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Auditor General
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Mental health services for people in crisis

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Sir

Under the provisions of section 16 of the *Audit Act* 1994, I transmit my performance audit report on *Mental health services for people in crisis.*

Yours faithfully

J.W. CAMERON
Auditor-General

17 October 2002

Contents

Foreword

Mental disorders are a leading cause of disability in the community, reducing an individual's sense of wellbeing, and placing stress on family and social relationships and the wider community. Unemployment, substance abuse, physical illness and social dislocation are generally higher among people with a serious mental disorder.

Victoria's *Mental Health Act* 1986 requires persons with a mental disorder to be treated in the community wherever possible. As a consequence, Victoria, more than any other State, has transferred the treatment of patients and resources from stand-alone mental health facilities to community-based settings. People with a mental disorder can access a range of health services, including general practitioners and private psychiatrists, but public mental health services are the major source of 24-hour crisis assessment and treatment, and must be available for involuntary patients.

We have focused this audit on the provision of services for adults facing a mental health crisis. This audit identifies a range of concerns about the timeliness of service provision, the completion of key service delivery processes in compliance with relevant standards and guidelines, and the burdens placed upon carers and families. In making these findings, I do not wish to impugn the many dedicated professionals providing mental health services. It is clear that the service system is under significant stress, due to demand pressure, work force shortages and the increasing complexity of mental disorder in our society.

In responding to the findings of the audit, the Department has maintained that the absence of documentation of a particular action does not preclude the possibility that the action occurred. I agree, but would add that the opposite equally applies. Documentation does not guarantee quality outcomes. However, I encourage all agencies to work towards effectively documenting their actions because such documentation can provide:

- evidence that the planned activities which contribute to effective outcomes took place;
- information from which to learn from past experiences; and
- assurance to individuals accessing services and the wider community that appropriate actions are indeed being taken.

The findings and conclusions of this audit are based on more than simply a review of file documentation. We sought corroboration of our overall findings from various other sources, including consumers and carers. Our judgement was that, on balance, key service delivery processes may not have been undertaken adequately or in a timely fashion.

This report provides a number of suggestions to the Department of Human Services, Area Mental Health Services and the Mental Health Review Board that can improve the services provided to people with a mental illness and their carers.

On 4 September 2002, as I was finalising this report, the Government and the Department of Human Services launched a 5-year plan for public mental health services in Victoria, titled *New Directions for Victoria's Mental Health Services.* Many of the things discovered in the course of the audit and discussed with the Department have been recognised in this plan. Effective implementation of the recommendations made in this report will see many of the proposals in the *New Directions* initiative achieved.

J.W. CAMERON
Auditor-General

17 October 2002

Part 1

Executive summary

INTRODUCTION

1.1 Mental disorders are a leading cause of disability in the community, accounting for 26 per cent of the non-fatal health burden in Victoria. In 2001, about 55 000 Victorians received services from the public mental health system and demand is expected to increase over the next 5 years. Public mental health services received a budget allocation of $588.5 million in 2002-03. This represents an average increase of 8.6 per cent per year since 1999-2000. In September 2002, the Department of Human Services released a 5 year plan outlining priorities for public mental health services in Victoria which recognises many of the things discovered in the course of this audit.

1.2 Poor mental health reduces an individual's sense of wellbeing and may impact negatively on family and social relationships, and the wider community. Unemployment, substance abuse, physical illness, and social dislocation are generally higher among people with a mental disorder. People with psychotic disorders (such as schizophrenia) often experience considerable difficulty coping with everyday tasks, maintaining social relationships and occupational functioning.

1.3 In the 1980s and 1990s, Victoria led other States in legislative and service reforms in mental health. More than any other State, Victoria has transferred the treatment of patients and resources from stand-alone mental health facilities to community-based settings. Victoria's *Mental Health Act* 1986 requires persons with a mental illness to be treated in the community wherever possible.

1.4 While alternative mental health services, such as those provided by general practitioners and private psychiatrists, may be accessed by consumers, public mental health services must be available for involuntary patients and are the major source of 24-hour crisis assessment and treatment.

1.5 Recent Statewide reviews report that it is becoming increasingly difficult for people experiencing a mental health crisis to gain timely access to appropriate mental health services. Consumers of mental health services and those who care for persons with a mental disorder report that the response to people in psychiatric crisis is often slow and inappropriate. This is problematic because a delayed service response can increase the risk of self-harm, suicide or violence, placing both the consumer and the public (potentially) at risk.

AUDIT OBJECTIVES AND SCOPE

1.6 The objectives of the audit were to determine:

- whether Area Mental Health Services (AMHSs) were providing timely and appropriate services to people aged 16 to 64 years who were experiencing a crisis associated with their mental illness, or who were at significant risk of experiencing a crisis;
- the impact of the current mental health service system on carers and families of people with a mental disorder;

- whether the rights of patients subject to community treatment orders and involuntary admission to hospital have been adequately protected;
- whether funds allocated to public mental health services have been distributed according to need; and
- whether an effective framework was in place to measure and monitor the effectiveness of mental health crisis prevention and response, at a Statewide and individual hospital level.

1.7 The scope of the audit was confined to adult public mental health services and the operations of the Department of Human Services, the Mental Health Review Board, and 6 of Victoria's 21 AMHSs. Adult mental health services consume about 76 per cent of the State mental health budget. The audit focused on crisis prevention and response services because this is an area which has significant social and cost implications for the community. This audit preceded the release of the September 2002 Department of Human Services' 5 year plan for public mental health services in Victoria.

AUDIT CONCLUSION

1.8 To assess the timeliness of service response, we examined 191 case files of people with a severe mental disorder who had presented to an AMHS and were rated as "urgent" by an AMHS clinician. People referred to private practitioners for assessment or treatment following initial contact with the AMHS were not included in the sample of files audited. Assuming our sample of 191 case files had been correctly assessed as urgent by AMHS clinicians, 65 per cent of initial service contacts rated as urgent did not receive a face-to-face assessment by an AMHS clinical staff member within 24 hours. Twenty-five per cent of urgent cases did not receive an initial face-to-face assessment by an AMHS clinical staff member for 7 or more days.

1.9 One important issue relates to the debate regarding the appropriate standard against which timeliness and appropriateness of service response during a psychiatric crisis should be measured. The relevant standards and guidelines are not universally accepted and there are differences in interpretation between the Department, AMHSs and mental health practitioners. AMHSs are also at varying stages in adopting the national standards. Accreditation against the national standards will commence in June 2003.

1.10 Professional advice received from the Victorian Branch of the Royal Australian and New Zealand College of Psychiatry is that clinical assessments of urgent referrals need to occur within one hour (allowing for travelling time) and, aside from exceptional circumstances, these assessments should be conducted face-to-face. Professor Harvey Whiteford, Chair of the 1997 National Mental Health Working Group for mental health standards, advised that:

> *"For presentations rated as urgent by an AMHS clinical staff member at the initial point of contact with the service, a clinically appropriate intervention should occur within 24 hours. This clinical intervention should, in most instances, be a face-to-face assessment by a clinical staff member or another appropriate clinician (e.g. general practitioner) determined by the AMHS. The intervention could commence as a telephone intervention where this is deemed by the AMHS to be clinically appropriate and sufficient to respond to the immediate needs of the consumer".*

1.11 Documentation in client files was used to establish the timeliness and appropriateness of service provision. The standard of this documentation was poor; a major finding of the audit. While the file audits were conducted according to a rigorous methodology using experienced mental health consultants who were familiar with the nature of both the files and the processes being audited, the poor documentation means that there may have been processes which occurred but for which there is no evidence on the file. The audit focused on what was documented. This should be taken into account by the reader. The audit accepted the clinical judgement of AMHS practitioners, specifically in relation to their assessment of risk and urgency of patient needs. The audit noted the need for clear guidance for practitioners to ensure consistency of service delivery.

1.12 The audit found that people in psychiatric crisis faced difficulty accessing acute psychiatric beds due to increasing demand pressures and static bed numbers in some regions. Aspects of service provision have been impacted by demand pressure, work force shortages, significant gaps in completion of key service delivery processes (including comprehensive assessments, individual service plans and case closure plans), and limited involvement of consumers and carers.

1.13 Carers and families believe services for consumers, and support for carers and families, are inadequate. Carers indicate that they require better information, education, consultation, training and support.

1.14 The operational efficiency of the Mental Health Review Board has improved significantly ($472 per completed case in 1987-88 to $251 in 2000-01) and reviews and appeals are being scheduled by the Board within legislative time frames. Changes in mental health treatment practices and a reduction in the duration of treatment for involuntary inpatients have meant that, currently, nearly 70 per cent of involuntary patients are released from their involuntary status without coming before the Board for a hearing, unless they appeal. The implications of this are unclear for the Board's objective of seeking to balance the needs of individuals to receive treatment, the loss of freedom that the individual experiences when they are treated involuntarily, and the interests of the community.

1.15 Over time, the Department has made considerable progress in the redistribution of funds to AMHSs on a more equitable basis, but discrepancies remain. We endorse the Department's strategy to examine and revise the resource allocation model.

1.16 The current set of mental health measures and key performance indicators (KPIs) do not provide sufficient information to management and the Government to measure the effectiveness of the services being delivered. Most of the current measures and KPIs are not tied to departmental objectives and relate to service delivery (i.e. outputs) rather than consumer outcomes. The current set of measures and indicators is also limited in its coverage of mental health services.

AUDIT FINDINGS

Responding to people in psychiatric crisis

1.17 Between 1997 and 2001, the total number of registered Area Mental Health Service (AMHS) consumers increased by 20 per cent. There has also been a 36 per cent increase in registered client contacts during the same period. ***(para. 3.5)***

1.18 Data on the prevalence of mental disorders in the community indicate that 2 to 3 per cent of the adult population may have a severe mental disorder. If the figure of 3 per cent is compared with the number of registered service users, up to one-third of people with a mental disorder meeting the AMHS target group may not be receiving treatment from AMHS. In Victoria, this translates to about 40 000 people who may be accessing alternative mental health services, such as general practitioners and private psychiatrists. ***(para. 3.7)***

1.19 The relationship between presenting problem and service response suggest that the majority of consumers rates as urgent receive an AMHS service response. During interviews with consumers and carers, a common source of complaint was that consumers and carers believed that AMHSs provided services based on a person's diagnosis as opposed to their level of need and disability. AMHSs noted the difficulties they face in providing services to a broad target group, in an environment of limited resources. ***(paras 3.56 and 3.58)***

1.20 A recent Statewide review of adult acute psychiatric inpatient services reported that it is becoming increasingly difficult for consumers to gain access to acute inpatient beds in some areas. Victoria has emphasised community-based services providing a higher proportion of its services and beds in community settings than other States. The overall number of designated acute psychiatric inpatient beds in Victoria has remained relatively constant since 1996, despite a 20 per cent increase in overall service demand. Victoria now has 21.8 acute beds per 100 000 adults; 2.6 beds below the national average. ***(para. 3.73)***

1.21 Increasing service demand and associated levels of unmet demand are resulting in service access difficulties for many consumers, early discharge from hospital, and increased burden on family and carers. These outcomes increase the likelihood of future unplanned re-admissions. ***(para. 3.10)***

1.22 Based on our limited observations during the audit and data provided by the Royal Melbourne Hospital Emergency Department (ED), consumers presenting to EDs with serious mental health problems often experience lengthy waiting periods. Physical infrastructure in hospital EDs were inadequate for the assessment and treatment of mental health consumers. ***(para. 3.48)***

1.23 Our review of 935 clinical files found that 31 per cent of 583 consumers treated in the community did not receive either an individual service plan or an inpatient management plan. None of the 402 individual service plans examined addressed all of the criteria as recommended by Department of Human Services' clinical guidelines. ***(para. 3.96)***

1.24 Patients and carers benefit greatly from receiving appropriate information about the nature, causes and treatment of mental disorders. "Psycho-education" is generally considered an integral part of the treatment and recovery process and is emphasised in the national standards. Interviews with consumers and carers and the file audits indicate that consumers of public mental health services are not routinely receiving psycho-educational services from the public mental health system or being referred to the private system for these services. ***(paras 3.100 and 3.101)***

1.25 Thirty per cent of hospital discharge plans reviewed included no evidence that consumers had been linked into appropriate community-based services for ongoing treatment following inpatient discharge. Similarly, 48 per cent of all case closure plans (or service exit plans) reviewed had no documentation indicating that consumers had been linked into appropriate services for ongoing care in the community. ***(para. 3.114)***

Carers and families

1.26 In order to be effective, public mental health services must take into account the important role of carers and families, and be responsive to their needs where possible. This has been recognised in the second National Mental Health Plan and in the Department's own policies and framework for service delivery. ***(para. 4.31)***

1.27 The amount of time carers spend looking after the person with a mental illness, ranges from under 10 hours per week to more than 50. ***(para. 4.14)*** Carers most frequently sought help from public mental health service psychiatrists and case managers, but found the services provided by carer associations and support groups more helpful. Some of these associations and support groups receive funding from the Department. ***(para. 4.17)***

1.28 As part of a survey undertaken for this audit, carers were asked to rate the impact of the person's mental disorder on themselves and their family. The majority of carers reported that they and their families experienced a number of negative consequences in terms of their level of happiness, their leisure time, their physical and mental health, their personal relationships, and their standard of living. This evidence is consistent with the findings of a national survey of carers that was undertaken in 1999 by the Carers Association of Australia. ***(para. 4.26)***

Rights of involuntary patients

1.29 Since its establishment in 1987, the operational efficiency of the Mental Health Review Board has improved significantly. The Board's workload has increased by more than 600 per cent since 1987-88, while the cost per completed case has fallen from $472 in 1987-88 to $251 in 2000-01. ***(para. 5.14)***

1.30 Under the *Mental Health Act* 1986 the Mental Health Review Board is required to review all involuntary patients within 8 weeks of their admission, hear appeals from patients who wish to be discharged from their involuntary status, review all involuntary patients at least every 12 months, and review every decision to extend a community treatment order. The audit found that while the vast majority of these reviews and appeals are being scheduled for hearing in a manner consistent with legislative time frames, there is an opportunity to further improve the administration of hearing processes. ***(paras 5.58 and 5.59)***

1.31 During 2001, patients were not present at 38 per cent of hearings. In 31 per cent of hearings, the patient gave prior notice that they did not wish to participate, and in 7 per cent of hearings the patient simply did not attend on the day. This pattern was similar for both metropolitan and regional venues. ***(para. 5.33)***

1.32 During 2001, 51.6 per cent of involuntary patients were discharged within the first 2 weeks of admission and were not, therefore, listed for initial review by the Board. Of the 6 372 initial reviews listed for hearing in 2001, 37.8 per cent of patients listed for hearing were discharged from their involuntary status prior to the hearing date. Thus, the majority of involuntary patients (nearly 70 per cent) do not appear before the Board to have their situation independently reviewed, unless they appeal. ***(para. 5.37)***

1.33 The Board determined 5 690 cases in 2001; with 6.2 per cent resulting in the patient being discharged from their involuntary status and 93.8 per cent were confirmed as meeting the criteria for continued involuntary status. The rate of discharge has remained relatively constant since 1987, and is similar for both metropolitan and regional patients. ***(para. 5.49)***

1.34 Patients with legal representation were more likely to have their involuntary status discharged. Further research will be required to clarify the cause of this result. It is not known whether the legally represented patients were less unwell than those not legally represented. ***(para. 5.50)***

Funding of Area Mental Health Services

1.35 Over the period 1992-93 to 1997-98, mental health spending on stand-alone hospitals reduced by $137.6 million (74 per cent) and $157.5 million was directed to the development of replacement services, mainly in community-based settings. ***(para. 6.4)***

1.36 Across areas, funding aligns fairly well with the model-determined share of funding based on the Department's weighted population formula. However, discrepancies remain. The biggest discrepancies are in the inner metropolitan area (which receives more than its model-determined share) and the central-east of Melbourne (which receives less than its model-determined share). The Department advises that redistribution of funding to match weighted population share is achieved through the allocation of new funding. ***(para. 6.8)***

Measuring the effectiveness of mental health services

1.37 In the 2002-03 State Budget, $588.5 million was allocated to Mental Health outputs. This represents 7 per cent of total recurrent funding to the Department of Human Services and 11 per cent of the Health budget. The major output targets for mental health services for 2002-03 include:

- 17 400 inpatient separations provided to people with a mental illness;
- 55 000 continuing clients in clinical community care;
- 9 124 clients receiving Psychiatric Disability Support Services; and
- 19 521 training hours of clinical staff. ***(para. 7.5)***

1.38 The Department's set of mental health key performance indicators and performance measures are not sufficiently comprehensive to provide management with the necessary information to measure the effectiveness of mental health services. In particular, they do not provide any indicators of service demand. In the absence of a broader set of indicators, many AMHSs have developed their own management reports. While the 4 performance indicators currently used by the Department should be retained, improved performance information could enhance the management effectiveness of the sector. ***(para. 7.18)***

RECOMMENDATIONS

Paragraph number	*Recommendation*
Responding to people in psychiatric crises	

3.70	We recommend that the Department of Human Services work with Area Mental Health Services (AMHSs) to:
	• Clarify definitions and interpretations of the standards for urgency, timeliness and nature of initial service response in line with the national approach, and ensure that there is sufficient guidance and training for AMHS staff to implement the agreed standards consistently;
	• Review current arrangements for the assessment and treatment of psychiatric patients in hospital Emergency Departments (EDs) with the aim of improving response times and treatment to people in psychiatric crisis, including:
	  • the respective roles and responsibilities of ED clinical staff and mental health staff during a psychiatric crisis need to be clarified; and
	  • physical infrastructure in EDs, including areas designed for the assessment, management and restraint of psychiatric patients;
	• Monitor and report on service provision within AMHSs against agreed standards to enable appropriate responses to be made where standards are not achieved; and
	• Improve Duty documentation procedures at AMHSs to enable appropriate service monitoring and accountability. Specific areas for improvement include ratings of urgency and risk of harm to self and others, and key intake criteria and completion of key assessments.

3.85	We recommend that the Department and AMHSs significantly improve current discharge practices. Particular attention should be given to post-discharge arrangements with ongoing community-based services, and consumer and carer collaboration in discharge planning.
3.120	We recommend that: • the Department implement a comprehensive demand management strategy; • AMHSs ensure that all components of service delivery are completed and documented, including completion of comprehensive assessments, individual service plans, and Case closure planning conforming to national standards; and • the Department continue to develop new service interface initiatives and expand existing initiatives which have proven successful. Linkages with primary care providers, drug and alcohol services, and housing services are particularly important in this regard.

RECOMMENDATIONS - *continued*

Paragraph number	*Recommendation*
Carers and families	
4.34	We recommend that the Department and AMHSs ensure that: • Public mental health services are sensitive to the needs of carers and families. This will require carers and families to be consulted in the development of mental health polices, and clinical staff to actively collaborate with carers and families in the delivery of services; and • Carers are provided with the information, education, training and support they require to effectively manage persons with a mental illness.
Rights of involuntary patients	
5.60	We recommend that when the *Mental Health Act* 1986 is next reviewed, provisions in relation to the Mental Health Review Board should be assessed in light of the significant changes to treatment practices that have occurred since the Act was first introduced.
5.61	We recommend that the Board, the Department and AMHSs should ensure that: • Involuntary patients are given the support and assistance necessary to enable them to participate effectively during Board hearings; • Involuntary patients are made aware of their rights, and that service staff protect these rights. This requires the ongoing education of both involuntary patients and service providers beyond the use of posters and brochures, and the implementation of appropriate monitoring and complaints mechanisms; and • Research is undertaken to identify why a significant proportion of involuntary patients do not attend Board hearings, and action is taken to increase attendance.
5.62	We recommend that the Board and AMHSs take action to reduce the number of cases that are rescheduled or adjourned prior to being heard. In particular, the number of cases deferred as a result of doctors being unable to attend hearings, doctors attending hearings but not being familiar with the patient and patients being transferred between service locations.
Measuring the effectiveness of mental health services	
7.27	We recommend that as part of the process of development and revision of its performance measures and key performance indicators (KPIs), the Department should: • consider the measures and indicators proposed by this audit; • continue to consult with service providers on their appropriateness; • continue to develop information systems and reporting mechanisms to support decision-making; • provide training to senior managers to interpret measures and KPIs; • publish a comparative set of Area-level measures and KPIs at least annually; and • analyse and review the measures and KPIs every 12 months to ensure their ongoing relevance.

***RESPONSE** provided by Department of Human Services*

The Department of Human Services (DHS) welcomes the report and acknowledges the pressures under which the system operates. Increasing demand and work force shortages in the public sector, particularly of mental health nurses and psychiatrists, were the drivers for the New Directions in Victoria's Mental Health Services policy released in September 2002.

DHS notes the audit took place over a 12 month period during which time DHS was also consulting consumers, carers, clinicians and service providers. The New Directions for Victoria's Mental Health Services document identifies the gaps in the system and action taken to date to improve public Mental Health services, and outlines a vision for the next 5 years. Key stakeholders all contributed substantially to the New Directions document. DHS has, as part of its strategy, commenced addressing many of the issues identified by audit. New services are being developed between hospitals and the community, step-up/step-down services, improved methods for handling complaints and an extensive recruitment and retention campaign for mental health nurses, and new training and education initiatives are underway.

In response to growing demand for mental health services the Department is expanding existing services and has commenced the development of a demand management strategy which is one of the strategies in the New Directions for Victoria's Mental Health Services document This strategy will address service system pressure points through service improvement and diversion initiatives. It will also focus on the further development of need reduction strategies, including strategies in relation to prevention and early intervention.

Audit Objectives and Scope

The Department accepts that there was insufficient and poor documentation on client files in some of the services audited. Documentation of service provision clearly requires improvement.

The Office of the Chief Psychiatrist Clinical Reviews have made recommendations to services about appropriate Duty contact documentation including documentation of risk levels, actions taken, and other relevant information.

Office of the Chief Psychiatrist Clinical Reviews have also made recommendations that all non-accepted referrals be subject to a secondary check regarding eligibility decisions by the clinical team or another senior clinician, and signed off. This is gradually being implemented in services.

The Office of the Chief Psychiatrist will provide further education sessions on documentation to area mental health services, and will develop guidelines for clinical documentation.

***Further comment** by the Auditor-General*

The audit found significant gaps in the completion of key service delivery processes, based on a file review, interviews with key stakeholders, surveys of consumers and carers, and analysis of system data. Audit is encouraged by the Department's commitment to improve documentation.

***RESPONSE** provided by Department of Human Services - continued*

24 Hour Face to Face Assessment by Area Mental Health Service Clinicians

While welcoming the report, DHS has some issues about the way in which the audit has assessed performance on urgent cases. The National Mental Health Standards were agreed by Ministers in December 1996. Audit did not assess the services on their implementation of these Standards. Instead, audit assessed whether the response of the Area Mental Health Service (AMHS) met the standard set by audit of a "face-to-face" assessment by an AMHS clinician within 24 hours. This is not required by existing standards and DHS considers that measuring against a new standard does not present a fair view of system performance.

The relevant National Standard 11.2.12, page 30 of the National Standards document states: "The MHS has a system which ensures that the initial assessment of an urgent referral is commenced within one hour of initial contact and the initial assessment of a non-urgent referral commences within 24 hours of initial contact. Notes and examples: professional assessment of urgency, the assessment process may be commenced with initial history taking, risk assessment, needs assessment over the telephone by an appropriately qualified mental health professional".

The Standard does not require face-to-face assessment by AMHSs within 24 hours. For urgent referrals, commencing the process by telephone is appropriate. If, as in some cases, face-to-face assessment is judged as clinically required it does not always have to be by an AMHS Clinician but may be able to occur in consultation or liaison with another service provider, or there may be a referral to another service provider.

Victorian public mental health services are a key provider of services to a proportion of consumers with serious mental illness through provision of clinical inpatient and community services and psychiatric disability support services. The Audit does not adequately take into account that the private and broader health sectors also play a key role in the treatment of consumers with serious mental illness and serious mental disorders. The target group defined on page 12 of the Introduction is not just the target group for Area Mental Health Services.

As part of Victoria's commitment to continuous quality improvement in mental health services, and in the exercise of the Chief Psychiatrist's responsibilities under the Mental Health Act 1986 *(Victoria), the Department's Mental Health Branch has developed a protocol for conducting Clinical Reviews of Mental Health Services.*

The Clinical Review Program commenced in November 1997 and is in the final year of a 5-year cycle. In this period, it has reviewed 20 of the 21 AMHSs, and considered around 2 000 patient files and over 500 duty contact sheets. In examining service response to incoming referrals, the Clinical Reviews have found that the majority of referrals deemed urgent receive an appropriate response in a timely manner.

The Auditor-General's findings do not accord with the findings of the Office of the Chief Psychiatrist. DHS will ask the Office of the Chief Psychiatrist to undertake another review of a sample of files to ensure that the existing system of assurance is reliable. The discrepancy between the Auditor-General's finding and those of the Chief Psychiatrist, is in our view, due to differences in methodology and the difference between the Auditor-General standard and that adopted by DHS.

***Further comment** by the Auditor-General*

Audit sought to provide information to Parliament and the community on the timeliness of response to people with a mental illness who are in crisis. The Department is concerned with our use of data from our file review which recorded the proportion of urgent cases seen within 24 hours.

There are 2 parts of the national standard which are relevant. Standard 11.2.12 and the related Notes and Examples quoted above. This standard is confusing. The Notes and Example relate to the professional assessment of urgency which is relevant to the Entry or Duty phase. However, Standard 11.2.12 provides guidance for the initial assessment once the consumer has already been rated as urgent. Standard 11.3 – Assessment and Review provides further guidance on the nature of that initial assessment: *"Wherever possible, the MHS conducts face-to-face assessments but may use telephone and video technologies where this is not possible due to distance or the consumer's preference"*. This Standard (11.3.13) clearly relates to the Intake assessment.

Reflecting the above, we examined the files to establish first that an assessment of urgency had been made at Entry (sometimes referred to as Duty or triage) and then that those who had been assessed as urgent had received a face-to-face assessment in the stated time frame.

In the context of the above, the audit examined 935 case files in 6 AMHS, documenting the 2 steps in the process from presentation or referral to the service:

- *Duty (sometimes called entry or triage)*. At this point, an initial assessment of risk and urgency is made. The Duty worker also takes responsibility for making external referrals where appropriate or, alternatively, organising for an Intake assessment. Due to documentation problems, we could not determine the urgency rating in 53 per cent of presentations. Of the remaining 444 presentations, 34 were excluded because they were referred to other service providers and not to be treated by the AMHS and 60 were excluded because they were not rated as urgent. The remaining 350 presentations of people in crisis were rated by an AMHS clinician as requiring urgent assistance. It is these urgent presentations for whom we sought information on the timeliness of response. Unfortunately, timeliness of response could only be calculated for 191 presentations; and
- *Intake (sometimes called initial assessment)*. The next step in the process is an intake assessment. As pointed out by the Department, the national standard says these assessments should be commenced within one hour for urgent cases and within 24 hours for non-urgent cases. Recording was poor, so we were only able to report in days. For the 191 urgent presentations, we found that 65 per cent (or 124 people in crisis) did not receive a face-to-face assessment by an AMHS clinician within 24 hours. After 7 days, there were still 25 per cent (or 47) of them who had not received a face-to-face intake assessment by an AMHS clinician. While specific information was not recorded, our reviewers found little evidence on file that these urgent presentations were being treated by someone else (since those with documented referral had already been excluded) and only very few cases of telephone contact with the person.

We welcome an assessment by the Office of the Chief Psychiatrist to assure the Department of the timeliness of service provision in AMHSs.

Data Issues

Audit makes a statements about changes in service delivery over time, but provides no actual, trend or comparative data to support these.

There are, for example, claims about increases in additional unplanned inpatient re-admissions, longer response times, reduction in the quality of care and access rationing with no supporting data. Data collections in these areas do not currently exist so these claims cannot be tested. DHS is putting in place systems to collect data on unplanned patient re-admissions and response times.

***RESPONSE** provided by Department of Human Services - continued*

Audit, in paragraph 2.34, states that there has been a reduction in work force. Audit is using data from the National Mental Health Report that includes domestic and administrative staff. Use of data for clinical staff which is also in the National Mental Health report is a better indicator of service levels and shows a 14 per cent increase in clinical staff from 1997-99 to 1999-2000.

Carers

The Victorian New Directions for Victoria's Mental Health Services document acknowledges carer contributions and the increased carer burden. The development of formal systems for carer involvement in mental health policy and planning, at both the Government and local service levels, will continue to be a high priority.

Funding

The Department welcomes Audit acknowledgement that DHS has made considerable progress in distributing funds to Area Mental Health Services on a more equitable basis. DHS has updated the weighted population formula with more recent data and commissioned a qualitative review of its methodology.

Performance indicators

The Measures and KPIs are deliberately output focussed as they are used for aggregate reporting to Government on output performance. These indicators are not intended to be used for service management or outcomes measurement purposes.

The Department agrees with the audit that outcome measures are important. As acknowledged by Audit, Victoria was the first jurisdiction to trial the use of routine outcome measurement, commencing with a small number of pilot agencies in the mid-1990s, and subsequent development of policy and training materials. An Information Development Agreement with the Commonwealth was signed in October 2001, providing $9.2 million to establish information infrastructure to support a national focus on service effectiveness, including the comprehensive introduction of outcome measures. Victoria leads the way in the implementation of outcome measurement in Australia, and when fully implemented in all States and Territories, Australia is expected to be the first country in the world to have implemented outcome measurement across both the public and private sectors.

Victoria is aiming to have 70 per cent of AMHSs reporting outcomes data by June 2003.

In addition to implementing outcome measurement across AMHSs, the Department will consider the measures and key performance indicators put forward by audit.

Future Response

There are pressures on the system. There are increasing numbers of people with mental health problems and growth in the numbers of people seeking, and being provided with, specialist services by AMHSs. This growth in demand is acknowledged and is being addressed.

In September 2002, the Victorian Government launched New Directions for Victoria's Mental Health Services. The New Directions report sets out overall directions and strategies for the development of mental health services and programs over the next 5 years. It outlines how the mental health service system will be better positioned to respond to existing and future demand for care by building on the strengths of the current system, developing an appropriate mix and level of service, and implementing new and innovative approaches to consumer needs. Some of the key initiatives which are being implemented include:

- *more acute beds and expanded community mental health services to better manage growing demand;*
- *new and innovative "sub-acute" and intensive treatment and support models of service delivery to improve responsiveness to consumer needs;*
- *tailored responses for young consumers to reduce the impact of mental illness on their future development and opportunities;*

- *integrated responses to the growing group of people with both mental illness and substance abuse problems;*
- *a comprehensive plan for the mental health work force focussing on its future development and management; and*
- *strengthening and extending consumer and carer participation and support.*

The actions and initiatives described in the New Directions document also include a strong focus on future long-term planning and structural improvements to manage demand for mental health services and build the capacity of the service system. As implementation occurs, the State will be in a position to further extend these initiatives and improve services for Victorians with mental health problems.

The 6 key directions for the next 5 years are:

- *expanding service capacity;*
- *creating new service options;*
- *extending prevention and early Intervention;*
- *building a strong and skilled workforce;*
- *strengthening consumer participation; and*
- *improving carer participation and support.*

***RESPONSE** provided by Barwon Mental Health Service*

Thank you for the opportunity to be involved in this audit and I trust that Victorian Parliamentarians will be interested in its content and conclusion. We look forward to benefiting from any initiatives from government to improve and enhance services to people who suffer from a mental illness. [Specific comments provided in relevant Part.]

***RESPONSE** provided by St Vincent's Mental Health Service*

Thank you for the opportunity to respond to the performance audit report. As it is now 6 years since major reform of Victorian mental health services took place, it is timely to examine the performance of mental health services, particularly in response to people in crisis.

While the report identifies many shortfalls in the delivery of mental health services for people in crisis, it fails to comment on the significant improvements in the mental health service system over the last ten years. It should be noted that until 1994, there were only a small number of Crisis Assessment and Treatment Services operating in Victoria, and community services had very limited outreach capacity. After 1994, these services were developed across Victoria. In 1999, these services were funded to provide services on a 24 hour basis. Until 1995, there was no comprehensive case-management system that aimed to identify a primary contact for each person accessing mental health services. Acute inpatient services have also undergone major reform – with purpose-built facilities co-located with general hospitals replacing old and decrepit buildings in institutional settings.

Consumers, carers and staff with whom we have had contact acknowledge that although the current system is not perfect, it is a great improvement on what was there before. Victoria is the only Australian state to have comprehensive mental health services across all areas. At the recent Australian and New Zealand Mental Health Services Conference, the achievements in Victoria stood out, whether it was in relation to consumer and carer participation, development of cross-sector services such as dual diagnosis initiatives, the integration with the general health sector or the provision of non-government psychosocial rehabilitation services, or the availability of a 24 hour response to psychiatric crises.

The report notes the increased demand on mental health services, and highlights the need of mental health services to respond to all people with high mental health needs, not only those with psychotic disorders. The Primary Mental Health Service initiative has shown promise in expanding the capacity of the service system, but further resources will be needed, plus education and practice change, to ensure that mental health services are able to respond adequately to people in crisis.

We agree that documentation of response to people in crisis could be considerably improved, and that there needs to be a system-wide approach to assessment of urgency and risk.

Part 2

Introduction

THE MENTAL HEALTH OF VICTORIANS

2.1 This audit involves an examination of Victoria's public mental health services, with a focus on the response to adults in psychiatric crisis. The audit also examines the responsiveness of the mental health system to the needs of those who care for a person with a mental disorder; the protection of patient rights through the Mental Health Review Board; mental health funding and resource allocation; and the framework for monitoring performance in the public mental health system. A full description of the audit's objectives, scope and methodology is provided in Appendix A of this report.

2.2 In 2001, about 55 000 Victorians received services from the public mental health service system. Recent estimates from the Victorian Burden of Disease study suggest that mental disorders are a leading cause of disability, accounting for 26 per cent of the non-fatal health burden in Victoria. The 1997 National Mental Health and Well Being survey reported that 18 per cent of Australians (about 2.4 million people) have a mental disorder. Demand for services is increasing, and this trend is likely to continue over the next 5 years[1].

2.3 Poor mental health reduces an individual's sense of wellbeing, and may impact negatively on family and social relationships, and the wider community. Unemployment, substance abuse, physical illness and social dislocation are generally higher among people with a mental disorder. Overall quality of life is reported as lower, and most experience difficulty functioning effectively in the community and maintaining healthy relationships. People with psychotic disorders (such as schizophrenia) often experience considerable difficulty coping with everyday tasks, maintaining social relationships and occupational functioning.

