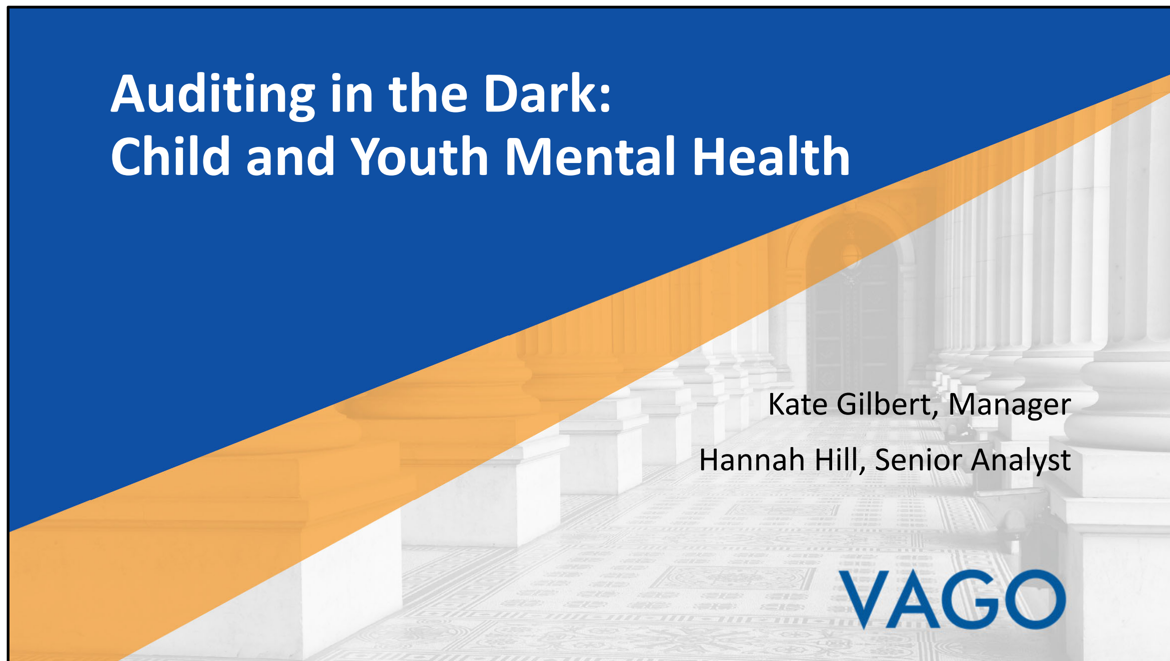


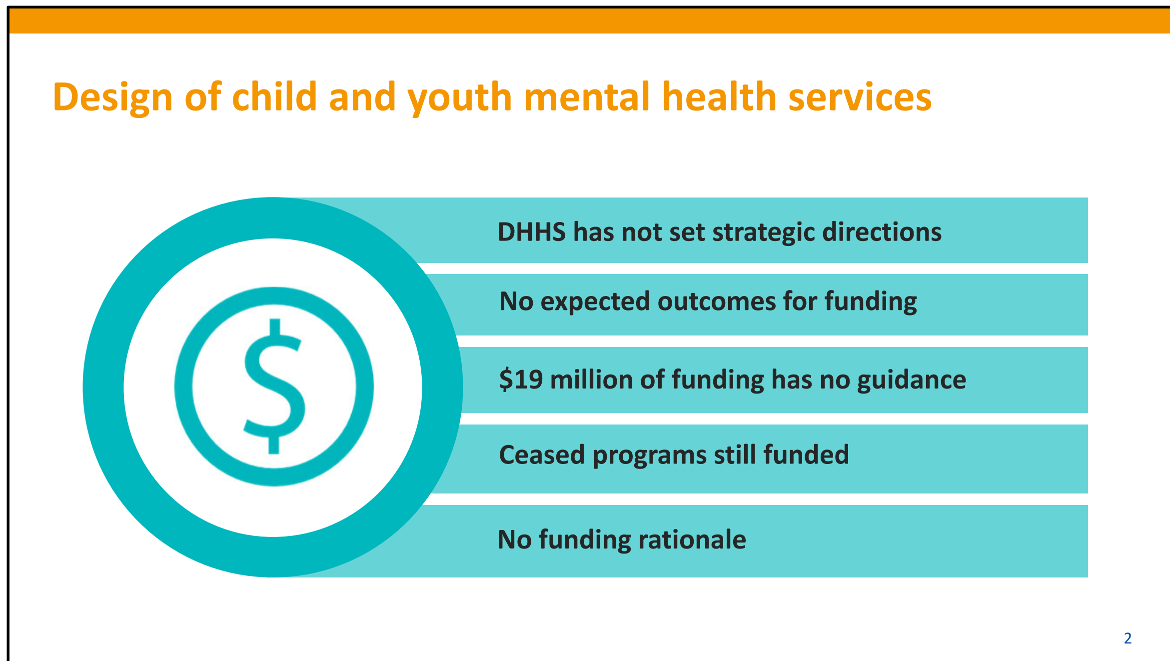
In May 2019, the Victorian Auditor-General tabled a performance audit which was the first substantial, publicly released review of child and youth mental health services in Victoria.

