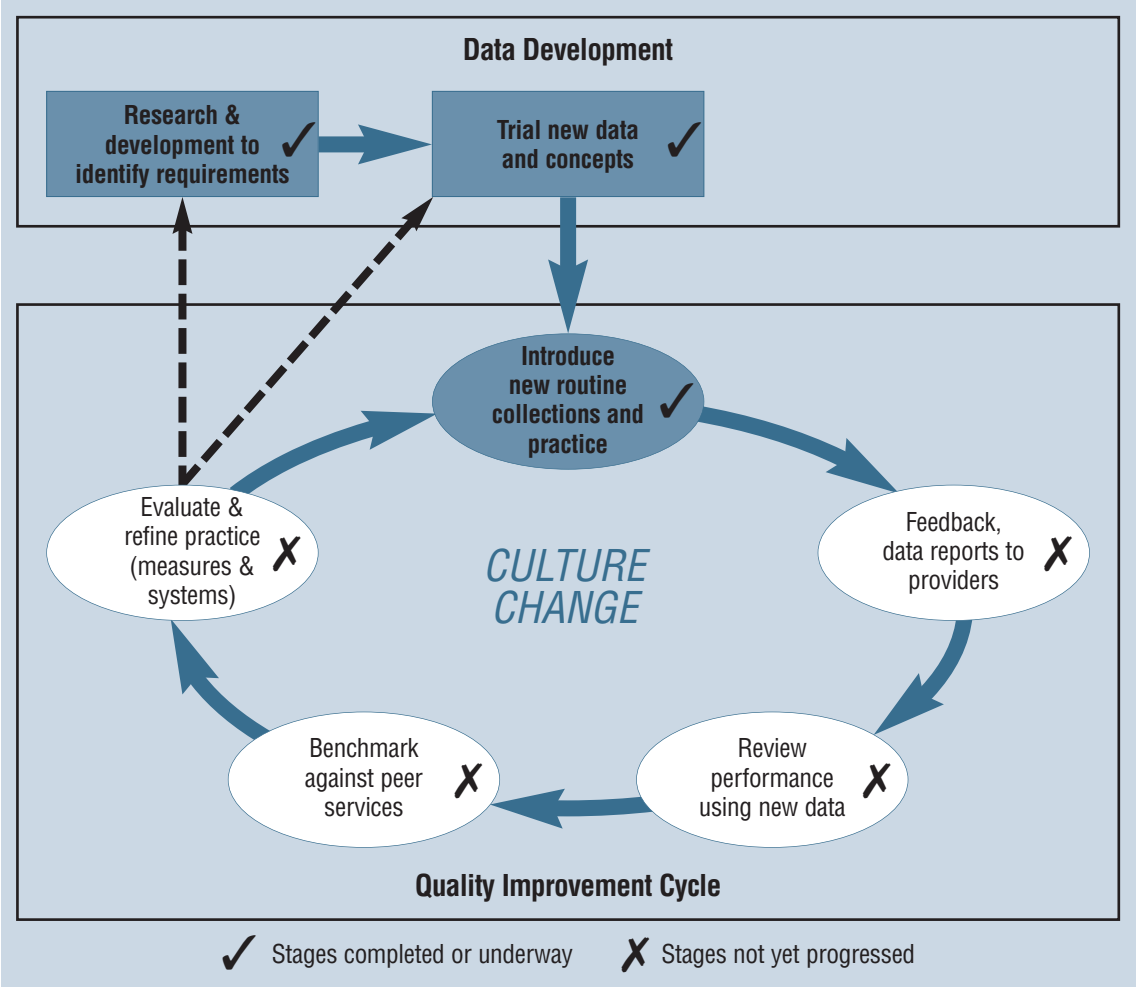
## 3.1 From information collection to information use

Data standards and collections mean little unless they are used to support decision making. The investments made so far by jurisdictions have concentrated primarily on the basic collection aspects – putting systems in place, preparing documentation, training the clinical workforce and so forth.

These activities have taken place within a workplace culture where information collection is perceived as an administrative burden rather than as a means to drive quality improvement and benefits for consumers. This is not surprising given that the historical approach within the mental health sector has emphasised information as a reporting obligation rather than as a resource. Years of mistrust and lack of confidence have built up within the workforce around information collections that are seen to be intrusions into their busy schedules and provide no benefit to either providers or consumers.

This is clearly changing but it is important to be mindful that, while the sector has taken major steps, these are early in the sequence of actions entailed in applying information to the performance management and quality improvement cycle. The results of research and development have been applied and new concepts introduced to routine collections. The next steps to be undertaken involve the provision of feedback systems for service providers to use in reviewing their performance, benchmarking to identify best practice, evaluating services against results and adjusting service delivery systems based on what has been learnt. Figure 6 summarises the status of the mental health sector within the 'measurement for quality improvement' cycle at June 2003.

**Figure 6: Status of the mental health sector in the 'measurement for quality improvement' cycle at June 2003**




There is strong consensus between all jurisdictions that the main challenge for the future is to engage service providers to build a culture of information use where:

- consumer outcome measures are used routinely to contribute both to improved clinical practice and service management;
- benchmarking is established as the norm with all services having access to regular reports on their performance relative to similar services that can be used in a quality improvement cycle;
- casemix tools are available to assist in understanding the contribution of provider variation to performance differences between agencies; and
- policy and planning decisions are regularly informed by reliable information on service delivery and outcomes.

This will require investing in approaches that foster the use and application of data for clinical and management purposes at the service delivery level. Feedback systems are required that provide timely access to those collecting the data. Additionally, incentives and training need to be in place to facilitate individual service providers and organisations in using information routinely for clinical review, evaluating performance, benchmarking and related activities.

These activities figure prominently in the work plan described in Part 4 of this document.

## 3.2 From projects to sustainable systems

There are also challenges to be faced in securing the long-term sustainability of the initiatives that have been taken. Much of the work to date has been conducted as special projects or 'research and development' activities, involving time limited funds and appointment of special task groups. While most jurisdictions are progressively incorporating the new initiatives within their recurrent budgets and operational systems, sustainability requires attention to ongoing workforce training issues and longer term planning to keep the work evolving.

## 3.3 Responding to new policy drivers

The National Mental Health Plan 2003-2008 further extends mental health policy beyond its initial focus on the specialist sector, particularly in the emphasis given to promotion and prevention, and the role of the primary health care sector. National information in relation to each of these is substantially less developed compared to other areas covered by the Plan and will require strategies to chart a future development path.

PART 4

# National Priorities for Mental Health Information Development

# National Priorities for Mental Health Information Development

The work program outlined in this section is set against the background of mental health information development over the past decade. It takes account of the work required to complete the agenda set out in the first edition of the national mental health information priorities and adds new elements, designed to support the directions advocated by the National Mental Health Plan 2003-2008.

The potential agenda for national mental health information is substantial, so not all areas of work can be progressed simultaneously. In addition, different stakeholders also hold varying views on the relative priority to be given to any specific area.

A national workshop was held in February 2004 to provide an opportunity for stakeholders to contribute to future planning. Many views were expressed, but substantial consensus emerged about those areas of work requiring consolidation and the new items that need to be added to the agenda over the next few years.[22]

The final list of priority areas described in this section for national action has been developed with consideration to:

- the level of importance of specific proposals as rated by stakeholders at the national workshop;
- the need for significant effort to be made in consolidating the gains made under the previous information development framework, particularly, the embedding of an outcomes focus into routine service delivery;
- the feasibility of implementation in the short to medium term; and
- the need for work to be undertaken on a national basis to extend into a number of new areas outside the scope of specialist mental health services, consistent with the emphasis of the National Mental Health Plan 2003-2008.

A total of 10 priority areas and 42 specific initiatives are identified for action.[23] This section summarises the rationale for each area identified for priority development and outlines the key initiatives to be taken.

## 4.1 Using outcome measurement to improve mental health care

### 4.1.1 Rationale

As noted earlier, considerable resources and effort have been invested by all jurisdictions to introduce an outcomes focus within mental health service delivery. Despite the progress made to date, there is agreement between all parties that substantial work lies ahead beyond the basic

22 Department of Health and Ageing (2004b). *Report of proceedings of National Mental Health Information Priorities Workshop (Sydney)*.

23 Relative priorities within the group of 42 initiatives are not outlined in this document, but will be developed as specific work plans are refined.

implementation tasks to achieve the vision of an 'informed mental health industry'. Long term sustainability depends ultimately on the extent to which consumer outcomes data are applied in ways that support service delivery and are perceived to be useful tools within a quality improvement framework. To this end, further National Mental Health Program funding is being made available by the Australian Government to assist States and Territories in ensuring that sustainable systems are in place by 2006.

In addition to initiatives to be taken by individual States and Territories, more work is needed to develop accessible, nationally comparable information on mental health consumer outcomes. The recent establishment of AMHOCN as the vehicle for national information has commenced the process and needs to be developed in the years ahead.

Further work to refine the measurement instruments used to collect consumer outcome data and develop supplementary measures for specific purposes was foreshadowed in the first edition information priorities framework, but not progressed to any significant degree. The experience to date in implementing routine consumer outcome measurement in Australia's mental health services has emphasised the need to keep this work on the agenda.