2.4 The provision of mental health services to the community involves the Commonwealth, private service providers and the public mental health system. The Commonwealth provides funding to State and Territory Governments to support the ongoing reform of mental health service delivery systems. It also provides funding for income and disability support through a range of Commonwealth programs for people with mental disorders. Private psychiatrists and general practitioners are funded by the Commonwealth through the Medicare Benefits Schedule, and psychiatric medications through Pharmaceutical Benefits subsidies.

2.5 General practitioners and private psychiatrists have an important role to play in providing services. In 1999-2000, an estimated 10 per cent of general practice encounters involved the management of at least one mental health-related problem. In 1999-2000, private hospitals accounted for a third of mental health treatment episodes, and public hospitals the remainder.

[1] Victorian Department of Human Services, *Victorian Burden of Disease study* (1999).

2.6 Victorian public mental health services have a key role in responding to people with serious mental illness and assisting their family or carers, particularly during a psychiatric crisis. It is, therefore, important that public mental health services offer timely and appropriate care to Victorians in need of such services.

What is a mental disorder?

2.7 A "mental disorder" is defined as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual, which is associated with distress, disability or with a significantly increased risk of suffering death, pain, disability or a significant loss of freedom[2] . This definition encompasses disorders which affect a number of people in the community, including depression and anxiety disorders, and less common psychotic disorders, such as schizophrenia.

Who uses public mental health services in Victoria?

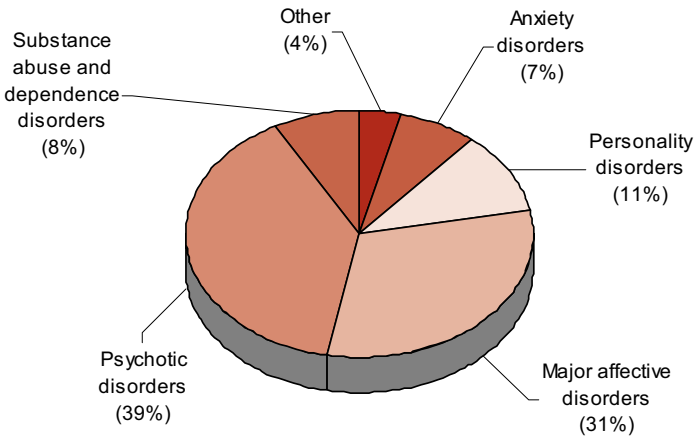
2.8 The public mental health service system responds to people of all ages who have mental health problems requiring specialist expertise. The 1994 Framework for Mental Health Service Delivery in Victoria defines the "target group" for adult public mental health services as follows:

> *"... people with serious mental illness and/or an associated significant level of psychosocial disability. This includes clients suffering from functional psychoses, both acute and persistent, severe mood and eating disorders, or with severe anxiety disorders, as well as those who present with situational crises which may lead to self harm or inappropriate behaviour directed towards others. People with severe personality disorder whose behaviour places themselves or others at risk of harm are included in the target group".* (page 26)

2.9 In 1999, 32 350 adults, 9 628 children and adolescents, and 8 176 aged persons were registered with a Victorian public mental health service. Chart 2A illustrates the diagnostic breakdown of people receiving services.

[2] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, (1980) 4th Edition, Washington DC.

CHART 2A
RELATIVE PROPORTIONS OF VICTORIANS REGISTERED WITH MENTAL HEALTH SERVICES, BY DIAGNOSIS, 1998 TO 1999



Note: Data for 2001-02 could not be provided by the Department of Human Services.
Source: Department of Human Services, 2002.

2.10 Chart 2A illustrates that public mental health services in Victoria respond to a relatively large number of people with psychotic disorders. While psychotic disorders accounted for 39 per cent of service registrations in 1998-99, their rate of occurrence in the community is relatively low (estimated at around one per cent of the population). People with more common (or "high prevalence") disorders, such as depression and anxiety, tend to be referred to primary health care providers, general practitioners or private practitioners for ongoing treatment. Table 2B shows the estimated prevalence of mental disorders among Australian adults in the community.

TABLE 2B
ESTIMATED PREVALENCE OF MENTAL DISORDERS
AMONG AUSTRALIAN ADULTS
(per cent)

Mental disorder	*Estimated prevalence*
Anxiety disorders	10
Substance abuse and dependence disorders	8
Personality disorders	6
Affective disorders	6
Other mental disorders *(a)*	5
Psychotic disorders	1
No mental disorder	78

(a) Includes eating, adjustment and somatoform disorders.

Note: A person may have more than one disorder, therefore, the components when added may be greater than 100 per cent.

Sources: Australian Bureau of Statistics (1997), *Mental Health and Wellbeing Profile of Adults, Australia;* Commonwealth Department of Health and Aged Care (1999), and *People living with psychotic illness: an Australian study 1997-1998*.

Economic and social cost of mental disorders

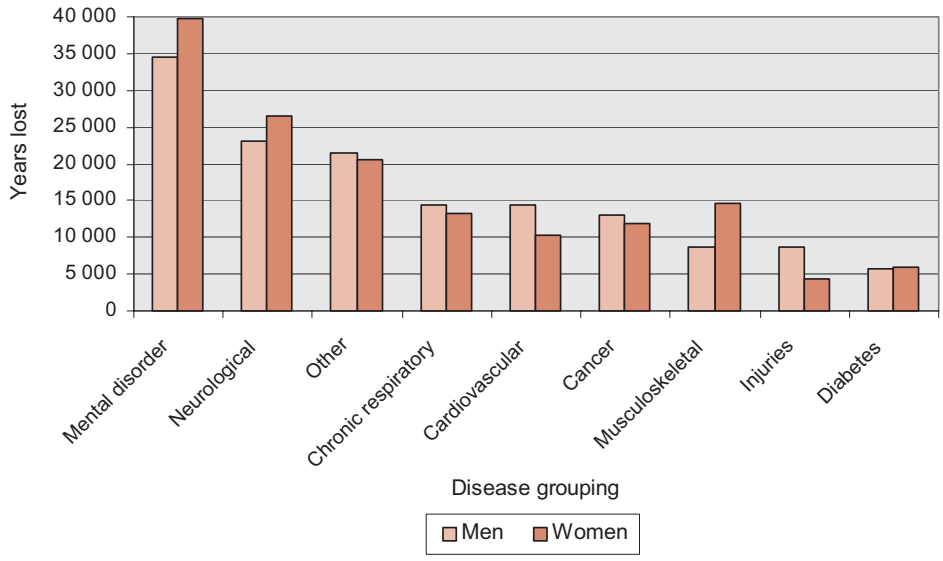
Victorian Burden of Disease study

2.11 Mental disorders have a significant economic and social impact on the wider community. The Victorian Burden of Disease study provides the first comprehensive assessment of the health status of the Victorian population and quantifies the contribution to the "burden of disease" of mortality, disability, impairment, illness and injury arising from 176 diseases, injuries and risk factors. The study was conducted in 1996 and published in 1999.

2.12 The study reported that mental disorders are the leading cause of disability in Victoria. Depression was reported as the leading cause of non-fatal burden in both men and women, accounting for 8 per cent of the total burden.

2.13 Chart 2C illustrates the burden in lost years due to disability in both men and women. Mental disorders and neurological conditions contribute most to the total non-fatal burden, accounting for two-fifths in men and almost half in women.

CHART 2C
NON-FATAL DISABILITY BURDEN,
BY SEX AND BROAD DISEASE GROUPING, VICTORIA, 1996



Source: Victorian Burden of Disease Study, 1999.

Suicide

2.14 Australia has one of the highest suicide rates in the Western world. While the overall suicide rate has not changed significantly, youth suicide in Victoria has increased over the past 40 years, and is now the third largest cause of death among young people aged 15 to 24 years, behind motor vehicle accidents and cancer-related illness. Between 1990 and 2000, 6 049 Victorians aged 15 or more committed suicide. Victoria's suicide death rate averaged around 12 per 100 000 population and the suicide rate was lower than the national average in each of these 11 years.

2.15 The Victorian Suicide Prevention Taskforce Report (1997) indicated that up to 90 per cent of young people who commit suicide suffer from a mental disorder, such as depression or schizophrenia. Consistent with national standards, public mental health services have a responsibility to respond to people at risk of serious self-harm or harm to others during or following a psychiatric crisis, whether this is due to a first or recurring episode of acute mental disorder.

Co-morbidity

2.16 National surveys consistently report a relationship between mental disorder and substance abuse, particularly among people with psychosis. Harmful substance use was reported by 49 per cent of people with a psychotic disorder in the 1999 national psychosis survey[3]. Moreover, 25 per cent of the total sample reported a lifetime history of cannabis abuse.

2.17 *Australian Health (2000)*, a report by the Australian Institute of Health and Welfare, highlights the high levels of physical problems associated with mental illness. Fifty per cent of people diagnosed with depression in one survey reported a physical illness or condition requiring treatment. The report also noted that people with a mood disorder were 2 to 3 times more likely to have a heart attack during their life compared with the general population. Cigarette smoking rates are 2 to 4 times higher among people with a mental disorder, and approximately 80 per cent of people with psychosis are regular smokers[4].

Unemployment

2.18 People with mental disorders are significantly more likely to be unemployed than people with good mental health. The 1997 National Mental Health and Well Being survey estimated that 36 per cent of males and 32 per cent of females with a mental disorder were unemployed during the 12 months prior to the survey. In a study of people with psychotic disorders, 72 per cent of people surveyed were unemployed, highlighting the considerable occupational burden of psychotic disorders[5].

Housing and accommodation

2.19 A high proportion of people with mental health problems use public housing. The Commonwealth's 1999 national study of people with psychotic disorders reported that 45 per cent of those surveyed were reliant on accommodation in institutions, hostels, group homes, supported housing or crisis shelters. Eighty-five per cent of the sample were reliant on welfare benefits. Obtaining safe, affordable housing was difficult or beyond the financial capacity of most people surveyed.

2.20 The national study also noted that for most people with a mental disorder, the provision of stable, affordable accommodation is a necessary prerequisite for recovery. Access to secure housing with appropriate support services may provide an environment conducive to recovery which reduces the likelihood of recurring mental illness and future need for mental health services.

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[3] Commonwealth Department of Health and Aged Care, *People Living with a Psychotic Illness: An Australian Study* 1997-1998 (1999).

[4] J. de Leon, F.J Diaz, T. Roger, D. Browne & Dinsmore, *Initiation of daily smoking and nicotine dependence in schizophrenia and mood disorders*. Schizophrenia Research, (2002), *v.56*, pp. 47-54.

[5] Commonwealth Department of Health and Aged Care, *People Living with a Psychotic Illness: An Australian Study 1997-1998*, (1999).

Police and ambulance services

2.21 Police and ambulance services are increasingly involved in responding to mental health crises. Between January 2000 and December 2001, the Victorian Metropolitan Ambulance Service (MAS) responded to 2 047 people with mental health concerns[6]. The MAS reports a 27 per cent increase in the emergency transport of people with a mental illness between 1996 and 2000. A new set of mental health response protocols for the MAS[7] was issued in February 2001.

2.22 Similarly, in 2001, Victoria Police responded to 843 incidents where mental health concerns were reported[8]. This represents a 33 per cent increase from the previous year. Victoria Police have recently introduced new guidelines for responding to people with mental disorders which aim to improve the appropriateness of response.

NATIONAL MENTAL HEALTH STRATEGY

2.23 In 1992, State and Commonwealth Governments in Australia endorsed the National Mental Health Policy and Strategy, foreshadowing reform of how services were provided to people affected by a mental disorder. The endorsement covered both a national direction and a framework for governments to work together to change a system that was widely acknowledged as inadequate and long neglected by policy makers[9].

2.24 Broadly, the aims of the National Mental Health Policy and Strategy were to:

- promote the mental health of the Australian community and, where possible, prevent the development of mental health problems and mental disorders;
- reduce the impact of mental disorders on individuals, families and the community; and
- assure the rights of people with mental disorders.

2.25 The Strategy was articulated in 4 major policy documents: the *National Mental Health Policy*; the *First National Mental Health Plan 1992*; *the Mental Health Statement of Rights and Responsibilities*; and *the Medicare Agreements 1993-98*. In combination, these documents outlined a new approach to mental health service delivery, and the action plan for implementing the proposed changes over the first 5 years of the Strategy.

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[6] Figures provided by the Metropolitan Ambulance Service (MAS). Includes all psychiatric patients transported by MAS (emergency or non-emergency).

[7] Victorian Department of Human Services, *Ambulance Transport of People with a Mental Illness*.(2002).

[8] Figures based on a subjective judgement of the reporting officer as to the presence of a "mental handicap".

[9] Commonwealth Department of Health and Family Services, *Evaluation of the National Mental Health Strategy – Final Report* (1997).

Key service reforms under the National Mental Health Strategy

Mainstreaming and integration

2.26 From 1993, a number of key reforms to public mental health services began across Australia. Reform included relocating acute psychiatric beds from isolated psychiatric institutions to general hospitals. This was accompanied by the closure of several large stand-alone psychiatric institutions. The rationale behind these changes was a belief that stigma could be reduced and care improved by bringing the delivery and management of specialist mental health services within the general health system – a process referred to as "mainstreaming".

2.27 A further element of reform was the integration of mental health services across inpatient and community-based service components. Integration of services aims to provide continuity of care so clients can move between service elements as their needs change and receive the most appropriate service response at any time.

Expansion of community-based services

2.28 The National Mental Health Strategy also sought to change the mix of services available, replacing stand-alone psychiatric institutions with a comprehensive range of inpatient, residential, community treatment and community support services. A community-oriented approach to the provision of mental health services was promoted. Commonwealth Reform and Incentive Funds were made available to support States and Territories in developing community-based mental health treatment services, and community residential and support facilities. The range of community-based mental health services was to include:

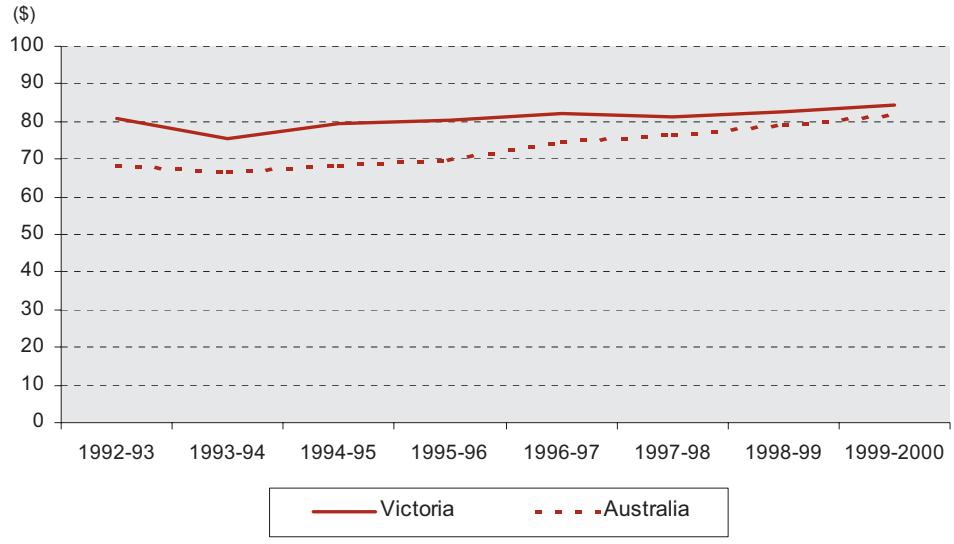
- assessment, treatment and rehabilitation services provided on a clinic, domiciliary or outreach basis for people affected by mental disorder;
- community-based residential units staffed by mental health professionals on a 24-hour basis that provide rehabilitation for people with long-term disabilities associated with severe mental disorder; and
- services provided by not-for-profit non-government organisations, funded by governments to provide residential and non-residential rehabilitation programs and outreach support services for people with a psychiatric disability arising from a mental disorder.

Funding changes

2.29 Total recurrent expenditure on specialised mental health services in Australia increased by an average of 6.0 per cent per year between 1992-93 and 1999-2000[10]. This was almost double the corresponding Victorian increase of an average of 3.3 per cent. Funds allocated to mental health services in Victoria are projected to grow by an average of 8.6 per cent from 1999-2000 to 2002-03[11]. These funds in the 2002-03 Budget amounted to $588.5 million, or 7 per cent of total recurrent funding in the Department of Human Services and 11 per cent of the Health budget[12].

2.30 As shown in Chart 2D, per capita expenditure on mental health services in Victoria has remained above the national average since 1992, however, the gap has reduced in recent years. Issues concerning regional funding to public mental health services in Victoria are described in Part 6 of this report.

CHART 2D
MENTAL HEALTH EXPENDITURE, VICTORIA AND AUSTRALIA
(recurrent per capita expenditure, $ in constant prices)



Source: Victorian Auditor-General's Office, based on Commonwealth Department of Health and Aged Care, National Mental Health Report 2001, draft appendices.

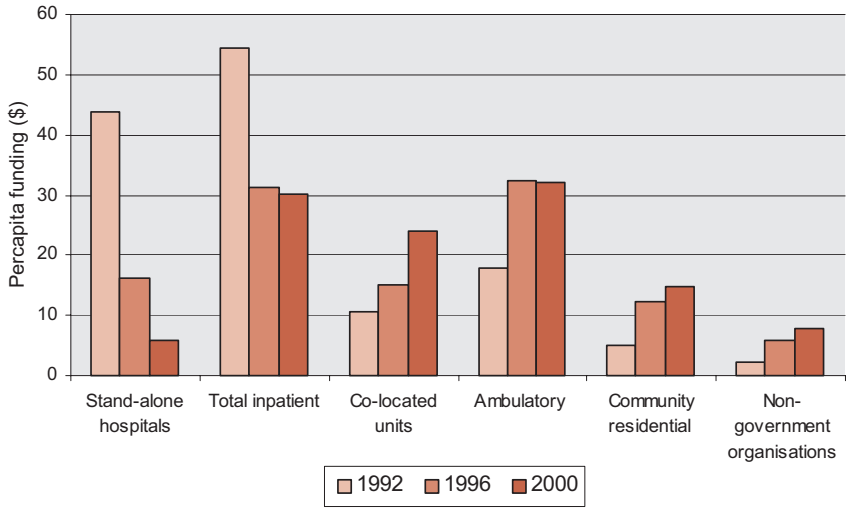
[10] Commonwealth Department of Health and Aged Care, *National Mental Health Report, Draft appendices* (2001).

[11] Government of Victoria, 2002-03 Budget, *Budget Paper No. 3,* Statement No. 2 and earlier Budget papers.

[12] Victorian Department of Human Services, *Victorian Public Hospitals and Mental Health Services Policy and Funding Guidelines* (2002-2003).

2.31 The shift towards community-based care was accomplished through a significant redirection of Commonwealth and State Government funding. Chart 2E highlights the redistribution of funding in Victoria during this time. Between 1992 and 2000, per capita funding to stand-alone psychiatric hospitals and total inpatient services decreased by 860 and 125 per cent, respectively. During the same period, per capita funding to co-located psychiatric units, community residential services, ambulatory services and non-government organisations increased by 45, 185, 80, and 226 per cent, respectively.

CHART 2E
SPECIALISED MENTAL HEALTH SERVICES
EXPENDITURE, PER CAPITA, VICTORIA, 1992 TO 2000



Source: Commonwealth Mental Health Branch.

2.32 A breakdown of total mental health expenditure in Victoria by age group is shown in Table 2F. This illustrates the large proportion of annual funding allocated to adult mental health services (the focus of this audit), compared with child and adolescent and aged care services. The Department of Human Services advises that this allocation is consistent with the distribution recommended in its 1996 framework.

TABLE 2F
MENTAL HEALTH SERVICE EXPENDITURE
BY AGE GROUP, VICTORIA, 2001-02

Age group	*Percentage of total*
Child and adolescent	9.6
Adult *(a)*	76.4
Aged	14.0

(a) Adult specialist and Statewide services.
Source: Department of Human Services, 2002.

Service linkages

2.33 Recognising the complex needs of mental health consumers, formal linkages with other service systems, including drug and alcohol, housing, ambulance and emergency services, were also encouraged under the National Mental Health Strategy. The Strategy also promoted shared care arrangements between general practitioners, private psychiatrists and public mental health services.

Work force changes

2.34 As Victorian services have become mainstreamed with a shift towards community-based treatment, human resources have been redirected accordingly. Full-time inpatient staff reduced by 45 per cent between 1993-94 and 1999-2000, and ambulatory and community residential staff increased by 42 and 212 per cent, respectively. Overall, the total number of full-time equivalent staff employed in specialist mental health services decreased by 7 per cent during the same period[13].

National standards in service delivery

2.35 As part of the National Mental Health Strategy, a set of National Mental Health Standards were developed and endorsed by all States and Territories in 1997. These Standards were developed as a guide to service enhancement and continuous quality improvement. The Standards relate to human rights, links with other services, access and response issues, and care and treatment of mental health patients and their carers.

Evaluation of the First National Mental Health Strategy

2.36 The agreement of all Australian and State Governments to the National Mental Health Strategy included a commitment to evaluate both the progress and outcomes of the various initiatives. An evaluation was undertaken and published in 1997[14].

2.37 Overall, the evaluation concluded that while the range and quality of services available in Australia had improved substantially over those that existed in 1992, many service delivery objectives had not been attained and consumer treatment and carer support had been adversely affected as a consequence.

Second National Mental Health Plan (1998 to 2003)

2.38 In July 1998, a Second National Mental Health Plan was endorsed by all Australian Health Ministers. The Plan provided a 5-year (1998 to 2003) framework for activity at national and State levels, building upon the achievements of the First National Mental Health Plan (1993 to 1998).

[13] Commonwealth Department of Health and Ageing, *National Mental Health Report, Draft appendices* (2001).
[14] Commonwealth Department of Health and Family Services, *Evaluation of the National Mental Health Strategy* (1997).

2.39 The Second Plan emphasised 4 additional areas of reform:

- mental health promotion and prevention - increasing community awareness and acceptance of mental disorders through advertising campaigns;
- partnerships in service reform and delivery - improving links both within mental health service systems and between the mental health service system and other systems;
- monitoring service quality and effectiveness - development of outcome measures and agreement on accreditation of services against national standards for mental health services by June 2003; and
- illness prevention and early intervention.

Progress under the Second National Mental Health Plan

2.40 In November 2001, a mid-term review of the Second National Mental Health Plan was conducted[15]. That review supported the principles of the Plan, noting that "the Plan reflects exemplary mental health policy leadership". However, a number of concerns were raised in relation to the Plan's delivery at a national and Statewide level. The review concluded that:

- The response received during a mental health crisis is often slow and unreliable;
- Crisis services were not consistently responsive to people with early signs of relapse, indicating that the current capacity for crisis response services is only sufficient to intervene for those in the most severe crisis situations;
- Despite the provision of early intervention teams, some people with severely disabling mental health problems are unable to access treatment and care unless they are in an advanced state of illness;
- Australia is experiencing a serious, if not critical, mental health work force shortage in numbers, with an uneven distribution of clinicians of all disciplines;
- Service "silos" exist whereas seamless systems are needed to co-ordinate delivery of mental health, housing, education, disability and family services;
- With one exception (WA), mental health and substance abuse services are separated, which makes operational co-ordination of services for people with these disorders difficult;
- Mental health services in rural and remote areas are generally recognised to be less available than those in metropolitan areas. Concerns were raised in terms of difficulties in recruiting and maintaining staff, and that crisis assessment services do not operate fully out of hours;
- The application and monitoring of service standards, while acknowledged as important, have so far been introduced in an ad-hoc manner; and

[15] Commonwealth Department of Health and Ageing, *International Mid-Term Review of the Second National Mental Health Plan for Australia* (2001).

- Despite the increasing government focus on mental health services over the past decade, many needs remain, especially for people with the more common disorders and people living in rural or remote areas.

MENTAL HEALTH SERVICES IN VICTORIA

Legislative framework

2.41 The *Mental Health Act* 1986 provides the legislative framework which guides and regulates the provision of services to people with a mental disorder in Victoria. The Act indicates that services must operate so that people who are mentally ill receive the best possible care and treatment in the least restrictive environment, enabling care and treatment to be provided effectively.

2.42 Clear directions are provided under the Act for the Department of Human Services about the way services should be delivered. Services must:

- provide standards and conditions of care and treatment for persons who are mentally ill which are, in all possible respects, at least equal to those provided for persons suffering from other forms of illness;
- take into account the religious, cultural and language needs of persons who are mentally ill;
- minimise the adverse effects of mental illness in the community;
- be comprehensive, accessible and acceptable;
- be designed to reduce the incidence of mental illness in the community;
- provide for intervention at an early stage of mental illness; and
- support the patient in the community and co-ordinate with other community services.

2.43 Importantly, the Act also defines the rules and safeguards which must apply when care is provided to any person on an involuntary basis, including the laws governing the operation of the Mental Health Review Board which determines appeal and review decisions for involuntary treatment.

Roles and responsibilities

Department of Human Services

2.44 The process of mainstreaming mental health services emphasised the different roles and responsibilities of the purchaser (the Department) and service providers (the Area Mental Health Service). The Department defines its role as:

- development of policy and guidelines which support government decisions;
- regional and Statewide service planning;
- purchasing service provision for each of the service areas; and
- monitoring the quality and quantity of services provided to people in each area.

2.45 The *Mental Health Act* 1986 defines the legislative requirements of the Departmental Secretary. Specific requirements relevant to the present audit include the following:

- *Service planning and co-ordination:* to facilitate the planning, co-ordination and development of a comprehensive and accessible range of mental health services which are integrated within an identifiable mental health program and which are provided within the organisational arrangements for general health services;
- *Continuity of care*: to promote the development of systems and services which improve continuity of treatment and care, and which enhance access to general health, mental health and welfare services;
- *Service monitoring and evaluation*: to oversee and monitor standards of mental health services;
- *Consumer rights (information)*: to facilitate the provision of appropriate and comprehensive information and education to people receiving treatment for a mental disorder in an approved mental health service and other people with a mental disorder about their mental disorder, its treatment and the services available to meet their needs;
- *Education:* to facilitate education, assistance and consultation programs about mental disorders for primary health care workers in order to help them understand, manage and appropriately refer people with a mental disorder;
- *Carer support*: to support the development of services which assist carers and promote self-help and advocacy for people with a mental disorder and to facilitate the provision of information, education and support to carers and advocates; and
- *Early intervention*: to provide for intervention at an early stage of mental disorder.

Area Mental Health Services

2.46 In 1994, the Victorian Government initiated a major redevelopment of the public mental health service system[16]. Consistent with the national shift towards community-based treatment, all stand-alone psychiatric institutions would eventually be closed, and existing beds relocated to new local facilities across the State.

[16] Victorian Department of Human Services, *Victoria's Mental Health Service: The Framework for Service Delivery* (1994).

Area Mental Health Services provide assistance for people across their lifespan.

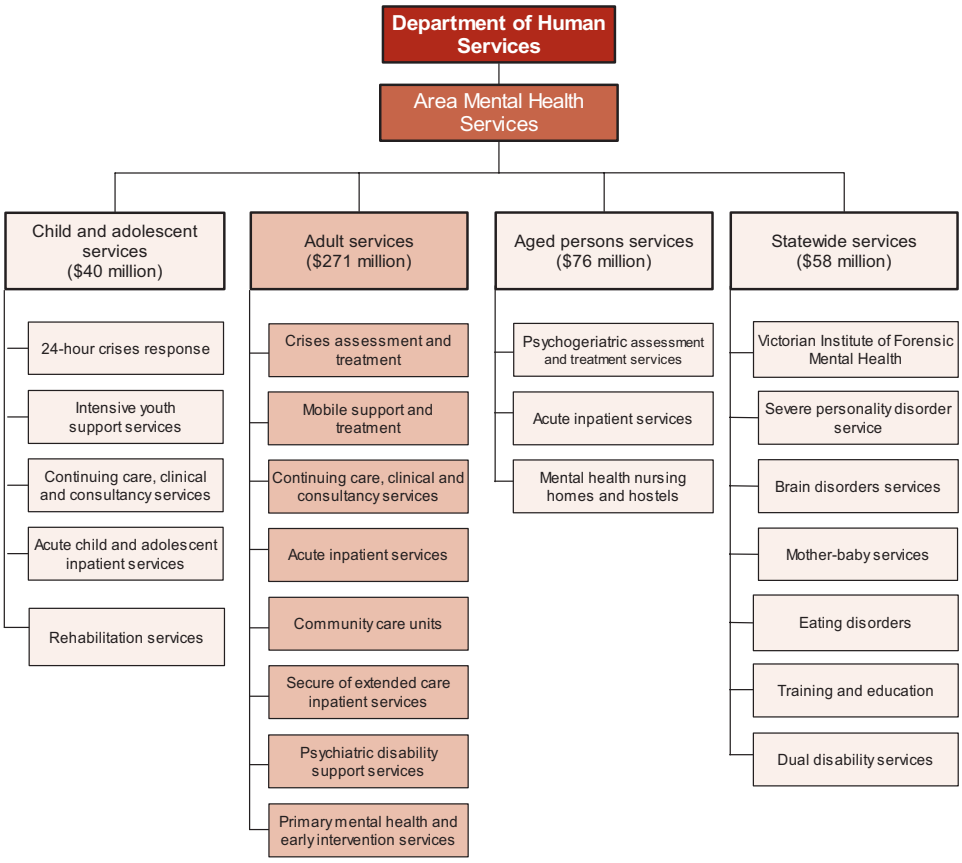
2.47 Mental health services in Victoria are now provided through 21 local Area Mental Health Services (AMHSs). All areas have access to a range of inpatient, community residential and ambulatory services. All clinical inpatient services have been mainstreamed into general hospitals and each AMHSs provides a range of general services and, in some cases, specialist Statewide services. Service delivery within AMHS across Victoria includes:

- 21 Adult Area Mental Health Services, which assess and treat adults (aged 16 to 64) with serious mental illness;
- 17[17] Aged Persons Mental Health Services, which assess and treat older people (aged 65 and over); and
- Child and Adolescent Mental Health Services, which assess and treat children and adolescents (up to 18 years of age) who have a serious mental disturbance or who are known to be at risk of such disturbance.

2.48 Each AMHS is responsible for the timely and appropriate provision of services consistent with national standards and State legislation. Chart 2G shows the core service elements of each AMHS, as well as specialist services provided on a regional or Statewide basis.

[17] Service regions for child, adolescent and aged person's mental health services cover larger regions of Victoria than adult services.

CHART 2G
VICTORIAN MENTAL HEALTH SERVICE SYSTEM AND BUDGET FIGURES, 2001- 02



Source: Department of Human Services, 2002.

Service elements of the adult system (the focus of this audit) are described below.

Crisis Assessment and Treatment (CAT) Services

2.49 CAT services are often the "first port of call" for people experiencing a mental health crisis. CAT services provide assessment services in hospital emergency departments, screen all inpatient admissions, and provide community assessment and intervention for people with an acute psychiatric condition. CAT services assess whether an inpatient admission is required and can provide intensive home treatment and support as an alternative. They should be available 24 hours a day, 7 days a week[18]. CAT services also provide support to other mental health and general health practitioners, and the consumer's family or carers.

[18] Victorian Department of Human Services, *Mental Health services: Psychiatric crisis assessment and treatment services – guidelines for service provision* (1994).

Mobile Support and Treatment (MST) Services

2.50 MST services provide intensive long-term community treatment and support on an outreach basis to consumers with substantial and prolonged severe mental disorder and associated disability. Most commonly, the consumer will have schizophrenia, however, the specific focus of the MST service are consumers who are especially prone to relapse and those at high risk of requiring hospitalisation. MST services have a high staff-to-client ratio and operate on an extended hours basis, 7 days a week.

Continuing Care, Clinical and Consultancy Services

2.51 Each AMHS has one or more local community mental health clinics providing assessment, acute and continuing treatment for consumers and consultancy for local general practitioners and other health and welfare agencies. These community mental health clinics provide an initial assessment service for people requesting assistance where a CAT service response is not required. Ongoing case management is usually provided by clinicians from these clinics. The focus is on people with serious mental illness who require treatment, monitoring and continuing support, as well as more specialist individual, group and family therapy programs.

2.52 The most intensive residential rehabilitation services are community care units (CCUs) which are managed by AMHSs. These are designed for people with serious mental disorders and marked disabilities, some of whom would have been patients of extended care wards of former psychiatric institutions. CCUs are purpose-built residential units in community settings which provide a home-like environment and 24-hour clinical support. The CCU provides an opportunity for community living and enhanced quality of life for residents.

Residential and Non-Residential Rehabilitation Services

2.53 Rehabilitation services are an essential component of a comprehensive mental health service system. Rehabilitation aims to assist people with psychiatric disabilities regain the social and practical skills for everyday living in the community, and is provided through both residential and non-residential services.

2.54 Residential rehabilitation services are generally managed by non-government organisations. Residents stay for periods ranging from a few months up to a year while re-establishing themselves in the community. Many of these residential rehabilitation services target young people and were established with government funding from the 1997 Victorian Suicide Prevention Initiatives.

2.55 Non-government organisations also provide non-residential rehabilitation services using both center-based and outreach approaches. These services aim to promote and maintain recovery and improve quality of life, complementing the assessment and treatment functions of clinical services. Day programs focus on strengthening the capacity of people with psychiatric disabilities to live successfully in the community. In addition, through the provision of rehabilitation on an outreach basis, psychiatric disability support services enable people with different levels of psychiatric disability to obtain and maintain public housing.

Acute Inpatient Services

2.56 Acute inpatient services are co-located with general hospitals and provide short-term assessment and treatment for people whose acute mental disorder cannot be safely managed in the community. Treatment is provided on a voluntary or involuntary basis during the acute phase of mental illness until the person has recovered sufficiently for treatment to be provided in a community-based setting.

Secure/Extended Care Inpatient Services

2.57 Secure/extended care inpatient services provide intensive treatment and support for people with unremitting and severe symptoms, together with associated significant behavioral disturbance that inhibits their capacity to live in the community. These services are generally provided on a regional basis due to the relatively small number of people in this category.

Statewide and Regional Specialist Services

2.58 Adult mental health services also include a range of specialist Statewide and regional services such as regional mother-baby units for mothers with a mental disorder and the Statewide forensic mental health service. Additional services established during the 1993 to 1998 period of service redevelopment included Statewide services for people with severe and borderline personality disorders, and for people with intellectual disability who have a mental disorder. In addition, a program to improve assessment and treatment for people with mental illness and substance abuse was successfully piloted in the western Melbourne metropolitan area. This has now been replicated in other regions.