I managed that audit and Hannah was the senior analyst.

We are going to talk with you today about the methodology we designed for this audit, and how we approached the difficult, but not that uncommon situation for performance auditors, of finding yourself auditing in the dark.

The darkness refers to a few different issues we unearthed in the early stages:

- There had never before been an independent review in this area.
- There was no clear expectations or standards which had been set to measure performance against
- There are different definitions of what constitutes “children and youth”, some excluding young children under 4, others not, some “cutting off” variously at 165, 18 or 25. There is essentially no correct answer. There are even more complex variations in the types and severity of mental health issues that this service is and isn’t designed for.



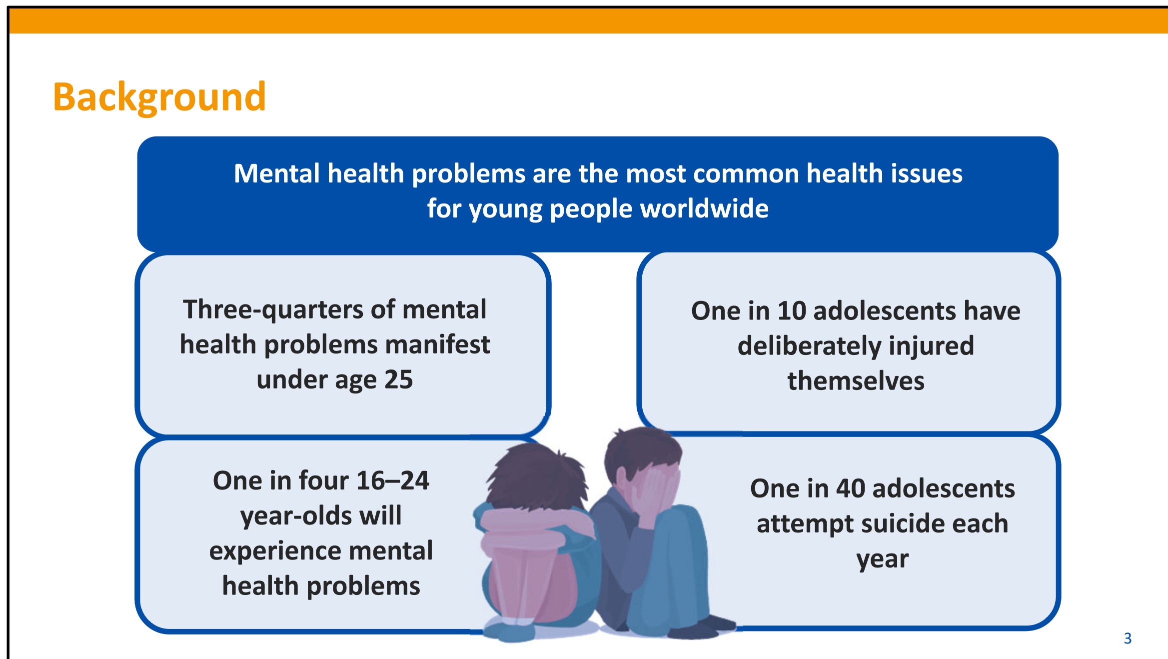
This is the first of our findings from the audit, which shows the problem we encountered in more detail:

- 1. The Department of Health and Human Services (DHHS) had not produced a strategic framework for child and youth mental heath, and work to produce one had stalled.

→ so we could not draw a picture of what you'd expect these services to deliver and look for how well they were achieving that?

