Measurement Strategy for

Connecting care to recovery

2016–2021

A plan for Queensland's State-funded mental health, alcohol and other drug services

Version 1

Queensland Government

Acknowledgment

The Queensland Government acknowledges and respects traditional owners and Aboriginal and Torres Strait Islander elders past and present, on whose land we work to support the provision of safe and quality healthcare.

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Measurement Strategy for '*Connecting care to recovery 2016-2021: a plan for Queensland's State-funded mental health, alcohol and other drug services', Version 1*

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Measurement Strategy for '*Connecting care to recovery 2016-2021: a plan for Queensland's State-funded mental health, alcohol and other drug services*'

Version 1

April 2017

Contents

Introduction

'*Connecting care to recovery 2016-2021: A plan for Queensland's state-funded mental health, alcohol and other drug services'* (*Connecting care to recovery*), released 10 October 2016, sets the direction and highlights priorities for action and investment across the state-funded health system.

Building on the vision of *My health, Queensland's future: Advancing health 2026* (*Advancing health 2026*), *Connecting care to recovery* focuses on strengthening collaboration and integration across the service system to respond more effectively to individuals with the most severe illness or problematic substance misuse, either episodic or persistent.

Connecting care to recovery aims to continue building more person-centred and recovery-oriented services and focuses effort across five priority areas (Figure 1). Underpinning these priority areas are the fundamental concepts of engaging with individuals, families and carers in all that we do and ensuring services are safe and continually improving.

Figure 1: Priority areas of *Connecting Care to Recovery 2016-2021*

Purpose

This measurement strategy provides a framework for the regular monitoring of the implementation of *Connecting care to recovery*, performance of services and the individual outcomes associated with receiving mental health and alcohol and other drugs care. It replaces the existing Queensland Health mental health alcohol and other drugs performance management framework released in 2013.

The focus of the strategy will be to inform monitoring of change over time and assist in identifying tangible levers for closing the gap between actual performance and targeted outcomes. It is anticipated that this strategy will offer insights into the progress of reform and help ensure that progress and initiatives remain aligned to the goals of *Connecting care to recovery*. Initially the capacity of this framework to achieve its purpose is limited by availability of comprehensive and consistent data sets, however, a range of actions under *Connecting care to recovery* are designed to develop and enhance information assets.

An independent evaluation will provide further assessment, utilising both qualitative and quantitative measurement, on whether *Connecting care to recovery*'s initiatives have improved the delivery of services and positively influenced the lives of persons accessing mental health and alcohol and other drug care.

Scope

The mental health, alcohol and other drugs service system is complex, with aspects of the system funded and administered by several levels of government and complemented by private health

arrangements. The system includes population based universal services, such as promotion and prevention as well as a range of bed-based and community treatment and support services.

Whilst *Connecting care to recovery* aims to strengthen collaboration and integration across all components of the system, the scope is on state-funded treatment and support services for individuals. Although private and primary health services are a critical factor in integrated service delivery, they are not state funded and therefore not in scope for this measurement strategy.

Broader performance environment

Queensland's mental health alcohol and other drugs services are subject to a number of state and national safety, quality, reform and performance systems, each with their own focus, governance and reporting requirements (Figure 2).

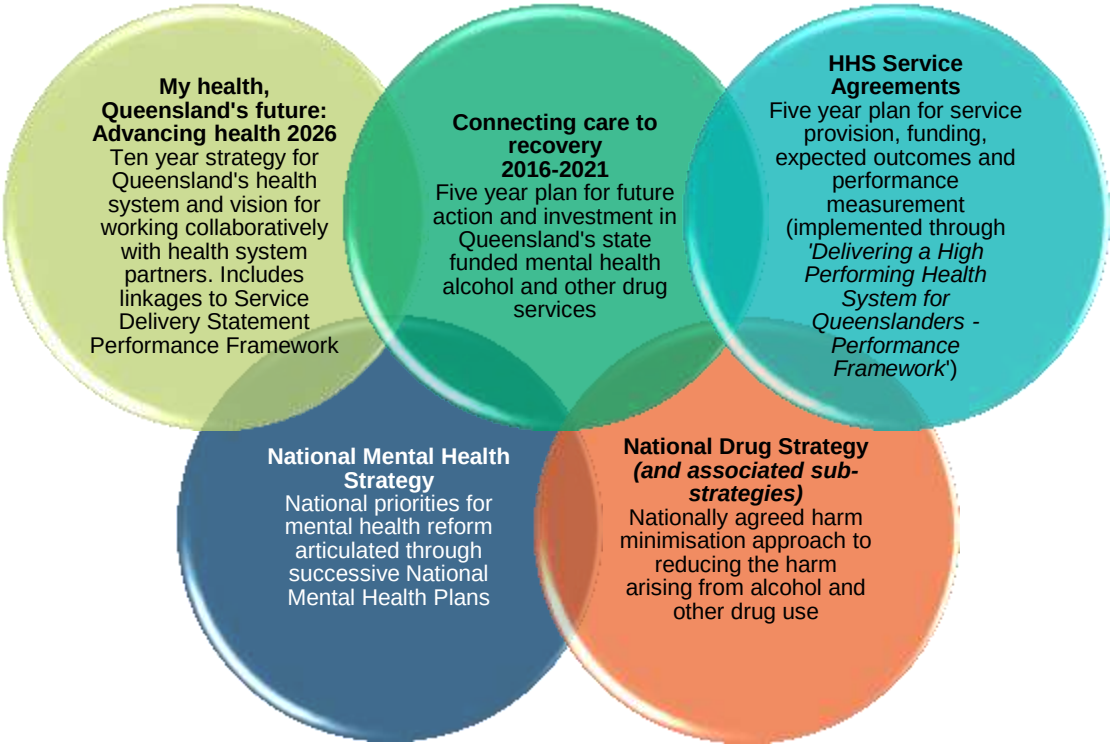

Figure 2: Performance drivers for Queensland's state-funded mental health and alcohol and other drug services

Although each plan and strategy serves a specific function within the overarching systems, there are parallels between their strategic objectives and expectations, and consequently in the areas of performance that are considered important to monitor.

The measurement strategy incorporates a number of indicators utilised in existing frameworks, such as the *Service Delivery Statements* and *Delivering a High Performing Health System for Queenslanders – Performance Frameworks*. This enables the measurement strategy to more closely align to broader, strategic frameworks and reduces potential for duplication of effort required to review, understand and change performance.

Framework for measurement

The measurement strategy is structured around a framework (Figure 3) that identifies three focus areas, which are further defined by a number of performance domains.