Recent service initiatives in Victoria

2.59 The Victorian Government identified a broad direction for mental health in its 1999 pre-election policy statement. The policy identified the following areas as requiring further development or improvement:

- access to services, particularly psychiatric inpatient services and after-hours services for people experiencing a mental health crisis;
- consumer and carer participation in treatment and discharge planning;
- mental health care in the “primary” health sector;
- training and development of the mental health work force;

- accommodation and support for people with mental illness; and
- early detection and treatment of mental disorders.

2.60 These broad principles were recently reinforced when the Department launched *New Directions for Victoria's Mental Health Services: The Next Five Years* on 4 September, 2002. Some of the recent initiatives described in this statement include:

- Primary Mental Health Teams to assist local primary care providers in recognising and treating common mental disorders, particularly depression;
- the Statewide Dual Diagnosis Program, for training and secondary consultation to AMHS staff working with clients who have a mental disorder and drug-use problem;
- an additional 30 acute inpatient beds and piloting of 30 sub-acute beds Statewide;
- new carer support programs;
- additional homelessness outreach services, as a response to the growing number of homeless people with a serious mental disorder; and
- re-engaging the work force through a comprehensive strategy that aims to attract and retain skilled people in all mental health disciplines.

Mental health service delivery in Victoria: the current situation

2.61 The Second National Mental Health Plan's emphasis on mental health promotion and prevention, partnerships in service provision, and effective service delivery, are strategies which set the scene for improving the mental health of the nation. Similarly, the proposed initiatives described in the Department's *New Directions* statement, aim to address some of the identified gaps in service provision.

2.62 Despite the establishment of new service initiatives over the past 5 years, recent Statewide reviews indicate significant gaps in service provision, and ongoing problems with current mental health service delivery practices in Victoria[19]. The reviews indicate that service access to both inpatient and community-based services is becoming increasingly difficult for many consumers. Quality of treatment, discharge practices, protection of patient rights, and consumer participation in service delivery have been raised as areas of concern by many consumers and carers, and stakeholders involved in service provision.

2.63 At present, only the public mental health system is available 24 hours a day, 7 days a week to respond to the needs of people in psychiatric crisis. A delayed or inappropriate service response increases the risk of self-harm, suicide and violence, placing both the consumer and the public at potential risk. Recent service reviews and submissions from consumer and carers groups indicate this is an important area of service provision requiring urgent attention.

[19] Victorian Department of Human Services, *Revitalising Acute Inpatient Services: report of the review of adult acute inpatient mental health services* (2000).

2.64 This audit undertook a comprehensive examination of public adult mental health services in Victoria. The following Parts of the report comment on:

- the response to people in psychiatric crises (Part 3);
- the responsiveness of the mental health system to the needs of carers (Part 4);
- the protection of patient rights through the Mental Health Review Board (Part 5);
- mental health funding and resource allocation (Part 6); and
- the framework for monitoring performance in the public mental health system (Part 7).

Part 3

Responding to people in psychiatric crisis

INTRODUCTION

3.1 A psychiatric crisis occurs when an individual experiences a pronounced, negative change in functioning associated with their mental disorder. The crisis may occur within the context of a pre-existing mental disorder, or it may arise spontaneously in response to stress or trauma. Psychiatric crises are often associated with extreme levels of distress, high risk of suicide and/or harm to other people. For these reasons, a timely and appropriate service response is critical.

3.2 Public Area Mental Health Services (AMHSs) play a critical role in responding to people during a psychiatric crisis, particularly after-hours when other support services may not be accessible. Public AMHSs are required to provide assessment, treatment and support to people with "serious mental illness" and/or an associated level of psychological disability[1].

3.3 This Part of the report examines key aspects of the response to people in psychiatric crises, including:

- systemic issues relating to unmet service demand and work force requirements;
- service delivery framework, including service access, priority and timeliness;
- psychiatric hospitalisation, including particularly bed numbers, length of stay, involuntary admissions and discharge practices; and
- community-based treatment, focusing on case management, comprehensive assessment and individual service planning, access to information, treatment options and service linkages.

SYSTEMIC ISSUES

3.4 In this Part of the report we address system-wide issues which impact on the timeliness and appropriateness of mental health service delivery in Victoria.

Service demand

3.5 Demand for public mental health services in Victoria is increasing. Between 1997 and 2001, the total number of registered AMHS consumers increased by about 20 per cent. There has also been a 36 per cent increase in registered client contacts during the same period. Additional evidence of service demand increases include:

- Crisis Assessment and Treatment (CAT) team contacts have increased by 52 per cent across all public mental health services between 1997 and 2000;

[1] Victorian Department of Human Services, *Mental Health Services in Victoria, the Framework for Service Delivery* (1994).

- Psychiatric Disability Support consumer participants increased by 39 per cent between 1997 and 2000; and
- acute adult inpatient admissions increased by 7 per cent between 1997 and 2000[2].

3.6 Our review of the relevant literature indicates that factors which may be contributing to service demand increases include:

- population growth (up 1.15 per cent between 1997 to 2001);
- increased prevalence of mental health problems, especially depression and related disorders;
- improved professional and community recognition of mental disorder;
- a rise in the number of people presenting with multiple diagnoses, particularly co-existing mental disorder and substance abuse problems;
- increased demand for carer support services;
- increasing demand for psychiatric consultation from the acute health system, through greater recognition of the overlap between physical and emotional disorders; and
- limited availability of after-hours crisis response by other services, including alcohol and drug services, general welfare services, general practitioners (GPs) and private psychiatrists.

Evidence of unmet demand

3.7 Audit findings and Statewide data indicate a high level of unmet demand for mental health services in Victoria. Evidence for this conclusion comes from several sources:

- Data on the prevalence of mental disorders in the community indicate that 2 to 3 per cent of the adult population may have a severe mental disorder. If the figure of 3 per cent is compared with the number of registered service users, potentially up to one-third of people with a mental disorder meeting the AMHS target group are not receiving treatment from AMHS. In Victoria, this translates to about 40 000 people who may be accessing alternative mental health services such as GPs and private psychiatrists;
- A recent review of Statewide psychiatric inpatient services[3] concluded that there is a significant shortfall in the current supply of psychiatric beds for people with serious mental disorders, and that the distribution of beds Statewide is variable;
- Accommodation and support options for people with a mental illness are severely limited. There is a Statewide shortage of residential and inpatient treatment options for consumers with dual diagnoses. After-hours services for homeless people with a mental illness are also in short supply;

[2] Victorian Department of Human Services, including Prism Records Information System Manager (PRISM, 1997-2000, and Victorian Psychiatric Disability Support Services Minimum Data Set, 1997-98 to 2001.

[3] Victorian Department of Human Services, *Revitalising Acute Inpatient Services: report of the review of adult acute inpatient mental health services* (2000).

- Lack of alternatives to inpatient services, including services for consumers at different stages of recovery, have been identified in focus groups conducted by the Department of Human Services;
- Statewide waiting list data indicates that there is a high unmet demand for community-based residential, rehabilitation and outreach support services for people with severe and prolonged mental disorders[4]. Waiting lists for all psychiatric disability support services increased by 118 per cent between 1998 and 2000. Waiting lists for home-based support services increased by 113 per cent during the same period[5];
- Consumers and carers report a serious shortage of community-based mental health services for consumers with diverse and complex needs[6]; and
- An Australian study of psychotic disorders reports that *"... there is a serious lack of, and need for, community-based rehabilitation programs for people with psychotic disorders"*[7].

Consequences of unmet demand

3.8 Increasing and unmet service demand is impacting negatively on the public mental health system at several levels:

- Audit observations suggest that discharge decisions are influenced by demand pressures, rather than based solely on clinical needs. There has been increased consumer "throughput" (bed utilisation) and reduced length of stay in hospital, thereby increasing the likelihood of future readmission. The Department's *New Directions* plan, released in September 2002, notes the need to increase the capacity of acute inpatient services and for a demand management strategy;
- Audit data indicate that crisis response times have risen as a consequence of high demand, resulting in consumer distress;
- Carers interviewed during the audit and the Department expressed concern about the shortage of supported community-based services for consumers, and the significant burden this placed on families and carers creating a related demand for carer support services; and
- The need to focus on meeting current needs allows limited capacity for early intervention and/or prevention of mental disorders. This is a strategy outlined in the Department's *New Directions* plan.

3.9 The impact of unmet demand is illustrated in Chart 3A.

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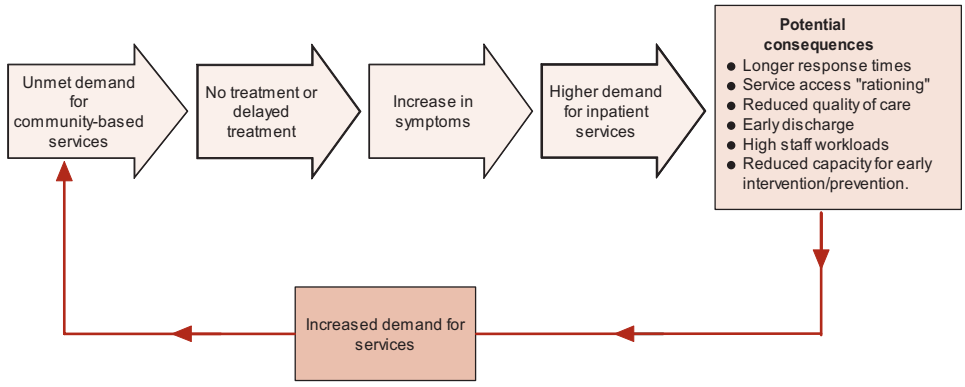
[4] Psychiatric Disability Support Services Waiting List Register 1998 – 2000.

[5] Victorian Psychiatric Disability Support Services Minimum Dataset 1998/99 to2000/2001.

[6] Evidence comes from interviews and focus groups conducted during the audit, and Department of Human Service report *Overview of findings from mental health focus group, October 2001-February 2002.*

[7] Commonwealth Department of Health and Aged Care, *People living with a psychotic illness: an Australian study, 1997-1998*, (1999).

CHART 3A
CAUSES AND CONSEQUENCES OF INCREASING SERVICE DEMAND



Source: Victorian Auditor-General's Office, 2002.

3.10 In summary, increasing service demand and associated levels of unmet demand are resulting in service access difficulties for many consumers, early discharge from hospital, and increased burden on family and carers. These outcomes increase the likelihood of future unplanned re-admissions.

Demand strategies

3.11 The Department has implemented a number of strategies in an attempt to manage the increasing demand given the level of resources and to overcome some of the issues described above.

3.12 Between 1998 and 2001, the Mental Health Branch provided additional resources to the following areas:

- Crisis Assessment and Treatment Services;
- Residential Rehabilitation;
- Psychiatric Disability Support Services (PDSS)
- Home Based Outreach Support Services; and
- recurrent funding to recognise population growth and an increased awareness of mental health (targeted to some community-based clinical services and acute inpatient services).

3.13 More recently, resources have been directed to the following areas through the Department's *New Directions* Plan:

- 30 new acute inpatient beds and the piloting of 30 sub-acute beds Statewide;
- primary mental health care - partly in response to the recognition that more resources are needed for people with common (high prevalence) disorders;
- early intervention - linked to the primary mental health initiatives and targeted to reducing more serious illness;

- dual diagnosis - a Statewide initiative targeting improved service provision to people with a dual diagnosis; and
- high prevalence disorders – funding of "Beyondblue", the national depression initiative.

3.14 The initiatives described in the Department's *New Directions* statement aim to expand the capacity of the current service system. It recognises that demand management and need reduction will be essential to success.

Work force issues

3.15 The delivery of effective mental health services requires an appropriately qualified and experienced mental health work force. AMHS consist of multi-disciplinary teams, including consultant psychiatrists, clinical psychologists, psychiatric nurses, social workers and occupational therapists. This work force diversity helps to ensure that complex consumer needs are adequately met by appropriately trained staff. Commonwealth and State funding plays an important role in supporting the Victorian mental health work force.

3.16 Changes in the composition and distribution of the Victorian mental health work force have been consistent with National Mental Health Strategy directions, and the shift towards community-based care. Between 1993 and 2000, the total number of full-time equivalent staff employed in specialist inpatient services in Victoria decreased by 45 per cent, while staff employed in ambulatory mental health and community-residential services grew by 29 and 68 per cent, respectively[8]. Nationally, the mental health work force has grown just over one per cent on a per capita basis between 1992 and 2000. Victoria's specialist work force[9], however, has decreased by 7 per cent (per capita), despite large increases in overall service demand[10].

3.17 The Department's *New Directions* statement confirms that there are significant work force issues which place constraints on the mental health system. These include:

- Substantial shortages of nurse, psychiatrist and allied mental health professionals (including psychologists, social workers and occupational therapists), particularly in rural areas;
- Difficulties in recruiting and retaining allied health staff;
- Inadequate mental health nurse training at the university level;
- Relatively unattractive terms and conditions for psychiatrists in the State system compared with the private sector (including lower pay and a more difficult consumer group);

[8] Commonwealth Department of Health and Ageing, *National Mental Health Report 2001 Draft Appendices Tables* (2002).

[9] Includes full-time equivalent staff employed in inpatient, ambulatory and community residential services.

[10] Commonwealth Department of Health and Ageing, *National Mental Health Report 2001 Draft Appendices Tables* (2002). (Figure excludes Psychiatric Disability Support Service employees).

- Significant pay discrepancies between the clinical and non-clinical sectors;
- As a result of these systemic work force issues, AMHSs are making high use of agency staff, and have high sick leave and staff turnover, which increases overall service costs; and
- The Commonwealth also plays a significant role through its funding of university places and its control of psychiatrist provider numbers and Medicare rebates. A number of initiatives taken by the Commonwealth to address other areas of the medical work force could be considered for mental health.

3.18 The Department's *New Directions* statement committed the Government to the development of a comprehensive mental health work force plan to be implemented over 5 years. The proposed initiatives seek to:

- attract more people to train and work in mental health;
- better prepare new entrants for work in the mental health services;
- better match availability and skills of existing work force to service needs; and
- encourage skilled and experienced workers to stay longer in the public mental health system.

3.19 We welcome these initiatives which have the potential to develop a sustainable mental health work force. However, the current shortages are having an immediate negative effect on service delivery. Responses from both the State and Commonwealth will be required to address the present work force issues facing mental health services in Victoria.

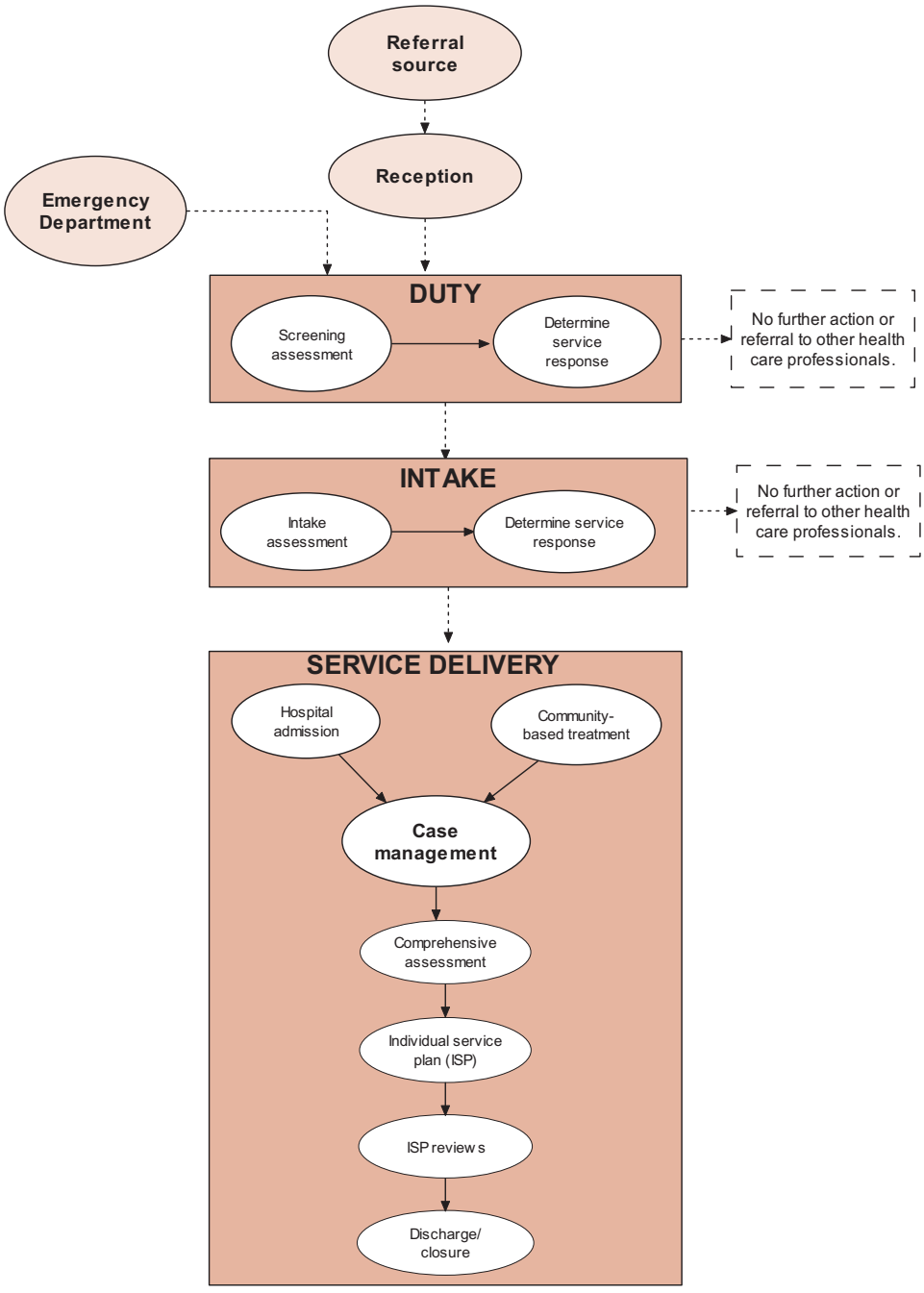
SERVICE DELIVERY FRAMEWORK

3.20 Guidelines published by the Department describe when and how AMHSs should respond to people during a mental health crisis. The "Client Services Model"[11] identifies what should happen after a potential consumer or referring agency makes contact with an AMHS. The model outlines the process of service delivery, which is built around a single point of entry to minimise delay in service response.

3.21 The model's primary objective is to ensure that consumer's needs are met effectively and efficiently through the implementation of a core set of processes and functions. Chart 3B shows the key components of the model.

[11] Victorian Department of Human Services, *Mental Health Services – Improved access through coordinated client care* (1995).

CHART 3B
MENTAL HEALTH SERVICE DELIVERY FRAMEWORK IN VICTORIA



Source: Victorian Auditor-General's Office, 2002.

3.22 Service activity in response to a referral is grouped into 4 phases. Broadly, these are: Reception, Duty, Intake and Service Delivery. Each phase requires a decision about whether the consumer's needs are best met through public mental health services or another appropriate service. A description of service access, incorporating Duty and Intake followed by the Service Delivery phases of the Client Services Model is presented below. National Mental Health Standards relevant to each phase, audit findings and conclusions are also discussed.

SERVICE ACCESS (DUTY AND INTAKE)

Introduction

3.23 Duty is the phase during which initial contact is made with a clinical AMHS staff member. Based on an *initial* screening assessment, the Duty worker determines the most appropriate service response. Departmental guidelines require that all Duty assessments should include an initial assessment of risk and urgency factors. The Duty worker also takes responsibility for making external referrals where appropriate or, alternatively, organising an Intake assessment. The AMHS must record all contacts made with the public on a "screening" form, regardless of whether the contact leads to further assessment or an external referral.

3.24 If the Duty worker considers that public mental health services are appropriate, a more detailed Intake assessment will be provided. The aim of this assessment is to obtain sufficient information to assess the type and level of service response required from the public mental health service. Typically, this will entail an assessment based on face-to-face contact with the person. The Intake assessment should address a number of areas, including: the presenting problem, a psychiatric history, mental state examination, physical assessment, and drug and alcohol use.

3.25 Intake for people in crisis will generally be the responsibility of the area Crisis Assessment and Treatment (CAT) service, particularly if the Duty screening indicates that the referred person may be in the acute stage of a mental disorder, and a response by the community health service is not sufficient to meet the person's needs.

Service utilisation and consumer characteristics

3.26 The following information summarises key consumer and service utilisation characteristics documented in a random sample of 935 Duty assessment forms at the 6 AMHSs audited:

- Forty per cent of the total sample of 935 referrals contacted the Duty worker for assistance between 9 a.m. and 5 p.m., 26 per cent made initial contact between 5 p.m. and midnight, and 8 per cent contracted services between midnight and 9 a.m. Time of initial contact was not recorded in 26 per cent of cases. Seventy-two per cent of all Duty contacts with the AMHS occurred via telephone, and 28 per cent occurred face-to-face;

- Forty-three per cent of people accessing services were aged between 16 and 34 years, 33 per cent were between 35 and 55 years, and 24 per cent were between 56 and 64 years;
- Referrals to the AMHS came from many sources, however, the most frequent (61 per cent) were referrals by the consumer or their family. Nineteen per cent came from the hospital Emergency Department, 18 per cent came from GPs, and 2 per cent from "other community sources", including the police and ambulance; and
- Forty per cent of people accessing services were currently registered AMHS consumers, 14 per cent had previously been registered and 21 per cent were new referrals. Due to omissions in AMHS documentation, the remaining 25 per cent were of unknown status.

Presenting problems

3.27 Table 3C illustrates the type and severity of problems, drawn from our sample, presenting to AMHSs. It should be noted that the "presenting problems" are descriptions based on information provided during the initial Duty screening assessment, and should not be interpreted as a final clinical diagnosis. This information provides the basis upon which initial service response decisions are made and can, therefore, influence both the timeliness and appropriateness of response.

TABLE 3C
PROBLEMS PRESENTED BY CONSUMERS AT ADULT AREA MENTAL HEALTH SERVICES
(n = 697)
(per cent)

Presenting problem	*Percentage (a)*
Attempted suicide/self-harm	37
Drug/alcohol problem or disorder	25
Depression/mood disorder	23
Psychotic symptoms/schizophrenia	22
Anxiety disorder/anxiety symptoms	12
Situational crisis	5
Other	2

(a) Includes cases with multiple presenting problems.
Source: Victorian Auditor-General's Office.

3.28 Presenting problems were documented in 96 per cent of the 935 Duty screening assessments examined, however, only 78 per cent of these noted a specific presenting problem or reason for contacting the service. Twenty-two per cent contained requests for information, or ambiguous descriptions, and were excluded from further analysis.

3.29 Self-harm, substance abuse and depression were the 3 most frequently documented presenting problems. Psychotic symptoms were documented in 22 per cent of cases; anxiety, violence and situational crises were present in 26 per cent of new referrals.

3.30 Multiple presenting problems were noted in 23 per cent of cases. The 2 most frequently reported combinations were self-harm and drug or alcohol abuse (9 per cent), and depression and self-harm (7 per cent).

3.31 The large percentage of self-harm referrals (37 per cent) highlights the need for services to record the outcome of risk assessments to ensure a focus on managing the risk of self-harm. The percentage of referrals with substance abuse issues also raises the need for services to establish effective links with drug and alcohol services.

Assessing service access and timeliness of response

3.32 National Mental Health Standards (1996), the *Mental Health Act* 1986 and relevant departmental guidelines[12] describe the principles for mental health service delivery in Victoria. These documents were referred to when we examined the processes relevant to the Duty and Intake phases:

- *Assessing urgency of response required.* The AMHS should have a system for prioritising referrals according to risk and urgency. These ratings should be clearly documented in the Duty and Intake records;
- *Accessibility and timeliness of service response.* The AMHS should be accessible 24 hours a day, 7 days a week, and provide intervention at an early stage of mental disorder (see paras 3.42 to 3.43). This initial, or intake, assessment is used to determine the person's needs and the most appropriate service required;
- *Determining priority for service provision.* Services should be provided to people within the defined AMHS target group (see para. 2.8 for definition). The service response should be based primarily on levels of need and disability[13]; and
- *Standard of documentation.* All contacts made with a public mental health service must be documented, regardless of whether or not the contact leads to service delivery.

[12] Victorian Department of Human Services, Mental Health Services: *The Framework for Service Delivery* (1994); Victorian Department of Human Services, Mental Health Services: *Improved access through coordinated consumer care* (1995); Victorian Department of Human Services, Mental Health Services: *Psychiatric crisis assessment and treatment services, guidelines for service provision* (1994).

[13] RANZCP (submission to the audit) define mental health need as: "subjective distress, the disabling nature of the symptoms in terms of social and/or occupational functioning, symptom severity".

Assessing the urgency of response required

3.33 Before a service response is initiated, the urgency of the response required must be assessed. National Mental Health Standards require that all services have "a system for prioritising referrals according to risk and urgency"[14]. Urgency ratings are made by clinical staff members during the Duty phase, when a referrer makes initial contact with the mental health service. This urgency rating determines the prioritisation of referrals.

3.34 Our examination of 935 Duty assessments revealed that ratings of risk and urgency of response were not recorded in 57 and 53 per cent, respectively, of all Duty assessments. Of those patients who did receive an urgency rating, 83 per cent were rated as "high" to "extreme", highlighting the serious nature of consumer's presenting problems.

3.35 The assessment of risk and urgency is a clinical judgement and we have not attempted to audit the veracity of the ratings given. We did, however, observe inconsistencies in the allocation of these ratings and in the responses which followed as a consequence. The nature and timing of service response by the AMHS is dependent on these ratings. AMHS clinicians need clear guidance on the interpretation of these urgency ratings in a range of situations (e.g. where the consumer is an existing client of the service) and training to ensure consistency in the application of those ratings.

3.36 The Department's *New Directions* statement commits to the development and piloting of standardised triage assessment for AMHSs. Our audit indicates this action is essential.

Accessibility and timeliness of service response

3.37 Access to AMHS treatment during a psychiatric crisis will typically involve 2 assessments: an initial Duty screening which is often completed by telephone; and an Intake assessment, normally conducted face-to-face by the Crisis Assessment and Treatment (CAT) team. The assessments aim to determine the appropriate service response and may lead to an inpatient admission, treatment in the community, or an external referral to a GP or other professional.

3.38 People experiencing a mental health crisis may also access services by initially contacting a hospital Emergency Department (ED) for assistance. Nineteen per cent of all mental health referrals during the audit originated from a hospital ED – 70 per cent of these referrals were received after-hours.

[14] Commonwealth Department of Health and Family Services, National Mental Health Standards (1996), standard 11.2, criteria 9.

Presentation to the AMHS

3.39 Analyses of 935 Duty screening assessments were conducted across the 6 AMHSs audited. Our aim was to determine the effectiveness of the Duty screening process in facilitating a timely service response. To achieve this, all 191 Duty presentations rated as "urgent", which also met the AMHS target group for service provision, were examined to assess the timeliness of the service response[15]. People referred to private practitioners for assessment or treatment following initial contact with the AMHS Duty worker were not included in the sample of 191 files audited. Table 3D shows the time (in days) between the rating of a case as "urgent" by the AMHS Duty clinician at the initial point of contact with the service and a face-to-face assessment by an AMHS clinician.

TABLE 3D
TIME IN DAYS BETWEEN AMHS RATING A CASE AS "URGENT" AND PROVIDING A FACE-TO-FACE ASSESSMENT
(n = 191)
(per cent)

Time till face-to-face assessment (a)	*Rural services (b)*	*Metropolitan services (c)*	*All services*
Less than 1 day	38	26	35
1 day to less than 2 days	23	17	22
2-6 days	17	24	18
7-13 days	10	17	12
14-27 days	5	7	5
28 days +	7	9	8

(a) Face-to-face contact with an AMHS clinical staff member.

(b) Includes Goulburn Valley, Gippsland and Barwon.

(c) Includes Dandenong, Mid-West and Inner Urban East.

Source: Victorian Auditor-General's Office 2002.

3.40 Assuming our sample of 191 case files had been correctly assessed as "urgent" by AMHS clinicians, the data in the above table shows that 65 per cent of initial service contacts rated as "urgent" did not receive a face-to-face assessment by an AMHS clinical staff member within 24 hours. Twenty-five per cent of urgent cases did not receive an initial face-to-face assessment by an AMHS clinician for 7 or more days.

3.41 Overall, rural services were faster to respond to urgent referrals than metropolitan services. Differences between individual services and response times during the day versus overnight could not be reported due to incomplete AMHS data. However, the audit found that demand for services was typically high during the evening and overnight period, partly because other community-based services and private psychiatrists are generally not available after-hours. Reliance by AMHS on one Duty worker overnight also meant that for some referrals there was a delayed response if an assessment was in progress.

[15] The sample includes presentations of acute suicidality and deliberate self-harm, severe depression, substance abuse, acute psychosis, and severe situational crises with high risk of self-harm.

3.42 There is debate regarding the appropriate standard against which timeliness and appropriateness of service response during a psychiatric crisis should be measured. The relevant standards and guidelines are not universally accepted and there are differences in interpretation between the Department, AMHSs and mental health practitioners. AMHSs are also at varying stages in adopting the national standards. Accreditation against the national standards will commence in June 2003.

3.43 Professional advice received from the Victorian Branch of the Royal Australian and New Zealand College of Psychiatry is that clinical assessments of urgent referrals need to occur within one hour (allowing for travelling time) and, aside from exceptional circumstances, these assessments should be conducted face-to-face. Professor Harvey Whiteford, Chair of the 1997 National Mental Health Working Group for mental health standards, advised that:

> *"For presentations rated as urgent by an AMHS clinical staff member at the initial point of contact with the service, a clinically appropriate intervention should occur within 24 hours. This clinical intervention should, in most instances, be a face-to-face assessment by a clinical staff member or another appropriate clinician (e.g. general practitioner) determined by the AMHS. The intervention could commence as a telephone intervention where this is deemed by the AMHS to be clinically appropriate and sufficient to respond to the immediate needs of the consumer.*

Intake assessments

3.44 Intake assessments follow the initial screening assessment by the AMHS Duty worker and aim to determine the type of service response required. Intake assessments for consumers who received treatment from an AMHS were examined at the 6 AMHSs audited during the file review. The results indicated that 22 per cent of the 935 files examined did not contain an intake assessment. Of the 729 files that did contain an assessment, 87 per cent were incomplete; that is, one or more of the criteria noted in Table 3E were not addressed in the Intake assessment. Where Duty and Intake occurred concurrently, we rated the criteria as met if there was evidence in *either* the Duty or Intake assessment forms.

TABLE 3E
INTAKE ASSESSMENTS, FILE AUDIT FINDINGS
(n = 729)
(per cent)

Criteria or standard	*Cases which met criteria*
Presenting problem(s) documented	97
Mental state examination	88
Psychiatric history	81
Drug/alcohol use issues	75
Family/living situation	71
Type of intervention or service response required	68
Risk assessment (of harm to self)	64
Urgency of intervention required	34
Intake assessments reviewed meeting all the above criteria	**13**

Source: Victorian Auditor-General's Office 2002.

3.45 Evidence of referrals to appropriate services for consumers referred externally were documented in only 24 per cent of cases. Examples of good practice were noted at Barwon and Goulburn AMHS, where Intake information was appropriately documented, stored securely and placed in an accessible file to allow effective review of those who do not enter the system or who re-present to services at a later date.

Presentations to Emergency Departments

3.46 All presentations to Emergency Departments (EDs) are initially assessed by the ED triage worker. If the presentation indicates a mental health crisis, the AMHS clinician will be contacted to organise an appropriate mental health service response. During a psychiatric crisis, this will normally involve the Crisis Assessment and Treatment (CAT) team.

3.47 One hundred and seventy-one (18 per cent) of all mental health referrals during the audit originated from a hospital ED. Analysis of ED referral data shows consumers presenting with serious mental health problems, including risk of deliberate self-harm, substance abuse, depression and psychotic symptoms. Audit findings from the 6 AMHSs indicated that:

- 68 per cent of all referrals from an ED were rated as high to extreme risk of self-harm;
- high risk of self-harm was reported in 47 per cent of presentations;
- drug and/or alcohol problems were documented in 48 per cent of cases;
- aggressive behaviour was also common, reported in 28 per cent of presentations; and
- 25 per cent of all ED presentations with a mental health component came via the police.

Emergency Departments are a critical access point to after-hours mental health services.

3.48 A number of problems with current ED arrangements for assessing and treating people with mental health problems were identified during the audit. These included:

- Based on our limited observations during the audit, consumers presenting to EDs with serious mental health problems often experience lengthy waiting periods. Waiting for an inpatient bed or a CAT service were responsible for delays on several occasions;
- Often a slow response to people in psychiatric crisis, particularly overnight. Data provided by the Royal Melbourne Hospital ED indicates that average waiting times in the ED for psychiatric inpatient beds ranged from 5 to 20 hours in April 2002[16];
- Inadequate physical infrastructure for psychiatric patients. In most of the 6 EDs, private, quiet areas for the assessment of patients and carers were not available (St Vincent's hospital was an exception);
- Uneven use by EDs of the Australia Triage Scale for the assessment of young people with evidence of deliberate self-harm, rather than the routine use recommended by the Australasian College of Emergency Medicine[17]; and
- No routine collection and analysis on a Statewide basis of information concerning the number and type of mental health cases presenting to ED. This prevents services from appropriately monitoring trends in service utilisation, and adjusting resource allocation accordingly. The Department, as part of its demand management strategy, proposes collection and analysis of such data.

[16] The average length of stay for a psychiatric patient in the ED at the Royal Melbourne Hospital between 14 April and 24 April 2002 was 17 hours. Three patients remained in the ED for 3 days. *Source***:** Royal Melbourne Hospital Emergency Department (2002).

[17] Australasian College of Emergency Medicine, *Guidelines for the Management of Deliberate Self Harm in Young People* (2000).

Consumer and carer views on access and timeliness

3.49 Seventy-four per cent of consumers interviewed about their experiences reported that the service response was "too slow" and "not treated with sufficient urgency"[18]. Consumers reported that in many cases, the delay led to an escalation of the crisis and involvement with police or admission to hospital.

3.50 Carers reported feeling "completely helpless" during a psychiatric crisis, noting that services were "extremely reluctant" to offer immediate assistance unless the person being referred was acutely psychotic or suicidal. Carers noted a tendency for services to deflect responsibility to the carer or family member in circumstances where an urgent response was required, placing an immense strain on family members. This was particularly common when assistance was sought from services after-hours (that is, between 5 p.m. and 9 a.m.).