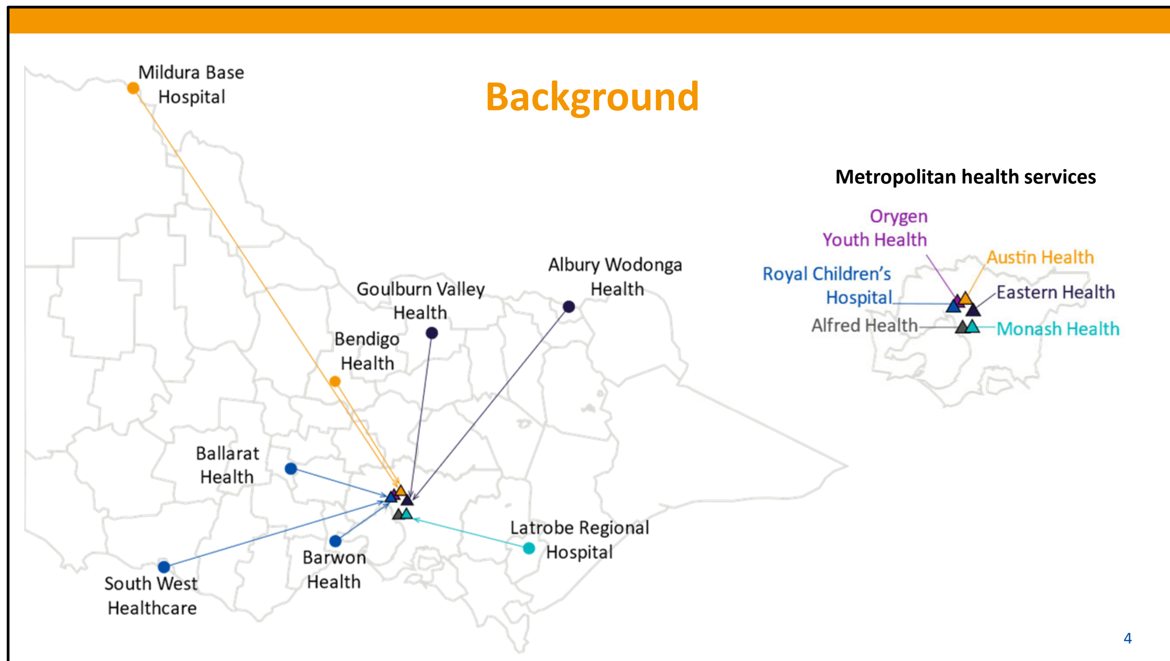
- 2. DHHS hadn't set outcomes for most of the funding they provided to services. We also found that only two out of 14 programs delivered in the community had any guidelines, four had brief descriptions and eight had no guidance at all. These programs account for $19 million in funding. In addition, we found that DHHS still funds some programs which have technically ceased.

→ at the program level, there was also no clear picture of what was funded or the expectations of that funding, which you could measure performance against.



To backtrack a little to why we chose to look at such a difficult audit topics:

- Mental Health problems are the most common health issues facing young people worldwide. Three quarters of all mental health problems manifest in people before the age of 25, with one in four young Australians aged 16-24 experiencing mental health problems in any given year.
- The likelihood of mental health problems increases exponentially where there are other indicators of vulnerability such as unstable housing and poverty, neglect and ab use, intergenerational trauma or developmental disabilities.
- Intervention early in life, and early in mental illness, can reduce the duration and impact. Early intervention is especially important for children and young people because many m ental health problems can affect psychosocial growth and development, which can lead t o difficulties later in life.
- In 2017–18, clinical mental health services in Victoria treated almost 12 000 children and young people up to the age of 18 and admitted just over 2 000 to hospital. These numbers were a 10 per cent increase on the previous year.



Unpacking the child and youth mental health system was complex. There are 17 publicly funded child and youth mental health services across Victoria. Health services don't all provide the same treatment programs or treat the same age groups.

Specialised mental health services that we audited cater for children, adolescents and youth who have moderate to severe mental illnesses. The services are delivered through a mix of community programs, inpatient services and a small number of community residential services. Our audit concluded that this system is fragmented and overstretched, meaning children and young people with moderate to severe mental illness are not getting the help they need.

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How do you audit in the dark?

- Evaluative approach
- A tapestry of 'micro' audits
- Strong engagement with audited agencies

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We're going to focus today less on the audit and its findings, though they are fascinating and we've been very pleased to see them informing the early work of the Victorian Mental health royal commission etc, but on the strategies we used to design and conduct this performance audit.

Three things:

- How we brought an evaluative approach to the audit, bringing in evaluation methodologies to the auditing space, which is a surprisingly natural fit
- How we looked for opportunities to do a series of "micro" audits , which came together into a tapestry with similar themes emerging
- How we put significant time and resource into engaging with the audited agencies, especially the health services. In the absence of DHHS being able to clearly describe the system, we needed to work closely with the service providers to understand and map it out ourselves.

An evaluative approach

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'Evaluative thinking' - a systematic process of collecting and analysing data to tell the story about your strategy, initiative, program, policy or organisation. It is based on the belief that a systematic process is valuable and necessary.

Involves:

- identifying assumptions about what you think works and doesn't work and why
- posing thoughtful questions about what change you expect to see during and after you implement your effort
- pursuing deeper understanding through reflection and dialogue
- communicating what was learned without underestimation or exaggeration
- making informed decisions in preparation for action

W. K. Kellogg Foundation, Step-by-step Guide to Evaluation, 2017

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I'm sure I'm not the only person with evaluation training in the room, so apologies if this is already in your back pocket, but it is a useful definition to consider.