### 4.1.2 Consolidation activities

- **Completing the basic implementation tasks**

  Additional steps will be undertaken by all jurisdictions to complete the comprehensive implementation of routine consumer outcome measurement across specialist mental health services under their control:

  – For most State and Territory jurisdictions, this involves completing the information infrastructure enhancements and orientation training programs for the clinical workforce commenced under the previous Information Development Agreements.

  – Within the private hospital sector, the work program to establish routine outcome measurement is well advanced but will require consolidation targeted at promoting the uptake and application of available information by clinicians and service managers.

- **Local reporting systems to facilitate utilisation of consumer outcomes data**

  All States and Territories are committed to the development of outcome reporting systems that provide timely feedback to clinicians, consumers and carers. These will aim to integrate outcome measurement within clinical practice and support their use as tools for quality improvement initiatives.

- **National analysis and reporting**

  Steps commenced under the Second National Mental Health Plan to establish arrangements for the national pooling and reporting of consumer outcome information (through AMHOCN) will be extended over the 2003-08 period. A range of publications that provide aggregated results and norms, derived from the national collection, will be produced to facilitate interpretation of local data by service delivery agencies and benchmarking between agencies. Results will be stratified in ways that meet the needs of the various subspecialties within the mental health sector (for example, child and adolescent services).

- **Expert Advisory Groups**

  Expert advisory groups on adult, child & adolescent and older persons mental health will be maintained to advise on the use and ongoing development of outcome and casemix information in mental health services.

### 4.1.3 New initiatives

- **Review and refinement of clinical outcome measures for adult, child & adolescent and older persons**

  Where permitted by the various licenses governing use of copyrighted instruments, the consumer outcomes measures implemented nationally will be reviewed with the aim of improving their utility. This will be based on analysis of the data collected and reported by States and Territories, the views of clinicians, consumers and carers and advice from the outcomes expert groups. Special attention will be given to review and improvement of the HoNOS 'family' of instruments (HoNOS, HoNOS65+ and HoNOSCA). The scope for developing a single, consolidated instrument of clinical symptoms and functioning for adult populations will be examined. Parallel work on child and adolescent measures will also be undertaken.

- **Enhancement of consumer self-report measures**

  Action will be taken by States and Territories, individually and collaboratively, to move towards a national standard self-report measure that incorporates the domains identified by consumers as critical to the assessment of outcomes. This will be based on review of experience in the use of existing measures, in consultation with consumers, and may replace or supplement those measures.

- **Development of measures of carer outcomes and perceptions of care**

  Consistent with the National Mental Health Plan 2003-2008 emphasis on improved responsiveness to the needs of carers, available measures of carer wellbeing and burden will be evaluated, with a view to developing a national standard measurement tool for inclusion in the core outcomes suite. This work will also incorporate a measure of carer perceptions of care.

- **Information about Indigenous consumer outcomes**

  Preliminary explorations by several jurisdictions, aimed at adapting available clinical measures to improve their utility and validity in assessing outcomes for adult Indigenous consumers, will be continued and extended to include child and adolescent and older person populations. New work will be commissioned to develop nationally agreed, culturally valid alternatives for self reporting on outcomes by Indigenous consumers and their families.

- **Development of measures of consumer perceptions of care**

  Initiatives being taken by several jurisdictions to regularly monitor consumer perceptions of care will be reviewed with the aim of developing a national standard set of indicators for use by all States and Territories. These will be incorporated in the key performance indicator framework being developed to monitor Australia's public mental health services.

- **Measures designed for older persons**

  Work will be undertaken to improve the relevance of the outcomes measures for older persons, particularly in the approach taken to the assessment of functioning. Special issues arising from the need to rationalise information collections specific to mental health services also subject to general aged care reporting requirements, will also be addressed.

## 4.2 Further development of a mental health casemix classification

### 4.2.1 Rationale

Australia's investment in developing a casemix classification for mental health services was initiated in the mid 1990s, culminating in a 'first generation' classification (MH-CASC) that was foreshadowed for further development. Further research and development to improve the classification was suspended over the 1998-2003 period, while States and Territories implemented arrangements for the collection and national reporting of the required data.

As that work nears completion, Australia is in a position to recommence its planning for a casemix classification, building on the work completed in the 1990s. The original rationale for commencing on the path to develop a casemix for mental health remains as relevant today as it was then.

Casemix is often seen as solely concerned with the funding of health services, and as such, has been viewed with concern by the mental health community. However, its original purpose was to provide a basis for quality assurance. In Australia, casemix was introduced initially as a management information system to assist in improving efficiency, standards and patient outcomes, not as a basis for determining payments. This role of a casemix classification is often lost in discussions about its potential in the mental health field, a barrier that remains to be crossed.

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

Casemix classifications are inherently evolutionary and require an ongoing investment in research and development. Casemix classes need to be modified with experience, cost weights adjusted based on changing patterns of care, and so forth. Compared with the acute health field, where such work has been in progress for more than 20 years, the mental health sector is only at the beginning of this cycle.

### 4.2.2 Consolidation activities

- **Completing the implementation of the MH-CASC collection requirements**

  Most States and Territories have further work to ensure comprehensive coverage of services in their data collection and reporting arrangements.

- **Promoting the understanding and application of casemix in mental health services**

  Considerable misunderstanding exists in the mental health workforce about the purpose of casemix and its value as a tool in quality improvement activities. In the years ahead, a range of information and training resources will be developed through AMHOCN that are designed to promote a more informed workforce.

### 4.2.3 New initiatives

- **Trialing and refinement of the classification**

  As data of sufficient quality become available, a range of analyses will be undertaken to further develop the casemix classification produced by the Mental Health Classification and Service Costs (MH-CASC) Project. This will include addressing issues identified in the 1999 'first edition' of national information priorities such as:

  – testing the classification based on its performance in explaining service utilisation (as proxy measures for cost);
  – implementing desirable clinical modifications to improve its utility in quality assurance and other clinical applications;
  – identifying cost weight refinements and possible future costing studies; and
  – addressing the need to rationalise classifications in the field of aged care.

## 4.3 Using information to improve safety in mental health care

### 4.3.1 Rationale

The growing emphasis on safety in health care and strategies for its improvement highlight the importance of information about the process of health service delivery and its outcomes. Although concerns about consumer rights and prevention of abuse have underpinned the National Mental Health Strategy since its beginnings, the mental health sector is only at an early stage in translating the concepts about patient safety that are being developed within the acute hospital sector.

The Australian Council for Safety and Quality in Health Care provides leadership in this area. Established in January 2000 by agreement of all Health Ministers, the Council's role is to coordinate national efforts to improve safety and quality of health care, with a particular focus on minimising the likelihood and impact of error.

A priority of the Council has been to enhance the collection and use of data to drive safety and quality improvements. Examples of the Council's work in this area relevant to the mental health sector include:

- the development of consensus between State and Territory jurisdictions on an agreed national list of core sentinel events;
- identification of the components of the effective incident management systems for use in Australian health care and agreement by Health Ministers to the introduction by all public hospitals of incident management systems to monitor, investigate, analyse and guide their actions in dealing with patient safety and quality incidents, by June 2005;
- completion of a review of current approaches to reporting and investigation of deaths associated with health care related adverse events;
- improvements in the use of routinely collected hospital mortality and morbidity data for safety improvement;
- agreement by all Health Ministers that, by the end of 2005, public hospitals will report all agreed core sentinel events and contribute to a national report on Sentinel Events to be produced by the end of 2005; and

- working with jurisdictions and relevant expert groups to identify what nationally consistent information should be collected and reported, and to ensure national consistency in data definitions, classifications, and reporting.

Within the mental health field, accreditation agencies have developed tools and indicators for use in reviewing services against the National Standards for Mental Health Services, including those that are specific to safety. Additionally, the Australian Council on Healthcare Standards regularly publishes clinical indicators, including safety indicators.[24] Beyond this, little work has been undertaken to date to build the national information foundation needed for a systematic approach to improving safety in mental health care, for example:

- no information is routinely reported across the mental health sector on whether safety protocols exist that make the activities and environment of mental health services safe for consumers, carers, families, staff and the community. Whilst some of this information is provided in a number of different ways including accreditation, there is no agreed information standard;
- reliable national information is not available on the safe and quality use of medicines. This includes information on the extent of education given to consumers, carers and families as well as reporting systems for adverse medication events;
- no nationally agreed information is routinely reported on a number of other sentinel events in mental health; and
- indicators to monitor safety in mental health care are not yet included in the national framework agreed by all States and Territories to monitor the performance of mental health services (see section 4.4).

The National Mental Health Working Group established the Safety and Quality in Mental Health Partnership Group to address these gaps. The Partnership Group is working collaboratively with the Australian Council for Safety and Quality in Health Care and other stakeholders, to develop a national plan for addressing safety priorities in mental health. This will also address information development requirements. Priorities identified are:

- reducing suicide and deliberate self-harm in mental health and related settings;
- reducing use of, and where possible eliminating, restraint and seclusion;
- reducing adverse drug events in mental health services; and
- safe transport of people experiencing mental disorders.