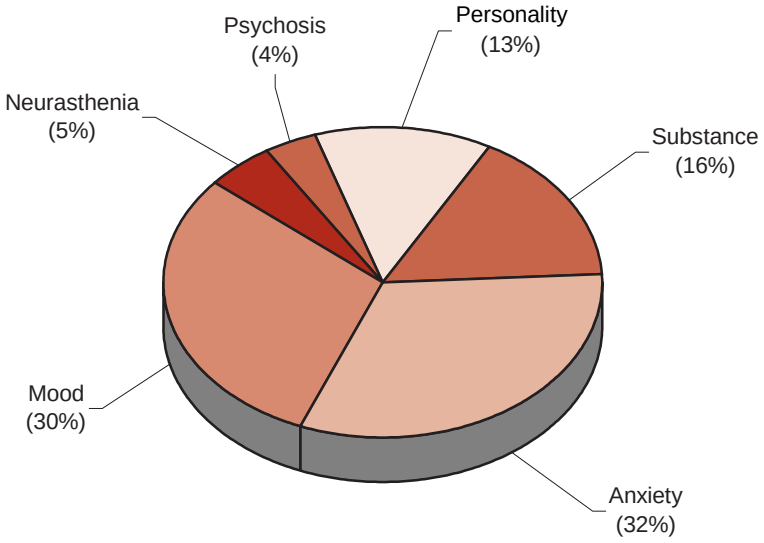
Determining priority for service provision

3.51 The Government's objective is to provide public mental health services to a broad target group. The Department's Framework for Service Delivery (1994) indicates that the target group for service provision includes people with "serious mental illness", defined as consumers suffering from *"... functional psychoses, both acute and persistent, severe mood or eating disorders, or with severe anxiety disorders, as well as those who present with situational crises which may lead to self-harm or inappropriate behaviour directed towards others. People with a severe personality disorder whose behaviour places themselves or others at risk of harm are included in the target group"*. Importantly, national standards and departmental guidelines note that service access should be based primarily on consumer need and associated levels of disability.

3.52 The prevalence of "common" mental disorders, including depression and anxiety in the Australian community, is approximately 5 to 10 times higher than the prevalence of psychotic disorders. Moreover, associated levels of "disability" may be equally as high (or in some cases higher) in presentations of severe depression and anxiety. The Victorian Burden of Disease Study (1999) and the national surveys of Mental Health and Well-Being (1997-1998) have been used to estimate the "disability burden" of mental disorders in terms of years lost due to disability (YLD). The results indicate that the disability burden of mood, anxiety and personality disorders, which, when serious, fall within the AMHS target group for service provision, is significantly higher than the total disability burden associated with psychotic disorders. These differences are illustrated in Chart 3F.

[18] Data from 87 one hour interviews conducted with consumers from each of the 6 AMHSs audited. Consumer consultation methodology is described in Appendix A of this report.

CHART 3F
ESTIMATED DISABILITY BURDEN (YLD)
BY DIAGNOSIS, AUSTRALIA, 1997 TO 1998



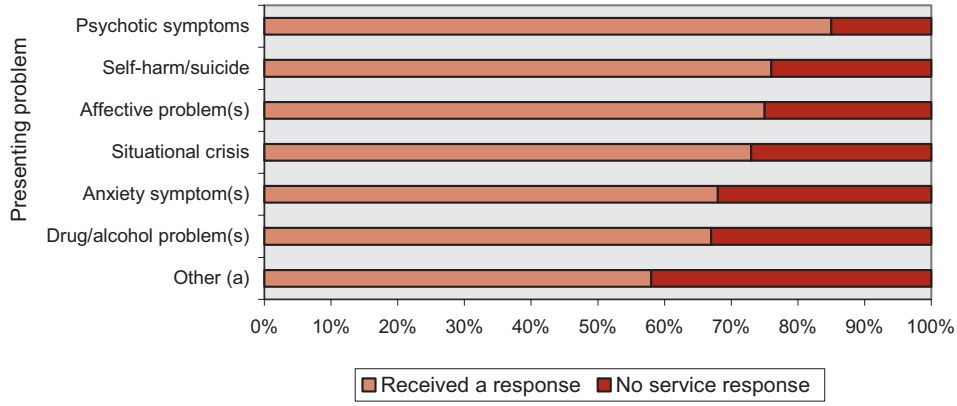
Source: Gavin Andrews et al, World Health Organisation Collaborating Centre for Evidence for Health Policy, UNSW at St Vincent's Hospital, Sydney. Paper presented at the Mental Health Services Conference, Sydney, 21 August 2002.

3.53 The Second National Mental Health Plan (1998) notes that an unforseen consequence of the first Plan's (undefined) use of the term "serious mental illness" was that it lead to variable local interpretations of the term and for some public services to "erroneously equate severity with diagnosis rather than level of need and disability". In practice, this has generally lead to psychotic disorders gaining access ahead of the more common mental disorders. The Second Plan (1998, p. 10) goes on to note that "... *it is therefore important to acknowledge the problems created by the overly narrow interpretation of the original policy which can result in consumers not gaining access to services …*"

3.54 The audit sought to assess whether AMHSs were providing services to consumers based upon their level of need and disability (in accordance with national standards and departmental guidelines), or according to the consumers' diagnosis. The audit examined data relating to the consumer's presenting problem since this is the only information available at the point of duty/intake when the decision is being made to provide the consumer with a service or refer them elsewhere.

3.55 Data was available for 697 presenting problems, as shown in Chart 3G. These data show that persons with psychotic symptoms are more likely to receive a service from AMHSs. Consumers with other presenting problems including self-harm, depression, situational crises, anxiety, eating and personality disorders (all of which are included in the AMHS target group for service provision) were more likely to have their file marked "No further action required" or to be referred to a non-AMHS service provider.

CHART 3G
AMHS SERVICE RESPONSE FOR ALL PRESENTING PROBLEMS
(n = 697)
(per cent)



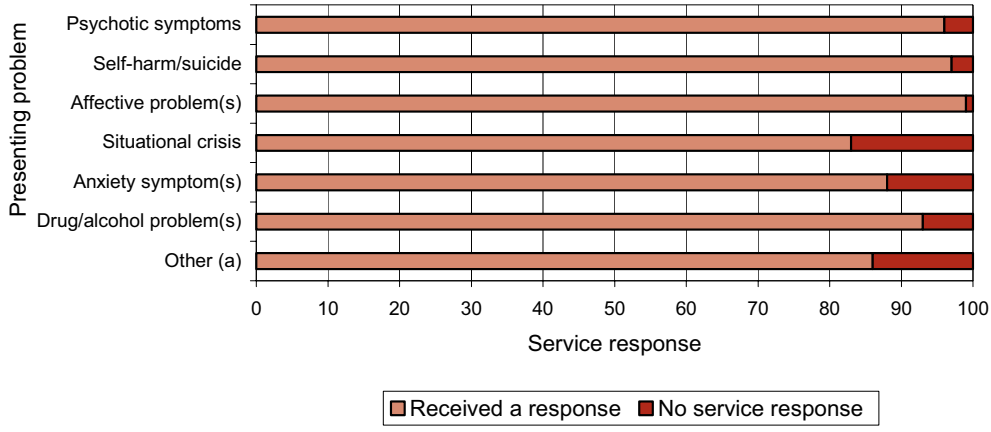
(a) Presenting problems include personality disorders, eating disorders, adjustment disorders and organic disorders.

Source: Victorian Auditor-General's Office, 2002.

3.56 The severity of the presenting problems in Chart 3G will vary and some may reasonably be referred elsewhere to be dealt with by service providers other than AMHSs. We therefore examined a subset of the files for consumers who had been classified as "urgent" and compared the provision of services on the basis that people classified as "urgent" should have a similar level of need[19]. The relationship between presenting problem and service response as shown in Chart 3H suggests that the majority of consumers rated as urgent received an AMHS service response.

[19] There are 320 files for consumers classified as urgent for whom presenting problems were recorded. Note that this is a larger number than presented in Table 3D, since that table refers to 191 files which contained data on consumers who were rated as urgent and the timeframes for service provision.

CHART 3H
RELATIONSHIP BETWEEN PRESENTING PROBLEM AND AMHS SERVICE RESPONSE TO "URGENT" REFERRALS
(n = 320)
(per cent)



(a) Presenting problems include personality disorders, eating disorders, adjustment disorders and organic disorders.

Source: Victorian Auditor-General's Office, 2002.

3.57 Table 3I shows the diagnoses of psychiatric patients registered in 2001, obtained during the file audit, across the 6 AMHS audited. The data indicates that people with psychotic disorders (including schizophrenia) constitute the largest diagnostic group of patients, while mood disorders and all other mental disorders account for 34 and 22 per cent of all diagnoses, respectively.

TABLE 3I
PRINCIPAL DIAGNOSES OF PEOPLE REGISTERED WITH AREA MENTAL HEALTH SERVICES IN VICTORIA *(a)*
(n = 580)

Diagnosis	*Percentage*
Psychosis	44
Mood disorders	34
Adjustment disorders	7
Substance abuse disorders	5
Personality disorders	3
"Situational crises"	3
Other *(b)*	4

(a) Diagnoses are taken from MH1 registrations forms for consumers registered in 2001.

(b) Includes eating, somatoform and dissociative disorders, and other mental disorders due to brain damage.

Source: Victorian Auditor-General's Office, 2002.

3.58 During interviews with consumers and carers, a common source of complaint was that consumers and carers believed that AMHS provided services based on a person's diagnosis as opposed to their level of need and disability. AMHSs noted the difficulties they face in providing services to a broad target group, in an environment of limited resources. The data examined by this audit has not been able to clarify whether or not there is a differing service response for consumers with similar levels of disability and need, but different diagnoses.

Standard of documentation

3.59 Documentation of Duty referrals is important for quality assurance, service efficiency and monitoring purposes. We found that there was considerable variation in the comprehensiveness of the 935 Duty records examined, with significant omissions noted across all services, including basic demographic information, such as date of birth, address and gender not recorded. Time of call to the Duty worker was not recorded in 26 per cent of cases, impeding the capacity of services to monitor their response times in hours.

3.60 The documentation of Duty processes at St Vincent's Mental Health Service was particularly concerning. There was no system for collating and analysing data on referral sources; Duty notes did not allow recording of risk levels; new consumers could not be distinguished from existing service users; and entries were recorded on separate Word documents, making data analysis exceptionally difficult.

3.61 By contrast, Barwon, Gippsland and Goulburn Valley AMHSs all used standardised psychiatric Duty assessment forms, which included all relevant fields, prompting the Duty worker to collect important information, including both risk and urgency ratings. Similarly, Goulburn Valley AMHS had developed a comprehensive local Duty database, enabling easy access and analysis of all contact details.

3.62 While the majority of Duty assessments audited contained clear, legible descriptions of the presenting problems, we noted across all 6 services a number of vague descriptions, and in some services stigmatising or unprofessional descriptions, such as "he's really sick", "he's going bananas" and "she's lost the plot". Moreover, the rationale for the Duty worker's decision to accept or refer a consumer externally was not consistently documented.

3.63 This issue has been recognised by the Department in its *New Direction* plan and it is proposed to better clarify roles and responsibilities, and target groups between services.

Conclusions

3.64 People accessing public adult mental health services present with a range of complex problems, and a high degree of need and distress. They are frequently at risk of suicide or self-harm, with substance abuse, depression and psychotic symptoms present in a majority of cases. The severe nature of these presenting problems highlights the importance of a timely, appropriate service response.

3.65 In our sample review, ratings of urgency and risk of self-harm were absent in 53 and 57 per cent, respectively, of all Duty assessment forms. We observed disparate ratings of similar presenting problems within services. In the absence of documented criteria or guidelines, ratings of urgency and risk were based on the personal judgement of individual clinicians. This makes it difficult for services to consistently prioritise new referrals according to urgency and risk, as required under the National Mental Health Plan.

3.66 Our sample review found that 65 per cent of referrals rated as "urgent" by the AMHS Duty clinician at the initial point of contact with the service, did not receive a face-to-face assessment by an AMHS clinical staff member within 24 hours.

3.67 Nineteen per cent of all presentations in the audit sample came through the hospital ED. Audit findings indicate that psychiatric patients often experience lengthy delays in the ED. Audit observations indicate that the physical infrastructure in most EDs was not adequate for the assessment and management of psychiatric patients.

3.68 During interviews with consumers and carers, a common source of complaint was that consumers and carers believed that AMHS provided services based on a person's diagnosis as opposed to their level of need and disability. AMHSs noted the difficulties they face in providing services to a broad target group, in an environment of limited resources. The data examined by this audit has not been able to clarify whether or not there is a differing service response for consumers with similar levels of disability and need, but different diagnoses.

3.69 While all 6 AMHSs audited had systems in place to enable collection of service access data, there were significant omissions in the data being recorded by clinical staff. AMHS staff are not currently completing the majority of Intake assessments appropriately. This increases the risk of the psychiatric assessment being compromised, and may lead to an inappropriate service response. This situation is adversely affecting the extent to which services can monitor and evaluate service access and entry information, which is required under the national standards.

Recommendations

3.70 We recommend that the Department work with AMHSs to:

- Clarify definitions and interpretations of the standards for urgency, timeliness and nature of initial service response in line with the national approach, and ensure that there is sufficient guidance and training for AMHS staff to implement the agreed standards consistently;
- Review current arrangements for the assessment and treatment of psychiatric patients in EDs with the aim of improving response times and treatment to people in psychiatric crisis, including:
    - the respective roles and responsibilities of ED clinical staff and mental health staff during a psychiatric crisis; and

  - physical infrastructure in EDs including areas designed for the assessment, management and restraint of psychiatric patients;
- Monitor and report on service provision within AMHS against agreed standards to enable appropriate responses to be made where standards are not achieved; and
- Improve Duty documentation procedures at AMHSs to enable appropriate service monitoring and accountability. Specific areas for improvement include ratings of urgency and risk of harm to self and others, and key intake criteria and completion of key assessments.

SERVICE DELIVERY: PSYCHIATRIC HOSPITALISATION

3.71 Hospitalisation aims to provide assessment and acute management of consumers in psychiatric crisis until they can reasonably be managed in a less restrictive setting. Inpatient care is particularly important for consumers during the acute phase of a crisis, as it enables a level of specialised, 24-hour care which is generally not available in the community.

Hospitalisation provides assessment and support for people during a mental health crisis.

3.72 The following principles, taken from the National Mental Health Standards (1996) which have been accepted by the Department, are relevant to psychiatric hospitalisation and have been adapted as audit criteria:

- The AMHS ensures access to high quality psychiatric inpatient services for consumers who meet the AMHS target group for service provision. Admission to psychiatric inpatient services should be based on consumer need, and the level of urgency and risk associated with the presentation, with every attempt made to promote voluntary admission for the consumer; and
- A discharge plan should be developed in consultation with the consumer on admission to the facility. The plan should describe treatment and discharge strategies as described in departmental guidelines[20].

Access to inpatient services

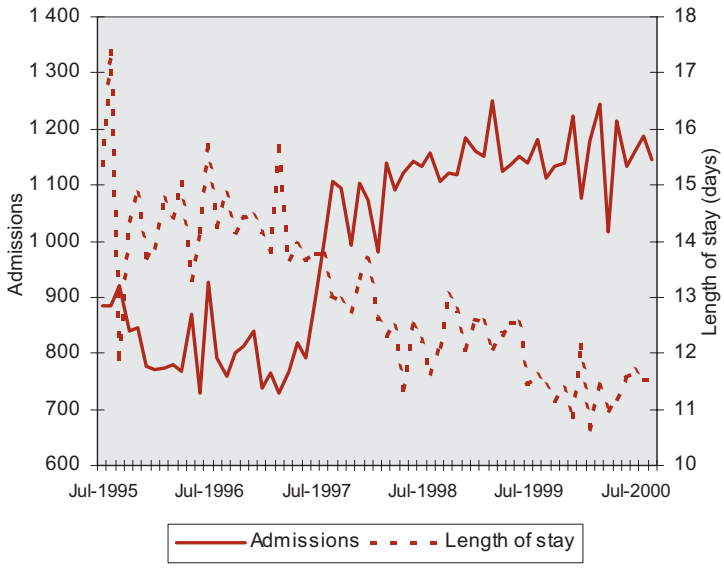
3.73 A recent Statewide review of adult acute psychiatric inpatient services reported that it is becoming increasingly difficult for consumers to gain access to acute inpatient beds in some areas. Victoria has emphasised community-based services providing a higher proportion of its services and beds in community settings than other States. The overall number of designated acute psychiatric inpatient beds in Victoria has remained relatively constant since 1996, despite a 20 per cent increase in overall service demand. Victoria now has 21.8 acute beds per 100 000 adults; 2.6 beds below the national average[21].

3.74 Chart 3J illustrates recent changes in demand for inpatient beds (measured by the number of admissions), and corresponding changes in the average length of stay.

[20] Victorian Department of Human Services, *Clinical Review of Area Mental Health Services: review guidelines* (2001).

[21] Victorian Department of Human Services, *New Directions for Victoria's Mental Health Services: The Next Five Years*, (September 2002).

CHART 3J
CHANGES IN ADULT ACUTE INPATIENT SERVICE DEMAND AND AVERAGE LENGTH OF STAY



Source: Department of Human Services, 2002.

3.75 While demand has increased just under 10 per cent per year between 1995 and 2000, the average length of stay (LOS) has decreased from 16 days to 12 days and the number of per capita beds available has remained relatively constant. The Department advised that one and 2 day admissions have increased in recent years, contributing to the reduction in average LOS. The trend towards shorter inpatient admissions appeared to be reversed in 2001, when average LOS was estimated by the Department to be around 14 days. Average LOS data for 2002 could not be provided by the Department within our timeframe due to data extraction difficulties with the new Statewide database, "RAPID"[22].

3.76 Changes in average LOS alone do not indicate a shortfall in the supply of inpatient services, since there have also been ongoing changes in treatment approaches. However, audit review of files indicate that it is becoming increasingly difficult for people to gain access to acute inpatient services and a very high level of symptom severity is necessary to gain access to beds. Within this context, reductions in average LOS appear to reflect, at least to some extent, a service response to managing increasing demand and a constant supply of acute inpatient beds.

[22] Length of stay figures are calculated from information collected at service delivery level and entered into the Department's IT systems. Data to 1999-2000 presented in Chart 3I were derived from the PRISM database and later data are derived from the RAPID database. There are doubts regarding the comparability of these data.

3.77 Increasing demand for psychiatric beds has also resulted from a 23 per cent increase in the total number of involuntary admissions from July 1995 to September 2000[23]. (Note: data concerning more recent trends in involuntary status could not be provided by the Department due to data extraction problems with the new Statewide database, "RAPID"). The inpatient bed shortage has been recognised by the Government in its *New Directions* statement, and an additional 30 acute beds and 30 sub-acute (or "step-down") beds are to be funded.

Discharge from inpatient services

3.78 For most consumers, ongoing support will be necessary after discharge from an inpatient service. This may include case management in the community or referral to an external agency or private practitioner. Discharge planning helps to ensure that consumers receive appropriate ongoing treatment in the community. This process maximises the opportunity for recovery and may reduce the likelihood of future unplanned re-admissions. The AMHS case manager and inpatient staff are jointly responsible for developing the discharge plan, and ensuring that consumers are linked into, and followed-up by, appropriate community-based services[24].

3.79 Departmental guidelines[25] and national standards describe what an appropriate discharge plan should include. During the clinical file audit, discharge plans for consumers who received inpatient treatment in the previous 12 months were reviewed against these guidelines. Discharge plans were present for 78 per cent of consumers in the audit sample. However, all these plans were incomplete (i.e. one or more key standards were not addressed in the plan). The results of our assessment against the guidelines are shown in Table 3K.

[23] Victorian Department of Human Services (2002).

[24] Victorian Department of Human Services, *Victoria's Mental Health Services, improved access through coordinated client care* (1995).

[25] Victorian Department of Human Services, *Mental Health Services: Crisis assessment and treatment services, guidelines for service provision* (1994).

TABLE 3K
DISCHARGE PLANS, RESULTS OF CLINICAL FILE AUDIT
(n = 315)
(per cent)

Standard	*Discharge plans which met criteria*
Post-discharge arrangements	
• Linkages to relevant services were documented for consumers with ongoing mental health needs	70
Consumer involvement and information	
• Consumer advised how to re-access the service	64
• Evidence of consumer collaboration in discharge planning	20
• Consumer provided with emergency contact numbers	16
• Copy of plan provided to consumer	1
Carer involvement and information	
• Evidence of family/carer collaboration in discharge planning	15
• Evidence of assessment of impact on family/carers	4
• Carer advised how to re-access the service	15
• Copy of plan provided to carer (for applicable cases only)	1
Crisis prevention and relapse prevention strategies identified	**4**
Percentage of discharge plans reviewed meeting all the above criteria	**0**

Source: Victorian Auditor General's Office, 2002.

3.80 Key findings from the file audit include:

- Eighty-nine per cent of 315 previously hospitalised consumers reported that they were discharged while still acutely unwell, with a high level of need for ongoing support;
- Thirty per cent of all discharge plans reviewed included no evidence that consumers had been linked into appropriate community-based services for ongoing treatment following inpatient discharge. Risk of suicide among mental health consumers reaches a peak during the weeks immediately following inpatient treatment, highlighting the importance of appropriate discharge planning and ongoing support;
- Evidence that carers were consulted in the formulation of a discharge plan and consulted regarding impending discharge arrangements were absent in the majority of plans examined. Carers interviewed during the audit reported that patients were frequently discharged without their knowledge or involvement, placing considerable burden on family/carer support; and
- Information regarding early warning signs of relapse, re-accessing services, relapse prevention or community follow-up plans were rarely recorded on file as having been provided to consumers or carers.

3.81 These findings highlight significant problems with current discharge practices from psychiatric inpatient facilities in Victoria. Poor discharge planning has the potential to compromise ongoing patient care, increase the burden on families and carers, and may result in unplanned re-admission to hospital.

Conclusions

3.82 Audit findings, Statewide data and the recent review of psychiatric inpatient facilities commissioned by the Department indicate that access to psychiatric inpatient beds for eligible consumers is becoming increasingly difficult.

3.83 The audit found that consumers are frequently discharged from inpatient facilities without being connected into appropriate community-based services for ongoing care. This situation increases the likelihood of future unplanned re-admissions to hospital.

3.84 Significant gaps in the completion of key discharge criteria were noted during the file audit, including limited evidence of consultation with consumers and carers, indicating that current discharge practices are not consistent with national standards and guidelines.

Recommendation

3.85 We recommend that the Department and AMHSs significantly improve current discharge practices. Particular attention should be given to post-discharge arrangements with ongoing community-based services, and consumer and carer collaboration in discharge planning.

Ongoing community-based treatment is critical for prevention of mental health crises.

SERVICE DELIVERY: COMMUNITY-BASED TREATMENT

3.86 Service delivery at each AMHS is achieved through case management of individual consumers. The case manager's role is to co-ordinate the provision of care to meet the consumer's individual psychiatric and social needs. This may involve the direct provision of clinical treatment by the case manager.

3.87 Comprehensive assessments and the development of individual service plans (ISPs) form the basis of effective case management and consumer care. Discharge planning following inpatient admission, and case closure after community treatment are the responsibility of the case manager. Audit findings relevant to each of these core service delivery elements are described in this section. Relevant national standards and departmental guidelines which have been adapted as audit criteria include:

- All registered AMHS consumers should be assigned a case manager upon entry to the service. The case manager's role is to develop and implement appropriate treatment plans, and to co-ordinate care to meet individual consumer needs;
- A comprehensive needs assessment should be completed by each consumer's case manager. The assessment should address key areas of need and functioning described in departmental guidelines;
- There should be documented evidence of an individual ISP in the clinical file of each consumer registered with a public mental health service. The ISP should address treatment goals and strategies, and should be developed in collaboration with the consumer and (where available) the carer;
- ISPs should be formally reviewed at least once every 6 months. Evidence of the review should appear in the clinical file;
- The AMHS case manager should ensure that the consumer and family members (or carers) receive appropriate information about the nature of the mental disorder and relevant treatment options - a process referred to as "psycho-education";
- Consumers should have access to a range of treatments, including psychological and psychosocial interventions[26];
- Treatment outcome measures should routinely be used and recorded by the service;
- A case closure plan should be formulated for each consumer prior to exiting the service. The closure plan should address key criteria described in departmental documents[27]; and
- The AMHS and other relevant services should develop and maintain appropriate links with other service providers to ensure specialised co-ordinated care and promote community integration for people with mental disorders[28].

[26] Refers to non-drug treatments, such as cognitive behavioural therapy.

[27] Victorian Department of Human Services, *Victoria's Mental Health Services: improved access through coordinated consumer care* (1995).

Case management

3.88 Effective case management is central to mental health service delivery in Victoria. The Department's 1994 Framework for Service Delivery requires that every consumer registered with a mental health service must have a designated case manager who is responsible for the co-ordination of services to meet their individual needs. The core functions of case management include the assessment of consumer needs, treatment planning and co-ordination, symptom monitoring and review, and discharge or case closure planning.

3.89 Our audit of 935 clinical files indicated that 97 per cent of all registered AMHS consumers had a case manager. However, allocation of case managers to individual consumers did not always occur on the day the consumer was registered with the AMHS, as required by national standards. In the audit sample, 67 per cent were allocated on the same day, while the remaining 33 per cent were allocated 2 to 7 days after the consumer registration date, indicating that some consumers had to wait several days before being assigned a case manager. The Department advises that all consumers should have a contact person until a case manager is assigned.

3.90 Case management guidelines indicate that it is preferable for consumers to work with the same case manager while they are registered with the service. This helps to maximise "continuity of care" for the consumer, while also encouraging a therapeutic alliance between the case manager and the consumer. Departmental documentation was insufficient to enable this requirement to be tested, however, 62 per cent of all consumers interviewed during the audit indicated that high case manager turnover and poor continuity of care during AMHS treatment were a "serious concern".

3.91 Eighty-seven consumers and 85 carers interviewed during the audit reported specific concerns with the implementation of the case management model, including:

- the "accessibility" of case managers, particularly during critical stages of service delivery or when a relapse occurred;
- poor communication with carers about assessments, treatment planning, discharge and case closure; and
- the apparent reluctance or inability of case managers to assertively follow-up consumers in the community, particularly treatment of non-compliant or "difficult" consumers.

[28] Commonwealth Department of Health and Family Services, National Mental Health Standards (1996) – standard 8.2.

Comprehensive assessments

3.92 When a consumer is accepted for treatment, a comprehensive assessment addressing key areas of need and functioning must be completed and documented in the clinical file. The assessment is crucial in the determination of the level of response and the requirement for external agency involvement. Comprehensive assessments also form the basis of the consumer's ISP.

3.93 In total, 239 comprehensive assessments were examined for registered consumers who received treatment with an AMHS. Each assessment was examined to determine whether 6 key criteria had been addressed, consistent with departmental guidelines[29]. The audit found that 96 per cent of the 239 comprehensive assessments examined were missing one or more of the 6 key criteria. Results are shown in Table 3L.

TABLE 3L
COMPREHENSIVE ASSESSMENTS: FILE AUDIT RESULTS
(n = 239)
(per cent)

Criteria or standard	*Available cases which met criteria*
Mental state examination *(a)*	94
Psychiatric history	89
Risk assessment (of harm to self)	48
Psychosocial assessment *(b)*	10
Results from physical examinations	45
Evidence of carer consultation during the comprehensive assessment	14
Comprehensive assessments reviewed meeting all of the above criteria	**4**

(a) While the majority of assessments contained a mental state examination, auditors found that the majority were not completed adequately.

(b) Barwon AMHS was the only service audited which routinely documented psychosocial assessments as required by departmental guidelines.

Source: Victorian Auditor-General's Office, 2002.

3.94 These results highlight a focus on clinical examinations and indicate significant gaps in the documentation of other important assessment criteria used to formulate ISPs. The absence of this information in clinical files raises concern regarding the comprehensiveness of the assessments used to formulate treatment planning and service delivery.

[29]Victorian Department of Human Services, *Victoria's Mental Health Services: improved access through coordinated consumer care* (1995).

Individual service planning

3.95 Individual service plans (ISPs) form the basis of community-based psychiatric treatment. Every consumer registered with a public mental health service who receives community-based treatment from an AMHS must have an ISP. The ISP should be developed in collaboration with the consumer, be reviewed at least every 6 months, and address key areas of need and functioning[30].

3.96 A review of 935 clinical files found that 31 per cent of 583 consumers treated in the community did not receive either an ISP or an inpatient management plan. Furthermore, none of the 402 ISP examined addressed all of the criteria as recommended by Departments' clinical guidelines. The results are shown in Table 3M.

TABLE 3M
INDIVIDUAL SERVICE PLANS: FILE AUDIT RESULTS
(n = 402)
(per cent)

Criteria or standard	*Available cases who met criteria*
Goals for the admission were documented	70
Strategies for achieving treatment goals	68
Risk management strategies stated	48
Information regarding mental disorder and available treatment options provided to the consumer	46
Evidence of carer collaboration in the formulation of ISPs	9
Evidence of consumer collaboration in the formulation of ISP's	12
ISPs reviewed meeting all the above criteria	**0**

Source: Victorian Auditor-General's Office, 2002.

3.97 Interviews with consumers reinforced the file audit findings. Thirty-one per cent of consumers interviewed stated that an ISP had not been developed for them. Only 25 per cent of these consumers recalled any involvement in ISP development. The general theme which emerged from the interviews was that consumers and carers felt excluded from this critical process[31].

[30] Victorian Department of Human Services, *Mental Health Services: improved access through coordinated client care* (1995).

[31] St Vincent's and Goulburn AMHSs were an exception - rates of ISP documentation and consumer/carer involvement were higher than at other services.

ISP reviews

3.98 ISPs must be reviewed at least once every 6 months. The review aims to ensure that the progress of treatment goals is evaluated and treatment strategies are updated to ensure they remain relevant to the consumer's changing needs. The ISP review should be a collaborative effort between the consumer and their case manager. With the consumer's consent, family and/or carer(s) should be involved in this process.

3.99 File audit results indicated that only 24 per cent of the available 402 files containing an ISP showed evidence of having been reviewed within the required 6 month period. Modification of ISP's goals rarely occurred before the scheduled 6 monthly review. In cases where a review was present, less than 5 per cent contained evidence of consumer collaboration. Carer involvement was cited in less than one per cent. Illegible writing, and the absence of signatures and the designation of staff members were also common.

Access to appropriate information

3.100 Patients and carers benefit greatly from receiving appropriate information about the nature, causes and treatment of mental disorders. "Psycho-education" is generally considered an integral part of the treatment and recovery process[32] and is emphasised in the national standards. The responsibility for providing psycho-education typically rests with the AMHS case manager.

3.101 Evidence of consumer and carer psycho-education was absent in 84 and 98 per cent, respectively, of consumer files audited. Audit observations and interviews with consumers and carers confirmed these file audit results. While it is possible that these results may reflect poor documentation practices, 68 per cent of consumers interviewed stated that their case manager did not provide any form of education about their mental disorder, nor were they referred to an alternative agency to receive this service. Similarly, carers often complained (during carer focus groups) about the lack of information and education they received from AMHSs regarding mental disorder generally, and treatment and prognosis.

Treatment options

3.102 National standards require that public mental health service consumers should have access to a range of appropriate medical and psychosocial treatments. Research indicates that medication and psychosocial interventions together are generally more effective in the treatment of serious mental disorders than medication alone[33]. In order to maximise the effectiveness of therapeutic intervention, and to reduce the likelihood of unplanned re-admission, it is important the consumers have access to appropriate treatments.

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[32] Meadows and Singh, *Mental Health in Australia: collaborative community practice,* Oxford University Press (2001).
[33] Ibid.

3.103 We found that psychosocial (or non-drug) interventions were documented in only 4 per cent of cases. Many consumers interviewed were concerned by the "over use" of medication and the "unavailability" of psychological interventions such as cognitive behaviour therapy. Similarly, carers generally believed that "treatment" equated to medical intervention in the public system. It is noted, however, that psychosocial intervention may be provided to some consumers with severe and disabling long-term mental disorders through Psychiatric Disability Support Services (PDSS). These services were not within the scope of this audit.

Outcome measures

3.104 Measuring the effectiveness of clinical care is an important service monitoring process. The inclusion of outcome measures in routine clinical practice enables examination of which treatments work best for different consumers, so that treatment effectiveness can be maximised.

3.105 For this reason, national standards note that all mental health services should "routinely monitor health outcomes for individuals"[34]. The Department also recommends that all AMHSs implement the Health of the Nation Outcome Scale (HoNOS) for the purpose of measuring treatment outcomes. Outcome measures should be completed by the case manager and documented in the clinical file.

3.106 File audit results indicated that 82 per cent of all registered consumers' files did not indicate that a HoNOS had been prepared before or after treatment. There was minimal evidence that alternative outcome measures were being used by services. Barwon AMHS was an exception to this finding; 55 per cent of registered consumer files contained a HoNOS.

3.107 We note that the Departments *New Directions* statement commits the Department to providing assistance to all clinical services in 2002-03 to enable them to implement routine outcome measurement. Our audit results confirm the need for such action.

Case closure

3.108 Case closure occurs when a consumer no longer requires public mental health services. Formal case closure requires the completion of an appropriate service exit process, which should address a number of key criteria as set out in the departmental guidelines[35]. The guidelines note that "the decision to close a case should be made together with the consumer and significant people in their life", and that the case closure plan should be developed prior to case closure, and include relapse prevention strategies and information about how to re-access the system.

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[34] Commonwealth Department of Health and Family Services, National Mental Health Standards (1997); standard 9.

[35] Victorian Department of Human Services, *Victoria's Mental Health Services: improved access through coordinated consumer care* (1996).

Case closure plans should include relapse prevention strategies and information about how to re-access the system.

3.109 Our file audit found that 36 per cent of all consumers who had received community treatment and exited the system did not have a documented case closure plan on their file. File audit results examining case closure plans are shown in Table 3N.

TABLE 3N
CASE CLOSURES: FILE AUDIT RESULTS
(n = 373)
(per cent)

Criteria or standard	*Available cases which met criteria*
Consumer advised how to re-access the system if a relapse occurs	50
Consumer advised of impending case closure prior to exit date	49
Carer advised how to re-access the system if a relapse occurred	37
Early warning signs of relapse were documented	29
Case closure was formalised in writing to the consumer	29
Risk assessment (of harm to self) was present	23
Evidence of consumer collaboration in the formulation of the closure plan	20
Relapse prevention strategies were documented	12
Evidence of carer collaboration in the formulation of the plan	6
Case closure plans reviewed meeting all the above criteria	**2**

Source: Victorian Auditor-General's Office, 2002.