Some examples of how our audit applied an evaluative approach:

Wide stakeholder consultations at the outset – no lack of organisations and experts keen to help us; actually showed us we would need some help with the technical and complex context – engaged an independent expert advisor to assist throughout audit

Risk Response Procedures Plan (Audit Plan) looks much like an evaluation plan:

- evaluative questions against each audit criteria (as per all VAGO performance audits)
- mixed methods approach
- also developed a data collection framework - each data collection activity addressed multiple criteria/questions, and each question had multiple data sources

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Taking a few points from the definition on the slide

Assumptions:

- intensive planning and scoping in the initiation stage, including external stakeholders outside the audited agencies
- engaged an SME for content knowledge, access to evidence on what works

Reflection and dialogue:

- multiple rounds of site visits
- One round of site visits requesting case studies of specific scenario (clinically unnecessary stays) be presented to us
- Workshops with audited health services:
  - test findings, and develop the recommendations
  - first without the Department of Health and Human Services, the funding body, second all together
- talk later more about how we prioritised intensive engagement with the audited agencies in the audit process

Decisions in preparation for action:

- recommendations developed in genuine consultation with audited services and agency
- including an intensive workshop to test and refine them plus discussions with individual agencies

Risk Response Procedure Plan: *Child and youth mental health*

1.0 The design of services supports their intended objectives

- clear strategic framework
- services funded and geographic distribution aligned with objectives
- funding model aligns to objectives, reviewed and updated regularly

2.0 DHHS effectively administers child and youth mental health services

- performance management and outcomes monitoring
- sets requirements, provides guidance for quality of program delivery
- monitors access and demand, priority populations
- service coordination for multiple and complex needs

Bringing these thing together, we landed at the following audit criteria.

A tapestry of 'micro' audits

While there were no clear expectations or standards to use as our overall measuring stick for what you should expect to find in terms of performance of the system, once we asked the bigger questions and started gathering evidence, we did begin to collect up quite a collection of things we could use to look at smaller parts of the system and audit their performance – ultimately creating a kind of tapestry as common themes that emerged across these many "micro" audits.

Some examples of 'micro' performance audits

- *Mental Health Act 2014* functions and principles
- Independent review of Office of the Chief Psychiatrist with 22 recommendations
- Guidance provided at program level

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We had to go back to first principles – the new Mental Health Act included some standards, such as the functions of the Secretary (and consequently her staff) , the functions of the Chief Psychiatrist – and we asked for evidence of how these were being met. Also defined principles for treating children and adolescents – we asked for evidence around this and later did our own data analysis to see if these were being met, which I'll show a little further on.

An independent review of the Chief Psychiatrist with 22 recommendations – follow up audit of sorts:

- 5 recs "not supported" but no rationale or alternative response to the underlying issues raised in review
- 3 recs that DHHS had acquitted as "fully implemented", we found evidence that contradicted this
- led to two recommendations in our report – including that a more thorough response to this review be prepared for the responsible Minister

Some examples of 'micro' performance audits

- *Mental Health Act 2014* functions and principles
- Independent review of Office of the Chief Psychiatrist with 22 recommendations
- Guidance provided at program level

Funding information was provided early in the audit broken down by program. We subsequently sought to understand what each of these lines were intended to fund/ achieve, and then brought this analysis back to a more simple question of whether there was any guidance or guidelines or similar – creating a table showing the funding breakdown by program, $, number of services in receipt of this program (not easy) and whether any guidelines or guidance existed. Subsequently showing that $19 million had no guidance attached.