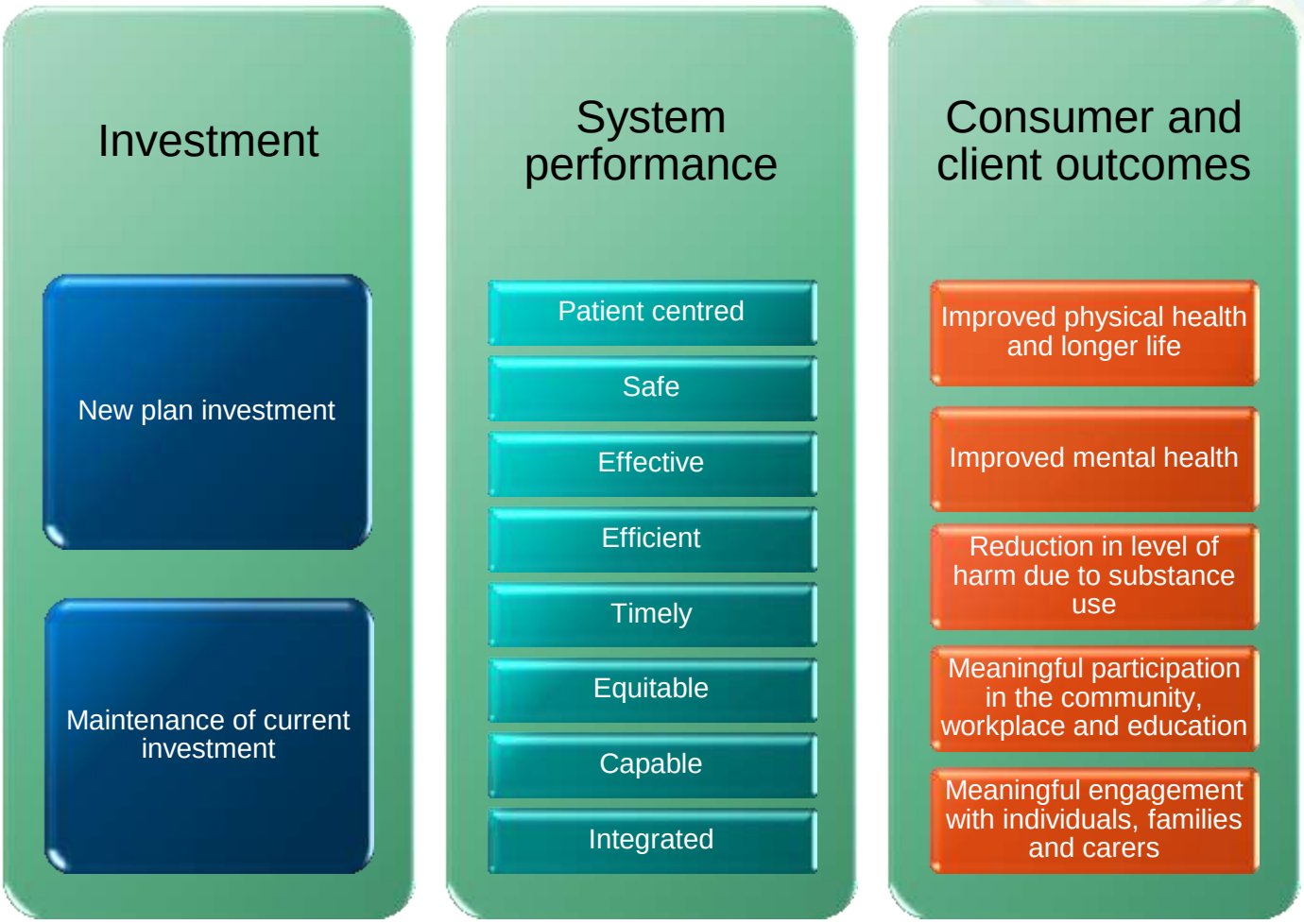

Figure 3: Overarching measurement framework

Areas of focus

The three areas of focus align with *Connecting care to recovery*'s deliverables:

- *Investment* refers to the inputs (financial and otherwise) that are available to deliver and reform service delivery
- *System performance* refers to the business processes, standards and policies that are implemented with the aim of changing or enhancing service delivery and, where possible, the outcomes of those processes
- *Consumer and client outcomes* refers to the impact of service delivery and reform on individual consumers and clients.

Performance domains

Each focus area contains a number of performance domains that articulate the most salient aspects of service delivery. Table 1 provides an overview of the identified domains, which align to state and national structures wherever possible and appropriate. The performance domains are generally reflective of the domains utilised in other performance frameworks, with additions to specifically address priorities of *Connecting care to recovery*.

Table 1: Summary of performance domains

Investment	
New plan investment	*Maintenance of current investment*
Investment identified through *Connecting care to recovery* is utilised as agreed	Current investment in the sector is maintained and aligns to the priorities of *Connecting care to recovery*

System performance		
Patient centred	*Safe*	*Effective*
Services provide healthcare that is respectful of and responsive to consumers' preferences, needs and values	Potential risks of an intervention or the environment are identified and avoided, or minimised	Care, intervention or action achieves desired outcomes
Efficient	*Timely*	*Equitable*
Achieving desired results through value for money investments	Ability of people to obtain health care at the right place and right time	Ability of people to obtain health care irrespective of income, geography and cultural background

Capable	*Integrated*
An individual or service's capacity to provide a health service based on skills and knowledge	People receive a continuum of healthcare through effective collaboration and coordination across providers

Consumer and client outcomes		
Improved physical wellbeing and longer life	*Improved mental health*	*Reduction in level of harm due to substance use*
Supporting people to monitor, maintain and improve their physical wellbeing	Good mental health and wellbeing is the foundation of thriving and prosperous individuals, families, communities and the economy	Reducing and preventing adverse health consequences associated with unsafe drug and alcohol use

Meaningful participation in the community, workplace and education	*Meaningful engagement with individuals, families and carers*
Supporting people living with mental health and substance use issues to be engaged in their communities and to be able to access housing, education and employment	Individuals, families and carers are involved in the full spectrum of health care, from policy development and legislation, to delivery and evaluation of services

Performance indicators

Performance measurement generally uses four main types of indicators (Figure 4). Determination of the type of indicators is based upon the purpose of the indicator as well as availability of appropriate data. Historically, measurement has focused on input, process and output measures. This is due in part to availability of data and infancy of measurement systems with mental health and alcohol and other drug services. The health sector is now placing a greater emphasis on outcome measures. All four types of performance indicators are included in the measurement strategy, providing a broad range of information on state-funded mental health and alcohol and other drug services.

The indicators included within this measurement strategy have been identified through a number of mechanisms including: a review of existing state, national and international performance frameworks; identification and assessment of available data sources; and consultation with stakeholders. A critical decision point was being able to identify a current data source or a data source that will be available within the first year of *Connecting care to recovery*.

Table 2 lists the initial set of core indicators, mapped against focus area and primary domain. Core indicators focus on delivery against *Connecting care to recovery's* strategic objectives. Due to limitations of available data, this initial indicator set is dominated by measures for mental health treatment services delivered through Queensland Health. As implementation of *Connecting care to recovery* progresses, new and improved data sources will be available for enhanced reporting and monitoring of alcohol and other drug and community managed mental health services.

It is difficult for a small set of indicators to provide a comprehensive picture of the performance of a broad and complex system. As a result a number of context indicators have been identified to provide a broader assessment of performance and will primarily be reported to support understanding and investigation of core indicators. Context indicators are also listed in Table 2.

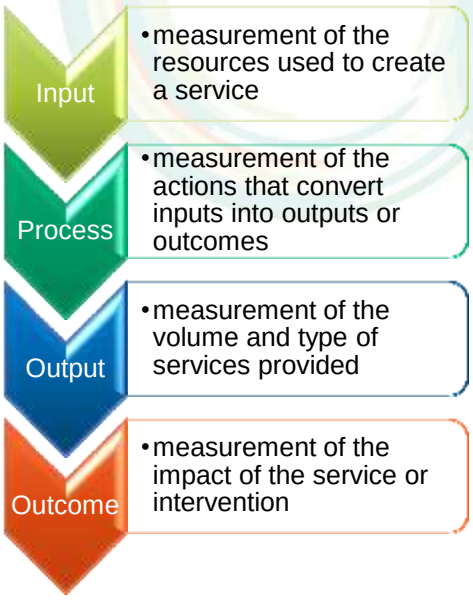

Figure 4: Types of indicators

Table 2: Summary of performance indicators

Investment		
Domain	**Indicators**	
	Core	Context
New plan investment	Queensland Government investment in mental health and alcohol and other drugs services	
	Mental health expenditure by service sector setting	
Maintenance of current allocation	Per capita expenditure in mental health and alcohol and other drug services	• Full Time Equivalent (FTE) staff employed by public mental health service organisations per 100,000 population • FTE staff employed by community managed mental health services per 100,000 population

System performance		
Domain	**Indicators**	
	Core	Context
Patient centred	Positive experience of mental health service	
	Proportion of mental health service episodes with a documented care plan	
	Rate of face-to-face community mental health follow up within 1-7 days following discharge from an acute mental health inpatient unit	
	Rate of community mental health contact in the 1-7 days prior to admission to an acute mental health inpatient unit	Rate of community mental health contact for *existing* consumers of public mental health services in the 1-7 days prior to admission to an acute mental health inpatient unit

System performance		
Domain	**Indicators**	
	Core	Context
Safe	Rate of seclusion events per 1,000 acute mental health admitted patient days	• Average duration of seclusion events • Proportion of mental health admitted patient episodes with at least one seclusion event
	Rate of absent without approval from acute inpatient care per 1,000 acute involuntary accrued patient days	Rate of involuntary treatment in public mental health services
	Proportion of presentations to Emergency Departments due to intentional self-harm with community mental health follow-up within 1-7 days	
Effective	Change in mental health consumers' clinical outcomes	• Proportion of outcome collection occasions where required clinical outcome measures were recorded • Proportion of ambulatory outcome collection occasions with completed consumer self-assessment outcome measures
	Proportion of readmissions to specialised acute mental health care within 28 days of discharge	
	Proportion of community alcohol and other drug treatment episodes completed as planned	Average length of completed community alcohol and other drug treatment episodes
	Rate of retention of clients in Opioid Treatment Services	
Efficient	Average length of acute inpatient stay in specialised mental health services	
	Proportion of valid community mental health treatment packages	Average treatment days per community mental health treatment package
Timely	Average duration from initial referral to contact with community mental health service	• Average duration of referrals to public community mental health services • Proportion of referrals to public community mental health services with a provision of service in which the consumer or carer participates
Equitable	Proportion of population accessing public specialised mental health services	
	Proportion of population accessing community alcohol and other drug treatment services	
	Rate of contact in community managed mental health organisations per 1,000 population	
Capable	-	
Integrated	-	