3.110 Consumers and carers expressed concern regarding the case closure process, including a general lack of involvement in case closure planning. The results indicate significant omissions regarding case closure planning and documentation.

Service linkages

3.111 Mental health consumers typically present with multiple problems requiring the co-ordination of different services. It has been estimated that up to 70 per cent of adults with a psychosis have a drug or alcohol abuse problem[36]. Similarly, rates of homelessness, and physical and intellectual disability are higher among people with a mental disorder, compared with the general population[37].

3.112 The number of consumers presenting to mental health services with complex problems is increasing. As the complexity of consumer need grows, effective collaboration and communication between mental health and other service sectors becomes increasingly important.

3.113 Service providers have not always been clear about their respective roles and responsibilities in managing consumers with multiple service needs, including drug and alcohol problems. Some consumers and carers interviewed during the audit reported being pushed between services and, consequently, failing to receive the services they required. In our consultations and those reported in the Department's *New Directions* statement, there is a recognised need for protocols to encourage collaboration and effective linkages between services. Protocols between mental health services, hospital Emergency Departments and disability support services require improvement, and successful pilot programs require further expansion.

3.114 File audit results indicated that 30 per cent of hospital discharge plans reviewed included no evidence that consumers had been linked into appropriate community-based services for ongoing treatment following inpatient admission. Similarly, 48 per cent of all case closure plans (or service exit plans) reviewed indicated no evidence that consumers had been linked into appropriate services for ongoing care in the community.

3.115 Mental health service staff report that communication has improved in some regions as a result of recent service initiatives (see Part 2 of this report). They described improvements in service efficiency (more appropriate referrals, sharing of skills/knowledge) and service effectiveness (improvements in the quality and continuity of care). Frameworks for collaborative arrangements between Mental Health and Drug and Alcohol services, the police and ambulance, and primary care providers (GPs) were generally praised. While the Department advises that the Dual-Diagnosis program is available Statewide for adults, significant problems remain in many regions, with consumers reporting inadequate co-ordination of services.

[36] Commonwealth Department of Health and Aged Care, *People living with a psychotic illness: An Australian study* 1997-1998, (1999).
[37] Australian Bureau of Statistics, *Mental Health and Wellbeing Profile of Adults: Australia* (1997).

Conclusions

3.116 Demand for mental health services is increasing. There is evidence of substantial unmet need for both acute inpatient and community-based mental health services in Victoria.

3.117 The present under-supply of community-based mental health services is increasing pressure on acute inpatient services, resulting in longer response times, access "rationing", high staff workloads, reduced quality of patient care and increased patient "throughput". These outcomes may lead to additional unplanned inpatient re-admissions.

3.118 Audit findings highlight significant gaps in the completion of key service delivery processes, including comprehensive assessments, ISPs and case closure plans. The absence of this information, together with consumer and carer feedback, suggests that service delivery is being compromised in these areas. Interviews with consumers and carers, and file audit results indicate that consumers of public mental health services are not routinely receiving psycho-educational services from the public mental health system or being referred to the private system for these services as recommended under national standards.

3.119 Recent departmental initiatives have led to improvements in the joint management of consumers with complex needs. However, significant gaps still exist, resulting in many of these consumers failing to receive timely and appropriate in services.

Recommendations

3.120 We recommend that:

- The Department of implement a comprehensive demand management strategy;
- AMHSs Services ensure that all components of service delivery are completed and documented, including completion of comprehensive assessments, individual service plans, and Case closure planning conforming to national standards; and
- The Department continue to develop new service interface initiatives and expand existing initiatives which have proven successful. Linkages with primary care providers, drug and alcohol services, and housing services are particularly important in this regard.

***RESPONSE** provided by Department of Human Services*

In relation to the urgency rating, DHS makes the following comment:

An urgency rating indicates the necessity for some immediate action to be taken. This could take a range of forms. The first step is generally the collection of information to help clarify the nature of the problem. Such information will frequently alter the original rating allowing for revised clinical judgement. This may, however, not be documented on the file.

The Department of Human Services acknowledges that more training should be provided to services so that urgency ratings are more consistent and that any action taken, which changes the rating is documented on the file.

Access to Beds

There are pressures on acute inpatient beds for a wide range of reasons, some at the front end of the service system and some at the extended care, high support end. The opening of 30 additional acute beds, and 30 sub-acute beds funded in the 2002-03 budget will assist in addressing this identified problem.

It should also be noted that 25 acute beds will be opened at Berwick in 2004.

As acknowledged in the New Directions for Victoria's Mental Health Services it is important to build on the strengths of the current system by developing an appropriate mix and level of services and implementing new and innovative approaches to consumer needs.

In the New Directions for Victoria's Mental Health Services Work force strategy was identified as one of the prerequisites to achieving the other key directions. Work force strategy development is underway.

Since 1999, there has been an increase in the number of direct care staff employed in Victorian mental health services, with services reporting an overall increase of more than 230 staff between 1999–2000 and 2000–01.

In addition, a commitment was made through the Psychiatric Services Enterprise Bargaining Agreement in 2000–01 to fund a wide range of nursing initiatives, including 116 education, training and supervisory positions and an additional 130 nurse positions over a three-year period.

These initiatives included a significant increase in nurse training and development positions at Grade 4, 5 and 6 or 7 level, representing the first formal recognition of the need for training and development positions in mental health since mainstreaming occurred in the 1990s. Staff in these positions are supporting improvements in clinical practice and skill development and will assist nurses working in an increasing complex environment.

A specific localised mental health nurse recruitment and retention campaign has been developed, following on from the specialist nurse recruitment and retention campaign.

Audit Findings

See Department of Human Services comments at the end of the Executive Summary.

If the percentage of the population with a serious mental illness is closer to 2 per cent or 95 000 then the Mental Health Branch of DHS estimated that more than 100 per cent of the potential population of people with a serious mental illness receive services. If you assume 2.5 per cent of the population have a serious mental illness then almost all of the potential population with a serious mental illness are receiving a service. The National Mental Health report 2000 says that serious mental illness is between 2 and 3 per cent of the population.

Audit acknowledges that Victoria provides a higher proportion of services and beds in community settings than other states but then concludes that this is inadequate. Victoria has 22.9 inpatient beds per 100 000 and 20.0 24-hour residential beds per 100 000 bringing the beds to a total of 42.9 per 100 000. This includes aged, child and adolescent and adult beds.

RESPONSE *provided by Department of Human Services - continued*

The Department Inpatient Services Review 2000 found that the number of beds across the state appeared to be in line with other states but identified an inequitable distribution of inpatient beds across the state[38].

Since that review there has been considerable growth in service demand, and in 2002-03, 30 extra sub-acute and 30 acute beds plus more home-based treatment were funded. 25 Adult beds are to be developed at Berwick by 2004. A capital plan is being developed. The capital plan will form part of an asset investment model for all health facilities across Victoria including PDSS capital assets, supported accommodation issues and residential options for consumers, including those with a dual diagnosis.

DHS are putting in place systems to be able to collect data on unplanned readmissions and response times. This information is not currently available.

The clinical guidelines for Individual Service Plans (ISP) do not require all the criteria to be addressed. The criteria are not and should not be considered mandatory. For example evidence of carer collaboration can only be provided if the consumer has a carer.

Care planning has been identified in the Office of the Chief Psychiatrist Clinical Reviews as an area for improvement. DHS agrees that this in part reflects a training issue. DHS is working with services to improve care planning and will also ask Area Mental Health Services to address the issue of the development of Individual Service Plans.

The relevant National Standard and Clinical Practice Guidelines 11.4.D.2 page 42 states:

> *"... the MHS provides access to a range of accepted therapies according to the needs of the consumer and their carers. Notes and examples: the MHSD should provide therapies or refer to another service provider; group or individual methods; psychotherapeutic; psychoeducational, family centred, rehabilitative and supportive therapies might be provided"*

DHS and Area Mental Health Services support the delivery of psychoeducational services in a number of ways. Psycho-education has become an integral part of service delivery such that it is often woven into routine clinical contacts in such a way that it would not necessarily be documented. For example, a number of services are currently running carer groups. Similar input is also often provided by the PDSS sector, or carers are linked to other funded agencies such as Mental Illness Fellowship Victoria for information and mutual support. These activities tend to be poorly documented in individual patient files, so there are problems with Audit concluding that it is not happening at all.

DHS agrees that discharge planning processes and documentation need improvement. The Chief Psychiatrist has very recently issued Guidelines on "Discharge Planning for Adult Community Mental Health Services" (August 2002). These have been sent to all services. Guidelines specific to Aged Persons have been drafted and CAMHS guidelines will also be prepared.

The Audit conclusion that consumers were not linked in to appropriate services is not supported by the evidence. The evidence shows that lack of documentation is an issue. No conclusions can be drawn about whether consumers were or were not linked to appropriate services as Audit did not follow up consumers to check outcomes. Implementation of outcome measurement which is underway will address these issues.

Where patients being discharged from inpatient status are already under case management in the service, the discharge documentation is often in the form of a transfer summary or inter-service referral form. There is no mention of whether these documents existed in the services reviewed. They can be a most effective mechanism for aiding continuity of care.

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[38] Revitalising Acute Inpatient services. DHS response and report of the Review of Adult Acute inpatient Mental Health services.

***RESPONSE** provided by Department of Human Services - continued*

Case closure is related to Discharge Planning and DHS would agree that this is an area in need of improvement.

More often there is some evidence of case closure and discharge discussions in the clinical notes, but these are not always well documented. It is an area for improvement, and will be assisted by the recent circulation of the Discharge Guidelines and the introduction of outcome measurement.

Recommendations

Urgency/Timeliness

The Department will continue to clarify definitions of urgency, timeliness and the nature of initial service response in line with the National approach and will continue to support Area Mental Health Service staff to implement agreed standards.

Emergency Departments

In the recently released New Directions for Victoria's Mental Health Services the Department has identified action being taken to address issues for people with mental health problems attending emergency departments.

Monitor and Report on Service Provision

DHS agrees with Audit that outcome measures are important. As acknowledged by Audit, Victoria was the first jurisdiction to trial the use of routine outcome measurement, commencing with a small number of pilot agencies in the mid 1990s, and subsequent development of policy and training materials. An Information Development Agreement with the Commonwealth was signed in October 2001, providing $9.2 million to establish information infrastructure to support a national focus on service effectiveness, including the comprehensive introduction of outcome measures. The following diagram presents the expected progress in implementation of regular consumer outcome measurement within mental health services. Victoria leads the way in the implementation of outcome measurement in Australia. And when fully implemented in all States and Territories Australia is expected to be the first country in the world to have implemented outcome measurement across both the public and private sectors.

Victoria is aiming to have 70 per cent of Area Mental Health Services reporting outcomes data by June 2003.

In addition to implementing outcome measurement across Area Mental Health Services DHS will consider the measures and key performance indicators put forward by Audit.

Improve Duty Documentation

Action will be taken to assist AMHSs to improve duty documentation procedures and the Department will consider the specific areas for improvement identified by audit. Risk assessment guidelines are currently being developed by the Office of the Chief Psychiatrist.

Discharge practices

In 2002-03, new "sub-acute" service models are being developed and piloted in Melbourne and in a major rural centre. The pilots will offer 30 new sub-acute places, including bed-based services and, if needed, in-home support.

In order to improve the co-ordination and integration of services, the Department will work with mental health services to improve discharge planning and transition processes between elements of the system.

Implementation of Discharge guidelines recently issued by the Chief Psychiatrist will support improved discharge practices.

***RESPONSE** provided by Department of Human Services - continued*

Demand Management Strategy

As identified in the New Directions for Mental Health document, in 2002-03, the Department has commenced development of a comprehensive demand management strategy for mental health services in metropolitan and rural Victoria.

Individual Service Plans/Treatment Plans

The Department will monitor and support AMHSs' implementation and documentation of service delivery for Individual Service Plans, Case Closure plans and comprehensive assessments according to the National Standards.

Service Interface Initiatives

Many of the strategies and initiatives described in the New Directions for Victoria's Mental Health Services report will support early intervention and relapse prevention for people with mental illness. For example, improved access to community-based services, in particular access to continuing care, case management and supported accommodation services, will assist in preventing crisis and relapse in people with mental illness. Victoria has the most extensive community-based services in Australia and has given priority to extending service interface initiatives with a range of service providers.

***RESPONSE** provided by Barwon Mental Health Service*

Paras 3.20 to 3.22

These sections do not adequately describe the process currently used to screen, engage, assess and service clients who present to Barwon. Duty, intake and crisis assessment and response can be encapsulated in the one service response by, or facilitated by the one clinician. Barwon does not have a CAT but rather a 24-hour Triage service with on-call emergency backup. This difference is important in the context of the comparison results between the response times for services with a CAT and those with integrated team service structures. It is not accurate to leave the readers of this report with the view that the Duty, Intake model as described is the only model generally used.

Paras 3.39 to 3.43

The requirement that the service response only commences with a face-to-face response is very high. The service response will potentially start with inquiries into the history of the situation and liaison with many parties.

It may also be necessary to delay the Mental Health response due to other more pressing requirements, such as Ambulance/Police or Emergency medical response needs. It may also be prudent for the safety needs of staff or others involved not to attend immediately but wait for appropriate circumstances to be in place before attending a client situation. Cases initially defined as "urgent" may become less urgent as more information is attained or the situation changes. Barwon Mental Health Service does not accept the results of Table 3D and believe this table is distorted by lack of clarity about the definition of urgent.

***RESPONSE** provided by Goulburn Valley Area Mental Health Service*

Para. 3.56

The service response to consumers in crisis and the outcome of that response has to be regarded in the context of the legislation. We operate within the "constraints" of the Mental Health Act and believe that there is a lack of understanding among the general population about what we can and cannot provide when a consumer does not wish to participate in treatment. Treatment must be provided in keeping with the philosophy of the "least restrictive environment" and this is often the point at which the service and the carers come into conflict.

Para. 3.67

Service to consumers in the Emergency Department (ED) is treated as a priority because the environment of that ED can be frightening and sometimes inappropriate for the client group. Response to ED is within one hour and not reliant on "medical clearance".

Para. 3.68

The Department of Human Services funds the service to manage the more complex psychiatric illnesses/disorders, that are unable to be managed either in the private psychiatric system or by primary care providers. Historically, the general interpretation of the phrase "serious mental illness" did seem to concentrate on psychoses, however, this service does not preclude entry and assessment to persons suffering from a psychiatric illness other than psychosis. All presentations to the service are prioritised on the basis of a comprehensive assessment of needs rather than the provisional diagnosis.

***RESPONSE** by St Vincent's Mental Health Services*

The 1994 Mental Health Services Framework document focused on provision of public mental health services to the seriously mentally ill. Prior to this, community-based services traditionally had seen a wider group of consumers. With the move from institutionalised care to community care, it was necessary to ensure that those people with high levels of psychiatric disability received crisis intervention, assertive follow-up and case-management. This focus on serious mental illness has resulted in decreased responsiveness to those people with lower needs, however it should be recognised that people with psychotic disorders are likely to have higher needs because of the likelihood of disability and impairment as a result of illness. St Vincent's Mental Health Service emphasises that it is need for services that dictates response, however, it is acknowledged that there is at times an over-emphasis on diagnosis as a factor. An improved response would require additional resources for appropriately trained staff.

Para. 3.7

It is incorrect to assume that because approximately 32 per cent of people who might be eligible are not accessing public mental health services, they are not receiving treatment. Many people choose to access private psychiatrists, general practitioners and other health providers rather than be treated in the public mental health system. Public mental health services have devoted considerable effort to improving linkages with these providers. In order to cope with the increased demand, when possible people whose mental health is relatively stable are referred to general practitioners and psychiatric disability support services for ongoing treatment, care and support. There has been an increased emphasis on shared care arrangements between public mental health services and GPs and private psychiatrists.

It is acknowledged that with improved resources, public mental health services could respond to unmet demand.

The lack of appropriate accommodation with support cannot be emphasised enough. Resources such as public housing, psycho-social and residential rehabilitation services, supported residential services, and home-based outreach support services are in short supply and not equitably distributed across the State. If accommodation and support needs were met more adequately, the need for acute clinical services would be likely to diminish.

RESPONSE *by St Vincent's Mental Health Services - continued*

The need for increased emphasis on early intervention for people experiencing the first onset of mental illness is crucial. The funding of one Early Intervention Clinician in each AMHS has been welcomed, however it is only the western suburbs of Melbourne that have access to a comprehensive early intervention treatment response. There is much evidence to indicate that early intervention can significantly decrease the level of impairment.

Para. 3.17

St Vincent's Mental Health Service (SVMHS) aims to provide a career path for psychiatrists, by the creation of team psychiatrist roles which emphasise the provision of clinical leadership to community and inpatient teams. There is also the opportunity to become the authorised psychiatrist or Director of Clinical Services. Joint academic appointments are attractive to psychiatrists, however, a very limited number of these appointments are available. It is still extremely difficult to attract full-time psychiatrists with a commitment to public sector psychiatry as it is currently practised.

Chart 3B

This chart refers to non-urgent assessments. Urgent assessments at St Vincent's Mental Health Service would not go through a 2-tiered response duty and intake.

Paras. 3.39 - 43

Mental health services in Victoria are working towards full compliance with the National Mental Health Standards, as they move from the Australian Council on Healthcare Standards EQuIP accreditation model to the National Mental Health Standards. Some services would aim to be fully compliant as they have already been through the accreditation process, others are working towards full compliance – SVMHS will go through the full accreditation process in March 2003, and some other services will not do this for 2 or 3 years. DHS should require all services to conform to national standards, whether they have been through the new accreditation process or not.

The National Mental Health Standard 11.2.12 does not prescribe a "face-to-face" contact. It states:"... The assessment process may be commenced with initial history taking, risk assessment, needs assessment over the phone". Therefore, statements by the auditors regarding "lower standards" are incorrect. An urgent response does not necessarily mean a "face-to-face" contact within one hour. In some cases, a face-to-face contact may not occur in 24 hours, when it is difficult to locate a person. If potential extreme violence is involved, then police may attend urgently rather than mental health clinician, or if over-dose or other form of self-harm, it is likely to be more appropriate to call an ambulance immediately. The police, fire brigade and ambulance provide an emergency response which the Mental Health Service is not equipped to provide. The name "Crisis Assessment and Treatment Services" (CATS) has probably contributed to the common misperception that these teams provide an immediate emergency response.

Many factors need to be taken into consideration when dealing with an urgent referral. The CATS response is a planned one and is prioritised given the current work demands. Background information is needed and clinicians are reminded not to go into situations without this information due to safety reasons. It takes time to plan a response which involves consumers, carers etc. Where a "face-to-face" is not possible, telephone and co-ordination of supports are put into place. The "response" happens when the first intervention takes place – e.g. a phone call back to the referrer to discuss the plan.

Clarification and agreed guidelines should be developed by DHS in relation to what constitutes a response in this context.

***RESPONSE** by St Vincent's Mental Health Services - continued*

There are often occasions where referrals deemed urgent can be further categorised into "very urgent" and "less urgent" which allows for prioritising of response when workloads are heavy and service demand is high. Response time is influenced by many factors, including urgency and risk (to consumer/carer and staff), current situation and context, consumer and carer wishes and availability, and availability of other service components (e.g. police or ambulance) as well as current service demand.

Meeting the demand for crisis response after-hours is a challenge for St Vincent's Mental Health Service. At SVMHS it is recognised that the existing workloads are high and additional support is given to psychiatric triage during the evening shift by other CATS staff when needed and when possible. After hours response requires the triaging of all calls to the mental health service as well as assessment and treatment of people experiencing a mental health crisis. Many consumers contact the psychiatric triage services after-hours because they are lonely, find the night-time difficult to manage, and cannot sleep.

It is important to note CATS have to balance a number of duties. At any time, CAT services are seeing clients in their own homes for intensive follow-up, assessing new referrals in a range of settings, taking triage referral calls, attending clinical reviews and liaising with other services, GPs and private psychiatrists, and are involved in family work and support.

Para. 3.48

At St Vincent's, a fast-track referral form has been implemented to speed up the referral in the Emergency Department (ED) to mental health triage when general health concerns are not present.

SVMHS has a good relationship with the ED, and presence of SVMHS clinicians is appreciated and valued, and the high demands on both services is recognised. In the Chief Psychiatrist's clinical review of SVMHS, it was stated that:

> *"The Director of the Emergency Department reported the annual throughput of patients presenting to the Emergency Department with a primary psychiatric presentation as 1 200, with approximately 2 – 3 psychiatric patients treated in the Emergency Department at any one time. Overall he found the psychiatric input to be very good".*

There has been an increase in the police bringing consumers to the ED for assessment (under s10 of the MHA) which has increased demand for ED-based assessments.

Para. 3.59

Response should be related to need. St Vincent's Mental Health Service aims to avoid the term "serious mental illness". Considerable education, clinical supervision and policy development has been devoted to improving our response to people with personality disorder. However, it should be noted that those people diagnosed with schizophrenia, severe depression and those who have suicidal behaviour will be likely to receive a response for the simple reason that these conditions often require an urgent and specialised response that cannot be provided elsewhere in the health system. People with psychotic illness are likely to have highest need, experience greatest disability and impairment, have poorer physical health, and be more socioeconomically disadvantaged. They are a small group with high needs for mental health treatment.

Para. 3.60

Documentation of duty processes at St Vincent's Mental Health Service was identified as a problem prior to the audit, and had been a focus of the Chief Psychiatrist's Clinical Review. Documentation of these processes has now been improved. However, we believe that the previous poor documentation did not reflect a poor clinical response.

RESPONSE *by St Vincent's Mental Health Services - continued*

Chief Psychiatrist's review said of Clarendon Clinic at SVMHS:

> *"Non-accepted referrals were reviewed daily (although there was no documentary evidence of this). CATS had access to management plans on an electronic database (that was available at all treatment locations) and there was a selection of management plans available to the duty-triage worker to facilitate more effective response. There seemed to be few if any barriers in accessing CATS involvement in acute or relapsing states and collaboration seemed excellent with all team components. In addition the service seemed responsive to community requests for treatment and care, and to display a genuine commitment to facilitating appropriate access".*

Para. 3.65

There is no common practice across AMHS in regards to ratings of urgency and risk self-harm. There is some debate about the use of ratings, and the danger of using forms which might preclude use of rigorous clinical judgement. At the very least, however, there should be a clear statement regarding urgency, and rationale for judgement. There should be standardised procedures across the mental health service system, and clarity about what must be recorded. Hopefully, the RAPID database will have some capacity to provide standardised documentation.

Para. 3.68

As indicated previously, people with psychotic disorders are likely to have higher needs for services. From our data, in our service, people with severe depression, anxiety, and personality disorders receive services in inpatient and community services. We would tend to refer people with severe eating disorders to specialist services, however, as we do not have the expertise within our service at this time.

Para. 3.75

The length of stay in the St Vincent's Acute Inpatient Service has increased in the last year. The increase is attributed to the higher acuity level of patients, and the recognition that premature discharge results in unplanned re-admissions. The increase is also a result of 5 patients remaining in the Inpatient Service for 8 to 18 months due to a lack of appropriate treatment and accommodation options.

Table 3J

These results indicate major problems with documentation, some of these problems relate to short length of stay, high throughput and staffing shortages.

Paras. 3.78 – 3.81

For some patients, early discharge to CAT services is beneficial in ensuring that the person receives care with little disruption to their usual environment. CAT services and other community services offer an alternative to hospitalisation when possible.

At St Vincent's, discharge planning is part of every patient's management plan. Every consumer is discharged to follow-up, i.e. an AMHS, GP, private psychiatrist or Psychiatric Disability Support Service. Not all consumers are discharged to care by an AMHS.

In many instances, after the consumer has responded to effective psycho-pharmaceutical treatment, discharge is delayed due to psychosocial factors, lack of accommodation options or requests for families.

Lack of appropriate housing and support options is a major problem.

Paras. 3.88 – 3.91

It is commendable that the file audit results indicated that case managers were allocated to 97 per cent of registered consumers, and 2/3 were allocated within one day, and 1/3 after registration.

RESPONSE *by St Vincent's Mental Health Services - continued*

At St Vincent's Mental Health Service, case-management allocations often take place at a clinical review meeting where the most appropriate case manager who has the capacity to take on further consumers is identified. Issues to be considered are preferred gender, professional discipline, intensity of intervention required. Assignment of case managers relates to the particular needs of the consumer, for instance consumers with more complex issues are assigned to more experienced clinicians. If interim intervention is needed, then the team manager, or the duty worker would take responsibility so there is always an identified contact for every person. In some cases, the CATS case co-ordinator would be the case manager.

Although consumers are discharged from public mental health services when their needs can be managed by other service providers, some consumers remain in the system for years, so some turnover of staff is inevitable even in a metropolitan service that has relatively stable staffing compared with outer metropolitan or rural areas. Inevitably, there is staff turn-over, especially in times of staff shortages. We aim to maintain consistent case-management as much as possible, particularly as we are dependent on psychiatric registrars for medical care who usually rotate every 6 months.

We aim to keep case-loads as low as possible in order to provide effective case management. Our ability to keep case-loads low is dependent on funding availability. We also aim to distribute cases to the most appropriate clinician.

Although the introduction of a consistent model of case management services across Victoria, lead to improved continuity of care, it is now time to redevelop this model to ensure that it operates flexibly and is able to utilise the specialist skills of all disciplines.

A more sophisticated approach emphasises a multi-disciplinary response, where a consumer may have an identified case manager who is responsible for care co-ordination, but where other inputs are provided by other team members, for instance, cognitive behavioural therapy, a comprehensive living skills assessment or a nursing intervention.

Each clinician will bring specialist skills to how they work with a consumer. It is simplistic to say that case management reduces specialist skills, rather we should say that effective case management should utilise the specialist skills of multi-disciplinary team members. There is little evidence that it is difficult to attract allied health workers, more that it is difficult particularly in rural and outer metropolitan areas to attract staff per se.

We would support a review of the case management model. Changes to the model would require full consultation, and preferably provision of system-wide training.

It is very concerning that the report suggests that case managers are reluctant to follow-up consumers. We view assertive follow-up as a core function of our community mental health services.

Para. 3.96

The absence of ISPs is very problematic. ISPs should be completed for all consumers in our Service; the only exception will be when consumers move with short notice to other areas soon after entry, and sometimes when only assessment or short-term care is provided and the consumer is referred to more appropriate services. Use of Inpatient management and treatment plans may sometimes substitute for an ISP in some cases.

Documentation problems are concerning, and are likely to be related to the increased demand on services where clinicians prioritise clinical service delivery over documentation.

Also the devolution to management by metropolitan health services and the disbanding of the central training unit resulted in less resources for training regarding clinical standards, less consistency across services, and limited leadership from the metropolitan health services which have tended historically to focus on hospital-based services, although they are shifting towards a broader view of integrated acute, sub-acute and community-based services.

***RESPONSE** by St Vincent's Mental Health Services - continued*

Para. 3.100

It would appear that the auditors are using a very narrow view of what constitutes a psycho-social intervention, for instance provision of psychotherapy.

Apart from medical appointments where it is possible that only medication is discussed, or attendance to receive depot medication, all other involvement with AMHS would involve psychosocial interventions, for instance, supportive counselling, rehabilitation, home visits, referrals to Psychiatric Disability Support Services and other services, family work, and psycho-education. The auditors may be using a very narrow definition of non-drug interventions, for instance psychotherapy or CBT, which would not be provided to the majority of consumers.

It would appear to be self-evident, however, that if clinicians had more time they could provide a more intensive response. This is a matter of resources and access to appropriate training.

Paras. 3.114 – 3.115

Consumers presenting to St Vincent's Mental Health Service have increasingly complex needs. Linkages with housing, welfare and income support agencies are essential. We have welcomed the establishment of the Northern Dual Diagnosis Service (Northern NEXUS) which has improved our ability to respond to the many consumers who experience substance use and mental health problems. The organisational structure at St Vincent's Health enhances the links between Mental Health and Drug and Alcohol Services, with these services being part of the same Directorate.

Utilising the resources supplied by SPECTRUM in relation to consumers with personality disorders and the Victorian Dual Disability Service in relation to consumers with intellectual and psychiatric disability has also enhanced our ability to work with consumers with complex needs.

In our area, linking with agencies for homeless people has been essential, and we will be part of a pilot through the Victorian Homeless Strategy in which a SAAP-funded position auspiced by Outreach Victoria will work with our Inpatient Service in relation to provision of accommodation for homeless consumers following discharge.

In order to meet increased demand, AMHS need to maximise their linkages with other services, so that an optimal and complementary service can be provided.

St Vincent's Mental Health Service has put considerable emphasis on fostering linkages, which has contributed to participation in a Primary Care Partnership Service Co-ordination Project to develop protocols between clinical and PDS Services in Yarra, and the successful submission by St Vincent's Health for a Hospital Admission Risk Program project to work with people presenting with mental health and drug and alcohol problems presenting to the Emergency Department.

At St Vincent's Mental Health Service, we recognise that we alone cannot meet the needs of consumers, so considerable effort and time is put into linking consumers with other services and working in collaboration with those services. For instance, St Vincent's has increased the number of consumers linked to a GP in order to promote general health care.

Part 4

Carers and families

INTRODUCTION

4.1 Carers are family members and close friends who carry out a care-giving role for a person with a mental illness. In most cases, a caring family continues to be the most stable resource for mental health consumers throughout a lifetime of stressors, shifting resources and changing clinical services. Even if they do not live with the consumer, concerned family members find services for their ill relative, provide social, financial and emotional support, and serve as a last resort when the system fails. In 1998, it was estimated that there were about 104 500 carers in Victoria looking after persons in the areas of aged care, disability and mental health[1].

4.2 Research into the support and care of people with a mental illness confirms the critical role that families and other carers can play, the demands of care-giving, and the importance of family and carer satisfaction with services[2]. The shift from institutional to community-based delivery of public mental health services has further reinforced the role and importance of carers and families in the treatment of people with mental illness. Victoria's public mental health service has acknowledged that responding to the needs of carers and families is an essential aspect of effective service delivery[3].

4.3 This Part of the report presents the results of focus groups and a mail survey of the perceptions of carers of persons with a mental illness. Despite the most careful of procedures, all surveys involve potential errors that can introduce uncertainty or bias. The methodological approach used in our survey has ensured credibility and appropriateness in relation to intended use. In particular, successful efforts were made to obtain responses from carers who did not initially respond to the survey. Analysis of these late responses indicated little non-response bias.

NEEDS OF CARERS AND FAMILIES

4.4 A review of the international literature indicates that in order for family members and other persons to be effective carers, they require:

- An understanding of mental health services:
  - To become aware of what mental health services can and should provide, and how to access these services; and
  - To help plan for the future when they are no longer able to provide care;

[1] Australian Bureau of Statistics, 1998, *The Caring in the Community*, catalogue number 4436.0.

[2] Department of Human Services, 1996, *In Partnership – Families, Other Carers & Public Mental health Services*.

[3] Department of Human Services, 1996, *The Framework for Service Delivery: Better Outcomes Through Area Mental Health Services*; and Department of Human Services, 2002, *New Directions for Victoria's Mental Health Services*.

- Information concerning:
  - The early warning signs of mental illness in order to take measures to prevent relapse;
  - Medications and other types of treatment; and
  - The nature of mental health symptoms in order to create an optimal social and emotional environment for the mentally ill person;
- Training in the management of mental illness:
  - To cope with the unusual nature of the symptoms of mental illness; and
  - To learn problem-solving approaches to behavioural difficulties created by mental illness;
- Recognition and inclusion:
  - Public mental health services need to recognise the importance of family and carer participation in the planning, delivery and evaluation of services; and
- Support services for carers:
  - Emotional support to resolve feelings such as grief, loss, anxiety and fear which family members experience. The resolution of emotional problems enhances the capacity of carers to cope;
  - Crisis assistance when the person with a mental illness is particularly unwell; and
  - Respite care to provide "breaks" from care-giving[4].

SERVICES FOR CARERS AND FAMILIES

4.5 Under the *Mental Health Act* 1986, the objectives of the Department of Human Services include:

> *"To establish, develop, promote, assist and encourage mental health services which minimise the adverse effects of mental disorders on the individual and his or her family and community".*

4.6 The Act requires the Department's Secretary to:

- support the development of services which assist carers and promote self-help and advocacy for people with a mental illness; and
- facilitate the provision of information, education and support to carers and advocates.

[4] See: M Leggatt, 2001, "Carers and carer organizations" in G Thornicroft and G Szmukler, *Textbook of Community Psychiatry*, Oxford University Press; also Mental Health Council of Australia and Carers Association of Australia, 2000, *Carers of people with a mental illness – Final report*, Commonwealth Department of Health and Aged Care, Canberra ACT.

4.7 Victorian mental health policy recognises that carers are important partners in supporting people with a mental illness to live in the community. The 1996 Victorian "Carer Initiative" provided funding for services to work with carers in order to provide them with support, resources, education and respite. Since 1996, service development activities have included the provision of direct carer support as well as assisting mental health practitioners to better understand the needs of, and provide support to, carers and other family members. These activities include:

- Family Sensitive Training for all mental health services;
- Carer Crisis Support Program which provides flexible support to carers to assist them avert or overcome a crisis ($3.1 million in 2002-03);
- planned respite services to provide people with a mental illness and their carers with a change from usual living arrangements ($2.3 million in 2002-03);
- mutual support and self-help services which provide information and advice about mental illness and facilitate carer support groups ($1.2 million in 2002-03);
- carer support workers who work with the Commonwealth Carer Respite Centres to facilitate access to a range of services, including respite and carer support, either directly and/or through community development activities ($440 000 in 2002-03); and
- Koori carer support workers to provide support to family and community members who are caring for people with a mental illness, in order to prevent the breakdown of kinship networks ($500 000 in 2002-03).

4.8 The Department's Mental Health Branch also supports a biennial conference for carers of people with a mental illness and Carers Week activities.

4.9 As part of enhancing service quality and accountability for services provided to carers, in 1997 the Department commenced an annual survey of carer and consumer satisfaction. The results of the Department's carer surveys are consistent with other evidence which indicates that, while services to carers have improved in recent years, many carer needs and expectations remain unfulfilled[5]. The Department advises that government policy is to further strengthen support services for carers, as outlined in the Department's 2002 publication *New Directions for Victoria's Mental Health Services*.

4.10 In 2001, the Department commissioned an evaluation of the 1996 "Carer Initiative". The evaluation noted that data concerning trends in service utilisation by mental health carers was incomplete for programs such as the Carer Crisis Support Program and respite services. The evaluation itself was subject to certain methodological limitations (e.g. a 9 per cent survey response rate, the use of leading questions), and the evaluation's conclusions in relation to the effectiveness of carer support services should be treated with caution.