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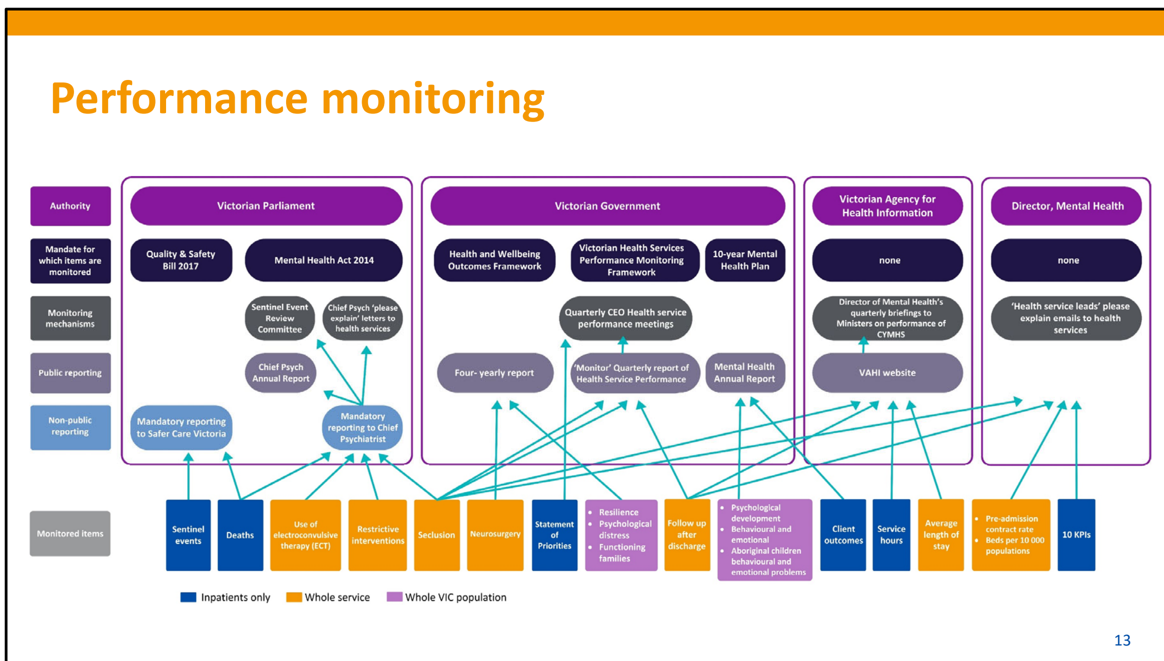

We identified all of the different performance monitoring activities that occur around child and youth mental health, and put them together into one diagram.

As you can see from this diagram, the performance monitoring around child and youth mental health is complex and confusing.

We showed that there are seven different systems involved. We also found that nobody has a full picture of what is happening because of this overlap and a lack of information sharing across the responsible areas.

National KPIs compared to DHHS's KPIs

Domain	National KPIs	DHHS Mental Health Branch's CAMHS KPIs	VAHI Victorian Health Services Performance public report	Victorian Health Services Performance Framework
Effective	Change in consumers' clinical outcomes	Percentage of clients with significant improvement case end (community only)	×	×
		Change in mean number of clinically significant HoNOS items (community only)	×	×
		Mean HoNOS at episode start	×	×
	28-day readmission rate		×	×
Appropriate	National service standards compliance		×	×
Efficient—inpatient	Average length of acute inpatient stay	Trimmed average length of stay, excluding same day stays and stays over 35 days	✓	×
	Average cost per acute admitted patient day		×	×

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DHHS had a suite of key performance indicators (KPI) it used, but could not provide any rationale or explanation for how or why they were selected, developed or used, beyond them being 'based on the national KPIs'.

We subsequently compared the national KPIs to DHHS's KPIs and found six national KPIs (marked as red in a chart, excerpt shown) that did not have a corresponding DHHS KPI and its rationale for excluding them was incomplete or absent. A further eight could be aligned but had been changed significantly. We used a traffic light chart, excerpt shown, to illustrate findings of this analysis.

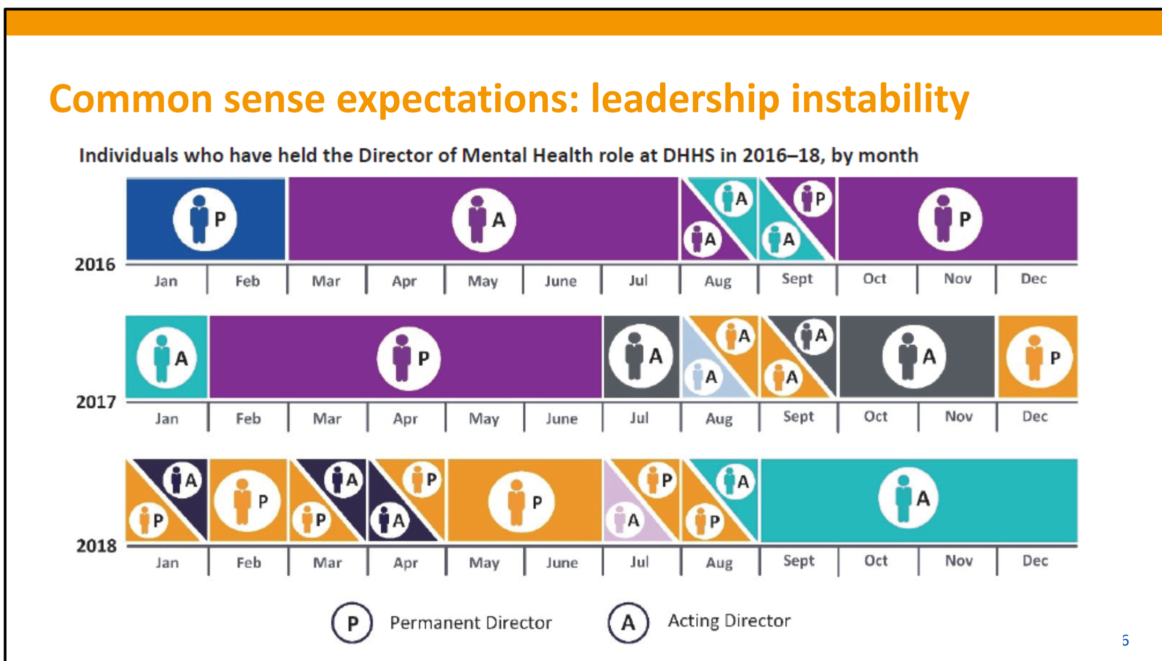
Evidence of action against legislated functions