### 4.3.2 Consolidation activities

- **Monitoring the implementation of national standards**

  Safety is a core component of the National Standards for Mental Health Services (Standard 2: Safety) and the National Practice Standards for the Mental Health Workforce (Standard 1: Rights, responsibilities, safety and privacy). Systems to monitor and report on the ongoing implementation of the standards, commenced under the Second National Mental Health Plan, will be extended over the 2003-08 period.

24 Australian Council on Health Care Standards (2003). *Determining the Potential to Improve Quality Care 4th Edition: ACHS Clinical Indicator Results for Australia and New Zealand 1998-2002*. ACHS, Ultimo, NSW.

- **Full implementation and use of incident monitoring systems**

  Most States and Territories have invested in establishing incident monitoring systems within their inpatient services for monitoring and guiding action in response to safety and quality incidents. Further work will be undertaken to make full use of the potential of these systems at the local and national levels, as well as identifying areas where changes may be needed to better reflect the nature of safety issues in mental health care. For example, adverse events associated with electro convulsive therapy (ECT), involuntary status (absconding/absence without leave), and the use of restraint and seclusion are not well catered for in existing incident management systems. Services will need to pay particular attention to each of the nationally agreed priority areas.

### 4.3.3 New initiatives

- **Development of national indicators of safety in mental health care**

  The Information Strategy Committee and the Safety and Quality in Mental Health Partnership Group will work together to develop nationally agreed performance indicators and associated data sets for the safety domain of the National Health Performance Framework. Indicators will be chosen based on their ability to support safety improvement initiatives and improve information on adverse events in mental health care.

- **Using local information collections and related data sources in safety and quality improvement processes**

  Data collections on incidents and adverse events maintained by individual States and Territories will be examined for their potential to contribute to a national approach to improving safety in mental health care. These include mandatory reporting to the various State and Territory Chief Psychiatrist offices or equivalent internal review units, complaints data, and reports from external scrutiny bodies (such as Australian Council on Healthcare Standards clinical data, accreditation reports, or official/community visitors). The feasibility for record linkage to make better use of this information will be explored.

## 4.4 Establishing performance indicators and benchmarking in mental health services

### 4.4.1 Rationale

Key performance indicators are a central component of health service quality improvement processes. They also provide a basis for accountability and monitoring, allowing assessment of whether a program or service does what it is intended to do and whether it does it well.

The absence of performance data on the mental health sector contrasts sharply with the increased profile being given to mental health in public policy. The *Report on Government Services*, an annual cross-jurisdictional publication produced under the auspices of the Council of Australian Governments, has made mental health a priority for reporting since 1999. Similarly, as noted earlier, the National Health Performance Committee has identified development of mental health indicators as a priority for inclusion in future editions of its biennial *National Report on Health Sector Performance Indicators* publication for Australian Health Ministers.

As discussed in section 2.10, a set of 'stage one' performance indicators has been agreed by the National Mental Health Working Group, based on the national health performance framework adopted by Health Ministers.[25] The task ahead is to progressively implement and refine these indicators in a way that meets the needs of key stakeholders.

The publication of indicators alone is not sufficient to stimulate a culture of quality improvement and benchmarking throughout the mental health industry.[26] The introduction of performance measurement systems requires attention not only to the technical issues, but also to the process of building interest, capacity and leadership within service organisations to use them creatively.

Lessons from the acute health sector have shown the benefits of applying roundtable and related methods to the health field. The engagement of organisations in learning about their performance through comparison with peer organisations grounds performance measurement in practice and provides a means for quality improvement to be realised.

A recent Australian report reviewed the status of benchmarking in mental health and concluded that much work was needed to make this a reality: *"The challenge for the mental health sector is clear. The use of performance indicators and the movement towards benchmarking is becoming routine in the Australian health care system. The challenge for the mental health sector is to develop a set of meaningful performance measures and to develop the culture and the processes so that benchmarking becomes the norm".*[27]

### 4.4.2 Consolidation activities

- **Implementing the agreed key performance indicators**

  Over the period 2003-08, States and Territories will implement the agreed 'stage one' indicators within a timetable that is consistent with each jurisdiction's capacity. This will be supported by the establishment of a National Mental Health Performance Sub-committee that will be responsible for preparation of technical documentation and the ongoing development of the national performance measurement framework for mental health services.

### 4.4.3 New initiatives

- **Further development of the national performance framework for mental health**

  Collaborative work between jurisdictions will be undertaken to refine the indicators based on experience, fill gaps where key aspects of health system performance are not currently covered, and extend the 'stage one' indicators to improve their utility beyond the specialist public mental health sector. Significant gaps in the current framework are indicators that measure the domains of responsiveness and safety of mental health care.

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25 NMHWG Information Strategy Committee Performance Indicator Drafting Group (2005). *Key Performance Indicators for Australian Public Mental Health Services.* ISC Discussion Paper No 5 Australian Government Department of Health and Ageing, Canberra.

26 The concept of benchmarking is used here to refer to *"… the systematic process of searching for and implementing a standard of best practice within an individual service or similar groups of services. Benchmarking activities focus on service excellence, customer/client needs, and concerns about changing organisational culture"* (Bullivant, 1994).

27 Eagar K, Burgess P and Buckingham W (2003). *Towards National Benchmarks for Australian Mental Health Services.* Information Strategy Committee Discussion Paper No.4. Commonwealth Department of Health and Ageing, Canberra.

- **Establishment of benchmarking forums**

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

- **National reporting on the performance of the mental health system**

  Steps will be taken to publicly report on the performance of Australia's mental health services in a form that protects agency confidentiality but provides sufficiently detailed information for comparative evaluation and monitoring of trends. National reports on mental health system service performance will be designed to provide benchmarks to support the use of indicators by service organisations while also satisfying accountability expectations under the current Australian Health Care Agreements.

## 4.5 Strengthening workforce uptake and capacity to use information

### 4.5.1 Rationale

The success of the various initiatives taken in Australia to improve mental health information depends, ultimately, on a change in the way information is both regarded and used by the mental health workforce. Much of the effort under the Second National Mental Health Plan was directed to introducing clinicians to the new information collections being put in place by all jurisdictions as well as implementing training in the use of standard outcome measures. By June 2003, approximately 10,000 clinical staff participated in training events designed to raise awareness of information developments and build basic skills that were conducted by the States and Territories.

More is needed to develop a workforce that is genuinely engaged, rather than simply cooperative with, the information developments taking place in Australia's mental health services. Feedback from clinicians points to the discrepancy between the information now available within the mental health sector and the capacity of the workforce to access, interpret and apply that information in ways that support quality improvement. A misconception is also evident regarding the intention of governments in providing support to information initiatives, based on concerns that it may be related to an underlying desire to reduce funding to mental health. Each of these factors compromises the extent to which the current investments in information will produce real benefits.

The work ahead requires action across three areas:

- First, continuing effort is needed to improve awareness of the objectives and scope of Australia's mental health information development approach. This will require communication through a range of media to promote accurate understanding of both the direction being taken as well as the potential benefits that are created for improving mental health services.
- Second, continuing training programs are needed to consolidate the achievements of the training forums conducted under the Second National Mental Health Plan. New training is required both to extend skills beyond the basic level and address the needs of new clinicians as they enter the mental health workforce.

- Third, specific initiatives are needed to improve the skill of the workforce in accessing and applying the new information for its intended purposes. This involves assisting clinicians in analysing and interpreting data for such purposes as development of care plans, monitoring client progress or informing risk management. Beyond the individual clinician, team leaders and service managers need to be equipped to use information to better understand their agency's performance and undertake quality improvement exercises.

The emphasis on developing an 'information literate' workforce is consistent with priorities emerging across the whole health sector. The recently established Australian Health Information Council has identified the development of information technology and information management skills in the health workforce as one of its early priority tasks.

### 4.5.2 Consolidation activities

- **Continuing training programs in data collection protocols and measurement instruments**

  Initiatives will be taken by all States and Territories to develop training approaches designed to maintain skill levels of the existing workforce and respond to new needs arising from staff turnover. Options for self-directed learning through interactive websites, CD-ROM formats and distance education will be introduced progressively to supplement more intensive face-to-face approaches.

- **Communication strategy for promoting industry awareness of information development objectives**

  Current State and Territory activities to inform their workforces about information developments through local websites, newsletters and other media will be extended. These will be complemented by a national-level communication strategy coordinated by AMHOCN that will include further development of the national 'casemix and outcomes' website (www.mhnocc.org) and its various user forums, conferences, newsletters and related publications.

### 4.5.3 New initiatives

- **Building competency in information use amongst clinical leaders and service managers**

  Initiatives will be taken by individual State and Territory jurisdictions to provide skill development opportunities for clinician leaders and service managers in using information outputs for a range of purposes. Training will focus on both the technical and conceptual aspects of data analysis and interpretation and use of information in service management and in clinical quality improvement.

- **Accreditation systems for professional trainers**

  Options will be explored to develop formally accredited education courses designed for professional staff who are responsible for implementing education programs in the routine use of clinical measurement instruments. This work will be progressed at a national level by AMHOCN.