[5] For example, see: G Thornicroft and V Betts, 2002, *International Mid-Term Review of the Second National Mental Health Plan for Australia*, Department of Health and Ageing, Canberra; and M Bohan, and J Nankervis, 2000, *Inclusion & support of family carers: How well are we doing in Mental Health?*, VICSERV Conference.

IMPACT OF THE MENTAL HEALTH SYSTEM ON CARERS AND FAMILIES

4.11 In order to assess the impact of the public mental health system on carers and families, interviews were undertaken with peak carer organisations, 6 focus groups for carers were conducted in both metropolitan and country venues, and a random sample of 780 carers were surveyed using a mailed questionnaire (338 replied for a response rate of 43 per cent). The survey had a margin of (sampling) error of about ±5 per cent, while error due to non-response was statistically non-significant.

Who provides care?

4.12 Fifty-five per cent of the 338 carers who responded to the survey were the parent of the person with a mental illness, 21 per cent were the husband/wife/partner of the person, 13 per cent were the son/daughter and 8 per cent were the brother/sister of the person. Nearly 75 per cent of carers who responded to the survey were female. Seventy-three per cent of all respondents were more than 50 years of age and 14 per cent were over 70.

4.13 Thirteen per cent of respondents reported being from a non-English speaking background, with less than one per cent being Aboriginal. About half or those surveyed indicated that they were in paid employment. The majority of carers (65 per cent) reported that they lived with the person they cared for.

Time spent caring

4.14 Table 4A shows that carers are highly variable in the amount of time they spend looking after the person with a mental illness, ranging from under 10 hours per week to more then 50 hours per week.

TABLE 4A
TIME SPENT BY CARERS LOOKING AFTER THE PERSON WITH A MENTAL ILLNESS
(n = 291)

Number of hours per week	*Percentage of carers*
0-10	39.3
11-30	21.9
31-50	9.9
51+	28.9
Total	**100.0**

Source: Victorian Auditor-General's Office, survey of carers, 2002.

4.15 About one-third of carers reported that they had been in contact with public mental health services for less than 5 years, one-third reported 5 to 10 years of contact, and one-third reported more than 10 years of contact with public mental health services. Eighty per cent of respondents reported that their most recent contact had been within the last 12 months.

Who receives care?

4.16 Survey responses indicate that 61 per cent of those receiving care were male. The majority of persons being cared for were under 50 years of age (84.7 per cent) with 38.8 per cent of persons being under 24 years of age. In addition to their mental illness, 25.8 per cent of persons being cared for also had drug/alcohol use issues, health problems (24.9 per cent), or an intellectual disability (7.8 per cent).

Help received by carers

4.17 Survey respondents were asked to rate how helpful various service providers had been in the last 12 months in helping the carer to look after the person with a mental illness. Table 4B shows that carers most frequently sought help from public mental health service psychiatrists and case managers, but found the services provided by carer associations and support groups more helpful. Some of these associations and support groups receive funding from the Department.

TABLE 4B
CARER RATINGS OF SERVICE UTILISATION AND HELPFULNESS
(n = 299)

Service provider	*Percentage of carers who used this service in the last 12 months*	*For carers who have used this service, the percentage who rated the service as "helpful" or "very helpful"*
Carer association/carer support group	61.6	77.7
Public mental health service case manager	88.1	46.8
General practitioner	79.3	46.2
Public mental health service psychiatrist	90.0	36.9
Respite services	43.4	36.9
Counselling service	49.5	35.8
Community health service	53.4	34.8
Drug/alcohol service	26.1	18.4

Source: Victorian Auditor-General's Office, survey of carers, 2002.

4.18 In their comments to the survey, carers indicated that what they most valued from carer support groups and general practitioners is the ease of access to such services, as well as the information and emotional support they received. In relation to public mental health service case managers, carers most valued their knowledge of the mental health system and the manager's skill in working with a person who has a mental illness. Carers also indicated that they wanted Area Mental Health Services (AMHSs) to improve carer access to psychiatrists and case managers, provide more information, better emotional support, greater involvement in decision-making and less turnover in staff.

Carer satisfaction with hospital-based mental health services

4.19 Of the carers who responded to the survey, 38.4 per cent indicated that the person they cared for had been admitted to hospital for treatment in the last 12 months. Forty-nine per cent of these admissions were on a voluntary basis and 51 per cent were involuntary. Carer satisfaction with hospital services is shown in Table 4C.

TABLE 4C
CARER SATISFACTION WITH HOSPITAL SERVICES
(n = 130)

Service feature	*Percentage of carers who were "satisfied" or "very satisfied" with this service feature*
Transport for the person you care for to get into hospital	62.0
Admission procedure for the person you care for to get into hospital	52.7
The information you were given about practical matters on the ward (e.g. visiting times)	47.2
Overall satisfaction with services received at the hospital	43.3
Information you were given about the condition and treatment of the person you care for	39.0
Hospital staff consulting with you prior to discharge	35.5
Information provided to you by the hospital service about what to do if a relapse occurs	26.5
Information provided to you by the hospital service about services to help you as a carer	13.3
Information provided to you by the hospital service about your rights as a carer	12.3

Source: Victorian Auditor-General's Office, survey of carers, 2002.

4.20 In their comments to the Auditor-General's survey, carers expressed considerable dissatisfaction with the following hospital practices:

- Hospitals not providing carers with information about the person's mental illness, the medications given and their possible side effects. As one carer said, *"If we had known that fainting was a likely side effect of our son's medication, we would have kept a closer eye on him. As it was he fell over and required stitches for a head wound"*;

- Hospitals not actively consulting with carers concerning the diagnosis and treatment plan for the person with a mental illness. As one carer said, *"In the past there have been many occasions when hospital and clinical staff have made us feel excluded and misunderstood. There has been some improvement in recent years but a greater effort is required to collaborate with carers"*; and
- Patients being discharged from hospital before their mental illness is under control/stabilised. Carers indicated that mental health patients are often released from hospital while they were still very unwell, and carers have neither the training nor the resources to cope with this situation. As one carer said, *"When patients are released from hospital too early it is inevitable that the person will relapse and it also puts a huge strain on the family in coping with all this"*.

4.21 The above results are consistent with the Department's own carer satisfaction survey in which carers tend to be the least satisfied with the provision of information by hospitals, the amount of contact carers have with hospital staff and the help carers were given to plan for the time when the person they care for left hospital.

Carer satisfaction with community-based mental health services

4.22 Carers were also asked to rate their satisfaction with community-based public mental health services, focusing on the service used most often in the last 12 months. As shown in Table 4D, carer satisfaction is quite low, with half or less being satisfied with the services they receive.

TABLE 4D
CARER SATISFACTION WITH COMMUNITY BASED SERVICES
(n = 313)

Service feature	*Percentage of carers who were "satisfied" or "very satisfied" with this service feature*
Getting help from the Crisis Assessment and Treatment Team between 9 a.m. and 5 p.m. during the week (Monday-Friday)	50.0
Whether the Crisis Assessment and Treatment Team listened to your concerns as a carer	47.1
Whether the Crisis Assessment and Treatment Team provided an appropriate referral for follow-up care	43.0
Getting help from the Crisis Assessment and Treatment Team after hours during the week (Monday-Friday)	37.9
The opportunity to have input in the development of a treatment plan with the person's case manager	37.4
Your overall satisfaction with the services provided by the public adult mental health service	36.3
Getting help from the Crisis Assessment and Treatment Team on weekends	34.9

Source: Victorian Auditor-General's Office, survey of carers, 2002.

4.23 In their survey comments, carers reported that outside of normal business hours it was very difficult to get a response from the Crisis Assessment and Treatment Team. While expressing their frustration with the limited access to services, carers also thought that the staff working in public mental health services appeared to be under-resourced and overworked.

4.24 The availability of services in regional areas was also a frequent source of complaint. As one carer said, *"Services for the mentally ill in regional Victoria are terrible, especially when a hospital admission is needed. My son has been sent home from assessments by doctors who do not know him, only to be admitted to hospital a few days later in an emergency situation. The incredible stress this places on carers is unacceptable, and the life threatening risk my son has been in is unacceptable".*

4.25 Carers complained strongly about not being consulted by public mental health service staff concerning the treatment plan for the person with a mental illness. As one carer stated, *"Mental illness is a family problem and not a consumer problem alone. Services need to listen to and be involved with carers and family".*

Impact of mental illness on carers and family members

4.26 As part of the survey, carers were asked to rate the impact of the person's mental illness on themselves and their family. As shown in Table 4E, the majority of carers reported that they and their families experienced a number of negative consequences in terms of their level of happiness, their leisure time, their physical and mental health, their personal relationships and their standard of living. This evidence is consistent with the findings of a national survey of carers that was undertaken in 1999 by the Carers Association of Australia[6].

TABLE 4E
EFFECT OF THE PERSON'S MENTAL ILLNESS ON CARERS AND FAMILIES
(n = 319 and 297)

	Percentage who reported a "moderate" or "major" effect'	
Issue	*Carers*	*Families*
Level of happiness	80.9	75.8
Leisure time	79.8	64.8
Physical health	74.9	57.0
Mental health	73.9	67.0
Personal relationships	73.3	67.5
Standard of living	65.3	51.3
Feeling part of the community	52.7	49.1
Employment status	48.5	31.8
Physical safety	35.6	31.3

Source: Victorian Auditor-General's Office, survey of carers, 2002.

[6] Carers Association of Australia, 2000, *National Survey of Carer Health and Wellbeing" Warning – caring is a health hazard.*

Services most needed by carers

4.27 As part of the survey, carers were asked to rate their need for different types of services. As shown in Table 4F, carers rated their most important need as being for "education about mental disorders", and their second most important need as "information about treatment options".

TABLE 4F
SERVICES MOST NEEDED BY CARERS
(n = 204)

Service	*Percentage of carers who reported this to be their "most important" or "second most important" need*
Education about mental disorders	61.7
Information about treatment options	55.4
Information about services for carers	38.7
Family counselling/therapy for carers	33.8
Carer support groups	32.3
Housing respite services	28.9
Counselling for family members	27.9

Source: Victorian Auditor-General's Office, survey of carers, 2002.

4.28 In their survey comments, carers frequently mentioned that persons with a mental illness often experience difficulty in accessing appropriate treatment and support services.

4.29 Consistent with other research findings[7], our survey of carers revealed that carers are looking for public mental health services to provide them with information, education, training and support in managing the person with a mental illness:

- *"We need education on how to manage daily crisis situations, as well as quasi criminal and fraudulent activity";* and
- *"Please understand the most critical time for a carer and their family is at the initial diagnosis stage. This is when support and adequate information and explanation is really needed".*

4.30 Survey respondents commented upon the need for better integration of drug and alcohol services and mental health services. As one carer said, *"Patients with both mental health and drug problems fall through the cracks. Mental health say my daughter has a drug problem and the drug service says she has a mental health problem (she has both). Each of the services abdicates responsibility in favour of the other service".*

[7] For example, see: Carers Association Victoria, 2000, *Carers Speak Out*, Melbourne.

CONCLUSIONS

4.31 In order to be effective, public mental health services must take into account the important role of carers and families and be responsive to their needs where possible. This has been recognised in the Second National Mental Health Plan and in the Department of Human Service's own policies and framework for service delivery.

4.32 Audit evidence demonstrates a major discordance between central policy directions and the experiences of carers and families. The survey results show that less than 50 per cent of carers rated community-based services as "helpful" or "very helpful", with the exception of carer associations and support groups. Similarly, less than 50 per cent of carers reported that they were "satisfied" or "very satisfied" with hospital services, with the exception of admission procedures.

4.33 Carers indicate that they require better information, education, consultation, training and support if they are to effectively fulfil their responsibilities as a carer while safeguarding their own wellbeing.

RECOMMENDATIONS

4.34 We recommend that the Department of Human Services and Area Mental Health Services ensure that:

- Public mental health services are sensitive to the needs of carers and families. This will require carers and families to be included in the development of mental health polices, and clinical staff to actively collaborate with carers and families in the delivery of services; and
- Carers are provided with the information, education, training and support they require to effectively manage persons with a mental illness.

REPONSE *provided by Department of Human Services*

The Department provides significant funding for carers. Victoria has more paid carer consultants, more carer support and greater carer involvement than other states. Victoria has introduced a number of innovative programs to support carers including carer consultants, carer satisfaction surveys and carer crisis support and respite programs and plans to further improve carer participation and support.

As outlined in the recently released New Directions for Victoria's Mental Health Services, in 2002-03 the Department will:

- *Encourage mental health services to make greater use of carer resources.*
- *Prepare user-friendly information about mental health services for inclusion in the telephone directory.*
- *Maintain an up-to-date service directory on the Internet.*
- *Review other ways of improving mental health information and referral.*
- *Support research on the needs of carers of people with high prevalence disorders.*

A carer information package developed in partnership with carers has recently been completed and is available in all Mental Health Services.

REPONSE *provided by Department of Human Services - continued*

The carer burden both nationally and internationally is well documented and is acknowledged by the Victorian Government in the recently released New Directions for Victoria's Mental Health Services.

This is acknowledged by the provision by DHS of a range of services designed to support families and other carers of people with a mental illness. These services include: the carer crisis support program; planned respite care; mental health carer support workers; and mutual support and self-help services.

In recognition of the importance of carers as partners in mental health care, the Department has committed to take further action to encourage the involvement of carers in treatment and care planning. Details of the proposals are in the New Directions Report.

DHS continues to support ministerial advisory groups (that is, the Ministerial Advisory Committee on Mental Health and the Victorian Community Advisory Group on Mental Health) and MHB reference groups/committees that enable carer consultation and participation in the development, implementation, monitoring and review of mental health policy and service delivery. Area Mental Health Services are increasingly involving carer representatives to undertake these activities at a local level, including the funding and appointment of carer consultants by the services.

DHS recently published a resource kit for carers titled Information for Families and Carers of People with a Mental Illness (July 2002).

The new Carer Survey of public area mental health services has been developed in consultation with carers during 2001/02 and will be implemented in 2002/03. The survey includes specific measures of information, access, treatment and support for carers within child and adolescent, adult and aged person's mental health services.

REPONSE *provided by Goulburn Valley Area Mental Health Service*

Para. 4.31

Subsequent to the audit, a number of issues relating to improving sensitivity to the needs of consumers and carers through the implementation of a collaborative project developed by the Goulburn Valley Area Mental Health Service and Mental Illness Fellowship Victoria.

The project was managed by a Project Advisory Committee consisting of carers, consumers and mental health staff. This Committee had, as one of its prime responsibilities, a commitment to ensuring that the recommendations arising from the group process were taken to the GVAMHS management committee for discussion and action.

Outcomes of the project include:

- *a number of recommendations regarding policy direction and service delivery;*
- *managerial support for the aims of the project resulting in changed attitudes of many staff towards carer and family issues;*
- *a carer consultant has been employed, markedly improving support and information services to carer;*
- *increased referrals of carers to family support service;*
- *a range of consumer/carer information materials have been produced including an information kit and an associated information pathway that is to be followed by staff to ensure that carers are informed throughout an episode of care;*
- *a Consumer and Carer Advisory Council has been established to actively represent the views and perspectives of consumers and carers, make recommendations to the organisation and to comment on outcomes achieved; and*
- *presentations regarding carer issues have been delivered over radio and in hospital-based and community forums.*

***RESPONSE** provided by St Vincent's Mental Health Service*

Para. 4.27

Provision of information and education for carers is a key concern of our Family and Carer Participation Strategy. We run regular sessions with the active involvement of volunteer carers, our paid carer consultant and our staff. A newsletter for consumers and carers has been started. We view consumer and carer education as integral to any case management process.

Consumer and carer information kits have been developed over the past 2 years. More recently, the role of carers has been highlighted and incorporated and integrated into all areas of service delivery through involvement in treatment plans and policy development. The degree of effectiveness of this is variable, however, and we need to improve further.

Part 5

Rights of involuntary patients

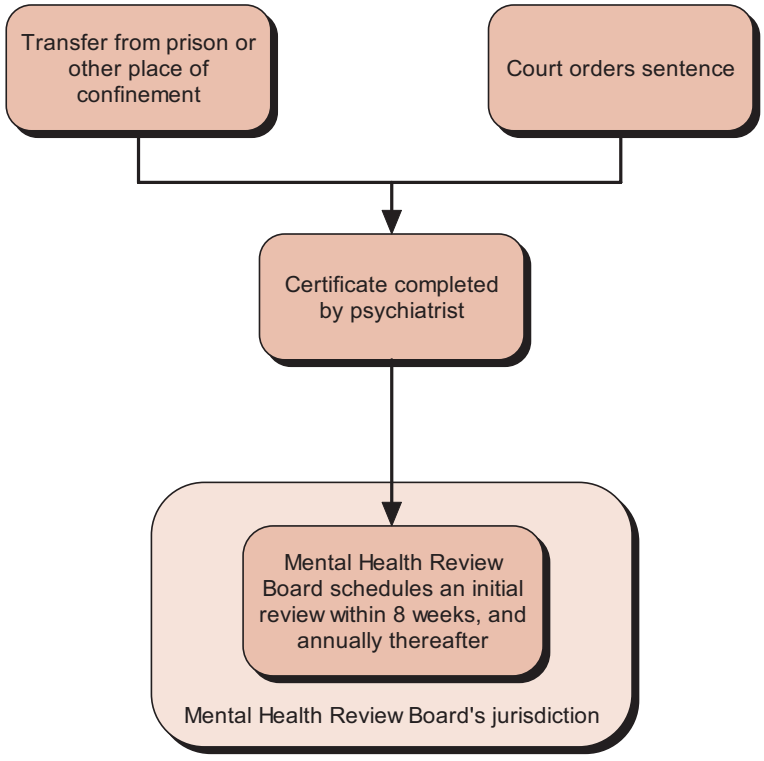
INTRODUCTION

5.1 A person with a mental illness may need to be given treatment against their wishes. Referred to as "involuntary" patients, such persons experience some loss of personal freedom. These involuntary patients comprise 3 main groups:

- patients who are referred from the criminal justice system, generally known as "security" patients, who receive involuntary treatment while they remain the joint responsibility of correctional services and public mental health services;
- involuntary inpatients detained within a mental health facility; and
- persons receiving involuntary treatment while they continue to live in the community (referred to as a "community treatment order" patients).

5.2 The admission process for security patients is shown in Chart 5A.

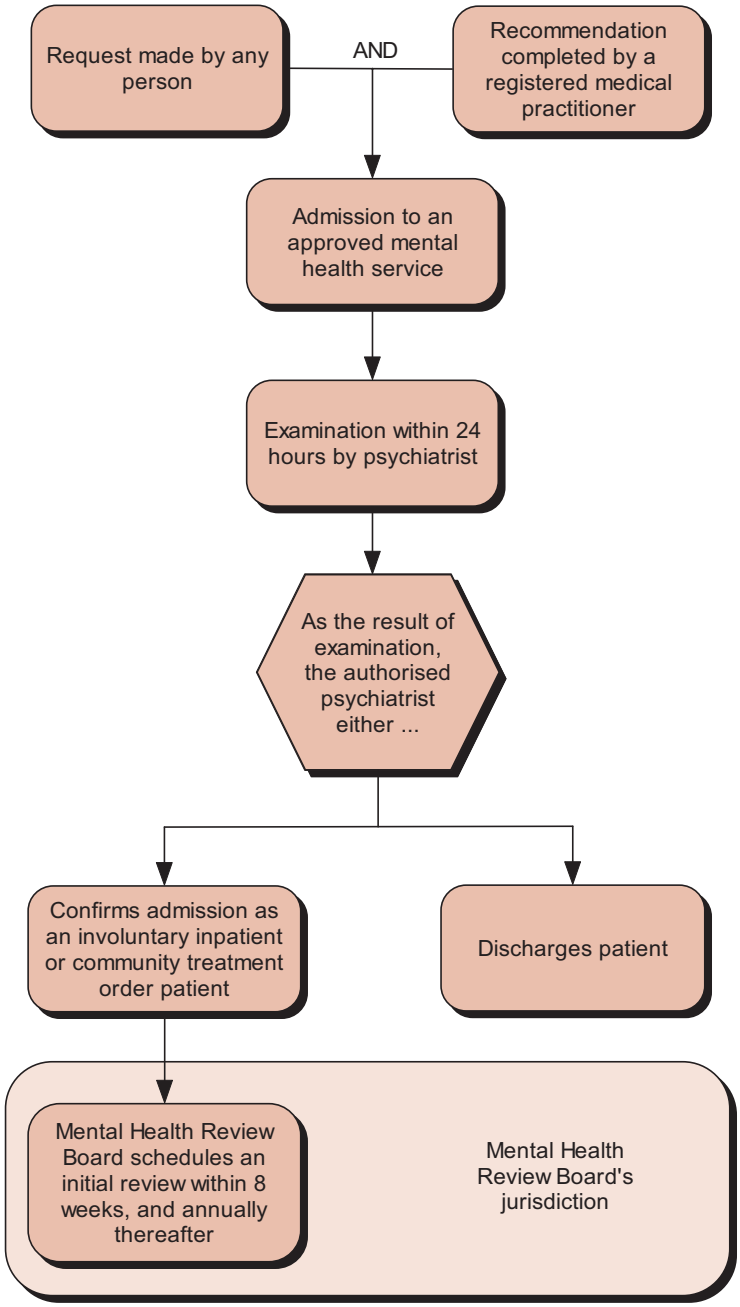
CHART 5A
ADMISSION PROCESS FOR SECURITY PATIENTS



Source: Mental Health Review Board, 2002.

5.3 The admission process for involuntary inpatients and community treatment order patients is illustrated in Chart 5B.

CHART 5B
ADMISSION PROCESS FOR INVOLUNTARY INPATIENTS AND COMMUNITY TREATMENT ORDER PATIENTS



Source: Mental Health Review Board, 2002.

5.4 Both administrative practices and management data from the Mental Health Review Board were examined by this audit. Seventy-five "administrative" patient files held by the Board and 935 "clinical" patient files held by Area Mental Health Services (AMHSs) were examined, and 30 involuntary mental health patients were interviewed. The operations of Boards in other States were also considered for comparative purposes.

MENTAL HEALTH REVIEW BOARD

Legislation

5.5 The Mental Health Review Board is an independent administrative review tribunal that conducts hearings to determine whether it is necessary for a person to continue to be treated as an involuntary patient. In making its decision, the Board must consider the need of the individual to receive treatment, the loss of freedom that the individual experiences when they are treated involuntarily, and the interests of the community.

5.6 Established under the *Mental Health Act* 1986, the main functions of the Board are to:

- review all involuntary patients within 8 weeks of admission to decide whether their involuntary status should continue;
- hear appeals from involuntary inpatients and security patients, and people on community treatment orders who want to be discharged;
- review all involuntary patients at least every 12 months to decide if their involuntary status should continue; and
- review every decision to extend a community treatment order.

5.7 In undertaking these appeals and reviews, the Board must assess whether or not the person in question satisfies certain criteria. The criteria for involuntary treatment as listed in the Mental Health Act are summarised below:

- the person appears to be mentally ill; and
- the person's mental illness requires immediate treatment, and that treatment can be obtained by an involuntary admission to an approved mental health service or by the patient being placed on a community treatment order; and
- the person needs to be treated as an involuntary patient for their own health or safety, or for the protection of members of the public; and
- the person has refused, or is unable to consent to, the necessary treatment; and
- the person cannot receive adequate treatment for their mental illness in a manner less restrictive of their freedom.

Resources

5.8 The Board presently has 77 sessional members who conduct hearings in accordance with the Mental Health Act. The Board has a full-time President, and 9 permanent staff members employed under the *Public Sector Management and Employment Act* 1998. The Board's operating expenses for 2000-01 were about $1.5 million.

Board operations

5.9 The Board states that its vision is:

- to be respected and recognised as an expert body that operates sensitively to the needs of its users and which fairly balances the rights of the mentally ill, their families and carers, and the community as a whole; and
- to remain an efficient, effective and independent organisation empowered to protect the rights of people with a mental illness.

5.10 Initial reviews of involuntary patients are heard by panels consisting of 3 Board members. Each panel must include a presiding member (who is a qualified lawyer), a psychiatrist member and a member representing the community. The Mental Health Act allows a single member Board to conduct annual reviews and reviews of extensions to community treatment orders.

5.11 Panels of the Board sat 917 times in 2001, and conducted hearings at 43 different venues around the State. Teleconferencing was used in 4 per cent of hearings in order to hear cases in remote areas. The Board has established a regular schedule of sitting dates and venues to which it adheres for the purposes of rostering its members. The frequency of sitting dates varies from fortnightly to monthly, depending upon the venue. In exceptional circumstances, the Board establishes special sittings.

Board members travelling to a regional venue.

5.12 Of the 5 690 cases determined by the Board in 2001, 82 per cent were reviews, while the remaining 18 per cent were appeals. A breakdown of cases by patient status and presenting issue is shown in Table 5C.

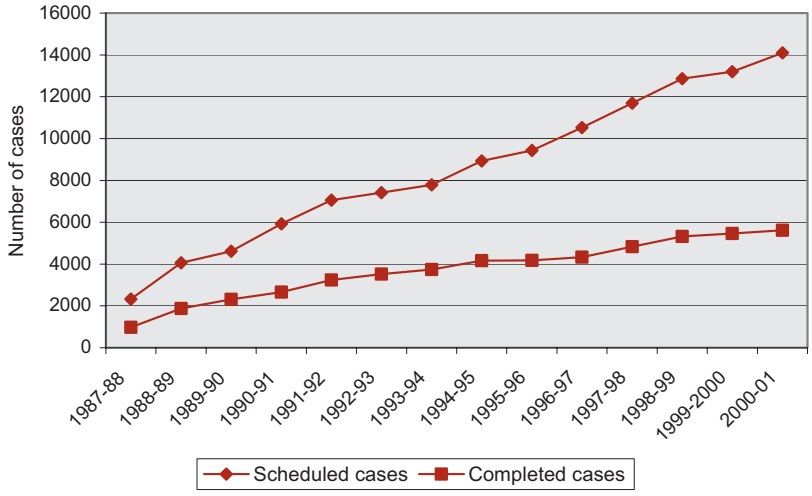
TABLE 5C
TYPES OF CASES HEARD BY THE MENTAL HEALTH REVIEW BOARD, 2001

Patient status and presenting issue	*Percentage of cases*
Inpatients (involuntary status)	29.0
Community treatment order patients (involuntary status)	68.2
Involuntary patients (other issues)	0.2
Security patients	2.6
Total	**100.0**

Source: Mental Health Review Board, 2002.

5.13 Trends in the Board's workload since commencing operations in 1987 are shown in Chart 5D.

CHART 5D
MENTAL HEALTH REVIEW BOARD
TRENDS IN SCHEDULED AND COMPLETED CASES *(a)*



(a) Scheduled cases also include cases that have been rescheduled or adjourned. Completed cases do not include persons released from their involuntary status prior to their case being heard by the Board.

Source: Mental Health Review Board, 2001.

5.14 Over the period 1987-88 to 2000-01, the number of cases scheduled to come before the Board increased by 607 per cent, while the number of cases actually completed by the Board increased by 574 per cent. Over this period of growth in cases, the Board's efficiency has improved, with the cost per completed case falling from $472 in 1987-88 to $251 in 2000-01.

Induction and training of Board members

5.15 The Board advises that all new Board members go through a comprehensive induction program. This involves observations of divisions of the Board, several induction seminars, a mentoring program and distribution of a comprehensive "Members' Manual". Regular meetings of Board members are held each year for the purpose of ongoing education and training, and to discuss any current operational issues.

All new Board members participate in a comprehensive induction program.

PROTECTING PATIENT RIGHTS

5.16 Apart from patients having the right to appeal to the Mental Health Review Board at any time about their involuntary status, the Board also protects the rights of patients by automatically scheduling and conducting reviews. Involuntary patients have certain rights in relation to the hearing of reviews and appeals, including:

- to be notified of the time and location of their hearing;
- to have a legal representative or other person attend the hearing;
- to have access to all information being submitted to the Board as part of their hearing;
- to be present at their own hearing;
- to have their case heard by a fair and impartial tribunal division conducting the proceedings informally, and without regard to technicalities or legal forms, according to equity and good conscience, and applying the rules of natural justice;
- to have their hearing conducted within the time frames specified in the Act;
- to request a written statement of reasons for a Board decision within 28 days of the hearing and to receive it within 14 days of the request; and
- to apply for a review of any decisions of the Mental Health Review Board to the Victorian Civil and Administrative Tribunal.

5.17 The Board's observation of these rights is considered in the following sections of this Part of the report.

Notice of hearings

5.18 Patients have a right to be notified of their Board hearing. Normally, notice of more than 7 days is given in order to allow time for patients and their doctors to prepare for the hearing. The Notice of Hearing includes a letter setting out the details of the matters to be heard. The time and place of the hearing, and a brochure providing information to assist the patient in preparing for the hearing is also included.

5.19 Involuntary inpatients are given their Notice of Hearing by a member of the staff of the mental health service. Patients living in the community are sent their Notice of Hearing by the Board through the mail. Of all the Notices of Hearing issued for 2001, 56 per cent were mailed to the person's home address; the remaining 44 per cent were faxed to the mental health service where the person was being treated.

5.20 Interviews with 30 involuntary patients did not raise any concerns with regard to patients receiving notice of their hearing.

Legal representation

5.21 Patients have the right to arrange for someone to represent them or assist them at their hearing. The Board's information brochure for patients advises that if the patient cannot afford the cost of legal representation, they can apply to Victoria Legal Aid or the Mental Health Legal Centre for assistance. However, not all such applications are granted. In contrast, the South Australian Mental Health Act legislates for the provision of free legal representation to people appearing before its Guardianship Board (which fulfils a similar function to the Victorian Mental Health Review Board).

5.22 Victorian patients were legally represented at about 10 per cent of all hearings during 2001. Of the representation provided, about 68 per cent was by Victorian Legal Aid, 24 per cent by the Mental Health Legal Centre and 7 per cent by private lawyers.

5.23 In an examination of 935 patient files held by Area Mental Health Services (AMHSs), 73 per cent were involuntary patients. In less than 31 per cent of these cases, the patient's file contained documented evidence that the patient had been provided with general information about their rights by the AMHS. The *Mental Health Act* 1986 requires that every involuntary patient be provided with a printed statement of their rights and an oral explanation of this information, upon their admission to a mental health service.

5.24 Of the 30 involuntary patients interviewed, almost half indicated that they were not aware of their right to be legally represented. Of those patients who were aware of this right, most reported that they learned about the availability of legal and advocacy services from notice boards within mental health services. This result was unexpected given that the Notice of Hearing served on patients contains information about the right to have representation when appearing before the Board.

5.25 Only one of the 30 patients reported that staff from the mental health service offered to help the patient arrange their legal representation. Correspondence between the Board and the Office of the Chief Psychiatrist in 2001 indicates that there is no consistent approach within AMHSs regarding the facilitation of legal representation for involuntary patients.

5.26 Interviews with involuntary patients and their advocates suggests that, despite the efforts of the Board to conduct hearings in an informal manner, patients can feel confused, powerless and intimidated by Board processes. This is particularly so for patients who are unrepresented, suffering from the effects of their illness and, at times, the negative side effects of their medication.

The right to information

5.27 A representative of the authorised psychiatrist, generally the patient's supervising doctor, is required to appear at the patient's Board hearing and must provide the Board with a written report. Patients have the right to inspect all documents that are to be given to the Board in connection with their hearing, including the doctor's report and the patient's own medical file. The patient must be given access to all these documents at least 24 hours before the hearing.

5.28 Interviews with stakeholders indicate that in their experience the Board does not routinely check, at the commencement of hearings, to ensure that patients have been made aware of their right to access information. This is a requirement of Board members as specified in the "Members' Manual".

5.29 The Board provides patients with advice about their right of access to information through an information brochure that is sent to patients prior to their hearing. During interviews with involuntary patients, about 30 per cent indicated they were not aware of their right to access information. Of those patients, who were aware of this right, a common source of complaint concerned difficulties patients experienced in gaining access to their own medical file and to the doctor's report to the Board. The Board initially brought this problem to the attention of the Office of the Chief Psychiatrist in 2001.

5.30 The *Mental Health Act* 1986 makes provision for doctors to apply to the Board for an order that certain documents not be inspected by the patient. The grounds for seeking such an order are either that such inspection would cause serious harm to the patient's health; or the health or safety of another person; or involve the unreasonable disclosure of information relating to the personal affairs of any person; or breach a confidentiality provision imposed by the person who supplied the information contained in the document. The Board received 26 applications to withhold information from patients in 2001.

5.31 Applications to restrict a patient's access to information are dealt with at the beginning of a Board hearing. The Mental Health Legal Centre advised that this practice presents difficulties for patients without legal representation, as no-one can assess the withheld information on behalf of the patient and assist the patient in contesting the application for non-disclosure. Should the Board decide to refuse the doctor's application for non-disclosure, the patient then has little time to consider the information in the contested document. In these circumstances the Board advises that, where necessary, extra time is allowed on the day for patients to read and understand any information to which they have not previously had access.

Attendance of patients

5.32 Patients have the right to appear in person at their hearing unless the Board decides that their appearance would be detrimental to the patient's health. The Board may hear a review or appeal without the patient being present if it is satisfied that the patient has made the decision not to attend of their own free will. A patient who does not wish to attend can sign a simple form to indicate their preference not to attend. Alternatively, the patient can telephone the Board to advise of their intentions.

5.33 During 2001, patients were not present at 38 per cent of hearings. In 31 per cent of hearings, the patient gave prior notice that they did not wish to participate, and in 7 per cent of hearings the patient simply did not attend on the day. This pattern was similar for both metropolitan and regional venues.

5.34 In the event of a person failing to attend their hearing without having given prior notice, or where the Board members are uncertain of the patient's intention to attend the hearing, the Board adjourns the hearing, and notifies the person of a new hearing date. Should the person fail to attend the second hearing, the Board then determines the case in the person's absence. In the case of inpatients, on rare occasions, a Board member will seek to speak with the patient to clarify that the person does not wish to attend their own hearing.

Patient access

Initial reviews

5.35 Victorian legislation requires that a person's continued detention be reviewed within 8 weeks of their initial admission. This is the longest period of unreviewed involuntary detention in the country, except for Western Australia which also stipulates 8 weeks.

5.36 In Victoria, the Board aims to schedule all initial reviews approximately 6 to 7 weeks after the patient's admission. Patients are listed for review by the Board after they have been registered as an involuntary patient for a minimum of 2 weeks.

