ACT Auditor-General's Office

Delivery of Mental Health Services to Older Persons

ACT Health

October 2010

ACT AUDITOR-GENERAL'S OFFICE

The Speaker
ACT Legislative Assembly
Civic Square, London Circuit
CANBERRA ACT 2601

Dear Mr Speaker

I am pleased to forward to you a Performance Audit Report titled '**Delivery of Mental Health Services to Older Persons**', pursuant to Section 17(5) of the *Auditor-General Act 1996*.

Yours sincerely

Tu Pham
Auditor-General
29 October 2010

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CONTENTS

Contents

LIST OF ABBREVIATIONS

AMHOCN	Australian Mental Health Outcome and Classification Network
BASIS 32	Behaviour and Symptom Identification Scale, where there are 32 queries
CATT	Crisis Assessment and Treatment Team
COAG	Council of Australian Governments
GP	General Practitioner
HoNOS	Health of the Nation Outcome Scales
HoNOS 65+	Health of the Nation Outcome Scales for aged 65 years and over
LSP16	Life Skills Profile, a 16-question version questionnaire
MHACT	Mental Health ACT
NGO	Non-government Organisation
OOS	Occasions of Service
OPMH	Older Persons Mental Health
OPMH Community Team	Older Persons Mental Health Community Team
OPMH Inpatient Unit	Older Persons Mental Health Inpatient Unit
OPMHS	Older Persons Mental Health Services
RANZCP	The Royal Australian and New Zealand College of Psychiatrists

1. REPORT SUMMARY AND CONCLUSION

INTRODUCTION

1.1 This report presents the results of a performance audit that reviewed ACT Health's delivery of mental health services to older persons in the community. The audit focused on ACT Health's capability and capacity to deliver mental health services to older persons with mental illnesses in the Territory.

BACKGROUND

1.2 One in five of Australian adults experiences a mental illness in any year, and one in four of these people experiences more than one *mental disorder*.[1] A *mental disorder* refers to the range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people.[2] Mental disorders are not only debilitating, they are also costly. They account for 13.1 percent of Australia's total burden of disease and injury[3] and are estimated to cost $20 billion annually, including lost productivity and labour participation.[4]

1.3 In 2003, the ACT Government estimated that approximately 7 percent of the ACT population would experience moderate to severe mental health problems, while a further 10 percent would be at risk of developing mental health problems or require early intervention.[5] The figures indicated that there were 51,705 people per year in the ACT (16 percent of the ACT population) experiencing a mental health problem, of which 21,450 would experience moderate to severe mental illness.[6]

Mental health of older persons

1.4 Although most older people enjoy good mental health, a significant minority experience one or more mental or behavioural disorders (9.5 percent of older people), high levels of psychological distress (10.9 percent), or take medication for their mental wellbeing (24 percent). The literature on mental health in Australia tends to focus on dementia. However, functional disorders and clinical depression are more prevalent.[7] Major life changes such as divorce, involuntary unemployment, retirement, becoming grandparents, illness or disability, caring or bereavement may contribute to mental health problems in older adulthood.[8]

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1 Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results,* ABS Cat. No. 4326.0, Canberra, 2007.

2 Australian Health Ministers, *National Mental Health Plan 2003—2008,* July 2003.

3 Australian Institute of Health and Welfare, *The burden of disease and injury in Australia,* 2003, Canberra, 2007.

4 Australian Government, *Portfolio Budget Statements 2010-11 Budget Related Paper No. 1.11,* Health and Ageing Portfolio.