Consumer and client outcomes		
Domain	Indicators	
	Core	Context
Improved physical wellbeing and longer life	Mortality gap for persons accessing public specialised mental health services	
	Mortality gap for persons accessing public community alcohol and other drug treatment services	
	Proportion of overnight separations from specialised mental health inpatient units where the smoking cessation pathway is offered to patients	
	Proportion of specialised community mental health service episodes with physical health assessments	
	Rate of suicide of persons in contact with public health services	
Improved mental health	-	
Reduction in level of harm due to substance use	-	
Meaningful participation in the community, workplace and education	-	
Meaningful engagement with individuals, families and carers	Your Experience of Service (YES) survey response rate	
	Proportion of community mental health service episodes where consumers' carer or family member is involved in care	Proportion of community mental health service episodes where consumers' carers or family members are identified

Target setting

Performance indicators measure the extent to which goals are achieved; while targets provide the 'markers' on the measurement scale that define the desired levels of performance. Identified targets have been informed by research, policy, expert opinion and consensus and assessed against the SMART criteria (that is, **S**pecific, **M**easureable, **A**chievable, **R**ealistic and **T**imely).

Target setting for many of the measurement strategy indicators is an evolving process and in some instances relies on an incomplete evidence base. As not all indicators within the measurement strategy are 'target ready', targets are only identified for a subset of indicators. As the evidence becomes available targets may be reviewed, set and/or modified to align to best practice and/or national standards (wherever possible).

Reporting, monitoring and governance

Regular reporting and monitoring is critical to the evaluation of performance, identification of emerging performance issues and ensuring confidence in Queensland's mental health, alcohol and other drugs service system. The Mental Health Alcohol and Other Drugs Branch is operationally responsible for the measurement strategy and will fulfil a reporting and monitoring role, as well as conducting an annual review of the indicator set to maintain currency and relevance.

Measurement strategy indicators are applicable to state-funded mental health and alcohol and other drug services, including those delivered through Hospital and Health Services (HHSs) and community managed or non-government organisations. It is important to note that not all indicators are applicable to all of these services and the initial indicator set is heavily biased towards the mental health treatment services delivered by HHSs. However, it is expected that as the foundation for data capture and reporting improves, there will be enhanced capability for performance reporting and monitoring across the other sectors.

Reporting against the indicator set will occur at multiple levels and at different intervals depending upon the purpose of the specific indicator, although availability of source data will influence the level and frequency of reporting. In general the system performance measures will be reported back to services on a regular basis (primarily monthly) and at lower levels that can be rolled up to organisational levels as required. Reporting will incorporate different population groups where appropriate, for example Indigenous and non-Indigenous populations.

Existing and new monitoring arrangements will be used to showcase and learn from areas of high and improved performance and provide an opportunity to discuss and escalate potential issues and areas of concern. When a performance concern is identified, consideration will be given to both the need for potential intensive support and whether adverse performance is consistent with the overall trajectory. Escalation will depend on the nature and severity of the issue and an assessment of the services' capacity to resolve the issue. The Mental Health Alcohol and Other Drugs Branch will engage with individual HHSs and non-government organisations in relation to performance trends and to address emerging risks or issues. Other divisions in the Department of Health with an active role in performance matters will be engaged as required. Performance issues requiring formal action or response will be managed through existing processes, including the HHS Performance Review process managed by the Healthcare Purchasing and System Performance Division. A high level summary of these processes is outlined in Figure 5.

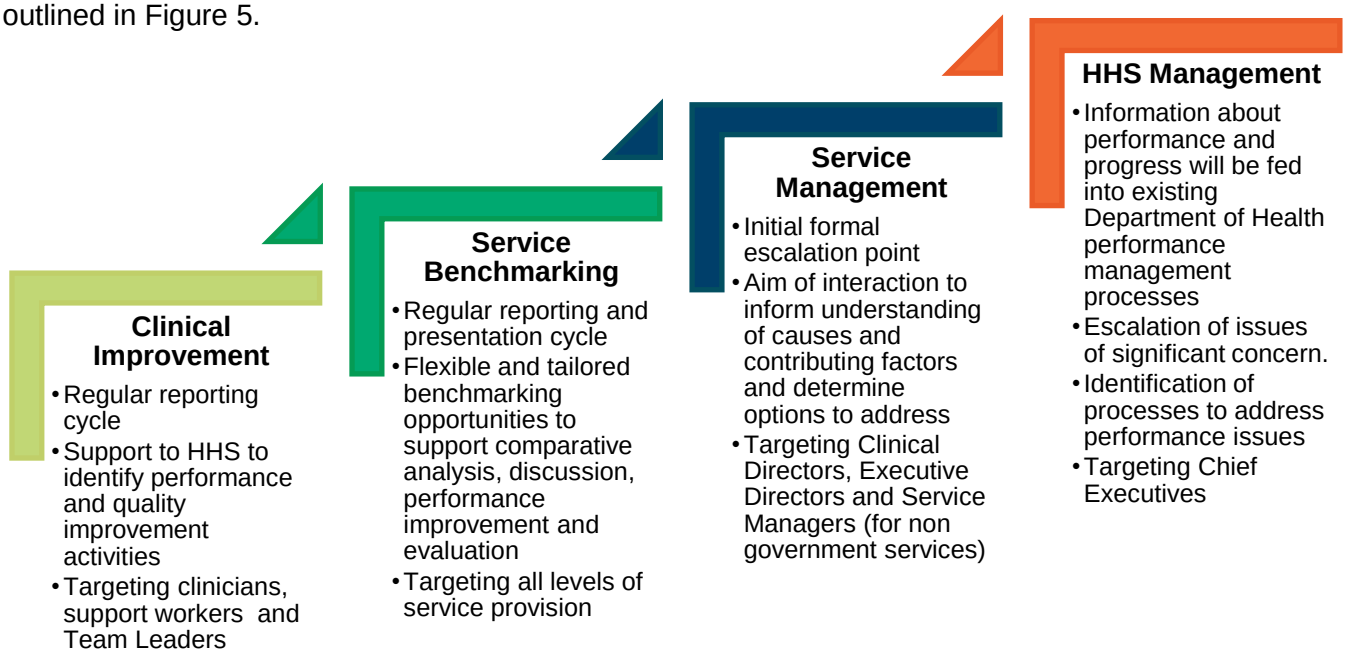

Figure 5: Reporting and monitoring processes

Data development

Connecting care to recovery is the first plan to focus on mental health and alcohol and other drugs service delivery across both government and non-government sectors. However, the majority of indicators identified within the initial set focus on public sector clinical mental health service delivery. This is due to the considerable investment made in information development for these services that has not been replicated in the other sectors.

A number of initiatives identified in *Connecting care to recovery* aim to improve the quality and availability of data across the sectors. As the building blocks are developed and implemented, new and

replacement measures will be incorporated into the measurement strategy. It is anticipated that the number of measures may be reduced as the impact of the new plan's initiatives come to fruition.

A range of actions outlined in priority three of *Connecting care to recovery* aim to improve the availability, quality and accessibility of data across all service delivery sectors, including:

- Building data and information assets associated with the alcohol and other drugs sector, community managed organisations and consumers, families and carers.
- Enhancing capability of the Consumer Integrated Mental Health Application (CIMHA) to meet the clinical and service delivery requirements for the mental health and alcohol and other drug services.
- Building capabilities of the Integrated Mental Health Data Reporting Repository (IMHDRR) to respond to changing information needs.
- Creating a Single Care Plan capability that is accessible to public, private, community managed organisations and primary health care services.

There is a significant information development program of work being progressed that complements initiatives identified in *Connecting care to recovery* and will provide the foundation for improved monitoring and reporting.

For the alcohol and other drug services provided through Queensland Health the focus is on delivering a system that supports the clinical and business requirements, with the aim of enhancing quality and availability of information to support clinical treatment and reporting, creating efficiencies in business processes and data entry, and improving integration of services. For community managed mental health services the Mental Health Non-Government Organisation Establishments (NGOe) Data Collection will be implemented statewide from 2016-17. The NGOe will support the collection and reporting of consistent information about the community managed mental health services funded to provide mental health services.

Keeping measurement relevant

To maintain its relevance and enable incorporation of improvements to data sources, the measurement strategy will be reviewed biennially. The aim will be to refine the indicator set, where appropriate and identify new or alternate indicators, particularly for those domains and service sectors where there are limited or no indicators currently identified. The review will also factor in outcomes of progress of implementation of *Connecting care to recovery* initiatives and consider the impact of significant state and national events, such as the finalisation of the Fifth National Mental Health and Suicide Prevention Plan and the roll out of the National Disability Insurance Scheme (NDIS).