A Board hearing in progress.

5.37 Statistics provided by the Department of Human Services show that, during 2001, 51.6 per cent of involuntary patients were discharged within the first 2 weeks of admission and were not therefore listed for initial review by the Board. Of the 6 372 initial reviews listed for hearing in 2001, 37.8 per cent of patients listed for hearing were discharged from their involuntary status prior to the hearing date. Thus, the majority of involuntary patients (69.8 per cent) do not appear before the Board to have their situation independently reviewed, unless they appeal.

5.38 The reason most involuntary patients do not appear before the Board is due to changes to mental health treatment practices over time. Since the Act was originally introduced and later amended in 1993, patient treatment times have fallen significantly. During 2001, for example, the average involuntary patient was released from their involuntary status after 21 days. Hence, the majority of patients (nearly 70 per cent) are released from their involuntary status without coming before the Board for a hearing, unless they appeal.

5.39 The Board conducted 2 179 initial reviews in 2001. With the exception of cases delayed because of adjournment, all but 25 initial reviews were heard within the legislated 8-week time frame. Extensions to community treatment orders are viewed similarly to new admissions and must also be heard within 8 weeks of their commencement. On average, it took 6 weeks to conduct hearings for each of 1 111 Community Treatment Order extensions in 2001 (excludes 412 cases delayed because of adjournments).

Annual reviews

5.40 The *Mental Health Act* 1986 also requires that involuntary patients be reviewed within 12 months of their previous review. With the exception of the South Australian Board which also reviews continued detention annually, all other States review ongoing detention at intervals of either 3 or 6 months[1]. Combined with an initial review by the relevant State Board or Tribunal, this arrangement generally makes for a more frequent independent assessment of the patient's status than is the case in Victoria.

5.41 About 8.3 per cent of annual reviews concern involuntary inpatients, 89.9 per cent concern Community Treatment Order patients and 1.8 per cent relate to patients detained under other sections of the Act, such as security patients. Of the 3 077 annual reviews listed for hearing in 2001, 22.3 per cent (or 686) of patients were discharged prior to their hearing date. The Board finalised 1 336 annual reviews in 2001. While these figures would appear to suggest a backlog of around 1 000 annual reviews over the year, this is not necessarily the situation. The figure of 3 077 annual reviews listed for hearing in 2001 also includes reviews that are rescheduled and/or adjourned. Hence, an individual review can be counted more than once.

Appeals

5.42 Involuntary patients have the right to appeal to the Board at any time, and patients may appeal as often as they choose. The *Mental Health Act* 1986 requires the Board to hear appeals without delay. Appeals are scheduled by the Board to be heard at the next available sitting day at the service location where the patient is receiving treatment. If the person appealing has not yet had an initial review of their detention, this review will be brought forward, as the Act permits reviews to be heard at the same time as the appeal. The person is then sent a notice of the appeal hearing, as well as information about the Board hearing process and their rights.

5.43 Of the 30 involuntary patients interviewed for this audit, 30 per cent claimed not to have been aware that they had a right to appeal to the Board against their status as an involuntary patient. The Board advises all involuntary patients of their right to appeal in a poster which the Board distributes to AMHSs. Information brochures produced by the Board specifically discuss this right of appeal.

5.44 Just over 15 per cent of the 2 077 appeals listed in 2001 did not proceed to hearing due to the patient being discharged from their involuntary status prior to the hearing date.

[1] "Review" in most other States is the Board/Tribunal hearing applications for the renewal of orders for involuntary treatment.

Rescheduled hearings and adjournments

5.45 On occasions, hearings are rescheduled to suit the needs of patients and/or their doctors. A decision to reschedule differs from an adjournment in that the decision to reschedule is made by the Board's administrative staff at least 24 hours before a hearing is listed to occur. During 2001, about 2 000 review cases were rescheduled. The Board advises that, in the case of patient appeals, both the patient and their doctor must agree to the hearing being rescheduled. However, the Board does not request that documentary evidence be provided to substantiate that the patient has consented to the rescheduling.

5.46 A total of 846 initial reviews were affected by adjournments in 2001, adding an average delay of 18.3 days to complete these hearings. In relation to annual reviews, 530 cases were delayed by adjournments, adding an average of 23.25 days to hearing completion. Of the 506 appeal cases heard singularly, 209 cases experienced delays due to adjournment, adding an average of 22.8 days to hearing completion.

5.47 Of all cases listed, patients having been transferred from one service location to another accounted for the most adjournments (1 033), followed by doctor absence (603), the patient not appearing (259), patients' personal reasons (258), and 232 adjournments occurred because the doctor attending the hearing was not familiar with the patient. In 365 instances, the reason for adjournment was recorded by the Board as "other".

Conduct of hearings

5.48 The Act requires that Board hearings be conducted informally and be bound by the rules of natural justice. During interviews with patients and their advocates, concerns were raised about the nature of Board hearings. A frequent comment was that many patients found the hearing process to be quite intimidating. This was due to sitting the 3 Board panel members behind a table, the older age of many panel members compared with the age of the patient and the absence of legal representation for about 90 per cent of patients. Interviews with 30 involuntary patients revealed that about 50 per cent felt that they had not been listened to by the Board and a similar proportion did not understand the reasons for the Board's final decision. Each of the 30 patients interviewed reported that mental health service staff do not attempt to ensure that patients understand Board decisions. Mental health service staff report that they generally do attempt to explain matters to patients, but the patient's illness can hamper this process.

Patient outcomes

5.49 The Board determined 5 690 cases in 2001: 6.2 per cent resulting in the patient being discharged from their involuntary status and 93.8 per cent were confirmed as meeting the criteria for continued involuntary status. The rate of discharge has remained relatively constant since 1987, and is similar for both metropolitan and regional patients. Discharge rates by patient type are shown in Table 5E.

TABLE 5E
DISCHARGE RATES BY PATIENT STATUS, 2001
(n = 5 690)

Patient status	*Percentage of cases*
Inpatients	5.7
Community Treatment Order patients	6.6
Security patients	2.0
All patient groups combined	**6.2**

Source: Mental Health Review Board, 2002.

5.50 During 2002, patient outcomes varied considerably for patients with and without legal representation. Overall, patients with legal representation were discharged from their involuntary status 15.1 per cent of the time, while patients without representation were discharged on 4.5 per cent of occasions. Further research will be required to clarify whether the legally represented patients were less unwell than those not legally represented.

5.51 In addition to represented patients having a higher rate of discharge, patient advocates report that legal representation assists patients by ensuring that their views are put to the Board, and patients feel less intimidated by the proceedings when they are legally represented.

5.52 Discharge rates for patients who did or did not attend their own hearing is shown in Table 5F.

TABLE 5F
DISCHARGE RATE BY PATIENT ATTENDANCE, 2001
(n = 5 690)

Patient status	*Percentage of cases discharged*
Patient attended their hearing	8.0
Patient provided prior notice that they did not wish to attend their hearing	2.7
Patient simply failed to attend on the day	7.2

Source: Mental Health Review Board, 2002.

Statement of reasons

5.53 Patients have the right to request the Board for a written statement of the reasons for its decision within 28 days of the decision having been made. Patients are advised of this right through an information brochure that is provided to them. Upon receiving a request for the reasons for its decision, the Board has 14 days to complete the statement. The Board reported that in 2000-01, the average time for completing the 153 statement requests it received was 15 days.

Further reviews

5.54 A patient who is not satisfied with a decision of the Board may lodge an appeal with the Board asking to be released from their status as an involuntary patient. In reviewing Board operations, we found that Board members are not disqualified from hearing appeals for individuals who have previously had a review or appeal against their involuntary status refused by that same Board member. Such a practice would appear to be inconsistent with the principles of natural justice and may cause some stakeholders to question the procedural fairness of hearings.

5.55 Patients can also apply to the Victorian Civil and Administrative Tribunal (VCAT) to review a Board determination. Patients may then have to wait 6 to 8 weeks for their case to be heard. In 2000-01, VCAT received 17 applications to review a Board decision; 8 of these applications were later withdrawn. Of the 9 applications that proceeded to a full hearing, in 7 cases the Board's decision was upheld and in 2 cases the Board's decision was set aside.

CONCLUSIONS

5.56 The Mental Health Review Board's workload has increased by more than 600 per cent since 1987-88, while the cost per completed case has fallen from $472 in 1987-88 to $251 in 2000-01.

5.57 Currently, nearly 70 per cent of involuntary patients are released from their involuntary status without coming before the Board for a hearing. Since the *Mental Health Act* 1986 was introduced and amended in 1993, many mental health treatment practices have changed and the duration of inpatient treatment has fallen significantly. The implications of this are unclear for the Board's objective of seeking to balance the needs of individuals to receive treatment, the loss of freedom that the individual experiences when they are treated involuntarily, and the interests of the community. Given the potential vulnerability of mental health patients, a review of the role of the Board and the scheduling of reviews and appeals appears warranted.

5.58 Under the *Mental Health Act* 1986 the Board is required to review all involuntary patients within 8 weeks of their admission, hear appeals from patients who wish to be discharged from their involuntary status, review all involuntary patients at least every 12 months and review every decision to extend a community treatment order. The audit found that the vast majority of these reviews and appeals are being scheduled for hearing in a manner consistent with legislative time frames.

5.59 While the Board is fulfilling its legislative requirements to conduct reviews and appeals, there is opportunity to further improve the administration of hearing processes. In particular:

- Patients can feel confused, powerless and intimidated by Board processes. This is particularly so for patients who are unrepresented, suffering from the effects of their illness or, at times, the negative side effects of their medication. Fifty per cent of the patients interviewed felt that they had not been listened to by the Board and a similar proportion did not understand the reasons for the Board's final decision. This is despite the efforts of the Board to provide patients with information about their rights, and to conduct hearings in an informal manner;
- A significant proportion of the patients interviewed reported being unaware of their rights, including their right to access information, their right of appeal and their right to be legally represented. Of those patients who were aware of their right to information, a common source of complaint concerned difficulties they experienced in gaining access to their own medical file and to the doctor's report for the Board;
- In 2001, some 38 per cent of patients did not attend their own Board hearing. This may be the result of patients being in agreement with their involuntary status, the severity of their illness at that time (and associated lack of awareness), or it may reflect a lack of confidence in Board processes. Further research will be required to identify the causes of patient non-attendance and appropriate strategies to address this; and
- A significant proportion of cases are either rescheduled or adjourned prior to being heard by the Board. This causes delays in the completion of hearings, unnecessarily disrupts the work of Area Mental Health Services' staff and may potentially disadvantage patients.

RECOMMENDATIONS

5.60 When the *Mental Health Act* 1986 is next reviewed, provisions in relation to the Mental Health Review Board should be assessed in light of the significant changes to treatment practices that have occurred since the Act was first introduced.

5.61 The Board, the Department of Human Services and Area Mental Health Services (AMHSs) should ensure that:

- Involuntary patients are given the support and assistance necessary to enable them to participate effectively during Board hearings;
- Involuntary patients are made aware of their rights, and that service staff protect these rights. This requires the ongoing education of both involuntary patients and service providers beyond the use of posters and brochures, and the implementation of appropriate monitoring and complaints mechanisms; and
- Research is undertaken to identify why a significant proportion of involuntary patients do not attend Board hearings, and action is taken to increase attendance.

5.62 The Board and AMHSs should take action to reduce the number of cases that are rescheduled or adjourned prior to being heard. In particular, the number of cases deferred as a result of doctors being unable to attend hearings, doctors attending hearings but not being familiar with the patient, and patients being transferred between service locations.

REPONSE *provided by Department of Human Services*

Para. 5.14

The Audit finding of the increased efficiency of the Mental Health Review Board is welcome.

Para. 5.60

DHS will consider the recommendation.

Para. 5.61

Patients not attending and participating in hearings is a typical pattern, which DHS understands has not changed over time.

The Department and the Board have made a significant commitment to ensuring that patients are able to participate effectively during Board hearings and that they are aware of their rights. These measures go beyond the use of posters and brochures and monitoring and complaints mechanisms. It is a legislative requirement of the Act that upon admission, involuntary patients are provided with a printed statement advising them about their legal rights including the right to obtain legal representation (s.18). These brochures are printed by the Department in a number of different languages. The Department also funds a telephone advice line to enable patients to hear a recording of these brochures in English and other languages. In addition, Services are required by section 18 to give patients an oral explanation of this information and to ensure that this information is conveyed in terms which the patient is most likely to understand.

In addition to these requirements, the Department funds the Mental Health Legal Centre to provide advice, legal representation and community education to patients. The Department has increased the funding of the Mental Health Legal Centre to provide a 1800 number for rural callers and to pilot a project aimed at increasing the level of legal representation of patients before the Board in rural areas. Significantly, the State also funds Victoria Legal Aid to provide a visiting advice service to metropolitan hospitals for involuntary patients.

Para. 5.62

Proposed improvements to improve the administration of hearing processes within current legislative requirements will be discussed with the Mental Health Review Board.

The Department will discuss the issue of rescheduling of cases with AMHSs and the Mental Health Review Board.

RESPONSE *provided by Mental Health Review Board of Victoria*

Para. 5.11

The Board currently services 44 venues throughout Victoria on a regular basis. Of these, 34 are visited fortnightly, 6 four-weekly, and the balance as required. Regularity of visits is based on a 6 monthly assessment of demand, taking into account budgetary and resource implications. The fortnightly roster, reviewed and prepared on a 6 monthly basis, provides for a predictable and comprehensive program designed to meet the needs of the Board's stakeholders, members and staff.

Paras 5.21 to 5.24

The Board has no input into the extent or distribution of the service provision of legal aid organisations in relation to the Board's client group. This is entirely dependent on their own budgetary and resource considerations.

RESPONSE *provided by Mental Health Review Board of Victoria - continued*

It is not appropriate for the Board to express a view about the issue of increased levels of legal representation of patients before the Board. However, if government were to decide that this would be desirable, consideration would have to be given not only to the budgets of the legal services, but also to its impact on the Board's caseload, finances and member resources, as such a decision would have significant implications for the scheduling and hearing processes of the Board.

Para. 5.26

Members of the Board are constantly aware of the necessity of conducting hearings in a manner appropriate to the important legal decisions they make affecting the liberty and lives of the patients about whom the hearings are required by law. At the same time, Board members are mindful of the potential for hearings to be a confusing and intimidating experience. As a result, over the years, the Board has attempted to develop hearings processes, which are, as far as reasonably practicable, flexible, informal and user-friendly.

Recently, more emphasis has been placed on induction and training of members around the notion of "therapeutic jurisprudence", which emphasises the efforts of members in attempting to achieve pro-therapeutic outcomes for hearings, irrespective of the formal determination of the Board. The Board will continue to give prominence to continuing education of members around best practice in hearings processes, procedures and practices.

Paras 5.36 to 5.38

The Board's listing process is entirely reliant on receiving weekly reports generated by the Department of Human Services' Statewide data system called RAPID. Patients whose involuntary status has been removed within 14 days of admission do not appear on the departmental reports and, therefore, cannot currently be listed by the Board for initial review hearings.

The Board acknowledges perceived changes in the nature of the Board's role in protecting patients' rights in the context of significant changes in the provision of treatment and care by mental health services, especially shorter inpatient admissions and increasing use of community treatment orders. It is a matter for government as to whether the review process and/or Board's role should change.

Paras 5.46 to 5.47

The Board regularly monitors trends in its hearing processes and reviews the rates of rescheduling and adjournments in an attempt to minimise any detrimental impact on its stakeholders. It also reinforces to the mental health services the importance of reducing the incidence of rescheduling and adjournments.

In doing this, the Board is always mindful of the pressure and workload of staff at mental health services. However, unlike courts, the Board is limited in the realistic sanctions available to it to enforce reasonable compliance by autonomous mental health services with its efforts to minimise unnecessary rescheduling and adjournments.

Para. 5.50

The Board agrees that research into the apparent causal connection between representation and discharge rates may be useful. Irrespective of this, it is the Board's view that, in the Board's non-adversarial jurisdiction, statistics about outcomes (in terms of detention/discharge) are generally unhelpful.

The Board agrees that potentially there are many benefits to patients deriving from legal representation at Board hearings. It is a matter for the government to decide whether legal representation of patients should be mandated at a higher level.

RESPONSE *provided by Mental Health Review Board of Victoria - continued*

Para. 5.54

The Board can understand the lay view that members should be automatically disqualified from hearing appeals in relation to patients about whom they have been involved in previous decision-making. The Board, however, disagrees that its current practice is in any way inconsistent with the principles of natural justice, as apprehension of bias, as a legal concept, requires more than the mere fact that the personnel of a division is the same on more than one occasion.

Repetition of appeals relating to the same patient is relatively uncommon. Aware of possible patient perceptions, and adopting a cautious approach, the President has already developed a practice to deal with such situations, generally precluding the same 3 Board members from being involved together in decision-making about the same patient on more than 2 occasions over a short time period.

Para. 5.60

The Board acknowledges the significant changes, which have occurred in mental health treatment practices and the duration of inpatient treatment since the commencement of the Board in October 1987. It is not appropriate for the Board to comment on matters of government policy in relation to the role of the Board and the scheduling of reviews and appeals. However, the Board reiterates that changes in these areas will have significant financial and resource implications for the Board, which must be taken into account if the suggested review is implemented.

Para. 5.61

The Board is keen to provide support and assistance to involuntary patients to assist their participation during Board hearings. The extent to which it is able to achieve this involves an important balance (and often overlooked distinction) between the obligations of the organisation as a statutory authority (that is, the Board as an administrative entity) providing government services and each separate division of Board members acting as an independent decision-maker in reviewing individual cases.

Part 6

Funding of Area Mental Health Services

2002-03 STATE BUDGET

6.1 Funds allocated to mental health services in Victoria in the 2002-03 State Budget amounted to $588.5 million. As part of the Government's policy to treat more people with a mental illness at home and in the community, and to improve access to hospital services, the State Budget provided for further funding of $61 million over 4 years for inpatient services as part of the Hospital Demand Management Strategy and for non-hospital-based community mental health services. The initiatives to be implemented include:

- an increase in the provision of acute inpatient services, adult and aged clinical community services and psychiatric disability support services to clients and in areas with high needs; and
- new diversion, early intervention and prevention initiatives, including providing further sub-acute beds, intensive support for homeless people with a mental illness and co-existing substance abuse, and expansion of the dual diagnosis program to young people with a mental illness and co-existing substance abuse.

REGIONAL DISTRIBUTION OF MENTAL HEALTH FUNDS

Move to reform

6.2 Until the early 1990s, mental health resources were largely distributed on a historical basis. Past concentrations of spending on mental health services in Victoria focused around existing psychiatric hospitals since most mental health services in Victoria were institutionally-based[1]. From the late 1980s, however, a policy of decommissioning major psychiatric institutions, and replacing them with "mainstream" inpatient mental health services, usually co-located with acute hospitals, occurred. In some instances, the physical infrastructure remained while responsibility for the facility was shifted to an acute health service. Resources were transferred from stand-alone mental health facilities to community-based settings, including clinical community ambulatory and residential services. These were supported by the establishment of psychiatric disability support services.

6.3 An initiative was launched in March 1994[2] announcing the redistribution of mental health funds from psychiatric hospitals toward services based on individual client entitlement. The mental health budget was to be distributed to regions on the basis of a weighted population formula that combined both population and proxy measures of service need. The additional cost of delivering services in rural areas was also taken into account.

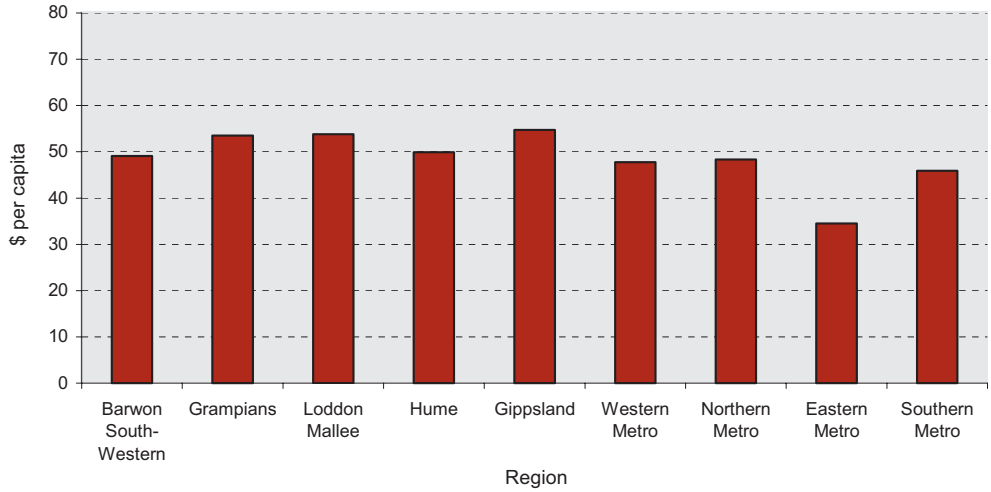
[1] Department of Health and Community Services 1994, *Victorian's Mental Health Service: The Framework for Service Delivery*.

[2] ibid.

6.4 Over the period 1992-93 to 1997-98, mental health spending on stand-alone hospitals reduced by $137.6 million (74 per cent), and $157.5 million was directed to the development of replacement services, mainly in community-based settings.

6.5 In April 1996, the Department of Human Services reported that the move away from historical funding of mental health services to a weighted population approach "was complete"[3]. Prior to the introduction of the weighted population formula, the allocation of funding across regions was rather variable. Chart 6A shows the current budget distribution by region, which is more even than prior to the redistribution.

CHART 6A
REGIONAL SHARE OF ADULT MENTAL HEALTH BUDGET, 2001-02



Source: Department of Human Services 2002. Data provided to Victorian Auditor-General's Office.

Establishing Area Mental Health Services

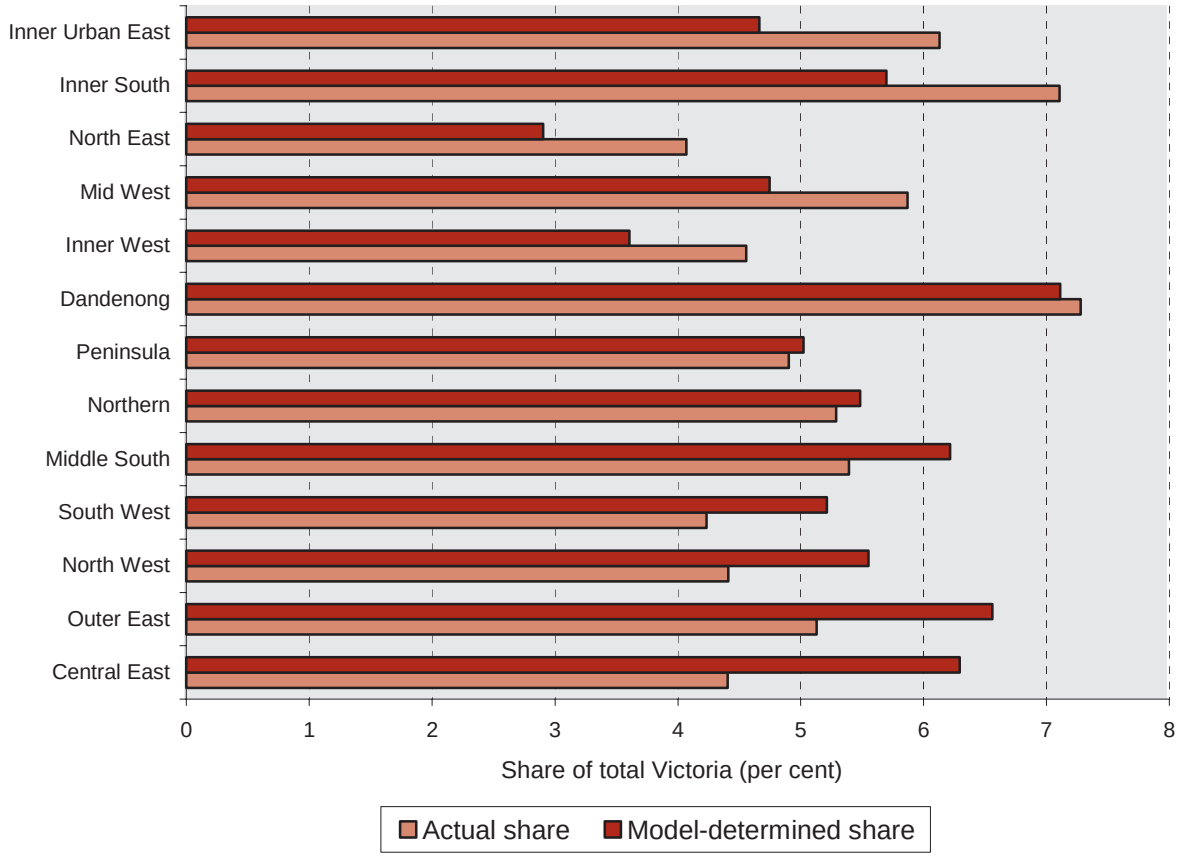
6.6 In 1996, the Department established a revised funding framework and weighted population formula that calculated shares on the basis of 22 mental health areas rather than the Department's regions as previously adopted[4]. While the formula retained the socio-economic and population structure factors, it also adopted a population density factor to replace "rurality" and included other factors.

[3] Department of Health and Community Services 1996, *Victoria's Mental Health Service, The Framework for Service Delivery Better Outcomes Through Area Mental Health Services*.

[4] In 2002, 2 of the Mental Health Service areas were combined resulting in 21 areas. Also, these areas are for Adult Mental Health Services only, since the catchments for Child/Adolescence and Aged Mental Health Services are different.

6.7 Chart 6B shows the actual share of funds for Adult Mental Health Services across metropolitan areas compared with the share determined by the weighted population formula for all mental health services (not just adult services). Chart 6C presents similar information for country areas. Total actual funding of AMHSs depicted in the charts is $220.1 million in 2001-02.

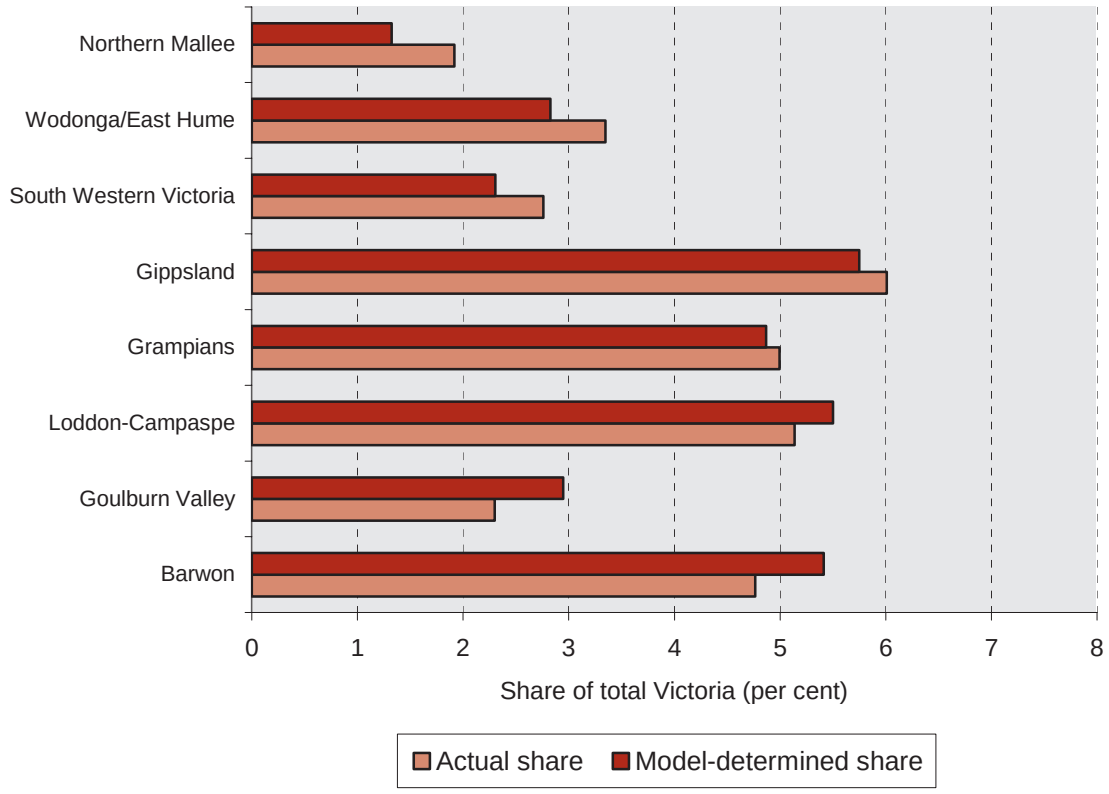
CHART 6B
ACTUAL VERSUS MODEL-DETERMINED SHARE OF ADULT MENTAL HEALTH FUNDING, METROPOLITAN AREAS, 2001-02



Notes: Actual funding data relate to recurrent funding of Adult Mental Health Services and include inpatient funding. Specialist services are excluded as are funding of Service System Capacity Development and Psychiatric Disability Support Services. Data for model-determined share are for 2002-03 and relate to total population (not just adults).

Source: Department of Human Services 2002. Data provided to Victorian Auditor-General's Office.

CHART 6C
ACTUAL VERSUS MODEL-DETERMINED SHARE OF ADULT MENTAL HEALTH FUNDING, COUNTRY AREAS, 2001-02



Notes: Actual funding data relate to recurrent funding of Adult Mental Health Services and include inpatient funding. Specialist services are excluded as are funding of Service System Capacity Development and Psychiatric Disability Support Services. Data for model-determined share are for 2002-03 and relate to total population (not just adults).

Source: Department of Human Services 2002. Data provided to Victorian Auditor-General's Office.

6.8 Across areas, funding aligns fairly well with the model-determined share of funding based on the weighted population formula. However, discrepancies remain. The biggest discrepancies are in the inner metropolitan area (which receives more than its model-determined share) and the central-east of Melbourne (which receives less than its model-determined share). For example, the Central East Area Mental Health Service (AMHS) obtained 4.4 per cent of the State's funding for Adult Mental Health Services in 2001-02, whereas the Department's formula would have provided 6.3 per cent[5]. The Department advises that redistribution of funding to match weighted population share is achieved through the allocation of new funding. In the case of the Central East AMHS, in 2002-03 it had been allocated about 6.9 per cent of the clinical growth funding for Aged and Adult Mental Health Services.

[5] In making this comparison, it is assumed that the distribution of the adult population across AMHSs is similar to the distribution of the total population across AMHSs.

6.9 The Department points out that while annual changes to funding allocations can be used to redistribute community-based resources relative to area needs, they cannot easily redistribute the current physical infrastructure, a process which can take years. This seeming inequity is balanced to a degree by inpatient services also providing services across area boundaries (so-called "out of area").

Factors in the weighting formula

6.10 The weighted population formula used to determine notional funding includes the following factors:

- Koori population;
- low English proficiency;
- rural population density;
- socio-economic disadvantage;
- population structure;
- availability of private psychiatric services; and
- homeless population.

6.11 While these factors appear reasonable, the regional resource allocation formula should be periodically reviewed and updated[6], because:

- new data sources become available and existing datasets are updated and revised; and
- the mental health environment is constantly changing.

The way forward

6.12 The Mental Health Branch of the Department has engaged a consultant to review the appropriateness of the current resource allocation formula. The revised formula is to take into account the potential for varying the formula between age groups and factors for higher costs associated with complex clients and rural service delivery. The final report is expected in October 2002.

CONCLUSION

6.13 Over time, the Department has made considerable progress in the redistribution of funds on a more equitable basis, but discrepancies remain. We endorse the Department's strategy to examine and revise the resource allocation model.

[6] The Department has advised that the formulae has been updated for the 2002-03 Budget.

***RESPONSE** provided by Department of Human Services*

Audit acknowledges Victoria's per capita Mental Health spending is above the national average per capita. In recent years between 1998-99 and 1999-2000 the average annual growth rate in State per capital expenditure was 2 per cent (adjusted for Commonwealth funding and constant prices), which was much greater than the average annual growth rate of 0.1 per cent achieved over the 5 years of the First National Mental Health Plan.

The total resource allocation formula including Aged, Child & Adolescent and adult has been used to indicate a funding "discrepancy" for adult.

In the case of the Central East Area Mental Health Service in 2002-03, Audit correctly indicates they have been allocated about 6.9 per cent of the new clinical community growth funding for aged and adult mental health services. The 6.3 per cent that Audit refer to is the total population share including child and adolescent services.

***RESPONSE** provided by St Vincent's Mental Health Service*

Resource allocation has occurred not only on the basis of the weighted population formula, but new initiative funds are allocated to achieve service viability. For instance to create viable Dual Diagnosis Teams, one position was allocated to each metropolitan AMHS, regardless of the weighting formula.

It is not only the allocation of funding that needs to be revised, but also the level of funding. Although considerable service system improvement can occur without additional funding, the increased demand for services indicates the need for increased funding.

Psychosocial disability support services have difficulty attracting and retaining staff because of the relatively low salaries they can afford to pay. Clinical services such as St Vincent's have experienced particular difficulty managing to come in on budget for last financial year and this year because of the under-funding of the Psychiatric Nursing Enterprise Bargaining Agreement. The cost of employing psychiatrists is very high.

Part 7

Measuring the effectiveness of mental health services

BACKGROUND

7.1 Given the importance of mental health services to the community and the significant level of program expenditure, the Department of Human Services requires a broad set of key performance indicators (KPIs) to measure their performance.

7.2 Appropriate KPIs can benefit an organisation by:

- making performance more transparent, allowing assessment of whether program objectives are being met;
- helping clarify government objectives and responsibilities;
- informing the wider community about government agency performance;
- encouraging ongoing performance improvement; and
- encouraging efficient service delivery.

Characteristics of good indicators

7.3 Effective performance management and reporting should support achievement of agency objectives and government outcomes. For public sector agencies, this requires:

- Government outcomes to be clearly specified;
- Outcomes to be linked to departmental objectives. This requires that departmental objectives are clearly defined and cover the key dimensions of departmental accountabilities and operations, i.e. address both the "purchaser" interest in deliverables, and the "owner" interest in organisational capability and long-term sustainability;
- The budget and resource allocation process to be integrated with the performance management and reporting system; and
- Information systems that efficiently provide data necessary to measure, monitor and manage government programs.