5 ACT Health, *ACT Mental Health Strategy & Action Plan,* 2003—2008.

6 Ibid.

7 Collier E., *Mental health and functional mental disorder in older adults. Nursing Older People,* 2006.

8 Australian Institute of Health and Welfare, *Older Australia at a Glance,* 4th edition, November 2007.

1.5 The overall proportion of people self-reporting a mental and behavioural condition has increased from 6 percent in 1995 to 11 percent in 2004–05. This may be partly due to more people being willing to report mental health problems as the stigma associated with mental illness diminishes. The most commonly reported problems among older people were mood (affective) disorders and anxiety-related problems (reported by 4.6 percent and 4 percent respectively of people aged 65 years and over). Men were more likely than women to have a substance use disorder and women were more likely than men to have anxiety or affective disorder.[9]

Providers of mental health services in the Territory

1.6 Mental Health ACT (MHACT), a business unit within ACT Health, provides a wide range of services for various mental health issues across the whole Canberra community. Its focus is on mental health promotion, prevention and early intervention initiatives and incorporates a recovery orientation in its programs.[10]

1.7 MHACT services to the community include: access and specialty services; acute and community mental health services; child and adolescent mental health services; rehabilitation and older persons mental health service; and an academic unit of psychological medicine.

1.8 Outside the ACT Government, the mental health community sector received ACT Government funding through funding arrangements administered by ACT Health's Mental Policy Unit. The sector delivers a vast range of services, including mental health promotion programs, information and referral, psycho-social rehabilitation, respite care, advocacy, vocational training and rehabilitation, and supported accommodation and outreach.

Estimated outcomes and targets of mental health services in the Territory

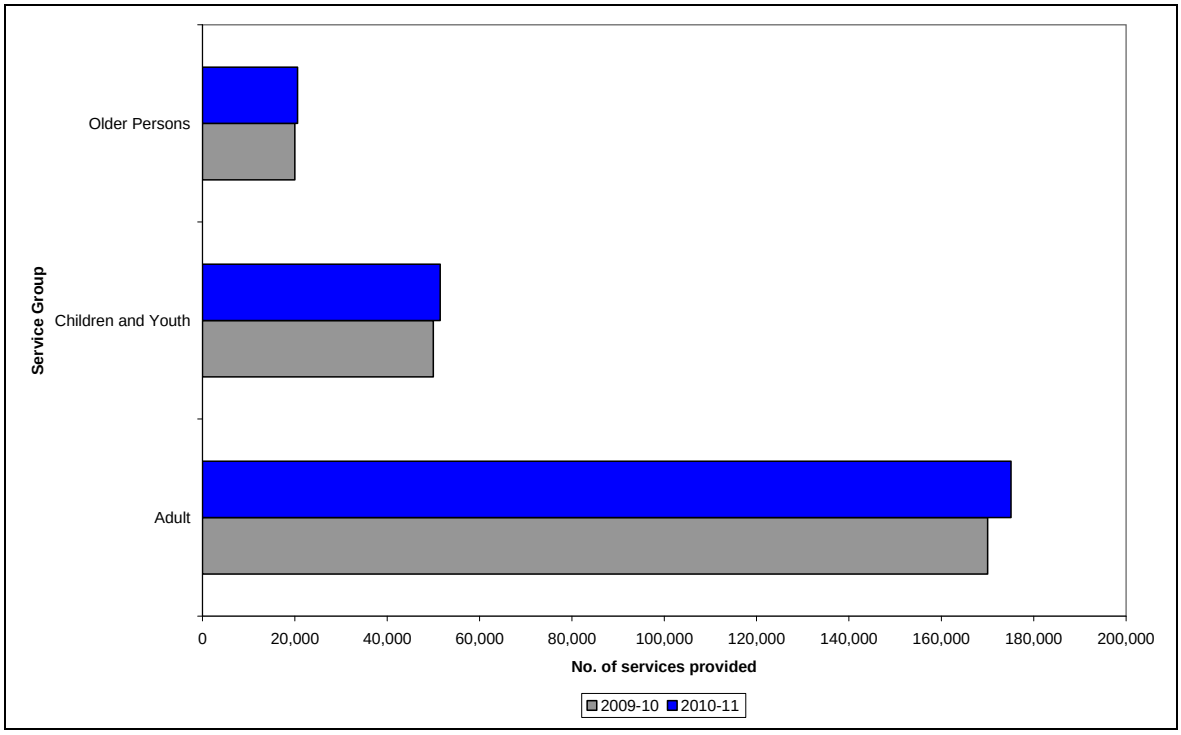
1.9 In ACT Health's Budget Statements for 2010–11, the estimated outcome figures for 2009–10 show that Older Persons Mental Health Services (for those people aged 65 years and over) comprise the least number of services to the community, standing at eight percent. Adult mental health services comprise the most number of services, 71 percent of total services. Current ACT Health classifications categorise adults as those people from 18 years to 64 years of age. In contrast, child and adolescent mental health services (those people from 0 to 17 years of age) account for 21 percent of total services.