Summary of indicators

This section provides a high level overview of the core indicator set, with the format and definitions as specified below. Comprehensive specifications, including a glossary of terms, detailed scope and methodology of both core and context indicators are available in the complementary Technical Supplement.

Indicator title	
Focus area: *The focus area the indicator maps to*	**Domain:** *The primary domain that the indicator maps to*
Rationale	The issues and reasons for inclusion of the indicator within the indicator set
Service sector	The component(s) of the state-funded system for which the indicator will be constructed and reported. These are primarily categorised as: • All state-funded mental health and alcohol and other drug services • Specialised public mental health services provided by Hospital and Health Services • Mental health community managed organisations • Community alcohol and other drug services provided by Hospital and Health Services • Alcohol and other drug services provided by non-government organisations
Description	An explanation of the specific service or performance to be measured
Numerator	A description of the number above the line in a fraction showing how many of the parts indicated by the denominator are taken
Denominator	A description of the number below the line
Calculation	The formula used to calculate the indicator
Presentation	A description of the type of number used to present the indicator
Indicator type	Identifies whether the indicator measures inputs, processes, outputs or outcomes
Data source(s)	The origin of the data used to populate the indicator. There may be one or multiple sources for each measure
Disaggregation(s)	Lists possible stratifications of the indicator that may prove beneficial to monitoring performance against the measure
Data availability	The frequency of collection of source data
Baseline year	The first year of reporting that acts as a reference point for measurement and change
Context indicator(s)	A list of indicators that will provide a broader assessment of performance and primarily reported to support understanding and investigation of core indicators. The detailed specifications for context indicators are available in the complementary Technical Supplement.
Target	
Target	Agreed targets informed by research, policy, best practice and/or national standards, expert opinion and consensus and assessed against the **SMART** criteria
Rationale	An explanation of the target and the vision for achieving goals
Notes	
Any additional information relevant to the indicator	

Queensland Government investment in mental health and alcohol and other drugs services	
Focus area: *Investment*	**Domain:** *New plan investment*
Rationale	New investment is critical to achieving the objectives of strategic reform. However, it needs to be expended in an appropriate and timely manner against agreed priority areas and timetable
Service sector	All state-funded mental health and alcohol and other drug services
Description	Proportion of expenditure as per agreed schedule of investment within the reference period against identified government investment priority areas: • providing Queenslanders with access to appropriate services • workforce development and optimisation of skills and scope • better use of information and communication technology (ICT) • early identification and intervention in response to suicide risk • strengthen patient's rights through the *Mental Health Act 2016*
Numerator	Actual expenditure against agreed priority areas within the reference period
Denominator	Planned expenditure against agreed priority areas within the reference period
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage
Indicator type	Input
Data source(s)	Specific reporting managed through Mental Health Alcohol and Other Drugs Branch
Disaggregation(s)	Priority area
Data availability	Annual
Baseline year	2016-17
Context indicator(s)	
Target	
Target	100%
Rationale	The identified investment should be expended as per agreed timetable and planning with the aim of full expenditure by the end of *Connecting care to recovery*
Notes	
Not all initiatives outlined in *Connecting care to recovery* will be funded by the $350 million investment identified for the plan. Funding for initiatives will also be complemented through other sources. Where appropriate, additional funding will be reported through this measure	

Mental health expenditure by service sector setting	
Focus area: *Investment*	**Domain:** *New plan investment*
Rationale	• Mental health care is provided across a number of service sectors and settings. It has been an objective of multiple reforms to increase the investment in community based services, including residential, clinical and support • In particular, growth in the community managed mental health sector is a key strategy of *Connecting care to recovery* and is consistent with the national objective to build a viable and sustainable community managed mental health sector
Service sector	• Specialised public mental health services provided by Hospital and Health Services • Mental health community managed organisations
Description	Proportion of direct expenditure on specialised mental health services by service sector and setting within the reference period
Numerator	Direct expenditure on specialised mental health services within the reference period, partitioned by service sector (community managed and specialised public mental health services) and setting (acute inpatient, extended treatment inpatient and community)
Denominator	Direct expenditure on specialised mental health services within the reference period
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage, partitioned by service sector setting
Indicator type	Input
Data source(s)	Mental Health Establishment Collection
Disaggregation(s)	Service sector
Data availability	Annual
Baseline year	2015-16
Context indicator(s)	
Target	
Target	
Rationale	
Notes	

Per capita expenditure in mental health and alcohol and other drug services	
Focus area: *Investment*	**Domain:** *Maintenance of current allocation*
Rationale	• The level of investment across the mental health and alcohol and other drug sectors has varied significantly across the past two decades • New investment can often come at the cost of existing investment
Service sector	All state-funded mental health and alcohol and other drug services
Description	Per capita expenditure on mental health and alcohol and other drug services by service sector during the reference period
Numerator	Total expenditure by service sector within the reference period
Denominator	Queensland Estimated Resident Population within the reference period
Calculation	Numerator ÷ Denominator
Presentation	Number
Indicator type	Input
Data source(s)	• Mental Health Establishment Collection • Queensland Health Finance Decision Support System • Service Level Agreements (community managed and non-government organisations) • Australian Bureau of Statistics Estimated Resident Population
Disaggregation(s)	Service sector
Data availability	Annual
Baseline year	2015-16
Context indicator(s)	• Full Time Equivalent (FTE) staff employed by public mental health service organisations per 100,000 population • FTE staff employed by community managed mental health services per 100,000 population
Target	
Target	Maintenance of baseline
Rationale	The new investment made in *Connecting care to recovery* should build upon, not divert, existing funding. Ideally, per capita expenditure should at a minimum be maintained at current levels in line with population growth
Notes	
Adjustments for inflation will be required to enable comparison over time	

Positive experience of mental health services	
Focus area: *System performance*	**Domain:** *Patient centred*
Rationale	Consumers' perceptions of health care has long been identified by services, consumers, carers and families as important to better understanding how health services are performing and to drive service quality improvement
Service sector	Specialised mental health services provided by Hospital and Health Services
Description	Total Your Experience of Service (YES) index score
Numerator	Total score associated with completed questions to the YES survey within the reference period
Denominator	Number of completed questions to the YES survey within the reference period
Calculation	Numerator ÷ Denominator
Presentation	Number
Indicator type	Outcome
Data source(s)	Your Experience of Service Collection
Disaggregation(s)	*Service variables*: Hospital and health service, service setting, target population, special service type, treating unit
Data availability	Annual
Baseline year	2015
Context indicator(s)	
Target	
Target	
Rationale	
Notes	

- The baseline year is only relevant for those services that participated in the collection. One Hospital and Health Service did not participate in 2015
- The YES survey was developed nationally and released for use in public mental health services in 2015, however, work on refining appropriate reporting and performance measurement is ongoing. As the program of work continues, this measure may be modified to align to the national reporting
- Development of a YES survey for mental health community managed organisations is ongoing at a national level. Expansion of the indicator to incorporate this sector will be considered once data becomes available

Proportion of mental health service episodes with a documented Care Plan		
Focus area: *System performance*		**Domain:** *Patient centred*
Rationale	• Care planning is an essential part of health care. Care plans articulate the goals, preferences and treatment priorities that clinicians provide to consumers, carers and their families • All consumers must have a care plan on record within six weeks of being accepted into a service, and plans should be updated at least every 91 days (Queensland Health, 2017)	
Service sector	Specialised mental health services provided by Hospital and Health Services	
Description	The proportion of open service episodes within the reference period where a Care Plan has been documented and/or reviewed within the service episode or within a 91-day period	
Numerator	Number of open service episodes within the reference period where a Care Plan has been documented and/or reviewed within the service episode or within a 91-day period	
Denominator	Number of open service episodes within the reference period	
Calculation	(Numerator ÷ Denominator) x 100	
Presentation	Percentage	
Indicator type	Process	
Data source(s)	Consumer Integrated Mental Health Application (CIMHA)	
Disaggregation(s)	*Service variables*: Hospital and health service, service setting, target population, special service type, treating unit	
Data availability	Continuous	
Baseline year	2017-18	
Context indicator(s)		
Target		
Target		
Rationale		
Notes		
Prior to March 2017, Care Plans were a component of a clinical note that also documented regular review of care. As a consequence it is not possible to identify the quantity of Care Plans developed for consumers of mental health services prior to implementation of the new clinical note template		