## 4.6 Improving national minimum data sets for mental health care

### 4.6.1 Rationale

National Minimum Data Sets represent the building blocks of all information strategies in the health field and are a pre-requisite to many of the activities described in this document.

Substantial progress has been made in developing national minimum data sets for mental health care through the work of the Australian Institute of Health and Welfare, working in collaboration with the States and Territories. These data sets enable consistent information to be collected and pooled nationally across all public sector specialised mental health service settings.

Notwithstanding these achievements, there remain significant gaps in the information available at the national level, which limit the extent to which informed policy choices can be made in response to emerging issues. Additionally, elements of these data available on the mental health sector have been developed outside the framework normally governing the reporting of national health information and, in some instances, differ from those requirements.

Achieving sustainability of national mental health information requires three steps:

1. incorporating the special collections that the mental health sector has developed over the course of the National Mental Health Strategy within mainstream health arrangements;
2. ensuring that health collections developed within other health sectors are responsive to mental health requirements; and
3. refining the existing national minimum data sets for mental health care to ensure their continuing relevance and that high priority gaps are filled.

### 4.6.2 Consolidation activities

- **Transfer of the National Survey of Mental Health Services to a National Minimum Data Set for Mental Health Establishments**

  The National Survey of Mental Health Services, conducted annually since 1994, has served as the main source of information on the progress of mental health reform in Australia. Conversion of this collection to a national minimum data set, collected and reported under the same arrangements applying to other national collections, is necessary to ensure future information for monitoring of the National Mental Health Strategy.

- **Progressive integration of the Mental Health National Outcomes and Casemix Collection (NOCC) within admitted patient, community care and residential care minimum data sets**

  The NOCC dataset provides the source information about consumer outcomes and casemix in mental health care. Developed as a 'research and development' collection, the aim of incorporating the various elements within existing collections was foreshadowed from the outset, subject to their review and proven worth. This is likely to take the full 2003-08 period.

- **Review of National Minimum Data Set for Admitted Patients – Mental Health Care**

  Introduced in 1997, this collection was the first of the national minimum data sets for mental health and provides the basis for reporting on the activity of all specialised psychiatric inpatient services. A review of the collection is being undertaken by the Australian Institute of Health and Welfare, with a view to improving its quality and utility for future requirements, such as informing policy development and reporting on performance.

### 4.6.3 New initiatives

- **Enhancement of National Minimum Data Set – Community Mental Health Care**

  This collection, introduced in 2001, is currently the largest of its type in the Australian health system, covering over 5 million community contacts and approximately 300,000 consumers per year. Further development will be undertaken to improve the way in which data are recorded when consumers are seen in the community, with a particular focus on establishing consistency in how community contacts are defined and recorded. The collection will also be enhanced with information on contact duration as a basis for quantifying the varying levels of care provided to mental health consumers in the community.

- **Development of nationally agreed mental health intervention codes**

  Work will commence to develop a national system for coding mental health interventions that will provide information on the types of services provided to mental health consumers. A nationally agreed system for describing services is essential to answer the question of 'what works for whom'.

- **Review of other health and welfare data collections and concepts to improve relevance to mental health requirements**

  A number of datasets developed in other areas have relevance to mental health and offer potential to improve our understanding of the needs of the Australian population. These will be reviewed with the aim of exploring opportunities to improve the capacity of the collections to inform mental health service development, or link to mental health datasets. Foremost among the collections to be examined are:

  – health labour force collections gathered by registration bodies;
  – alcohol and other drug treatment services national minimum data set;
  – national collections in relation to services provided by general practitioners;
  – Commonwealth/State/Territory Disability Agreement (CSTDA) minimum data set;
  – Supported Accommodation Assistance Program National Data Collection; and
  – Commonwealth/State/Territory Housing Agreement data.

## 4.7 Information to support mental health care provided external to the specialist sector

### 4.7.1 Rationale

The growing recognition of the extent of mental health care provided by health services operating external to the specialist sector has not been reflected in mental health information development at the national level. Major policy initiatives such as Better Outcomes in Mental Health Care, targeted at general practitioners (see section 2.11), and the National Institute of Clinical Studies Mental Health Emergency Care Interface Project, aim to enhance the capacity of the health system to respond to mental health issues. Information requirements to support such initiatives need to be identified, along with work designed to develop information at the national level that will guide further policy and planning.

Areas for initial work outlined below are those identified as the highest priority in terms of community impact.

### 4.7.2 New initiatives

- **Further development of outcome measures to enhance the role of general practitioners**

  Steps to support the use of outcome measures currently being collected under the Better Outcomes in Mental Health initiative will be explored in consultation with the Australian Divisions of General Practice. A number of options are available to make better use of the data including, for example:

  – development of normative data to guide interpretation by general practitioners;
  – incorporation of outcome measurement within general practitioner-based clinical information systems to support monitoring of individual patient progress and clinical decision making; and
  – analysis of samples of these data to inform the evaluation and future planning of primary mental health care initiatives.

- **Information support for improving emergency department mental health care:**

  A series of studies has described the role played by general hospital emergency departments in providing a front line response to people presenting with a mental illness, highlighting the need to improve the assessment, triage and referral process. Apart from 'one-off' studies, information is not collected at the national level to monitor developments in this area and inform future policy. Opportunities will be explored to link with related initiatives that have potential to contribute to future directions in this area including:

  – mental health related projects being progressed under the National Institute of Clinical Studies 'Emergency Care Community of Practice' projects;
  – the emergency department 'term set development project' being conducted through the National Centre for Classification in Health; and
  – the ongoing development of the Non-Admitted Patient Emergency Department Care National Minimum Data Set being led by Department of Health and Ageing.

## 4.8 Monitoring population mental health and wellbeing

### 4.8.1 Rationale

A population health approach is important across all areas of activity in mental health and all key themes of the National Mental Health Plan 2003-2008. The National Survey of Mental Health and Wellbeing, conducted during 1997 and 1998, provided the first comprehensive source of information on the distribution and type of mental health problems in the Australian population. The work produced vital information about population mental health needs that has guided the planning and development of many new initiatives under the Strategy.

The 1997-98 surveys set the baseline but regular surveillance will be needed to assess changes over time, and provide current information about mental health needs and service utilisation in the community that can inform future policy and planning. Refinements in surveying methodology are also needed to identify common risk factors that may act as determinants of mental health and wellbeing.

Several developments in population surveying have added to Australia's capacity to monitor mental health trends in the community:

- The Australian Bureau of Statistics has incorporated a mental health component in its general National Health Survey. The survey, conducted at three-yearly intervals, now includes a brief measure of psychological distress (the Kessler 10[28]). This is also used in similar population surveys in Canada and the United States, and enables time series information on the adult population.
- A number of individual States and Territories have established their own population health surveillance approaches, based on the Computer Assisted Telephone Interview (CATI) method, that complement information derived from national surveys. The Kessler 10 measure has been included in New South Wales, Western Australia and South Australia and has potential to be used in others. Possible approaches to national pooling of data are being progressed through the National Public Health Information Working Group.
- The Australian Bureau of Statistics Indigenous Health Survey, undertaken over 2004-05, incorporates aspects of social and emotional wellbeing that recognises the importance of including mental health in understanding the health status of Indigenous Australians.

A strategic approach to population mental health monitoring is required that establishes linkages between these related initiatives and builds an information base for ongoing mental health policy development. Regularly updated information on the extent of mental health problems in the community is also necessary to meet expectations under the National Health Performance Framework, agreed by all Health Ministers, which require reporting on changes in population health status and determinants of health.

From the perspective of national information priorities, the main tasks ahead are to develop a coordinating framework that:

- makes best use of the opportunities created by existing national and state-level general health population surveys to ensure that a basic mental health screening measure is included; and
- resolves how often these general collections should be supplemented by further specific national surveys of population mental health.

### 4.8.2 Consolidation activities

- **Continuation of a mental health component in general and specialist National Health Surveys**

  Action will be taken to maintain and build on the mental health component of the National Health Survey and Indigenous Health Survey conducted by the Australian Bureau of Statistics. This will give basic time series information on population mental health status and risk factors.

28 Kessler RC, Andrews G, Colpe LJ, Hiripi E, Mroczek DK, Normand S-LT, Walters EE and Zaslavsky A (2002). Short screening scales to monitor population prevalences and trends in nonspecific psychological distress. *Psychological Medicine*, 32(6): 959-976.

### 4.8.3 New initiatives

- **Strategic framework for population mental health surveillance**

  A strategy will be developed in consultation with stakeholders that maps out a coordinated and long term approach to the monitoring of population mental health and encompasses national and state-level surveying approaches. Particular attention will be given to opportunities for linkage and common methodologies between related surveys conducted by individual States and Territories, the Australian Bureau of Statistics and the Australian Institute of Health and Welfare. Ongoing collaboration will be pursued through the National Public Health Partnerships to develop a common agenda between mental health and public/population health.

- **Further national survey of mental health and wellbeing**

  As a component of this overall strategic framework, planning will be undertaken to conduct a second specialist epidemiological survey of mental health and wellbeing. Specific mental health surveys aim to add detail on risk factors, chronicity and service utilisation that are not possible through general surveys. The future survey will take account of the learnings from the 1997 survey and more recent international work as well as take into consideration how to best address specific age groups and sub populations. It is expected that the survey will be conducted approximately 10 years following the original 1997 survey, to give timely information that will guide the priorities for the National Mental Health Strategy beyond the current National Mental Health Plan.