1.10 Figure 1.1 illustrates the estimated outcome and targets of mental health services provided to specific population groups: adults, children and youth, and older persons in the ACT for 2009–10 and 2010–11.

[9] Ibid.

[10] ACT Health, *Mental Health ACT Directory of Services,* June 2009.

Figure 1.1: Estimated outcomes and targets of mental health services in the Territory, 2009–10 and 2010–11



Source: ACT Auditor-General's Office based on ACT Health documents

1.11 In March 2010, the Commonwealth announced structural health reforms that will impact the delivery of mental health services across Australia. A brief description of these health reforms and the specific mental health services that will be affected are included in Appendix C.

AUDIT OBJECTIVE

1.12 The objective of this audit is to provide an independent opinion to the Legislative Assembly on the efficiency and effectiveness of the delivery of mental health services to older persons in the ACT community. The audit focused on ACT Health's ability and capacity to meet the mental health needs of older persons and assess the administrative, operational and governance arrangements for the delivery of services.

1.13 Details on the audit criteria, approach and audit methodology are included in Appendix A, while a full list of external stakeholders consulted for this audit is provided in Appendix B.

AUDIT CONCLUSION

1.14 The conclusions drawn against the audit objectives are set out below.

ACT Health, through Mental Health ACT, has delivered a wide range of mental health services to older persons with mental illnesses in the community. The growing ageing population and the complexity of multifaceted mental disorders present a significant challenge to ACT Health.

In general, ACT Health has good processes in place to monitor and review its mental health services to older persons, and has responded to referrals in a timely manner. However, there is scope for improvement by addressing the following identified deficiencies:

- ambiguous entry and exit criteria for older persons with mental health illnesses;
- the lack of feedback mechanisms to referrers;
- the lack of reporting on the impact of growth in client numbers and inadequate analysis on the various types and prevalence of mental health illnesses that are being assessed and treated;
- the lack of collaborative and co-ordinated planning with relevant key stakeholders in the community;
- the lack of compliance regarding the use of the agency's mental health data collection system;
- inconsistencies in conducting suicide risk assessments; and
- weaknesses in monitoring and review of individual consumers.

KEY FINDINGS

1.15 The Audit conclusions are supported by the following key findings:

Information on mental health services for older persons

- The Older Persons Mental Health Services do not have well defined screening guidelines (i.e. entry and exit criteria). Guidelines on the current exemption to the age criteria and issues of ageing are vague.
- The screening guidelines (i.e. entry and exit criteria) of the Older Persons Mental Health Services were not well communicated to, or well understood by related agencies, peak bodies, community organisations and service providers.
- There was inadequate communication and engagement with consumers, carers and other external stakeholders in relation to dementia-related illnesses that can be assessed and treated by the Older Persons Mental Health Services.

- There was a strong view expressed by community groups that the Older Persons Mental Health Services' acceptance of consumers with dementia was arbitrary and inconsistent, that some consumers with dementia related illnesses were able to access treatment while others were not.

Management of the referral process

- Referrals to the Older Persons Mental Health Services are accepted from other government agencies or community organisations; families and carers; health professionals and General Practitioners (GPs) and self-referrals.
- The Older Persons Mental Health Services' orientation and procedural manual, the key document used by the Older Persons Mental Health Community Team, provided guidance on the various stages of the intake and referral process. However, this manual did not contain nor was it linked to clear guidance on urgent and non-urgent referrals and prioritisation of consumers contained in other policy documents.
- The Older Persons Mental Health Services does not have a good feedback mechanism to provide information, when permitted, to referrers (such as community organisations), on a consumer's status with the Older Persons Mental Health Services. Such information is important to the community organisation for the ongoing care of their consumers.
- Most referrals made to the Older Persons Mental Health Community Team come from GPs. However, GPs in the community, particularly the newer ones, have a low general awareness of the Older Persons Mental Health Services.