Rate of face to face community follow up within 1-7 days following discharge from an acute mental health inpatient unit	
Focus area: *System performance*	**Domain:** *Patient centred*
Rationale	• A responsive community support system for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission • Consumers leaving hospital after a psychiatric admission with a formal discharge plan, involving linkages with community services and supports, are less likely to need early readmission • Research indicates that consumers have increased vulnerability immediately following discharge, including higher risk of suicide
Service sector	Specialised mental health services with acute mental health inpatient units provided by Hospital and Health Services
Description	Proportion of overnight in-scope separations from an acute mental health inpatient unit(s) within the reference period for which an ambulatory mental health service contact, in which the consumer participated face-to-face (that is, in person or via videoconference), occurred in the 1-7 days following that separation
Numerator	Number of overnight in-scope separations from acute mental health inpatient unit(s), for which an ambulatory mental health service contact, in which the consumer participated face-to-face (that is, in person or via videoconference), occurred in the 1-7 days following that separation
Denominator	Number of overnight in-scope separations from acute mental health inpatient unit(s) occurring within the reference period.
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage
Indicator type	Process
Data source(s)	• Queensland Hospital Admitted Patient Data Collection (QHAPDC) • Mental Health Activity Data Collection (MHADC)
Disaggregation(s)	• *Service variables*: Hospital and health service, facility, target population, discharge ward • *Consumer variables*: Indigenous status
Data availability	Continuous
Baseline year	2015-16
Context indicator(s)	
Target	
Target	>65%
Rationale	The state target is based upon a nationally recommended target with modifications to account for variation in specification
Notes	
There is a similar indicator reported annually through national publications. The variation in the Queensland specification is that only face-to-face interactions are considered	

Rate of community mental health contact in the 1-7 days prior to admission to an acute mental health inpatient unit	
Focus area: *System performance*	**Domain:** *Patient centred*
Rationale	• To monitor continuity and accessibility of care via the extent to which public sector community mental health services are involved with consumers prior to being admitted into hospital, with the aim to: – monitor and manage increasing acuity of clinical presentation – support and alleviate distress during a period of great turmoil – relieve carer burden – avert hospital admission where possible – ensure that admission is the most appropriate treatment option – commence treatment of the patient as soon as possible where admission may not be averted • The majority of consumers admitted to public sector acute psychiatric inpatient units are known to public sector community mental health services and it is reasonable to expect community teams should be involved in pre-admission care for the majority of patients
Service sector	Specialised mental health services with acute mental health inpatient units provided by Hospital and Health Services
Description	Proportion of overnight in-scope admissions to acute mental health inpatient unit(s) within the reference period for which an ambulatory mental health service contact, in which the consumer participated, occurred in the 1-7 days immediately preceding the day of admission
Numerator	Number of overnight in-scope admissions to acute mental health inpatient unit(s) within the reference period for which an ambulatory mental health service contact, in which the consumer participated, occurred in the 1-7 days immediately preceding the day of admission
Denominator	Number of overnight in-scope admissions to an acute mental health inpatient unit(s) occurring within the reference period
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage
Indicator type	Process
Data source(s)	• Queensland Hospital Admitted Patient Data Collection (QHAPDC) • Mental Health Activity Data Collection (MHADC)
Disaggregation(s)	• *Service variables*: Hospital and health service, facility, target population, admitting ward • *Consumer variables*: Indigenous status
Data availability	Continuous
Baseline year	2015-16
Context indicator(s)	Rate of community mental health contact for existing consumers of mental health services in the 1-7 days prior to admission to an acute mental health inpatient unit
Target	
Target	>70%
Rationale	Nationally recommended target in the Fourth National Mental Health Plan measurement strategy
Notes	

Rate of seclusion events per 1,000 acute mental health admitted patient days	
Focus area: *System performance*	**Domain:** *Safe*
Rationale	• The reduction, and where possible, elimination of seclusion in mental health services has been identified as a priority in the publication *National safety priorities in mental health: a national plan for reducing harm* • This measure focuses on reducing the use of seclusion generally • High levels of seclusion are widely regarded as inappropriate treatment, and may point to inadequacies in the functioning of the overall system and risks to the safety of consumers receiving mental health care • The use of seclusion in public sector mental health service organisations is regulated under the *Mental Health Act 2016*
Service sector	Specialised mental health services with acute mental health inpatient units provided by Hospital and Health Services
Description	The number of seclusion events per 1,000 accrued admitted patient days in acute specialised mental health services, within the reference period
Numerator	Number of seclusion events occurring in acute specialised mental health services within the reference period
Denominator	Number of accrued admitted patient days in acute specialised mental health services within the reference period
Calculation	(Numerator ÷ Denominator) x 1,000
Presentation	Number
Indicator type	Outcome
Data source(s)	• Consumer Integrated Mental Health Application (CIMHA) • Queensland Hospital Admitted Patient Data Collection (QHAPDC)
Disaggregation(s)	• *Service variables*: Hospital and health service, facility, service setting, target population, ward • *Consumer variables*: Indigenous status
Data availability	Continuous
Baseline year	2015-16
Context indicator(s)	• Average duration of seclusion events • Proportion of episodes where at least one seclusion event • Rate of involuntary treatment in mental health services
Target	
Target	• ≤10 (acute general adult and older persons) • ≤15 (acute child and adolescent)
Rationale	Targets have been determined using nationally reported averages and expert advice from Queensland clinical mental health services
Notes	

- The *Mental Health Act 2016* came into effect on 5 March 2017, prior to this date the use of seclusion was regulated by the *Mental Health Act 2000*. The change in legislation is unlikely to impact upon trend analysis
- The disaggregation of this measure requires the use of different data source to historically reported data, which only had aggregate accrued patient days available

Rate of absent without approval from acute inpatient care per 1,000 acute involuntary accrued patient days	
Focus area: *System performance*	**Domain:** *Safe*
Rationale	• Involuntary patients leaving inpatient care against medical advice or without approval is a safety risk for patients and others • There is potential to improve patient safety and quality of care by reducing the number of patients who become absent without approval from specialised mental health inpatient units • The management of patients absent without approval from treatment is regulated under the *Mental Health Act 2016*
Service sector	Specialised mental health services with acute mental health inpatient units provided by Hospital and Health Services
Description	The number of absent without approval (AWA) events from general adult acute specialised mental health inpatient units per 1,000 acute involuntary mental health accrued patient days
Numerator	Number of absent without approval events from general adult acute specialised mental health services within the reference period
Denominator	Number of accrued patient days for involuntary patients in general adult acute specialised mental health inpatient unit(s) within the reference period
Calculation	(Numerator ÷ Denominator) x 1,000
Presentation	Number
Indicator type	Outcome
Data source(s)	• Consumer Integrated Mental Health Application (CIMHA) • Queensland Hospital Admitted Patient Data Collection (QHAPDC)
Disaggregation(s)	• *Service variables*: Hospital and health service, facility, ward • *Consumer variables*: Indigenous status
Data availability	Continuous
Baseline year	2015-16
Context indicator(s)	Rate of involuntary treatment in mental health services
Target	
Target	≤4.1
Rationale	The target aims to act as a tool to drive process and systemic change and as a measure against which to monitor the progress of service improvements. This target has been set in the context of current and previous performance of Hospital and Health Services
Notes	
The *Mental Health Act 2016* came into effect on 5 March 2017, prior to this date management of patients absent without approval from treatment was regulated by the *Mental Health Act 2000*. The change in legislation is unlikely to impact upon trend analysis	

Proportion of presentations to Emergency Departments due to Intentional Self-Harm with community mental health follow-up within 1-7 days	
Focus area: *System performance*	**Domain:** *Safe*
Rationale	• The risk of the person dying by suicide in the first year after an episode of self-harm has been found to be more than 50 times greater than the general population (Cooper et al. 2005; Hawton, Zahl & Weatherall, 2003) • The more serious the level of suicidal intent at the time of self-harm, the greater the risk of subsequent suicide (Harriss, Hawton & Zahl, 2005) • A high proportion of people have had contact with a healthcare professional in the months, weeks or days prior to their suicide attempt or death by suicide • Public mental health services and other acute healthcare settings such as emergency departments therefore play a crucial role in assessing and managing suicide risk
Service sector	Specialised mental health services provided by Hospital and Health Services
Description	Proportion of presentations to Emergency Departments due to *Intentional Self Harm* where the person was not admitted to the same or another hospital within the reference period, for which a mental health provision of service, in which the consumer participated, occurred in the 1-7 days following that presentation
Numerator	Number of presentations to Emergency Departments where the primary diagnosis is *Intentional Self Harm* where the person was not admitted to the same or another hospital within the reference period, for which a mental health provision of service, in which the consumer participated, occurred in the 1-7 days following that presentation
Denominator	Number of presentations to Emergency Departments where the primary diagnosis is *Intentional Self Harm* and the person was not admitted to the same or another hospital within the reference period
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage
Indicator type	Outcome
Data source(s)	• Emergency Department Collection (EDC) • Consumer Integrated Mental Health Application (CIMHA)
Disaggregation(s)	• *Service variables*: Hospital and Health Service, facility • *Consumer variables*: Indigenous status
Data availability	Continuous
Baseline year	2015-16
Context indicator(s)	
Target	
Target	
Rationale	
Notes	
• The construction of this measure is dependent upon coding of primary diagnosis within emergency department records. Therefore it is likely to be an under-representation of persons presenting to emergency with self-harm • There will be instances where a person declines follow-up from a specialised mental health service or is appropriately referred to other primary or private health services	