7.4 Sound KPIs have the following attributes:

- *Relevant.* The indicator has a logical and consistent relationship to the agency's objectives and is linked to the Government's desired outcomes;
- *Appropriate*. The indicator gives sufficient information to assess the extent to which the agency has achieved a pre-determined target, goal or outcome, by reference to:
  - the trend in performance over time;
  - performance relative to the performance of other similar agencies; and
  - performance relative to pre-determined benchmarks; and
- *Fairly represent performance*. The information must be capable of measurement, represent what it purports to indicate, and be accurate and auditable. Auditable means that quantifiable, consistent and verifiable data are available.

Departmental performance management and reporting framework

7.5 In the 2002-03 State Budget, $588.5 million was allocated to mental health outputs. This represents 7 per cent of total recurrent funding to the Department and 11 per cent of the Health budget. The major output targets for mental health services for 2002-03 include:

- 17 400 inpatient separations provided to people with a mental illness;
- 55 000 continuing clients in clinical community care;
- 9 124 clients receiving Psychiatric Disability Support Services; and
- 19 521 training hours of clinical staff[1].

7.6 In Victoria, the performance management and reporting framework shows output measures linked to outputs funded through the annual Budget process. These output measures, which are expressed in terms of time, quantity and cost, are published in the Budget Papers. Agencies are required to:

- account to the Treasurer quarterly against these targets in order to receive the moneys appropriated; and
- report their achievements against their output targets in their annual reports to Parliament.

7.7 In addition to output measures established under the performance management and reporting framework, performance measures may be established to provide management with the information it needs to make appropriate decisions linked to the organisation's day-to-day activities. Timely acquisition of relevant, reliable information is the key to determining whether the direction set is being followed, whether the health system is achieving the intended results and desired outcomes, and whether resources are being allocated appropriately.

Mental Health Outcomes Project

7.8 Following significant changes to public mental health services in the 1990s, in 1997 the Department commenced a study to develop outcome measures. In February 1999, the "Mental Health Outcomes Project" released a discussion paper[2] proposing a suite of measures for Adult Mental Health Services.

[1] Government of Victoria, 2002-03 Budget, *Budget Paper No. 3,* Statement No. 2.

[2] Department of Human Services, Aged Community and Mental Health Division, *Health Status and Outcomes in Victoria's Mental Health Services*, February 1999.

7.9 The indicators proposed for reporting *consumer* outcomes included:

- health status indicators, such as severity scales (HoNOS[3] scale and a self-rating tool[4]);
- change in level of disability (life skills profile[5]); and
- aim of treatment intervention (focus of care rating[6]).

7.10 The indicators proposed for reporting *service* outcomes included:

- KPIs derived from existing minimum datasets (these were unspecified);
- services' responsiveness to client need (listed as "under development");
- service integration (also listed as "under development"); and
- consumer and carer satisfaction.

7.11 The consumer and service outcome indicators were piloted by 4 Area Mental Health Services (AMHS) in 2000. The consumer outcome indicators are currently being "rolled-out" Statewide.

7.12 Work on the service outcome indicators was delayed until October 2001 when the Department engaged a consultant to revise the current set of KPIs. The development work is designed to:

- focus on outputs of mental health care;
- inform judgements about agency performance; and
- contribute to an understanding of population needs.

7.13 The project will produce a set of KPIs for use in child and adolescent mental health services, adult and aged persons services. The project is expected to conclude in September 2003.

[3] Health of the Nation Outcome Scales (HoNOS) measure the health and social functioning of people with mental illness. The 12-item scale measures behaviour, impairment, symptoms and social functioning, and can be determined by a health professional following routine clinical assessments.

[4] Two self-rating mental health indicators are suggested.

[5] The Life Skills Profile (LSP) is a 39-item scale that was developed as a measure assessing function and disability in persons with schizophrenia in the community.

[6] Focus of care is a measure that best describes the consumer's primary goal of care. The result is one of: Acute (short-term reduction in symptoms), Functional gain (improvement in personal, social or occupational functioning), intensive extended (minimisation of further deterioration) or maintenance (of current status).

ASSESSMENT OF MENTAL HEALTH KEY PERFORMANCE INDICATORS

Current mental health indicators

7.14 In 2001-02, the Department published 2 sets of performance measures for mental health outputs or deliverables. The first set appeared in the Department's *2000-01 Annual Report* and was replaced by a second set which appeared in the 2002-03 Policy and Funding Guidelines[7]. These measures are a mix of performance indicators (which focus of objectives) and performance measures (which relate to outputs) and are shown in Table 7A.

TABLE 7A
MAJOR OUTPUTS/DELIVERABLES – MENTAL HEALTH SERVICES, DEPARTMENT'S ANNUAL REPORT 2000-01, AND 2002-03 POLICY AND FUNDING GUIDELINES

Performance indicator or measure	*Unit of measure*	*2000-01 DHS Annual Report*	*2002-03 Policy and Funding Guidelines (a)*	*Whether performance indicator or measure*
Acute and sub-acute services				
Quantity -				
Acute inpatient treatment capacity	Beds	✓		PM
Acute inpatient separations	Number		✓	PM
Sub-acute treatment capacity	Beds	✓		PM
Registered clients	Number	✓		PM
Registered clients	Contacts	✓		PM
Quality -				
Inpatients re-admitted within 28 days (unplanned)	Per cent		✓	PI
Providers participating in Quality Incentives Strategy Projects	Per cent	✓		PM
Community care and support				
Quantity -				
Residential rehabilitation	Clients	✓		PM
Home-based outreach support	Clients	✓		PM
Continuing clients	Clients		✓	PM
Quality -				
Agency reporting on implementation and review of Individual Program Plans	Per cent	✓		PM
Clinical inpatient clients who have contact with clinical community care service providers during the 7 days prior to admission	Per cent		✓	PI
Clinical inpatient clients who have contact with clinical community care service providers within 7 days of post-discharge	Per cent		✓	PI

[7] DHS 2002, *Victoria – Public Hospitals and Mental Health Services, Policy and Funding Guidelines, 2002-03*.

TABLE 7A
MAJOR OUTPUTS/DELIVERABLES – MENTAL HEALTH SERVICES, DEPARTMENT'S ANNUAL REPORT 2000-01, AND 2002-03 POLICY AND FUNDING GUIDELINES - *continued*

Performance indicator or measure	*Unit of measure*	*2000-01 DHS Annual Report*	*2002-03 Policy and Funding Guidelines (a)*	*Whether performance indicator or measure*
Supported residential care				
Quantity -				
Psychogeriatric supported residential care capacity	Beds	✓		PM
Prevention and promotion				
Quantity -				
Mental Health Week events	Number	✓		PM
Primary Mental Health Response contacts	Number	✓		PM
Training, research and development				
Quantity -				
Mental health academic positions sponsored	Number	✓		PM
Postgraduate nursing placements (mental health)	Number of positions	✓		PM
Psychiatric Disability Support Services				
Quantity -				
Clients receiving Psychiatric Disability Support Services	Number		✓	PM
Quality -				
Individual Program Plans completed within 2 months	Per cent		✓	PI
Mental Health Service Systems Capacity Development				
Quantity -				
Number of clinical staff training hours	Number		✓	PM
Quality -				
Clinical staff successfully completing courses	Per cent		✓	PM

(a) Also in 2002-03 *Budget Paper No.3*.

7.15 The Department has undertaken extensive consultation in developing the current set of indicators and measures. It has also replaced the former Psychiatric Records Information Systems Manager (PRISM) data system with the Redevelopment of Acute and Psychiatric Information Directions (RAPID) system that collects a broader range of data. However, comparative data are not regularly published so Area Mental Health Services (AMHSs) cannot compare their performance.

Audit assessment

7.16 Performance indicators related to departmental objectives should address efficiency, effectiveness and the causal impact of programs, and can apply to the medium or long-term. However, output performance measures are directly related to the purchasing function and the annual resource allocation model. Because of this, there are fundamental differences in the attributes of a good performance indicator and a good performance measure, and the criteria for assessment of each will differ[8].

7.17 In particular, the *relevant* and *appropriate* criteria (shown in paragraph 7.4) are more difficult to assess in relation to performance measures. Table 7B sets out an assessment of each indicator based on these criteria. Of the 4 performance indicators, 3 meet all the criteria; the other one does not meet the *fairly represents* criterion, as there are concerns regarding the accuracy of the data required to calculate this indicator.

TABLE 7B
AUDIT ASSESSMENT OF MENTAL HEALTH SERVICES, 2002-03 PERFORMANCE INDICATORS AND MEASURES

Performance indicator or measure	*Relevant*	*Appropriate*	*Fairly represents*
Quantity -			
Acute inpatient separations	⊖	⊖	✓
Continuing clients in community care	⊖	⊖	✓
Clients receiving Psychiatric Disability Support Services	⊖	⊖	✓
Number of clinical staff training hours	No	No	Unknown
Quality -			
Inpatients re-admitted within 28 days (unplanned)	✓	✓	✓
Clinical inpatient clients who have contact with clinical community care service providers during the 7 days prior to admission	✓	✓	✓
Clinical inpatient clients who have contact with clinical community care service providers within 7 days of post-discharge	✓	✓	✓
Clinical staff successfully completing courses	⊖	⊖	Unknown
Timeliness -			
Individual Service Plans completed within 2 months	✓	✓	No

Legend: ✓ Yes.
⊖ To some extent, some attributes not addressed.

[8] Victorian Auditor-General's Office, *Departmental performance management and reporting*, November 2001, (p. 72).

7.18 The Department's set of mental health KPIs and performance measures are not sufficiently comprehensive to provide management with the necessary information to measure the effectiveness of mental health services. In particular, they do not provide any indicators of service demand. In the absence of a broader set of indicators, many AMHSs have developed their own management reports. While the 4 performance indicators currently used by the Department should be retained, improved performance information could enhance the management effectiveness of the sector.

7.19 We note that 4 AMHSs have been implementing clinical outcome measurement since July 2000 in a pilot project supported by the Commonwealth Government. Such measures will be valuable when eventually rolled-out to all AMHSs.

Potential indicators

7.20 Following our assessment of the performance indicators and performance measures in place, we have developed some suggestions that could enhance these indicators and measures.

7.21 We first examined the client pathway as described in Part 3 of this report (refer Chart 3B). We believe that each major phase of the client service model is a key component of the mental health system, and requires measures and indicators so its performance can be judged.

7.22 We then assessed each potential indicator based on our criteria, namely, indicators need to be relevant, appropriate and fairly represent performance. The relevance criterion is based on linking the indicator to one of the Department's objectives. These objectives are:

- waiting times for health, community care, disability and housing programs are at, or below, national benchmark levels;
- quality of human services improves each year;
- sustainable, well managed and efficient government and non-government services;
- reduce social dislocation and the need for secondary and tertiary service intervention through strengthening the communities, family support, early intervention and health promotion measures;
- increase the proportion of people needing the Department's funded services who remain in supportive families and communities; and
- reduce inequalities in health status and wellbeing, and in access to services[9].

[9] Department of Human Services 2002, *Departmental Plan, 2002-03*, Output Statement, Mental Health.

7.23 In suggesting indicators, we have done so with 2 audiences in mind:

- *External*. These indicators should inform strategic decision-making at the most senior level and be published to promote public accountability; and
- *Internal*. These indicators are at the operational level. They need to reflect how services are being implemented or managed, and highlight any problem areas that need attention.

7.24 Table 7C shows a proposed set of KPIs for mental health services. Table 7D presents a proposed set of performance measures. In both cases, we have identified:

- the type of measure/indicator (what should be regarded as "success");
- the performance measure/indicator;
- what the measure/indicator should be compared against;
- a suggested or potential data source on which the measure/indicator can be calculated;
- how frequently the measures/indicators should be reported; and
- to whom the measure/indicator should be reported.

TABLE 7C
POSSIBLE KPIs FOR MENTAL HEALTH SERVICES

Type of indicator	*Performance indicator*	*Comparison made*	*Data source*	*Frequency and recipient*
Objective 1 – Waiting times for health, community care, disability and housing programs are at, or below, national benchmark levels				
Timeliness -				
Proportion of urgent clients presenting to hospital Emergency Departments (EDs) seen in timely manner *(a)*	1. Percentage of initial assessments of urgent referrals commenced within one hour of initial contact 2. Percentage of initial assessments of non-urgent referrals commenced within 24 hours of initial contact	Trends over time Other emergency patient systems (such as acute hospital) " "	Victorian Emergency Minimum Dataset (VEMD) RAPID	Monthly - Executive
Proportion of clients have Individual Service Plans (ISPs) completed in timely manner *(a)*	Percentage of clients with ISP completed within 2 months	Trends over time Between AMHS	RAPID	Annual - Managers
Proportion of urgent clients who are referred to a CAT team are seen quickly	Percentage of urgent clients seen within one hour of making initial contact	Trends over time	RAPID	Monthly - Managers
Response time in ED	Percentage of admitted patients waiting less than 12 hours for a bed	Other types of patients in ED	VEMD	Monthly - Managers
Objective 2 – Quality of human services improves each year				
Quality -				
Client satisfaction	Percentage of clients satisfied with service	Trends over time Other health satisfaction surveys	Client survey	Annual - Executive
Improvement in clients' mental health	Percentage of clients with significantly decreased clinical score (entry to service versus closure)	Trends over time	RAPID (HoNOS, or similar measure)	Monthly - Managers
Carer satisfaction	Percentage of carers satisfied with service	Trends over time Other health satisfaction surveys	Carer survey	Annual - Executive
Proportion of on-going clients have ISP plans reviewed	Clients who have had an ISP reviewed (as a percentage of those with cases ongoing for at least 6 months)	Trends over time Between AMHS	RAPID	Annual - Managers
Proportion of inpatients re-admitted *(a)*	Percentage inpatients re-admitted within 28 days (unplanned)	Trends over time Rates for other patients groups	VAED	Monthly - Executive

TABLE 7C
POSSIBLE KPIs FOR MENTAL HEALTH SERVICES - *continued*

Type of indicator	*Performance indicator*	*Comparison made*	*Data source*	*Frequency and recipient*
Objective 2 – Quality of human services improves each year - *continued*				
Proportion of clients re-access the service	Percentage former clients (case closed) who re-access the service (become registered again) within 2 months of case closure	Trends over time Between AMHS	RAPID	Monthly - Executive
Seclusion rate	Percentage of inpatients having at least one episode of seclusion in an admission	Trends over time Possible benchmark	Office of Chief Psychiatrist	Monthly - Managers
Absconding rate	Percentage of patients absconding	Trends over time Possible benchmark	Office of Chief Psychiatrist	Monthly - Managers
Suicide rate	1. Percentage of registered clients who suicide 2. Percentage of population who suicide	Trends over time Between AMHS	Coroner	Annual - Managers
Objective 4 - Reduce social dislocation and the need for secondary and tertiary service intervention through strengthening the communities, family support, early intervention and health promotion measures				
Objective 5 - Increase the proportion of people needing the Department's funded services who remain in supportive families and communities				
Quality -				
Proportion of inpatient clients are seen by community care service providers pre-admission *(a)*	Percentage of clinical inpatient clients who have contact with clinical community care service providers during the 7 days pre-admission	Trends over time Between AMHS	RAPID	Monthly - Managers
Proportion of inpatient clients are followed-up by community care service providers post-discharge *(a)*	Percentage of clinical inpatient clients who have contact with clinical community care service providers during the 7 days post-discharge	Trends over time Between AMHS	RAPID	Monthly - Managers
Co-ordination of care	1. Percentage of clients who are jointly managed by Mental Health Services and general practitioner/private psychiatrist 2. Percentage of clients who are jointly receiving psycho-social and drug treatment therapy	Trends over time Between AMHS	RAPID	Monthly - Managers
Objective 6 - Reduce inequalities in health status and wellbeing, and in access to services				
Proportion of clients treated in local area	Percentage of clients treated in their local AMHS	General population statistics Between AMHS	RAPID	Annual – Managers

(a) Indicates is currently a Department of Human Services performance measure or indicator.

TABLE 7D
POSSIBLE PERFORMANCE MEASURES FOR MENTAL HEALTH SERVICES

Type of measure	*Performance measure*	*Comparison made*	*Data source*	*Frequency and recipient*
Objective 3 - Sustainable, well managed and efficient government and non-government services				
Cost -				
Cost of providing mental health services to population	$ per person in population	Trends over time Between AMHS Possible benchmark	DHS finance system RAPID	Monthly - Managers
Cost of triage	$ of CAT team per response	Trends over time Between AMHS	DHS finance system RAPID	Monthly - Managers
Cost of case management	$ per client	Trends over time Between AMHS	DHS finance system RAPID	Monthly - Executive
Cost per inpatient care	$ per bed day Length Of Stay Occupancy rate	Trends over time Between AMHS	DHS finance system RAPID VAED	Monthly - Executive
Cost of psychiatric disability support service	$ per client $ per attendance	Trends over time Between AMHS	DHS finance system RAPID	Monthly - Managers
Objective 4 - Reduce social dislocation and the need for secondary and tertiary service intervention through strengthening the communities, family support, early intervention and health promotion measures				
Objective 5 - Increase the proportion of people needing the Department's funded services who remain in supportive families and communities				
Quality -				
Community acceptance	Number and nature of complaints	Trends over time Between AMHS	Administrative records of DHS and AMHS	Annual - Executive
Objective 6 - Reduce inequalities in health status and wellbeing, and in access to services				
Quality -				
Mental health services are provided on an equitable basis	Percentage of clients registered over 12 month period from various population groups (e.g. female, non-English speaking background	Comparison with general population statistics Between AMHS	RAPID	Annual - Managers

CONCLUSIONS

7.25 The current set of mental health measures and KPIs do not provide sufficient information to management and the Victorian Government to appropriately monitor the effectiveness of the services being delivered. Most of the current measures and KPIs are not tied to departmental objectives and relate to service delivery (i.e. outputs) rather than consumer outcomes. The current set of measures and indicators is also limited in its coverage of mental health services.

7.26 We have proposed a set of measures and indicators that we believe would both inform strategic decision-making and assist line managers administer their programs. Most of the information required to calculate the measures and indicators is available from current systems. However, there may need to be some revisions to the Department's RAPID data system and an effort made to ensure data completeness.

RECOMMENDATIONS

7.27 We recommend that, as part of the process of development and revision of its performance measures and KPIs, the Department should:

- consider the measures and indicators proposed by this audit;
- continue to consult with service providers on their appropriateness;
- continue to develop information systems and reporting mechanisms to support decision-making;
- provide training to senior managers to interpret measures and KPIs;
- publish a comparative set of area-level measures and KPIs, at least annually; and
- analyse and review the measures and KPIs every 12 months to ensure their ongoing relevance.

***RESPONSE** provided by Department of Human Services*

The performance measures and key performance indicators are deliberately output focussed as they are used for aggregate reporting to government on output performance they are not intended to be used for service management or outcomes measurement purposes

Development of comprehensive key performance indicators has been funded by the Commonwealth under the Information Development Plan. They will be completed by June 2003. Outcome measurement will also assist in measuring effectiveness from a consumer and service perspective. The Department of Human Services will be pleased to consider audit's proposal for key performance indicators as part of this process.

***RESPONSE** provided by Department of Human Services - continued*

Para. 7.27

The Department is putting considerable effort into the further development of performance and outcomes measures, including:

- *Extension of clinical outcome measurement to all relevant Victorian mental health services. Outcome measurement has been used in a small number of services over recent years. In 2002-03, all remaining clinical services will receive assistance and training to support them in implementing routine outcome measurement based on the use of established tools;*
- *Establishing mechanisms for regular consultation with service managers and senior clinicians;*
- *Setting key performance indicators and benchmarks for service delivery, monitor performance of services against those benchmarks, and make the results publicly available;*
- *Refining current performance measures and the Quality Incentive Strategy; and*
- *Streamlining data collection and improve information systems to support service planning, delivery and monitoring.*

In this context, the Department will consider the measures proposed by audit.

***RESPONSE** provided by St Vincent's Mental Health Service*

Para. 7.26

The proposed key performance indicators appear reasonable. More comparative data between health services would be helpful, as long as it was accurate.

The performance of RAPID will need to be improved in order to facilitate the extraction of this data. Currently, extracting meaningful reports from RAPID is difficult and time-consuming. There are also discrepancies between data extracted locally and data extracted by the Department, which creates problems for service planning and performance management.

Appendix A

Conduct of the audit

AUDIT OBJECTIVES

The objectives of this audit were to determine:

- whether Area Mental Health Services (AMHSs) were providing timely and appropriate services to people aged 16 to 64 years who were experiencing a crisis associated with their mental illness, or who were at significant risk of experiencing a crisis;
- the impact of the current mental health service system on carers and families of people with a mental disorder;
- whether the rights of patients subject to community treatment orders and involuntary admission to hospital have been adequately protected;
- whether funds allocated to public mental health services have been distributed according to need; and
- whether an effective framework was in place to measure and monitor the effectiveness of mental health crisis prevention and response, at a Statewide and individual hospital level.

AUDIT SCOPE

Adult services were chosen because they are the biggest component of public mental health services in Victoria, absorbing three-quarters of total annual mental health funding. The audit focuses on crisis prevention and response within the Adult Mental Health Services because this is an area which has significant social and cost implications for the community. Moreover, consultations with key stakeholders indicate that people often experience difficulty accessing appropriate services during a mental health crisis.

The following services are not subject to examination as part of this audit:

- services for children under the age of 16 years;
- adults held within the correctional services system; and
- services for people over the age of 64.

The following agencies were subject to audit examination:

- *Department of Human Services* - the focus of examinations was within the Mental Health Branch and covered strategic planning, monitoring and funding; and
- *Adult Area Mental Health Services (including individual public hospitals)* – 6 out of 21 AMHSs were chosen for detailed examination:
    - Barwon Mental Health Services;
    - Dandenong Area Mental Health Services;
    - Gippsland Area Mental Health Services;
    - Goulburn Valley Area Mental Health Services;

- Mid-West Area Mental Health Service; and
- St Vincent's Mental Health Services.

This sample of hospitals provide coverage of metropolitan Melbourne, rural areas and the fringe of metropolitan Melbourne. It includes hospitals in varying demographic areas, including those with high populations of people from non-English speaking backgrounds.

Operations examined at each AMHS include Crisis Assessment and Treatment teams, Duty services, community-based services, inpatient services, patient rights, discharge procedures and case management.

At the Mental Health Review Board, review and appeal procedures for involuntary patients were examined to determine whether patient rights are being adequately protected.

AUDIT METHODOLOGY

The audit methodology comprised interviews with key stakeholders, consumer and carer consultations, a comprehensive file and policy/observation audit at each of the 6 AMHSs selected, and a review of relevant national and Statewide data sources.

Interviews with key stakeholders included:

- consumer and carer peak bodies;
- Department of Human Services (Mental Health Branch staff);
- directors of clinical services (in both Victoria and other States);
- AMHS;
- non-government organisations concerned with provision of mental health services;
- mental health research institutes;
- government departments (including the Health Services Commissioner, Office for the Public Advocate, Office of the Chief Psychiatrist);
- Aboriginal Health Service;
- directors of Psychiatric Disability Support Programs; and
- public hospital managers.

Consumers who had received services in the previous 12 months were invited to participate in audit interviews conducted by independent consultants using a semi-structured interview schedule. In total, 87 individual interviews with mental health service consumers were completed.

Six carer focus groups (with 12 to 15 participants in each) were conducted to gather information about the service needs of family members and carers. Participants were recruited through peak carer bodies located in different regions of Victoria.

A family/carer survey was mailed to 780 persons involved in the care of a mental health service consumer. Survey respondents were randomly selected from each of the 6 AMHSs audited and this was supplemented by a small number of additional respondents identified through peak carer bodies. A total of 338 surveys were returned for a response rate of 43 per cent.

Five contractors with considerable experience in the evaluation of mental health services were employed to conduct a comprehensive file, policy and observation audit at each of the selected AMHSs. The contractors were FLP Associates, Westwick Consulting Services, Beyond the Limits Training and Development Services, Robyn Guiney Pty Ltd, and Robyn Mills Pty Ltd. Contractors focused on the following issues:

- Service entry and access processes (triage) were examined through an audit of 150 triage records at each of the 6 AMHS. Observations of triage and service entry procedures, including links with emergency departments, were also recorded to enable comparisons between services;
- A comprehensive audit of 935 clinical files (approximately 150 at each AMHS) was conducted to determine whether important processes in the assessment, treatment and discharge of patients receiving services within the previous 12 months had been documented. This included an assessment of intake processes, individual service plans, discharge plans, evidence of medical reviews, and communication with patients and carers regarding rights; and
- A policy and observation tool was developed to assess whether key policies were in place at each of the 6 AMHSs audited. Observations within AMHSs and Emergency Departments (EDs) determined whether practice was consistent with policy, national standards and State legislation. Interviews with AMHS and ED staff were also conducted.

Comprehensive examinations of relevant administrative processes and management data at the selected AMHSs were conducted.

The statistics contained in this report were obtained from a range of Australian agencies, research bodies and international organisations. Key sources of data were the Department of Human Services (Mental Health Branch), the Commonwealth Department of Health, and reports published by government and private organisations.

The National Standards for Mental Health Services and the *Mental Health Act* 1986 were used to guide the assessment of service quality, effectiveness and efficiency.

PERIOD COVERED BY THE AUDIT

The audit considered relevant developments in Victorian mental health policy since 1994, while fieldwork at AMHSs covered the period January 2000 to March 2002.

COMPLIANCE WITH AUSTRALIAN ACCOUNTING STANDARDS

The audit was performed in accordance with Australian Accounting Standards applicable to performance auditing, and included such tests and procedures considered necessary to conduct the audit.

ASSISTANCE TO THE AUDIT TEAM

Reference group

A reference group comprising 7 mental health experts, including consumer and carer representatives, provided ongoing advice and feedback during the course of the audit. We would like to thank the following individuals for their assistance:

- Professor Harvey Whiteford, Chair, Australian Health Minister's Advisory Council, National Mental Health Working Group;
- Dr David Barton, Honorary Chair, Royal Australian and New Zealand College of Psychiatrists (Victorian branch);
- Ms Valerie Gerrand, private consultant;
- Mr Peter Waters, Executive Officer, Eastern Region Mental Health Association, (the largest provider of psychiatric disability support services in Victoria);
- Mr David Mithen, Information Officer Victorian Mental Illness Awareness Council;
- Ms Nina McDonough, Victorian Mental Illness Awareness Council; and
- Ms Robyn Duff, Program Manager, Mental Health Services for Youth and Kids.

Appendix B

Glossary of terms

GLOSSARY OF TERMS

Acute/sub-acute services

Services which provide short-term to medium-term care for mental health consumers with different levels of disability and need. Acute services generally refer to inpatient (or hospital-based) facilities which provide services for consumers in psychiatric crisis. Sub-acute services provide rehabilitative support to people recovering from an acute episode of mental disorder.

Advocates

A person or organisation authorised by a consumers to speak on their behalf, or represent their concerns and interests. Advocates must be directly accountable to the consumer. Examples may include a friend or relative, a legal representative or officer from a government organisation (e.g. from the Office of the Public Advocate).

Affective (mood) disorder

A mental disorder characterised by disabling disturbances in emotion. Includes depression, mania and bi-polar disorder (or manic-depression). In the case of depression, symptoms may include pronounced subjective changes in emotion (e.g. sadness, guilt, irritability) and/or overt changes in behaviour and appearance (e.g. blunted facial expression, slowed movement).

Appropriately qualified and experienced mental health professional

An individual with recognised qualifications and experience which enable them to provide appropriate treatment and support to the consumer and their carers. The degree of formal training and expertise required will be determined by factors such as the degree of specialisation required/available (e.g. staff specialising in child and adolescent mental health), the needs of the defined community (e.g. Aboriginal and Torres Strait Islander mental health staff, ethnic health workers) and the type of services being delivered (acute care, residential support, drop-in, rehabilitation).

Area Mental Health Service

Government-funded, public mental health services that provide a range of specialist services to consumers and carers with immediate and ongoing mental health needs. Services include (but are not limited to): crisis assessment and treatment teams, residential and non-residential rehabilitation services, and acute inpatient services, and psychiatric disability support services.

Assessment

A process which aims to determine a consumer's mental health status, diagnosis and ongoing needs. In most instances, psychiatric assessments will be conducted face-to-face with the consumer and/or significant others, where available. The assessment forms the basis of an individualised care plan, which is developed in collaboration with the consumer, their family or carers.

Care environment

The environment in which the Area Mental Health Service delivers treatment and support. It could be a living skills centre, a psychiatric inpatient unit, community centre, school or hostel.

Carer

A person whose life is affected by his or her close relationship with a consumer, or who has a role in assisting a consumer with daily living. Carer, in this document, may also refer to the consumer's identified family, including children and parents, or other legal guardians and people significant to the consumer. It is also acknowledged that for some people their carer may be their community.

Case closure

When a consumer no longer requires mental health services and leaves the system. (This should be distinguished from "discharge" which occurs when a consumer exits the hospital or inpatient service.)

Case manager

An identified and accessible Area Mental Health Service staff member who is responsible for co-coordinating the treatment and support provided to an individual consumer and their carers. (Also referred to as case co-coordinator, key worker, case worker.)

Clinical indicator

A measure of the clinical outcome of treatment or care; a method of monitoring care and services, which attempts to "flag" problem areas, evaluate trends and direct attention to issues requiring further review.

Community living

The ability of the consumer to live independently in the community with the best possible quality of life.

Co-morbidity

The co-occurrence of 2 or more disorders. Can refer to mental and physical disorders.

Consumer

A person making use of, or being significantly affected by, a mental health service.

Continuity of care

The co-ordinated, ongoing provision of services to meet individual consumer needs. Services must be co-ordinated and "barrier free" across services settings, whether hospital or community-based and across different types of services, such as treatment, rehabilitation and accommodation support.

Crisis assessment and treatment (CAT) teams

Mental health teams which provide 24-hour mobile support to all persons who are being considered for psychiatric hospital admission. CAT services also provide treatment and support for people whose acute mental illness can be managed in the community.

Defined community

The community to which the mental health service provides treatment and support. (For example, it might be a catchment area population, privately insured population, Statewide population, specific cultural group within the population.)

Disability

A disability is any restriction or lack of ability to perform an activity within the expected range for a human being.

Disability support service

A range of service responses which enable the individual to live as independently as possible and be included in the ordinary life of their community.

Discharge

Occurs when a consumer leaves an inpatient (hospital-based) mental health service.

Dual diagnosis

A mental disorder with a co-existing substance abuse disorder.

Entry process

The process provided by the mental health service which assists the consumer and their carers to make contact with the mental health service and receive appropriate assistance.

Family

The family of the consumer.

High prevalence disorder

A mental disorder with a high rate of occurrence in the community. Anxiety and affective disorders are regarded as "high prevalence" disorders in Australia.

Individual service plan

A documented set of goals developed collaboratively by the consumer and the Area Mental Health Service (usually the case manager). The individual service (or management) plan sets the direction for treatment and support, identifies necessary resources and specifies outcomes for the consumer. It is recorded in the consumer's individual clinical record.

Initial contact

When a consumer (already known to the service or new) makes first contact with a mental health service for assistance or information. Initial contacts are usually made to the Duty or Triage worker, who records the presenting problem(s), assesses risk of harm and the urgency of follow-up response required.

Integrated mental health service

A mental health service which brings together a number of specialised components into a unified system to maximise continuity of care for consumers. These components include a unified management system between inpatient and community services, a case management system, a single point (or process) of entry into the service, multi-disciplinary teams, active involvement of consumers and carers, specialist crisis intervention, assessment, acute care, ongoing care and rehabilitation care across the consumer's lifespan.

Linkages

The formal and informal aspects of the relationship within and between the mental health service and another service providers, agencies or sectors.

Mental disorder

A mental disorder may be defined as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual, which is associated with distress, disability or with a significantly increased risk of suffering death, pain, disability or a significant loss of freedom.

Mental health

Mental health is the capacity of individuals within the groups and environment to interact with one another in ways that promote subjective well being, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice.

Mental health problem

A mental health problem is a disruption in the interactions between the individual, the group and the environment producing a diminished state of mental health.

Mood disorder

See Affective (mood) disorder.

Other service provider

An organisation outside the Area Mental Health Services, or individual practitioner who provides a direct health or welfare service to the consumer.

Personality disorder

Maladaptive personality traits and behaviours that are of long-standing and deviate significantly from the expectations of an individual's culture.

Primary health care providers

Community-based, general health care providers such as general practitioners, alcohol and drug services, and disability support services.

Psychiatric disability support services

Support services in the community for people with severe and disabling mental disorders, designed to assist with independent living.

Psycho-education

The ongoing provision of relevant information to a consumer and/or carer regarding mental disorder, symptoms, treatment options, prognosis etc. The consumer's age, cultural background and mental state should be considered in the provision of this information.

Psycho-social factors

Social and environmental factors that influence an individual's psychological state.

Psychosis (or psychotic disorder)

A mental disorder characterised by one or more of the following: delusions, hallucinations, disorganised speech, and grossly disorganised or catatonic behaviour. Schizophrenia, schizo-affective disorder and bipolar disorder are classified as psychoses.

PRISM

Psychiatric Records Information System Manager. An information system for the collection of patient data from inpatient mental health services.

Program

A part or function of the mental health service such as the rehabilitation team, health promotion unit, the crisis team, the living skills centre or inpatient psychiatric unit. (For example, some mental health services have only one team which performs all these functions.)

Psychiatric inpatient unit

A ward, unit, or facility located within a hospital for the assessment and treatment of mental disorders. Inpatient units normally include high dependency units and areas for seclusion or patients.

RAPID

Redevelopment of Acute and Psychiatric Information Directions. An information system for the collection of patient data from inpatient mental health services.

Service evaluation

A systematic evaluation of the performance of the mental health service, in full or in part, using valid and reliable methodology. (For example, could be a description of service activity, consumer satisfaction with the service, monitoring of individual health outcomes for consumers.)

Situational crisis

Any event which evokes a pronounced emotional response requiring intervention by a mental health professional.

Strategic plan

A plan that is organisation-wide, establishes an organisation's overall objectives and seeks to position the organisation in terms of its environment.

Support

Direct services and interventions provided to a person with a mental disorder and/or mental health problem and associated disability aimed at reducing handicap and promoting community tenure (e.g. assistance with cooking and cleaning). Support services do not necessarily have a treatment or rehabilitation focus.

Therapies

The range of treatment approaches which reflect best available evidence and are used in mental health care (excluding medication and other medical technologies). This may include psycho-therapeutic, psycho-educational, rehabilitative, collaborative approaches using individual and/or group methods.

Treatment

Specific physical, psychological and social interventions provided by health professionals aimed at the reduction of impairment and disability and/or the maintenance of current level of functioning.

Triage (also "Duty")

A system for determining the relative priority of new referrals, typically based on assessments of risk and urgency.

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