OCP's actions against the Chief Psychiatrist's legislated functions that relate to service quality

Legislated function	Evidence of action in 2017–19
(a) to develop standards, guidelines and practice directions for the provision of mental health services and publish or otherwise make available those standards, guidelines and practice directions	• Sixteen current guidelines published. • Four new guidelines completed and released. • New reporting instruction on sexual safety violations. • Clinical practice framework for intensive mental health nursing. • Guideline and practice resource: Family violence.
(b) to assist mental health service providers to comply with the standards, guidelines and practice directions developed by the chief psychiatrist	• **Minimal.** New guidelines are sent to authorised psychiatrists by email. No guidance or support is provided on their implementation. Evidence that some are not implemented and no follow-up.

Another example: The Chief Psychiatrist has legislated functions with regards to service quality in mental health services.

- We looked for evidence of action against each of those functions and found that two of the seven functions had minimal actions.
- We tested this with health services who confirmed that the lack of guidance in these two areas were creating significant challenges for them in delivering their services.

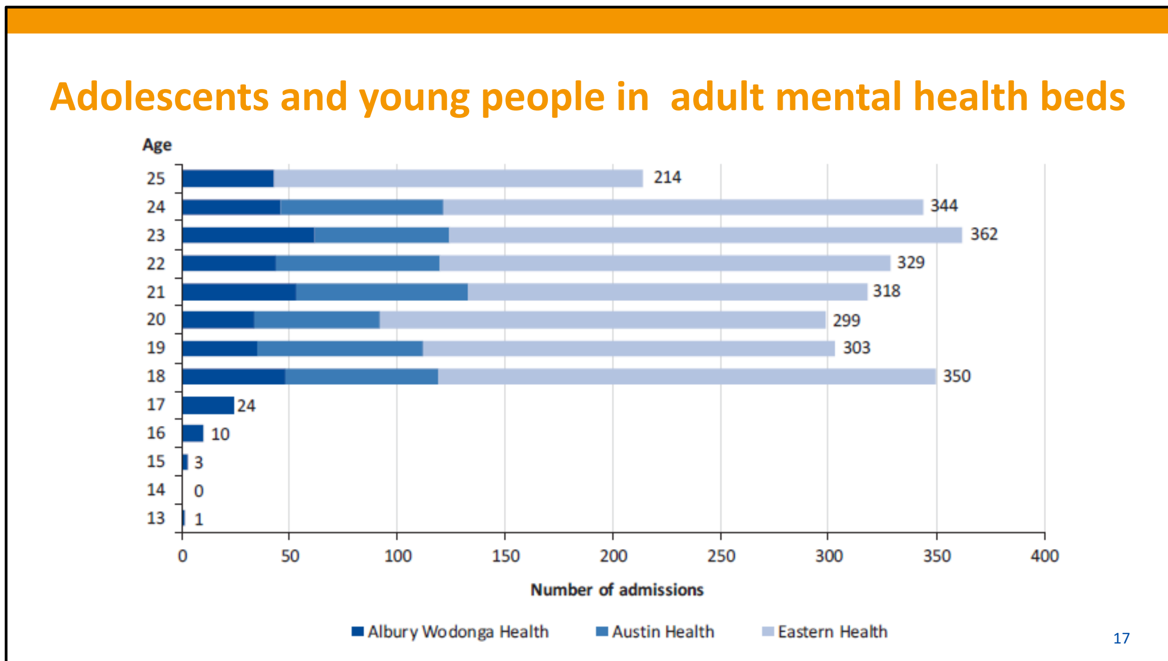


The term "Acting Director" appeared frequently in the documents we analysed, and audit meetings we scheduled, in the early stages so we requested HR records for the Director role and were able to construct this diagram to show the instability in the role and therefore the leadership of the area.

Before we requested the data, we asked about leadership instability as a challenge.