Change in mental health consumers' clinical outcomes	
Focus area: *System performance*	**Domain:** *Effective*
Rationale	• Mental health services aim to reduce symptoms and improve functioning. Their effectiveness can be compared using routinely collected measures. This will assist in service benchmarking and quality improvement • The implementation of routine mental health outcome measurement in Queensland provides the opportunity to monitor the effectiveness of mental health services across the state
Service sector	Specialised mental health services provided by Hospital and Health Services
Description	The proportion of specialised mental health service episodes within the reference period, partitioned by consumer grouping (*completed acute inpatient, completed community and ongoing community*), where there was: *statistically significant improvement*, *statistically significant deterioration*, or *no statistically significant change*, identified between baseline and follow up scores of completed outcome measures from the Health of the Nation Outcome Scale (HoNOS) family
Numerator	Number of service episodes within the reference period with completed outcome measures from the HoNOS family, partitioned by consumer grouping, where either significant change/significant deterioration/no significant change was identified between baseline and follow-up
Denominator	Number of service episodes within the reference period with completed outcome measures from the HoNOS family at baseline and follow-up, partitioned by consumer grouping
Calculation	(Numerator ÷ Denominator) x 100, partitioned by significance and consumer groupings
Presentation	Percentage
Indicator type	Outcome
Data source(s)	Consumer Integrated Mental Health Application (CIMHA)
Disaggregation(s)	• *Service variables*: Hospital and health service, service setting, target population, ward • *Consumer variables*: Indigenous status
Data availability	Continuous
Baseline year	2015-16
Context indicator(s)	• Proportion of outcome collection occasions where required clinical outcome measures were recorded • Proportion of community mental health service episodes with completed consumer self-assessment outcome measures
Target	
Target	
Rationale	
Notes	

Proportion of readmissions to specialised acute mental health care within 28 days of discharge	
Focus area: *System performance*	**Domain:** *Effective*
Rationale	• Readmissions to an acute mental health unit following a recent discharge may indicate that inpatient treatment was incomplete or ineffective, or that follow-up care was inadequate to maintain the person's treatment out of hospital. In this sense, rapid readmissions may point to deficiencies in the functioning of the overall care system • Avoidable rapid readmissions place pressure on finite beds and may reduce access to care for other consumers in need • International literature identities one month as an appropriate defined time period for the measurement of unplanned readmissions following separation from an acute psychiatric inpatient unit
Service sector	Specialised mental health services with acute mental health inpatient units provided by Hospital and Health Services
Description	Proportion of overnight in-scope separations from acute mental health inpatient unit within the reference period that are followed by an in-scope admission to same or another acute mental health inpatient unit within 28 days of the initial separation
Numerator	Number of overnight in-scope separations from acute mental health inpatient units within the reference period that are followed by an in-scope admission to the same or another acute mental health inpatient unit within 28 days of the initial in-scope separation
Denominator	Number of overnight in-scope separations from acute mental health inpatient unit within the reference period
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage
Indicator type	Process
Data source(s)	Queensland Hospital Admitted Patient Data Collection (QHAPDC)
Disaggregation(s)	• *Service variables*: Hospital and health service, target population, discharge ward • *Consumer variables*: Indigenous status
Data availability	Continuous
Baseline year	2015-16
Context indicator(s)	
Target	
Target	≤12%
Rationale	Nationally recommended target in the Fourth National Mental Health Plan measurement strategy
Notes	

Proportion of community alcohol and other drug treatment episodes completed as planned	
Focus area: *System performance*	**Domain:** *Effective*
Rationale	• A range of evidence-based treatment types are delivered by Alcohol and Other Drug Treatment Services across the state • The proportion of treatment episodes completed as planned can be indicative of effectiveness of service delivery and that an agreed treatment plan was concluded • Effective services will impact on a range of client outcome domains
Service sector	• Community alcohol and other drug services provided by Hospital and Health Services • Alcohol and other drug services provided by non-government organisations
Description	The proportion of community alcohol and other drug treatment episodes for *counselling*, *rehabilitation*, *withdrawal management*, or *case management*, that were completed as planned within the reference period
Numerator	Number of community alcohol and other drug treatment episodes where the main treatment type was identified as *counselling*, *rehabilitation*, *withdrawal management*, or *case management*, that were completed as planned within the reference period
Denominator	Number of community alcohol and other drug treatment episodes where the main treatment type was identified as *counselling*, *rehabilitation*, *withdrawal management*, or *case management*, that ended because treatment was completed or the client ceased to participate, within the reference period
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage
Indicator type	Outcome
Data source(s)	Alcohol and Other Drug Treatment Services National Minimum Data Set
Disaggregation(s)	• *Service variables*: Hospital and health service, agency, main treatment type • *Client variables*: Indigenous status, Principal Drug of Concern
Data availability	Annual
Baseline year	2015-16
Context indicator(s)	Average length of completed community alcohol and other drug treatment episodes
Target	
Target	-
Rationale	-
Notes	
Data specific to services provided by Queensland Health alcohol and other drug services is available on a continuous basis. The data availability is limited by current arrangements in place for submission of non-government organisation data to the National Minimum Data Set	

Rate of retention of clients in Opioid Treatment Services	
Focus area: *System performance*	**Domain:** *Effective*
Rationale	• Research shows that the length of time and continuity of treatment in alcohol and other drug treatment programs predicts treatment success. However, high treatment attrition rates present a major obstacle to improving treatment outcomes (Porter 2013) • Clients should be encouraged to remain in treatment for at least 12 months to ensure enduring lifestyle changes • Opioid treatment services should routinely monitor retention rates as a quality activity and aim for retention rates of at least 40 per cent at 12 months (Queensland Health 2012) • In 2015, 7.5 per cent of clients in the Queensland Opioid Treatment Program (QOTP) accessed treatment for the first time. The majority of clients (65.3 per cent) were continuing treatment and the remaining 27.2 per cent) re-entered treatment after a lapse (Australian Institute of Health and Welfare 2015)
Service sector	Community alcohol and other drug services provided by Hospital and Health Services
Description	The proportion of public Queensland Opioid Treatment Program (QOTP) treatment episodes where the client remains continuously in treatment for at least a 12 month period
Numerator	Number of public QOTP treatment episodes where the client completes treatment or remains continuously in treatment for at least a 12 month period
Denominator	Number of QOTP treatment episodes commenced within the reference period
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage
Indicator type	Outcome
Data source(s)	Monitoring of Drugs of Dependence System (MODDS)
Disaggregation(s)	
Data availability	Annual
Baseline year	2015
Context indicator(s)	
Target	
Target	
Rationale	
Notes	
Although the data source covers both public and private prescribers, the scope of this measure is only on services delivered through Queensland Health	

Average length of acute inpatient stay in specialised mental health services	
Focus area: *System performance*	**Domain:** *Efficient*
Rationale	• Length of stay is a key driver of variation in admitted patient day costs and reflects differences between mental health service organisations practice and casemix, or both • The aim of this indicator is to better understand the factors' underlying variation (such as costs) as well as providing a basis for utilisation review. For example, it allows for the assessment of services provided to particular consumer groups against clinical protocols developed for those groups
Service sector	Specialised mental health services with acute mental health inpatient units provided by Hospital and Health Services
Description	The average length of stay (in days) of overnight in-scope separations from specialised acute mental health inpatient units within the reference period
Numerator	Number of accrued patient days in specialised acute mental health inpatient units accounted for by overnight in-scope separations from those units during the reference period
Denominator	Number of overnight in-scope separations from specialised acute mental health inpatient units occurring within the reference period
Calculation	Numerator ÷ Denominator
Presentation	Number
Indicator type	Process
Data source(s)	Queensland Hospital Admitted Patient Data Collection (QHAPDC)
Disaggregation(s)	• *Service variables*: Hospital and health service, facility, target population, discharge ward • *Consumer variables*: Indigenous status
Data availability	Continuous
Baseline year	2015-16
Context indicator(s)	
Target	
Target	
Rationale	
Notes	