## 4.9 Information to support mental health prevention and promotion

### 4.9.1 Rationale

Promotion of mental health and prevention of mental illness have been central objectives in the National Mental Health Strategy since it began in 1992.

Under the First National Mental Health Plan (1993-1998) activities focused on reducing stigma, raising community awareness, and highlighting the importance of early intervention. Promotion and prevention subsequently became a key theme under the Second National Mental Health Plan with the release of the *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*[29] and the *LIFE Framework*[30] guiding promotion, prevention and early intervention activity over the past five years. Under the current Plan, promotion and prevention are now cornerstones of the National Mental Health Strategy.

However, national information in relation to promotion and prevention is significantly less progressed compared to other areas covered by the National Mental Health Strategy. This is due to several factors:

- the long-term nature of promotion and prevention activities – information on outcomes may not be collectable until some time after the activity has occurred;

29 Department of Health and Aged Care (2000a). *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health.* Commonwealth of Australia, Canberra.

30 Department of Health and Aged Care (2000b). *Living Is For Everyone (LIFE): A Framework for Prevention of Suicide and Self-Harm in Australia.* Commonwealth of Australia, Canberra.

- the many sectors and settings outside of mental health and health in which promotion and prevention activities happen; and
- difficulties in tracking resources dedicated to promotion, prevention and early intervention activities. Jurisdictions indicate that such tracking is currently very problematic.

All jurisdictions have committed to increasing their mental health promotion and prevention capacity under the National Mental Health Plan 2003-2008 and agreed to the need to establish processes to monitor the extent to which this occurs.

### 4.9.2 Consolidation activities

Given the current level of development in the area of information to support promotion and prevention activities in mental health, the task ahead is one of initiating work on agreed new priorities rather than building on past work.

### 4.9.3 New initiatives

- **Development of a 'promotion and prevention scorecard' to monitor State and Territory programs**

  Work will be undertaken through collaboration between the National Mental Health Information Strategy Committee and the Mental Health Promotion and Prevention Working Party to develop a structured process for monitoring the extent to which promotion and prevention is included in government programs (the 'Promotion and Prevention Scorecard'). The aim will be to establish baseline information that can be monitored over time about progress in development of promotion and prevention policies and programs, and the ongoing commitment to them. The scope of the scorecard is expected to examine:
  - policies and strategies implemented at State and Territory level and their relation to key priorities in this field;
  - implementation against State and national targets and priorities;
  - progress in development of key partnerships with agencies for promotion and prevention, and their roles and responsibilities;
  - workforce capacity, training and central coordination;
  - resources allocated to promotion and prevention activity;
  - community, consumer and carer involvement and commitment beyond mental health; and
  - involvement of general practitioners.
- **Targeted information collections and data linkage to monitor outcomes of specific prevention programs**

  The potential to develop a national approach for monitoring the impact of prevention programs, through data linkage between currently independent State/Territory and national collections, will be explored.
- **Incorporation of mental health literacy components in existing State/Territory and national health surveys**

  Specific proposals regarding the possibilities for this will be explored.

## 4.10 Monitoring and reporting of progress under the National Mental Health Strategy

### 4.10.1 Rationale

Evaluation and accountability are key themes of the National Mental Health Strategy and were the drivers of much of the information development that occurred in the early years. The agreement by all governments to a national approach to mental health recognised that an important aspect of the reform process was to ensure the process would be monitored and reported publicly on a regular basis. This has been achieved through regular reporting of progress in the National Mental Health Report, supplemented by independent evaluations of each five year National Plan.

The National Mental Health Report series has reported on all years of the Strategy since 1993 as a specific requirement of the Australian Health Care Agreements 1998-2003 and the former Medicare Agreements. When the current series concludes, the reports will have provided detailed snapshots of mental health services in Australia across the 1993-2003 decade, charting the changes in spending, service mix and workforce that have resulted from the national reforms. The report has no counterpart in Australia's health system or in the international mental health field.

Additional benefits have accrued through the national monitoring process, particularly the provision of comparative data for use by States and Territories in planning and resourcing their services. It has also given insights into Australia's mental health reforms for consumers, carers and the community that would otherwise not be accessible. For these reasons, it is not surprising that feedback from the national consultation forum held in February 2004 argued strongly for continued access to this type of information.

While acknowledging these achievements, a new approach to national monitoring of mental health services is needed that responds to the emerging issues and priorities outlined in the National Mental Health Plan 2003-2008. The National Mental Health Report has been based on indicators developed in 1992 that emphasised structural changes in service mix and overall resourcing levels. These were appropriate to the original reform goals of the Strategy, but do not address the actual performance of the mental health system in meeting the needs of the community. Additionally, the focus of reporting to date has been confined primarily to public sector specialised mental health services, giving only limited attention to the role of primary mental health care and the private sector.

The objectives under the National Mental Health Strategy have broadened substantially over the past decade, from efforts to transform an outmoded and institution-centred system of care to wider concerns that reflect a new appreciation of the central place of mental health in the overall health and wellbeing of the community. Monitoring progress across all key Strategy areas requires an approach that continues the role of previous National Mental Health Reports in putting national data into the public domain, while also having the flexibility to report on the new and emerging issues.

### 4.10.2 Consolidation activities

- **Continued collection and reporting of national data on mental health resourcing**

  Data on State and Territory mental health spending, workforce and service mix, previously compiled through the annual National Survey of Mental Health Services, will be collected as a new National Minimum Data Set from 2005-06 (see section 4.6.2). This will ensure its sustainability and facilitate integration with 'mainstream' health datasets. Particular attention is being given in planning the transfer to make these data collected under the new arrangements comparable with these historical data, thereby allowing long term trends in mental health to continue to be monitored. Aspects of this information will be reported in the Department of Health and Ageing annual reports on the performance of States and Territories under the Australian Health Care Agreements, as well as in the Australian Institute of Health and Welfare's annual publication, *Mental Health Services in Australia*. These will provide important source data on mental health resources and service development.

### 4.10.3 New initiatives

- **Future monitoring of the National Mental Health Strategy**

  Periodic reporting on the progress of the National Mental Health Strategy will continue to ensure that the latest summary information on key indicators is available publicly. The specific format for reporting will be determined in consultation with stakeholders, but is expected to incorporate a broad range of input to give coverage across the full extent of National Mental Health Strategy activities.

- **Evaluation of National Mental Health Plan 2003-2008**

  As specified within the Plan, an independent evaluation will be undertaken to assess achievements and implementation of all key initiatives.

## 4.11 Summary of priorities

Table 3 summarises the 42 priorities that will provide the focus of future national mental health information development activities.

**Table 3: Summary of national information development priorities for mental health**

| Consolidation Activities | New Initiatives |
|---|---|
| ***USING OUTCOME MEASUREMENT TO IMPROVE MENTAL HEALTH CARE*** | |
| 1. Completing the basic implementation tasks<br>2. Local reporting systems to facilitate utilisation of consumer outcomes data<br>3. National analysis and reporting<br>4. Expert Advisory Groups | 5. Review and refinement of clinical outcome measures for adult, child & adolescent and older persons<br>6. Enhancement of consumer self-report measures<br>7. Development of measures of carer outcomes and perceptions of care<br>8. Information about Indigenous consumer outcomes<br>9. Development of measures of consumer perceptions of care<br>10. Measures designed for older persons |
| ***FURTHER DEVELOPMENT OF A MENTAL HEALTH CASEMIX CLASSIFICATION*** | |
| 11. Completing the implementation of the MH-CASC collection requirements<br>12. Promoting the understanding and application of casemix in mental health services | 13. Trialing and refinement of the classification |
| ***USING INFORMATION TO IMPROVE SAFETY IN MENTAL HEALTH CARE*** | |
| 14. Monitoring the implementation of national standards<br>15. Full implementation and use of incident monitoring systems | 16. Development of national indicators of safety in mental health care<br>17. Using local information collections and related data sources in safety and quality improvement processes |
| ***ESTABLISHING PERFORMANCE INDICATORS AND BENCHMARKING IN MENTAL HEALTH SERVICES*** | |
| 18. Implementing the agreed key performance indicators | 19. Further development of the national performance framework for mental health<br>20. Establishment of benchmarking forums<br>21. National reporting on the performance of the mental health system |
| ***STRENGTHENING WORKFORCE UPTAKE AND CAPACITY TO USE INFORMATION*** | |
| 22. Continuing training programs in data collection protocols and measurement instruments | 23. Communication strategy for promoting industry awareness of information development objectives<br>24. Building competency in information use amongst clinical leaders and service managers<br>25. Accreditation systems for professional trainers |