We did however conclude that:

DHHS advises that there has not been instability in the leadership of the Mental Health Branch because the same people rotated through the temporary appointments, which enabled continuity. However, the temporary, albeit rotational, leadership of the branch likely impacts its ability to maintain a clear long-term vision, and make and follow through on decisive actions.



In our planning work, we identified systemic conflicts around inpatient services for young people:

- The Act says children and young people should receive services separate from adults but does not define the age of young people
- DHHS does not clearly define eligibility criteria for adolescent inpatient beds
- DHHS defines eligibility for adult inpatient beds as 16 years and over

We followed this issue through, and with original analysis of data provided to us by the health services, we were able to describe an important issue – that regional health services had particular challenges in this area. Albury Wodonga Health had 86 admissions of (69 individuals) adolescents 13-18 years over 3 years. They subsequently did a file audit which we also reported and were able to explain the system barriers leading to this problem, and an internal improvement process was initiated off the back of our data analysis.

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Strong engagement with audited agencies

We determined early in the audit that there would be more than enough to keep us busy looking at the role that DHHS plays as system manager. It was also apparent that without the funding and system manager setting objectives and performance targets, it would not be feasible to audit the health services' effectiveness. We therefore reoriented to use the health services as key stakeholders in the audit, helping us to describe the system as a whole through examples of their own operations which represented a large portion of the system. To support this engagement, we prioritised the audit delivering value to the system and the services.

As I said early in the evaluative approach – we did extensive direct engagement with health services, which meaningfully involved them in the audit. At the early findings (end of conduct) stage, we brought them together to share and workshop the findings. Included asking them HOW we could best proceed with looking into some issues which were emerging, such as "clinically unnecessary stays" and working together to develop the methodology with the wisdom in the room – these included heads of child psychiatry from 5 major health services who'd worked in the field for many decades, who saved us a lot of time and energy by tapping their mighty brains! Also directed us to a range of work already done on some of our areas of interest, sometimes unpublished, which was invaluable.

Strong engagement with audited agencies

At the end of the audit, we brought them together again and this time included the government agency's staff, including the Chief Psychiatrist and his staff to discuss the recommendations and whether they were feasible and appropriate – several changes were made as a result of this meeting. We saw in this workshop how services and government interpreted a matter differently so we were able to make sure the recs were presented in a way that minimised this after the workshop.

DHHS had stopped bringing the services together in this way, so they found it helpful to reconnect. We also made a rec that DHHS recommence bringing them together.

Another outcome of having this level of involvement of the health services in the audit was that a substantial amount of the audit work was descriptive. The performance monitoring system chart shown early is one example. Our clinical data analysis also included a substantial amount of work which was describing the basic characteristics of the system, the types of diagnoses seen, number and demographics of clients, etc. But this had never been done before at the system level, despite DHHS collecting and managing more than enough data to do so.

Clinical data analysis

Objectives:

- key demographic and clinical characteristics of current clients and compare to population characteristics to determine whether priority populations are receiving access to services
- levels of acuity and complexity, and compare to previous 3 years to see changes over time
- **whether the data collected by CYMHS and the data systems used allow for effective monitoring of access and demand**

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Whilst we undertook the data analysis work, we also made observations of the data itself and the data systems and how capable the current data and system are at monitoring access and demand.

Auditors shouldn't be put off when they encounter less than fabulous data sets - examining and talking about that, and using what you can, with the right caveats, can help advance the improvement of that data.

As we did our analysis to describe the system, we also identified a range of specific gaps and issues – we convened a workshop with our data analysts and brought one of the health services' data custodians to test our findings, and subsequently reported a range of specific improvements that were urgently required.

For example, that the data system did not collect whether a child was in out of home care – despite there being a policy (when we went looking for targeted priority groups, it was the only thing we could find) that children in out of home care be given priority access – the data systems did not prompt or collect on the topic at all. We looked for local policies and found some were spoken of but none documented. We recommended this be addressed.

Service response for vulnerable populations

- No multiple and complex needs case coordination
- Challenges of discharging children and young people with complex needs:
  - 29 patients stayed longer than clinically necessary
  - 1 054 clinically unnecessary days
  - One patient stayed 254 days longer than necessary

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To illustrate two of the strategies we've been discussing today: engagement with the health services and doing original data analysis – is the work we did to identify clinically unnecessary stays in mental health inpatient facilities.

Staying for longer than necessary in an inpatient unit not only places unnecessary strain on the health services, but also has negative effects for the young person's health and wellbeing.

In our audit planning, health services talked with us about this issue. We continued the conversations, workshopped a number of different approaches to exploring the issue, and sought and took advice from senior staff in the services on how best to explore this complex but important issue.