Proportion of valid community mental health treatment packages	
Focus area: *System performance*	**Domain:** *Efficient*
Rationale	• There are a number of standards, policies and protocols that underpin the delivery of community mental health care that are intended to support the provision of efficient and effective treatment and care • Conceptualisation of community mental health services is complex, due in part to the extended and variable nature of contact with services. Packages of care provide a mechanism to consistently frame the significant volume of work undertaken by these services and align them to core standards and policies
Service sector	Specialised mental health services provided by Hospital and Health Services
Description	The proportion of completed community mental health treatment packages of care within the reference period that meet the identified minimum expectations
Numerator	Number of community mental health treatment packages of care ended within the reference period that meet the identified minimum expectations related to diagnosis, consumer participation, case review and collection of mandatory clinical outcome measures
Denominator	Number of community mental health treatment packages of care ended within the reference period
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage
Indicator type	Process
Data source(s)	Consumer Integrated Mental Health Application (CIMHA)
Disaggregation(s)	*Service variables*: Hospital and health service, target population, special service type, treating unit
Data availability	Continuous
Baseline year	2015-16
Context indicator(s)	Average treatment days per community mental health treatment package
Target	
Target	≥75%
Rationale	Ideally all packages of care should meet minimum expectations; however the target has been set in the context of current performance of Hospital and Health Services with the aim of incremental improvement over subsequent years
Notes	
The underlying model that supports the community mental health packages of care has been revised for 2016-17 based on feedback and advice from mental health services. The baseline year will be recalculated based on the new model	

Average duration from initial referral to contact with community mental health service	
Focus area: *System performance*	**Domain:** *Timely*
Rationale	The need for timely and appropriate triage and assessment is critical to the safety, effectiveness and efficiency of the provision of mental health services
Service sector	Specialised mental health services provided by Hospital and Health Services
Description	The average duration (in days) from initial referral to community mental health services within the reference period to the first provision of service in which the consumer, their carer or family member participated
Numerator	Number of days between initial referral to a community mental health service within the reference period to the first provision of service in which the consumer, their carer or family member participated
Denominator	Number of referrals to a community mental health service within the reference period with a provision of service in which the consumer, their carer or family member participated
Calculation	Numerator ÷ Denominator
Presentation	Number
Indicator type	Process
Data source(s)	Consumer Integrated Mental Health Application (CIMHA)
Disaggregation(s)	• *Service variables*: Hospital and health service, target population, special service type, treating unit • *Consumer variables*: Indigenous status, involuntary status, usual residence
Data availability	Continuous
Baseline year	2015-16
Context indicator(s)	• Average duration of referrals to public community mental health services • Proportion of referrals to public community mental health services with a provision of service in which the consumer participates
Target	
Target	
Rationale	
Notes	

Proportion of population accessing public specialised mental health services	
Focus area: *System performance*	**Domain:** *Equitable*
Rationale	Access to specialised clinical services is an area of ongoing concern expressed by consumers, carers and the wider community
Service sector	Specialised mental health services provided by Hospital and Health Services
Description	The proportion of unique persons who have a specialised mental health community or admitted patient service episode open at any point during the reference period
Numerator	Number of unique persons who have a public specialised mental health community or admitted patient service episode open at any point during the reference period
Denominator	Queensland Estimated Resident Population within the reference period
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage
Indicator type	Output
Data source(s)	• Consumer Integrated Mental Health Application (CIMHA) • Queensland Hospital Admitted Patient Data Collection (QHAPDC) • Australian Bureau of Statistics Estimated Resident Population
Disaggregation(s)	
Data availability	Annual
Baseline year	2015-16
Context indicator(s)	
Target	
Target	
Rationale	
Notes	
There is a similar indicator reported annually through national publications titled population under care. The variation in the national specification is that it also includes consumers who are only seen within referrals for triage and/or assessment	

Proportion of population accessing community alcohol and other drug treatment services	
Focus area: *System performance*	**Domain:** *Equitable*
Rationale	Access to specialised services is an area of ongoing concern in terms of the ability of the sectors to meet existing and evolving demand for treatment services, and ensuring services are available for different population groups including people living in regional and remote locations, from culturally diverse backgrounds and for people experiencing social and other disadvantage
Service sector	• Community alcohol and other drug services provided by Hospital and Health Services • Alcohol and other drug services provided by non-government organisations
Description	The proportion of persons with completed community alcohol and other drug treatment episodes during the reference period
Numerator	Number of unique persons with completed community alcohol and other drug treatment episodes during the reference period
Denominator	Queensland Estimated Resident Population within the reference period
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage
Indicator type	Output
Data source(s)	• Alcohol and Other Drug Treatment Services National Minimum Data Set • Australian Bureau of Statistics Estimated Resident Population
Disaggregation(s)	
Data availability	Annual
Baseline year	2015-16
Context indicator(s)	
Target	
Target	
Rationale	
Notes	
The measure is limited to completed treatment episodes by the scope of the National Minimum Data Set and the need to use its Statistical Linkage Key to identify unique clients	

Rate of contact in community managed mental health organisations per 1,000 population	
Focus area: *System performance*	**Domain:** *Equitable*
Rationale	• Community managed, recovery-oriented services that understand the impacts of stigma and discrimination and promote social inclusion are essential for supporting people affected by mental illness • Growth in the community managed mental health sector is a key strategy of *Connecting care to recovery* and is consistent with the national objective to build a viable and sustainable community managed mental health sector
Service sector	Mental health community managed organisations
Description	Rate of contact in community managed mental health organisations per 1,000 population
Numerator	Number of contacts (group and individual) in community managed mental health organisations within the reference period
Denominator	Queensland Estimated Resident Population within the reference period
Calculation	(Numerator ÷ Denominator) x 1,000
Presentation	Number
Indicator type	Process
Data source(s)	• Mental Health Non-Government Organisation Establishments (NGOe) Data Collection • Australian Bureau of Statistics Estimated Resident Population
Disaggregation(s)	*Service variables:* Service type
Data availability	Annual
Baseline year	2016-17
Context indicator(s)	
Target	
Target	
Rationale	
Notes	
This measure can only be constructed for a subset of community managed organisations as not all service types within the NGOe report mental health contact level data	

Mortality gap for persons accessing public mental health services	
Focus area: *Consumer and client outcomes*	**Domain:** *Improved physical wellbeing and longer life*
Rationale	• People with severe mental disorders on average tend to die earlier than the general population. There is a 10-25 year life expectancy reduction in patients with severe mental disorders (WHO 2014). The vast majority of these deaths are due to chronic physical medical conditions such as cardiovascular, respiratory and infectious diseases, diabetes and hypertension • The excess mortality associated with mental illness has been extensively documented, and research indicates that the gap in life expectancy of persons with a mental illness compared with the general population has widened over the past 20 years (Lawrence et al. 2013)
Service sector	Specialised mental health services provided by Hospital and Health Services
Description	The difference (in years) of the average life expectancy of persons accessing treatment from public specialised mental health services compared to the Queensland estimated resident population
Numerator	The average life expectancy of persons accessing treatment from public specialised mental health services in Queensland
Denominator	The average life expectancy of Queenslanders
Calculation	Numerator - Denominator
Presentation	Number
Indicator type	Outcome
Data source(s)	• Queensland Register-General's Death Register • Consumer Integrated Mental Health Application (CIMHA) • Queensland Hospital Admitted Patient Data Collection (QHAPDC) • Australian Bureau of Statistics Life Tables (Queensland Government's Statistician's Office)
Disaggregation(s)	
Data availability	Five-yearly
Baseline year	2013-2015
Context indicator(s)	
Target	
Target	Incremental reduction in gap
Rationale	Factors influencing changes in life expectancy are complex and multi-faceted and change will be incremental. It is not expected that there will be a significant, if any, shift during the five year life of *Connecting care to recovery*
Notes	
• To account for variability from small cohorts, particularly at younger ages where there are small numbers of deaths and at very old ages where the population at risk is small, the construction of this measure will rely upon methodology and assumptions tested in published research, abridged life tables and use of three year periods • There is a known overlap in the cohort for this measure with the cohort accessing public community alcohol and other drug treatment services	