Responsiveness to demand

- The number of older persons requiring mental health services has been growing. The Older Persons Mental Health Services has recorded a 400 percent increase in the number of consumers that had occasions of service since 2000–01.
- ACT Health collects good data, in that it monitors the number of consumers or older persons who avail of mental health services. ACT Health also monitors the diagnosis given to older consumers with mental health illnesses, and tracks the consumers that have been referred on or consumers that have not yet been diagnosed.
- There was inconsistent reporting on the actual number of consumers availing of the Older Persons Mental Health Services and a lack of reporting on the impact of demand on the services being delivered.
- There is an 'annual performance review' process that looks at various mental health data sets collected by ACT Health. However, this process is informal and does not include an analysis of various mental health diagnosis, or their prevalence and impact to the Older Persons Mental Health Services.
- ACT Health (Mental Health ACT) did not routinely consult or collaborate with the community including peak bodies, service providers, and other community organisations that deal with older persons in the community.

- Importantly, ACT Health has not communicated or collaborated effectively with relevant stakeholders to determine the extent of 'unmet needs'of older persons with mental health illnesses in the community.
- In general, the timeliness of response by the Older Persons Mental Health Services to demand was good. However, there was no clear process to monitor cases where the Older Persons Mental Health Services response was delayed, or where needs of at-risk groups are not met.

Staffing, training and development

- There was no regular analysis and evaluation of staffing data in the Older Persons Mental Health Services that could provide input to workforce planning and future recruitment strategies.
- There was no clear plan for the provision of specialised training for the Older Persons Mental Health Community Team. The Team did not have ready access to information regarding developments in the assessment and treatment of older persons with mental health disorders.
- The Older Persons Mental Health Community Team did not fully comply to the requirements regarding the use of the agency's mental health data collection system. As a result, the relevant data on older persons mental health services were not always complete or up to date.
- The Older Persons Mental Health Community Team relied on corporate knowledge when identifying external agencies or aged care facilities that consumers may be referred to. There was no consolidated list maintained by ACT Health (Mental Health ACT) for this purpose. Consequently, the approach used in 'referring on' consumers was inconsistent.

Suicide prevention and the Older Persons Mental Health Inpatient Unit

- ACT Health has comprehensive policy and guidelines on suicide prevention. However, these were not well implemented.
- ACT Health did not conduct suicide risk assessment in all cases as required by its policy. In the sample of cases examined by Audit, only 52 percent of cases had the required risk assessments done.
- There was no clear monitoring of the implementation of the suicide risk assessments.
- *Admission blocks* occur when consumers, for a variety of reasons, stay for a long period of time in the Older Persons Mental Health Inpatient Unit. There was no clear strategy to address the impact of *admission blocks* on the Older Persons Mental Health Services' staffing requirements and on other potential consumers of the Older Persons Mental Health Inpatient Unit.

Monitoring and review processes

- In general, the Older Persons Mental Health Services has good processes in place to monitor and review its consumers. The Older Persons Mental Health Community Team routinely conducted clinical meetings where new

referrals were presented and allocated, and feedback on current cases was discussed.

- However, the Older Persons Mental Health Services did not consistently conduct the required three-monthly reviews of long term consumers.
- There was no assurance that all mandatory tasks were being undertaken by the Older Persons Mental Health Community Team, particularly when unplanned staff leave occurred.
- ACT Health closely monitored and reported on its 'accountability indicators', which provided an accurate picture of the patient activity, accommodation rates and others. However, the monitoring and reporting of 'outcome measures' were inadequate. The Older Persons Mental Health Community Team did not fully comply with the implementation and use of outcome measures relevant to the Older Persons Mental Health Services.

RECOMMENDATIONS AND RESPONSES TO THE REPORT

1.16 The Audit made 16 recommendations to address the audit findings detailed in this report.

1.17 In accordance with section 18 of the *Auditor-General Act 1996*, a final draft of this report was provided to the Chief Executive of ACT Health for consideration and comments.