Service response for vulnerable populations

- No multiple and complex needs case coordination
- Challenges of discharging children and young people with complex needs:
  - 29 patients stayed longer than clinically necessary
  - 1 054 clinically unnecessary days
  - One patient stayed 254 days longer than necessary

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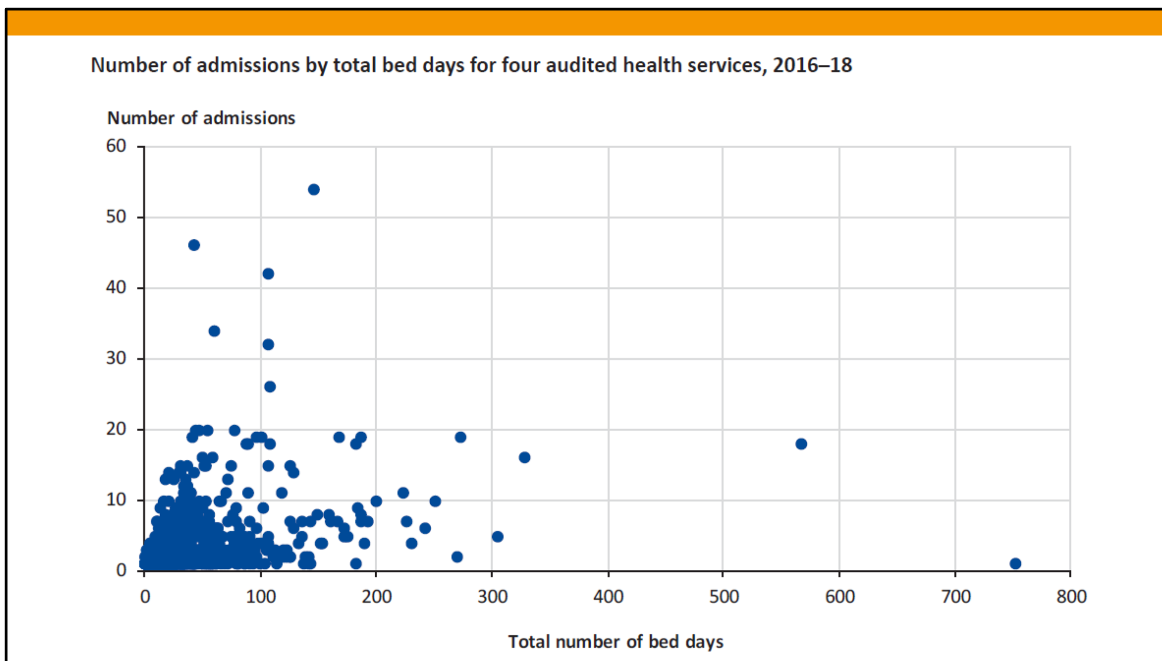
We found that multiple service providers often don't coordinate services for young people with complex needs to ensure a smooth transition back into the community from an inpatient stay. Senior clinicians told us that this lack of coordination causes longer than clinically necessary stays.

We examined 29 files from the four audited health services where young people during the past 12 months had stayed in inpatient facilities longer than clinically necessary. The length of the clinically unnecessary stays ranged from two days to 254 days. This adds up to 1 054 days, or almost three years. These 29 cases were only a sample of cases studies, and clinicians told us this problem happens frequently.



In a similar process, we heard about ‘long stays’.

Our data analysis showed that over three years there had been 228 inpatient stays greater than 35 days (a long stay) for clients aged 0–25 years in the four health services we looked at. This figure shows that long stays are only 3 per cent of the total number of inpatient stays, which may explain them being missed by DHHS. However, they represent a significant resource burden that should be monitored and better understood.

When we added clients’ multiple stays together, we found 394 young people over three years who had each been inpatients for a total of 35 or more days. Of these, 72 young people (2 per cent) had been inpatients for more than 100 days out of the three years.

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Recommendations

20 recommendations for DHHS

- Develop strategic directions for services
- Refine the performance monitoring approach and share reviews and evaluations
- Update triage and registration processes
- Provide guidance around complex care panels and consider establishing a High-Risk Complex Care Child and Youth Panel
- Establish a mechanism for health services to collaborate
- Chief Psychiatrist to independently brief the Secretary or Minister

This audit made 20 recommendations to DHHS around developing greater system stewardship by providing better guidance, sharing reviews, improving its evaluation of services and establishing a mechanism for health services to come together and collaborate. We also recommended the department establish a means for the Chief Psychiatrist to be able to directly brief the secretary or minister which, under the current structure, hasn't been possible.

DHHS accepted all the recommendations. The work is also informing the Mental Health Royal Commission.

Conclusion

We were able to shed some light on child and youth mental health, by bringing an evaluative approach, looking for opportunities to do a tapestry of 'micro' audits and engaging strongly with our audited service providers in the audit.

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Acknowledgments

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