**Table 3: Summary of national information development priorities for mental health** *(continued)*

| Consolidation Activities | New Initiatives |
|---|---|
| ***IMPROVING NATIONAL MINIMUM DATA SETS FOR MENTAL HEALTH CARE*** | |
| 26. Transfer of the National Survey of Mental Health Services to a National Minimum Data Set for Mental Health Establishments<br>27. Progressive integration of the Mental Health National Outcomes and Casemix Collection (NOCC) within admitted patient, community care and residential care minimum data sets<br>28. Review of National Minimum Data Set for Admitted Patients – Mental Health Care | 29. Enhancement of National Minimum Data Set – Community Mental Health Care<br>30. Development of nationally agreed mental health intervention codes<br>31. Review of other health and welfare data collections and concepts to improve relevance to mental health requirements |
| ***INFORMATION TO SUPPORT MENTAL HEALTH CARE PROVIDED EXTERNAL TO THE SPECIALIST SECTOR*** | |
| | 32. Further development of outcome measures to enhance the role of general practitioners<br>33. Information support for improving emergency department mental health care |
| ***MONITORING POPULATION MENTAL HEALTH AND WELLBEING*** | |
| 34. Continuation of a mental health component in general and specialist National Health Surveys | 35. Strategic framework for population mental health surveillance<br>36. Future National Surveys of Mental Health and Wellbeing |
| ***INFORMATION TO SUPPORT MENTAL HEALTH PREVENTION AND PROMOTION*** | |
| | 37. Development of a 'promotion and prevention scorecard' to monitor State and Territory programs<br>38. Targeted information collections and data linkage to monitor outcomes of specific prevention programs<br>39. Incorporation of mental health literacy components in existing health surveys |
| ***MONITORING AND REPORTING OF PROGRESS UNDER THE NATIONAL MENTAL HEALTH STRATEGY*** | |
| 40. Continued collection and reporting of national data on mental health resourcing | 41. Future monitoring of the National Mental Health Strategy<br>42. Evaluation of National Mental Health Plan 2003-2008 |

PART 5

# Arrangements for Managing the National Work Program

# Arrangements for Managing the National Work Program

This section of the document describes the national governance arrangements for overseeing information development in Australia and outlines:

- the various committees and task groups that have been established under the National Mental Health Strategy; and
- the relative roles of the Australian, State and Territory governments and other key stakeholders in progressing the work plan described in Part 3.

## 5.1 Overall health information governance arrangements

In July 2003, Health Ministers agreed to a revised national health information organisational structure to provide improved coordination and governance of national data collection, data standards and information technology development. The structure includes two peak bodies under the auspices of the Australian Health Ministers' Advisory Council (AHMAC) and the Australian Health Ministers' Conference (AHMC):

- the Australian Health Information Council, comprising experts drawn from within and external to the health industry, which advises on the longer term strategic directions for health information; and
- the National Health Information Group, comprising jurisdictional representatives from each of the States and Territories and the Australian Government, which oversees national health information activity and advises on information requirements, technology planning and management, and the allocation of resources to work groups.

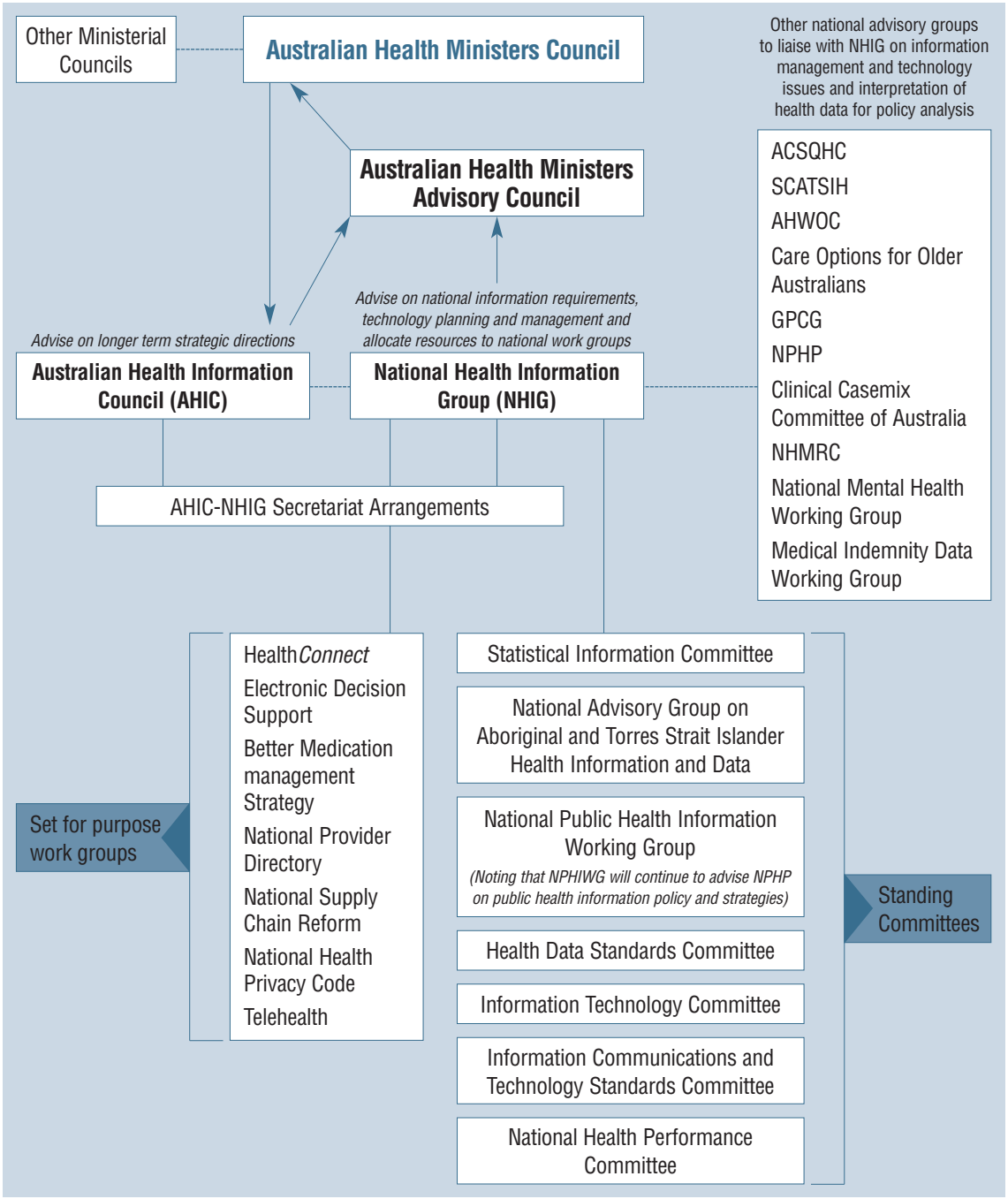
A number of other standing committees and working groups operate beneath and alongside these two peak bodies to take the national work forward in specific areas. Figure 7 summarises the arrangements.

## 5.2 National coordinating arrangements for mental health information

The mental health sector feeds into these processes through the Australian Health Ministers Advisory Council National Mental Health Working Group (NMHWG), which acts as the key forum to advise on and monitor the implementation of mental health reforms under the Strategy. The Working Group has established a number of standing committees to manage its work agenda. Within these, the National Mental Health Information Strategy Committee (ISC) has primary responsibility for information development activities and bringing all key parties together to foster collaborative effort. Details of membership of the NMHWG and ISC are provided at Appendices B and C respectively.

Several subcommittees and task groups have been set up by the ISC that are responsible for advising on various aspects of information development. Figure 8 provides a summary outline of the groups established under the auspice of the National Mental Health Working Group. Responsibilities of the groups with specific information development roles are summarised in Table 4.

**Figure 7: National health information governance structure at October 2003**[31]




31 A number of structural changes have since been made to these arrangements, in particular, the establishment of the National E-Health Transition Authority (NEHTA) in 2004 to promote the adoption of e-health across the Australian health sector.