1.18 The Chief Executive provided responses to each recommendation, as shown below.

Recommendation No. 1 (Chapter 2)

ACT Health should develop well defined screening guidelines (i.e. entry and exit criteria) for Older Persons Mental Health Services. This should include, at a minimum:

a) clarification as to the exemption to the age criteria, and issues of ageing; and

b) arrangements to ensure that other ACT Health related agencies, peak bodies, community organisations and service providers have access to, and are familiar with, the entry and exit criteria of Older Persons Mental Health Services.

ACT Health's response:

Agreed. *Screening guidelines to supplement clinical assessment in determining the appropriate service or referral on has been drafted for the adult component by Mental Health ACT (MHACT). The Policy Committee is finalising the draft for endorsement by Mental Health Strategic Executive. The Older Persons Mental Health Service (OPMHS) has been requested to draft the OPMHS screening guidelines using the same format by December 2010. Awareness raising will be a priority for OPMHS for the period January to June 2011. Information will be provided at points of contact with referrers and as a component of clinical assessment. The existing meeting structures with external stakeholders will be utilised as will other contact points opportunistically. General Practitioners information will be provided to the ACT Division of General Practice Mental*

Health Advisory Committee and an article in the ACT Division of General Practice newsletter. A representative of the Older Persons Mental Health Service will be available to speak at Carers ACT meetings and information will be provided for their newsletter.

Recommendation No. 2 (Chapter 2)

ACT Health should engage and communicate with consumers, carers and other external stakeholders in relation to dementia-related illnesses that can (or cannot) be assessed and treated by the Older Persons Mental Health Services.

ACT Health's response:

Agreed. *The definitional confusion and lack of care pathways for individuals with dementia-related illnesses are national issues. Recent consultations completed on behalf of Health and Human Services of the Department of Health and Ageing have reflected this lack of definitional consistency or models of care. Appendix C of the Audit Report flags the uncertainty in relation to the Commonwealth health reforms and their impact. This lack of certainty will not delay discussion with consumers, carers and stakeholders as a preliminary step in identification of concerns at the individual level. The Audit recommendation will heighten awareness for the Older Persons Mental Health clinicians in terms of providing comprehensive feedback on determinations in relation to provision of care or referral to another service.*

Recommendation No. 3 (Chapter 3)

ACT Health should ensure that orientation and procedure manuals for Older Persons Mental Health Services are consistent with other relevant policies and provide clear directives or guidance on:

a) urgent and non-urgent referrals;

b) prioritisation of consumers;

c) definition of a 'large number of referred consumers'; and

d) the acceptable clinician-consumer ratio.

ACT Health's response:

Agreed. *The National Triage Scale (NTS) defines the response times for contacts with mental health services. The NTS is embedded in the Mental Health Assessment Generation Information Collection (MHAGIC), the electronic medical record of Mental Health ACT. The NTS indicates response times for urgent and non-urgent contact and assists with re-prioritising of existing contacts. Information on the use of the NTS is provided at Mental Health ACT Orientation and in the continuing education program for existing staff. Mental Health ACT will provide two additional sessions of training at the Older Persons Mental Health Services by December 2010 to increase awareness levels. Mental Health ACT monitors demand using feedback from Team Leaders and formally monthly at the Mental Health Finance and Performance Committee meeting. Mental Health ACT is mindful of the number of referred consumers and the availability*

and capacity of staff to respond. The draft 'Clinical Management' policy articulates the matrix to be used in allocation for case management and will be finalised by December 2010. It provides a transparent basis for escalation to the Director level when capacity is under challenge.

Recommendation 4 (Chapter 3)

ACT Health should:

a) develop a feedback mechanism to referrers, that includes community organisations, of the consumer's status with the Older Persons Mental Health Services; and

b) ensure a clear understanding with the referrer as to what consumer or clinical information can be shared.