Mortality gap for persons accessing public community alcohol and other drug treatment services	
Focus area: *Consumer and client outcomes*	**Domain:** *Improved physical wellbeing and longer life*
Rationale	• Drug use continues to exact a significant toll, with valuable human lives and productive years of many persons being lost (UNODC, 2015) • Excessive consumption of alcohol and other drugs is associated with poorer health and social problems (UNODC, 2015)
Service sector	Community alcohol and other drug services provided by Hospital and Health Services
Description	The difference (in years) of the average life expectancy of persons accessing treatment from public community alcohol and other drug treatment services compared to the Queensland estimated resident population
Numerator	The average life expectancy of persons accessing treatment from public community alcohol and other drug treatment services in Queensland
Denominator	The average life expectancy of Queenslanders
Calculation	Numerator - Denominator
Presentation	Number
Indicator type	Outcome
Data source(s)	• Alcohol Tobacco and Other Drug Services – Information System (ATODS-IS) • Queensland Register-General's Death Register • Australian Bureau of Statistics Life Tables (Queensland Government's Statistician's Office)
Disaggregation(s)	
Data availability	Five-yearly
Baseline year	2013-2015
Context indicator(s)	
Target	
Target	Incremental reduction in gap
Rationale	Factors influencing changes in life expectancy are complex and multi-faceted and change will be incremental. It is not expected that there will be a significant, if any, shift during the five year life of *Connecting care to recovery*
Notes	

- To account for variability from small cohorts, particularly at younger ages where there are small numbers of deaths and at very old ages where the population at risk is small, the construction of this measure will rely upon methodology and assumptions tested in published research, abridged life tables and use of three year periods
- There is a known overlap in the cohort for this measure with the cohort accessing public specialised mental health services

Proportion of overnight separations from specialised mental health inpatient units where the smoking cessation pathway is offered to patients	
Focus area: *Consumer and client outcomes*	**Domain:** *Improved physical wellbeing and longer life*
Rationale	• Compared to the general population, consumers with a mental illness have higher smoking rates, higher levels of nicotine dependence and lower cessation rates • Despite smokers with a mental illness being as motivated to quit as the general population, and cessation being linked to improved physical and mental health, they are less likely to be offered support to quit
Service sector	Specialised mental health services provided by Hospital and Health Services
Description	The proportion of overnight separations from specialised mental health units within the reference period where the patient identified as a smoker and was offered the smoking cessation pathway
Numerator	Number of overnight separations from specialised mental health units within the reference period where the patient identified as a smoker and was offered the smoking cessation pathway
Denominator	Number of overnight separations from specialised mental health units within the reference period where the patient identified as a smoker
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage
Indicator type	Process
Data source(s)	Queensland Hospital Admitted Patient Data Collection (QHAPDC)
Disaggregation(s)	• *Service variables:* Hospital and health service, facility, service setting, target population, discharge ward • *Consumer variables:* Indigenous status, age
Data availability	Continuous
Baseline year	2015-16
Context indicator(s)	
Target	
Target	
Rationale	
Notes	
There are limitations in terms of the scope of services and applicability of the available data set, which is only collected for patients who are aged 18 years or more at the time of admission and have a length of stay of two or more nights. The data is only available from October 2015	

Proportion of specialised community mental health service episodes with physical health assessments	
Focus area: *Consumer and client outcomes*	**Domain:** *Improved physical wellbeing and longer life*
Rationale	• Consumers with a serious mental illness are known to experience significantly higher rates of physical illness than the general population and are at high risk of not receiving appropriate physical healthcare • Physical health assessment equals metabolic monitoring clinical note and/or provision of service (POS) intervention of physical assessment
Service sector	Specialised mental health services provided by Hospital and Health Services
Description	The proportion of community mental health service episodes open within the reference period where there is a metabolic monitoring assessment clinical note or a physical health assessment provision of service within the service episode or within a six-month period
Numerator	Number of community mental health service episodes open within the reference period where there is a metabolic monitoring assessment clinical note or a physical health assessment provision of service within the service episode or within a six-month period
Denominator	Number of community mental health service episodes open within the reference period
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage
Indicator type	Process
Data source(s)	Consumer Integrated Mental Health Application (CIMHA)
Disaggregation(s)	• *Service variables:* Hospital and health service, target population, special service type, treating unit • *Consumer variables:* Indigenous status, age
Data availability	Continuous
Baseline year	2015-16
Context indicator(s)	
Target	
Target	
Rationale	
Notes	

Rate of suicide of persons in contact with public health services per 100,000 population	
Focus area: *Consumer and client outcomes*	**Domain:** *Improved physical wellbeing and longer life*
Rationale	• Reducing suicide and its impact requires leadership and action from all parts of our community at all levels, including government and non-government service providers • The Queensland Suicide Prevention Health Initiative will convene a cross sector Suicide Prevention Health Taskforce focussed on strengthening the capacity of health services across both the public and primary care sectors to respond to the needs of people at risk of suicide • Mental Health and alcohol and other drug services play an important leadership role in cooperating with other local health service providers to plan and deliver health services aimed at reducing suicide
Service sector	Public health services (inpatient, community and emergency)
Description	The number of suicides by persons who had contact with a Queensland public health service within seven (7) days of death, per 100,000 population
Numerator	Number of suicides by persons who had contact with a Queensland public health service within seven days of death, per 100,000 population
Denominator	Queensland Estimated Resident Population within the reference period
Calculation	(Numerator ÷ Denominator) x 100,000
Presentation	Percentage
Indicator type	Process
Data source(s)	• Queensland Register-General's Death Register • Consumer Integrated Mental Health Application (CIMHA) • Queensland Hospital Admitted Patient Data Collection (QHAPDC) • Emergency Department Collection (EDC) • Alcohol Tobacco and Other Drug Services – Information System (ATODS-IS) • Australian Bureau of Statistics Estimated Resident Population
Disaggregation(s)	• *Consumer variables:* Indigenous status, age, sex
Data availability	Annual
Baseline year	2015
Context indicator(s)	Rate of suicide per 100,000 population
Target	
Target	Reduction
Rationale	Suicide prevention activities have been shown to have a positive effect in reducing suicide. However, factors influencing the rate of suicide are complex and multi-faceted and broader than the public health system. Change will be incremental and it is not expected that there will be a significant shift during the five-year life of *Connecting care to recovery*
Notes	
The data sources that are available to be linked for the calculation do not cover all health services provided in Queensland	

Your Experience of Service (YES) survey response rate		
Focus area: *Consumer and client outcomes*		**Domain:** *Meaningful engagement with individuals, families and carers*
Rationale	• Provision of high quality services that are responsive to the needs of consumers and carers is central to the reform of mental health services in Queensland • Engaging with consumers and their families supports improvements in service delivery	
Service sector	Specialised mental health services provided by Hospital and Health Services	
Description	The proportion of Your Experience of Service (YES) surveys offered that were completed and returned within the reference period	
Numerator	Number of YES surveys completed and returned for the collection period	
Denominator	Number of YES surveys potentially offered within the collection period	
Calculation	(Numerator ÷ Denominator) x 100	
Presentation	Percentage	
Indicator type	Process	
Data source(s)	• Your Experience of Service Collection • Consumer Integrated Mental Health Application (CIMHA)	
Disaggregation(s)	*Service variables*: Hospital and health service, service setting, target population, special service type, treating unit	
Data availability	Annual	
Baseline year	2016	
Context indicator(s)		
Target		
Target	-	
Rationale	-	
Notes		
The methodology for determining rate of offering has varied over the life of the collection. A new methodology and scope will be implemented for the 2016 collection		

Proportion of community mental health service episodes where a consumers' carer or family member is involved in care	
Focus area: *Consumer and client outcomes*	**Domain:** *Meaningful engagement with individuals, families and carers*
Rationale	• Provision of high quality services that are responsive to the needs of consumers and carers is central to the reform of mental health services in Queensland • Engaging with consumers and their families supports improvements in service delivery
Service sector	Specialised mental health services provided by Hospital and Health Services
Description	The proportion of community mental health service episodes where a consumers' carer or family member is involved in care
Numerator	Number of open community mental health service episodes during the reference period where there was a carer or family member identified and where there was at least one Provision of Service with a carer or family member within the service episode or within a 91 day period
Denominator	Number of open community mental health service episodes during the reference period where there was a carer or family member identified
Calculation	(Numerator ÷ Denominator) x 100
Presentation	Percentage
Indicator type	Process
Data source(s)	Consumer Integrated Mental Health Application (CIMHA)
Disaggregation(s)	• *Service variables*: Hospital and health service, service setting, target population, special service type, treating unit • *Consumer variables*: Indigenous status
Data availability	Continuous
Baseline year	2015-16
Context indicator(s)	Proportion of community mental health service episodes where a consumers' carer or family member are identified as external contacts
Target	
Target	
Rationale	
Notes	

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