**Figure 8: National Mental Health Working Group arrangements for mental health information development**

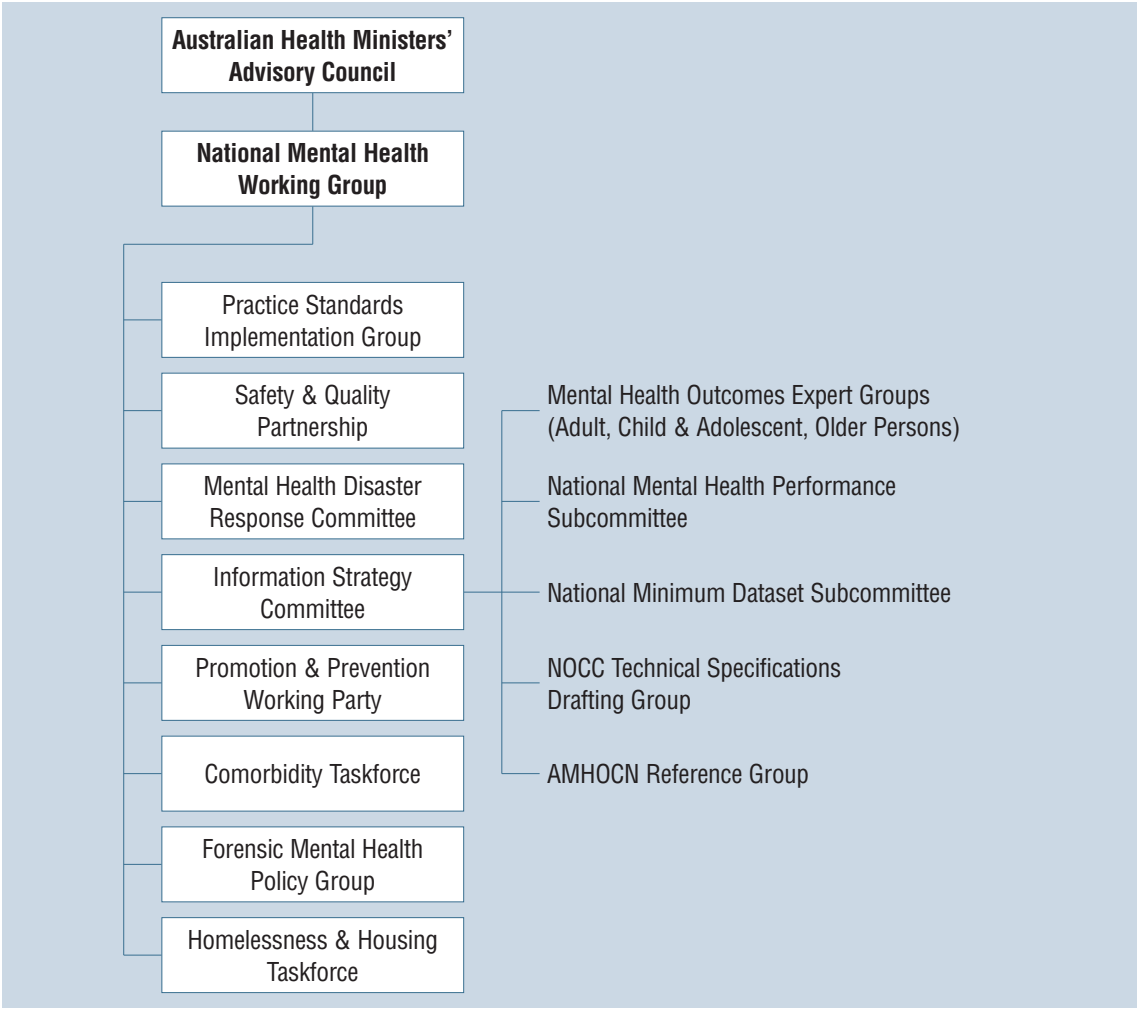


**Table 4: Roles of AHMAC National Mental Health Working Group committees and subcommittees with specific information development responsibilities**

| Group | Primary role |
|---|---|
| National Mental Health Working Group Information Strategy Committee | Provides advice and recommendations to AHMAC National Mental Health Working Group on initiatives to address the information requirements of the National Mental Health Strategy. |
| Outcomes Expert Groups (Adult, Child & Adolescent, Older Persons) | Provide expert clinical and technical advice on standardised measures used to monitor consumer outcomes including: use of routine outcome measurement to improve clinical practice and service quality; future modifications to the outcome measures; training and support requirements; data analysis and reporting. |
| National Minimum Data Set Subcommittee | Provides technical advice to the Information Strategy Committee and Australian Institute of Health and Welfare on developments in mental health information. |
| National Mental Health Performance Subcommittee | Provides advice on the ongoing development of a national performance measurement framework for mental health services, to support benchmarking for health services improvement and to provide national information on mental health system performance. |
| NOCC Technical Specifications Drafting Group | Provides advice on development of technical specifications for the collection and reporting of NOCC (National Outcomes and Casemix Collection) data. |
| AMHOCN Reference Group | Provides a liaison point between AMHOCN, ISC and Outcomes Expert Groups to interact and advise on jurisdictional requirements, AMHOCN work program and future directions. |

## 5.3 Relative responsibilities

Advancing the priorities described in this document is premised on cooperation between key parties to develop a coherent national approach. Ongoing collaboration between the States and Territories and the Australian Government is fundamental.

The work program includes activities that need to be jointly managed by the States and Territories and the Australian Government, as well as activities managed solely by each party. In summary terms:

- Collectively, all parties need to work together in setting directions, developing the framework for action and investing the necessary resources required by the work program.
- States and Territories will carry responsibility for the implementation of agreed concepts and systems within the public mental health services under their control. Additionally, individual jurisdictions will need to take the lead role on one or more national initiatives.
- The Australian Government's role is to create the enabling environment by establishing the required national infrastructure, contributing funding to projects undertaken on a national basis and facilitating coordination and action where a national approach is required.

The specific roles of the States and Territories and the Australian Government in each of the ten priority areas are summarised in Table 5.

**Table 5: Relative responsibilities of Australian and State and Territory governments in each of the priority areas**

| Priority area | States & Territories | Australian Government |
|---|---|---|
| 1. Using outcome measurement to improve mental health care | • Establish systems for the full introduction of agreed consumer outcome measures.<br>• Ongoing workforce development.<br>• Implement system enhancements for clinician feedback reporting systems.<br>• Develop processes for state-level analysis and reporting of data.<br>• National reporting of agreed consumer outcomes data.<br>• Contribute to national forums for ongoing development of outcomes focus. | • Contribute the national perspective on the further development of outcome measurement in mental health including: review and refinement of core outcome measures; consumer and carer perceptions of care; indigenous consumer outcomes; carer outcomes; outcome measures for older persons.<br>• Coordinate the national infrastructure to support an outcomes focus in mental health (expert groups, AMHOCN).<br>• Manage the national-level analysis and reporting of data.<br>• Ongoing development of national specifications for collection and reporting of data. |
| 2. Further development of a mental health casemix classification | • Establishing systems for comprehensive collection and reporting of classification data.<br>• Collaborate in the further development of classification system. | • National-level analysis and reporting of casemix data.<br>• National coordination of further development of casemix classification for mental health. |
| 3. Using information to improve safety in mental health care | • Full implementation of National Standards for Mental Health Services.<br>• Implementation of local incident monitoring systems.<br>• Review state-level data sources for potential to contribute to national approach to safety in mental health care. | • Contribute the national perspective on development of safety indicators for mental health.<br>• Stimulate strategic research to improve safety in mental health care.<br>• Coordinate linkages with relevant national organisations. |
| 4. Establishing performance indicators and benchmarking in mental health services | • Implement national key performance indicator framework and indicators.<br>• Development of state reporting and monitoring arrangements.<br>• Collaborate in development of national benchmarking forums and development on the national performance framework for mental health. | • Development of arrangements for national-level reporting of performance indicators.<br>• Establish funding arrangements for national benchmarking forums.<br>• Contribute the national perspective on further development of the national performance framework for mental health. |
| 5. Strengthening workforce uptake and capacity to use information | • Promote approaches to use of data to support delivery and management of services.<br>• Ensure availability of reporting systems at service delivery level.<br>• Introduce new training programs to build clinical leadership in use of data. | • Development of a national communication strategy, through AMHOCN, to promote industry awareness of information development objectives.<br>• Establish arrangements for the development of national accreditation approaches for trainers in the collection and use of mental health information. |

**Table 5: Relative responsibilities of Australian and State and Territory governments in each of the priority areas** *(continued)*

| Priority area | States & Territories | Australian Government |
|---|---|---|
| 6. Improving national minimum data sets for mental health care | • Continue the collection and reporting of all national minimum data sets.<br>• Establish new state-level collection arrangements to replace functions of National Survey of Mental Health Services.<br>• Ongoing development of systems for the incorporation of NOCC datasets within State and Territory-level mainstream collections. | • Collaborate with States and Territories in ongoing development of minimum data sets.<br>• Establish a negotiated framework for incorporation of NOCC data within national minimum data sets.<br>• Contribute the national perspective on the further development of national data relating to community mental health care.<br>• Establish a process to develop nationally agreed mental health intervention codes.<br>• Review national health and welfare collections to improve relevance to mental health requirements. |
| 7. Information to support mental health care provided external to the specialist sector | • Contribute to the development of emergency department national data collections.<br>• Promote linkage between specialist mental health services and general practitioners. | • Lead the further development of an outcomes focus in primary mental health care.<br>• Explore options for incorporating outcomes information within general practice clinical information systems.<br>• Establish linkage to relevant national projects to improve information on emergency department mental health care. |
| 8. Monitoring population mental health and wellbeing | • Incorporate nationally agreed measures of mental health status in State and Territory level population surveys.<br>• Contribute to development of a nationally consistent, strategic approach to population surveillance. | • Lead the development of a nationally strategic approach to population surveillance.<br>• Lead negotiations on the implementation of future national surveys of mental health and wellbeing. |
| 9. Information to support mental health prevention and promotion | • Collaborate in the development and implementation of a 'promotion and prevention' scorecard to monitor State and Territory programs. | • Contribute to the development of a national 'promotion and prevention' scorecard monitoring system.<br>• Coordinate national research efforts including data linkage studies to establish a process for monitoring the impact of promotion and prevention programs. |
| 10. Monitoring and reporting of progress under the National Mental Health Strategy | • Develop alternative State and Territory-level collections to replace the functions of the National Survey of Mental Health Services.<br>• Report agreed data nationally for publication on progress of National Mental Health Strategy. | • Coordinate the regular publication of mental health data that inform judgements about the progress of the National Mental Health Strategy.<br>• Coordinate an independent evaluation of the National Mental Health Plan 2003-2008. |