ACT Health's response:

Agreed. *Most referrals for the Older Persons Mental Health Services are received from General Practitioners (GPs). ACT Health has a number of e-health projects to facilitate better communication for referrals from GPs and discharge summaries to GPs using a secure portal to protect privacy. This automated communication will supplement telephone and faxed communication. ACT Health anticipates this technology will be extended to further improve communication to facilitate feedback to referrers during 2011.*

Mental Health ACT polices and guidelines indicate expectations on the sharing of information. As indicated in the response to Recommendation 3, Mental Health ACT will provide two additional sessions of training at Older Persons Mental Health Services by December 2010. The aim will be to ensure a clear understanding of the level of clinical information provided to GPs and services with medical staff and the information provided to non-medical settings and other referrers. Emphasis will be placed on the need to seek advice if there is any clarification required on the information to be shared.

Recommendation 5 (Chapter 3)

ACT Health should strengthen its general awareness programs relating to Older Persons Mental Health Services, and particularly target these to new General Practitioners in the community.

ACT Health's response:

Agreed. *ACT Health works closely with the ACT Division of General Practice (ACTDGP) and has developed priority actions in response to the ACTDGP - ACT Health Interaction Survey. A priority area is improving awareness of services. ACT Health has developed a dedicated secure Health Information Portal for General Practitioners known as ACT Health Net. Mental Health ACT will pilot the provision of information for General Practitioners on referral processes to be included on the General Practitioners website.*

Mental Health ACT will develop a general awareness program using both generic and area specific information. This information will be submitted for inclusion in the Division of General Practice newsletters and hard copy materials will be

created to supplement the web materials. These activities will be undertaken and delivered by June 2011. Mental Health ACT has two representatives participating on the ACT Division of General Practice Mental Health Advisory Committee and will request the Committee's assistance in identification of new General Practitioners who will be provided with an overview of Older Persons Mental Health Services.

Recommendation 6 (Chapter 4)

ACT Health should put in place robust arrangements to ensure that current and future mental health needs are met by:

a) consistently reporting the actual number of consumers availing of the Older Persons Mental Health Services and its likely impact to the services being delivered;

b) enhancing and formalising the 'annual performance review' process to include an analysis of various mental health diagnosis, their prevalence and the impact on the Older Persons Mental Health Services; and

c) collaborating with relevant stakeholders to identify and service the 'unmet needs' of older persons with mental health illnesses in the community.

ACT Health's response:

Agreed. *Data identifying actual numbers of consumers accessing Older Persons Mental Health Services is available, including a detailed monthly report that collates 'active cases' for each clinician. A break down is available that includes diagnosis, Occasions of Service (OOS), frequency of contact and time and total staff reporting OOS, new allocations per month and case closures. This data could be of more value if a level of analysis was undertaken and a refining of the information that facilitated analysis including trending and comparison with previous years was undertaken. Mental Health ACT commits to examination of existing reports and re-configuring monthly reports to Older Persons Mental Health by June 2011. Annual Performance Review for the Older Persons Mental Health program will be piloted at the Planning Day in 2010 and incorporate into subsequent agendas.*

A high level monthly review is conducted of program area level at the Mental Health Finance & Performance Committee. This Committee is examining the content of Team Leader reports and more effective management of Annual Performance Review.

Recommendation 7 (Chapter 4)

ACT Health should ensure that it effectively manages cases where the Older Persons Mental Health Services' responses were delayed, or where needs of at-risk groups are not met. Instances where the expected response times are not met should be closely monitored.

ACT Health's response:

Agreed. *Mental Health ACT concurs and will refine the monitoring mechanisms to ensure that variance from the National Triage Scale response time is identified and that tracking occurs using the Daily Clinical meeting process. Variance in relation to planned interventions should be discussed within the multi-disciplinary setting and considerations of risk and options to manage explored. The Older Persons Mental Health Team Leader will report on variance monthly to the Operational and Clinical Directors of Older Persons Mental Health Services.*

Recommendation 8 (Chapter 4)

ACT Health should strengthen its engagement with its external stakeholders, through regular consultation and collaboration with the community including peak bodies, service providers, and other community organisations that deal with older persons in the community.