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# Appendices

# Appendix A:
## Elements of the National Minimum Data Sets for Mental Health

| National Minimum Data Set for Admitted Patient Mental Health Care | |
|---|---|
| **Data elements** | **Supporting data elements and data element concepts** |
| • Additional diagnosis<br>• Admission date<br>• Area of usual residence<br>• Care type<br>• Country of birth<br>• Date of birth<br>• Diagnosis related group<br>• Employment status – acute hospital and private psychiatric hospital admissions<br>• Employment status – public psychiatric hospital admissions<br>• Establishment identifier<br>• Indigenous status<br>• Intended length of hospital stay<br>• Major diagnostic category<br>• Marital status<br>• Mental health legal status<br>• Mode of separation<br>• Person identifier<br>• Person identifier type – health care<br>• Principal diagnosis<br>• Referral to further care (psychiatric patients)<br>• Separation date<br>• Sex<br>• Source of referral to public psychiatric hospital<br>• Total leave days<br>• Total psychiatric care days<br>• Type of accommodation<br>• Type of usual accommodation | • Acute care episode for admitted patients<br>• Admission<br>• Admitted patient<br>• Diagnosis<br>• Episode of care<br>• Establishment number<br>• Establishment sector<br>• Hospital<br>• Patient<br>• Region code<br>• Separation<br>• State/Territory identifier |

| National Minimum Data Set for Community Mental Health Care | |
|---|---|
| **Data elements** | **Supporting data elements and data element concepts** |
| • Area of usual residence<br>• Country of birth<br>• Date of birth<br>• Establishment identifier<br>• Indigenous status<br>• Marital status<br>• Mental health legal status<br>• Person identifier<br>• Principal diagnosis<br>• Service contact date<br>• Sex | • Diagnosis<br>• Establishment number<br>• Establishment sector<br>• Region code<br>• Service contact<br>• State/Territory identifier |

| National Minimum Data Set for Residential Mental Health Care | |
|---|---|
| **Data elements** | **Supporting data elements and data element concepts** |
| • Additional diagnosis<br>• Area of usual residence<br>• Country of birth<br>• Date of birth<br>• Episode of residential care end date<br>• Episode of residential care end mode<br>• Episode of residential care start date<br>• Episode of residential care start mode<br>• Establishment identifier<br>• Indigenous status<br>• Leave days from residential care<br>• Mental health legal status<br>• Person identifier<br>• Principal diagnosis<br>• Referral from specialised mental health residential care<br>• Residential stay start date<br>• Sex | • Diagnosis<br>• Episode of residential care end<br>• Episode of residential care start<br>• Episode of residential care<br>• Establishment number<br>• Establishment sector<br>• Region code<br>• Resident<br>• Residential mental health care service<br>• Specialised mental health care service<br>• State/Territory identifier |

# Appendix B:

## Membership of Australian Health Ministers' Advisory Council (AHMAC) National Mental Health Working Group

*Current at February 2005*

### Chair (appointed by AHMAC)

Dr Tony Sherbon
Chief Executive
ACT Health

### State & Territory Representatives

Prof Beverley Raphael
Director, Centre for Mental Health, Department of Health
New South Wales

Ms Ann MacMillan
Manager Mental Health Unit, Queensland Health
Queensland

Mr Kevin Fjeldsoe
A/Manager, Mental Health Services, Department of Health & Human Services
Tasmania

Dr Peggy Brown
Director of Clinical Services, Mental Health ACT
Australian Capital Territory

Dr Jonathan Phillips
Clinical Associate Professor
Director Mental Health, Mental Health Unit
Department of Health
South Australia

Ms Bronwyn Hendry
Director
Mental Health, Department of Health and Community Services
Northern Territory

Dr Ruth Vine
Director, Mental Health, Department of Human Services
Victoria

Dr Aaron Groves
Director, Division of Mental Health, Department of Health
Western Australia

## Australian Government representatives

**Department of Health and Ageing**

Ms Marion Kroon
A/Assistant Secretary, Health Priorities & Suicide Prevention Branch

**Department of Veterans Affairs**

Mr Pablo Carpay
Branch Head, Younger Veterans Branch

## Consumer and Carer Representatives

Mr Keith Wilson (Carer Representative and Chair of Mental Health Council of Australia

Ms Helen Connor (Consumer Representative)

## Other organisations

**Strategic Planning Group for Private Psychiatric Services**

Dr Yvonne White
Chair, SPGPPS

Mr Phillip Taylor, Executive Officer (Observer)

**Primary Care**

Dr Julie Thompson
Chair, Better Outcomes in Mental Health Advisory Group

**New Zealand Ministry of Health**

Dr Janice Wilson (Official Observer)
Deputy Director – General
Mental Health Directorate

## Secretariat

Ms Alison Grant
Secretariat Manager
National Mental Health Working Group

# Appendix C:
## Membership of National Mental Health Information Strategy Committee

*Current at February 2005*

### Chair

Dr Aaron Groves
Director, Division of Mental Health
Department of Health, Western Australia

### Queensland

Ms Ruth Catchpoole
Manager, Systems and Outcomes,
Mental Health Unit
Queensland Health

### Victoria

Ms Lorna Payne
Manager, Service Monitoring & Review
Mental Health Branch
Department of Human Services

### Northern Territory

Mr Terry Barker
Mental Health Services
Department of Health and Community Services

### New South Wales

Mr Eugene McGarrell
Deputy Director, Information, Performance and Resource Management
Centre for Mental Health
NSW Health Department

### Western Australia

Ms Danuta Pawelek
Director
Systems Development
Division of Mental Health
Department of Health, WA

### Tasmania

Mr Raymond Kemp
Mental Health Services Tasmania
Department of Health and Human Services

### South Australia

Ms Chris Dayman
Manager, Policy and Information Knowledge Management
Department of Health

### Australian Capital Territory

Mr Mark Brown
Manager Outcomes
Mental Health ACT
ACT Health

### New Zealand

Ms Phillipa Gaines
Manager, Mental Health System Development
Mental Health Directorate
Ministry of Health

### Australian Institute of Health and Welfare

Ms Jenny Hargreaves
Head
Hospitals and Mental Health Unit

### Carer Representative

Ms Judy Hardy
Mental Health Council of Australia

### Consumer Representative

Ms Helen Connor
Mental Health Council of Australia

### Australian Bureau of Statistics

Ms Sally Goodspeed
Director
Health Section

### Steering Committee for the Review of Government Service Provision

Ms Julie Toth
Secretariat SCRGSP
Productivity Commission

### Strategic Planning Group for Private Psychiatric Services

Ms Moira Munro
Chief Executive Officer
Perth Clinic

### Australian Government

Ms Suzy Saw
A/g Director, Quality and Effectiveness Section
Health Priorities and Suicide Prevention Branch
Department of Health and Ageing

### Australian Health Information Council

Professor Helen Christensen
Centre for Mental Health Research

### National Health Performance Committee

Dr Indra Gajanayake
Assistant Director, Prevention and Performance Information Section, Health Information Policy Branch
Department of Health and Ageing

### Secretariat

Ms Janet Meuronen
Quality and Effectiveness Section, Health Priorities and Suicide Prevention Branch,
Department of Health and Ageing

### Observers

Mr Bill Buckingham
Buckingham & Associates Pty Ltd
Australian Government Consultant

Ms Gail Weaving
Hospitals and Mental Health Unit
Australian Institute of Health and Welfare

Mr Allen Morris-Yates
State Liaison Manager
Australian Mental Health Outcomes and Classification Network

# Appendix D:

## Contacts for information about mental health services

### Australian Government

Health Priorities and Suicide Prevention Branch
Health Services Improvement Division
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2601
Phone: (02) 6289 8070

### Northern Territory

Mental Health Branch
Department of Health and Community Services
PO Box 40596
CASUARINA NT 0811
Phone: (08) 8999 2553

### New South Wales

Centre for Mental Health
NSW Health Department
Locked Mail Bag 961
NORTH SYDNEY NSW 2059
Phone: (02) 9391 9307

### Victoria

Mental Health Branch
Department of Human Services
GPO Box 4057
MELBOURNE VIC 3001
Phone: (03) 9616 8592

### Queensland

Mental Health Unit
Queensland Health
GPO Box 48
BRISBANE QLD 4001
Phone: (07) 3234 0680

### Western Australia

Division of Mental Health
Department of Health Western Australia
189 Royal St
EAST PERTH WA 6004
Phone: (08) 9222 4099

### South Australia

Mental Health Unit
Department of Health
PO Box 287
Rundle Mall
ADELAIDE SA 5000
Phone: (08) 8226 6286

### Tasmania

Mental Health Services
Department of Health and Human Services
GPO Box 125
HOBART TAS 7001
Phone: (03) 6230 7727

### Australian Capital Territory

Mental Health ACT
ACT Health
GPO Box 825
CANBERRA ACT 2601
Phone: (02) 6207 1066