ACT Health's response:

Agreed. *Mental Health ACT has a number of Memoranda of Understanding with stakeholders and participates on relevant Advisory Groups, Committees and in inter-agency meetings. The feedback from the Audit is accepted and Older Persons Mental Health will re-invigorate this engagement by inviting stakeholders to the 2010 Planning Day to collaboratively identify barriers and solutions as well as contribute to future goals that will be reflected in the Business Plan 2011-2012.*

Recommendation 9 (Chapter 5)

ACT Health should regularly analyse and evaluate staffing data to:

a) identify trends and process improvements in a resource constrained environment; and

b) provide input to workforce planning and future recruitment strategies.

ACT Health's response:

Agreed. *Mental Health ACT reports monthly at the Mental Health Finance & Performance Committee on Full Time Equivalent staff and person counts, including leave, absences and vacancies. This data is readily available and accessible. This information can be linked to clinical activity data collected for the same time period. The MH Finance & Performance Committee will review Older Persons Mental Health reports linking clinical activity and workforce capacity to identify trends and opportunities to improve processes. The Mental*

Health Workforce, Strategy, Planning and Development Officer will liaise with Older Persons Mental Health on workforce planning and future recruitment strategies.

Recommendation 10 (Chapter 5)

ACT Health should:

a) develop a plan that includes arrangements for the provision of specialised training in the mental health of older persons; and

b) provide the Older Persons Mental Health Community Team good access to information regarding current developments in the assessment and treatment of older persons with mental health disorders.

ACT Health's response:

Agreed. *Mental Health ACT prioritises supporting clinical staff in the shared responsibility of ensuring access to and facilitation of professional development activities and access to resources to ensure the provision of competent and contemporary mental health services. Mental Health ACT Director of Service and Sector Development, assisted by the Discipline Principals, will facilitate planned Older Persons Mental Health professional development commencing for the 2011 calendar and then annually.*

Recommendation 11 (Chapter 5)

ACT Health should:

a) ensure the Older Persons Mental Health Community Team complies with the requirements regarding the use of the agency's mental health data collection system (the Mental Health Assessment Generation Information Collection); and

b) highlight the importance of completing and updating all required information.

ACT Health's response:

Agreed. *Regular staff training on the use of the Mental Health Assessment Generation Information Collection (MHAGIC) for all clinical and administrative staff required to access MHAGIC as part of their role is scheduled. New staff are not given access to the database until formally trained in MHAGIC. Existing staff are able to access refresher training and, if required, individual sessions arranged via the MHAGIC Support Team. To facilitate improvement, refresher training needs to be provided for Older Persons Mental Health Services and Mental Health ACT will negotiate with the MHAGIC Support Team to provide this training on site. This training will be completed by March 2011.*

Specific training in business processes, clinical documentation and clinical activity to be documented in MHAGIC will be incorporated in Older Persons Mental Health based delivery of the relevant essential education sessions developed to support standardisation.

Recommendation 12 (Chapter 5)

ACT Health should ensure that a consistent approach is adopted in 'referring on' consumers, by:

a) developing a consolidated list of external agencies, including aged care facilities, and community service providers, that can be used uniformly and consistently by the Older Persons Mental Health Community Team; and

b) keeping the list updated.

ACT Health's response:

Agreed. *As indicated, Mental Health ACT has developed the Care Co-ordination Links that compiles information on the community agencies, resources and related information focussed on adult orientated services. Feedback has been positive and Older Persons Mental Health has commenced collation of the information to develop a link similar to that for Adult for Older Persons Mental Health to address this gap. Maintaining the currency of the information on the Care Co-ordination Links for Older Persons Mental Health and Adult will be incorporate into the ACT Health e-health agenda.*

Recommendation 13 (Chapter 6)

ACT Health should:

a) ensure that suicide risk assessments are conducted consistently across Older Persons Mental Health Services, and that risk ratings are allocated accordingly; and

b) regularly monitor the implementation of the suicide risk assessments.

ACT Health's response:

Agreed. *Mental Health ACT will prioritise attendance at the Suicide Assessment (Introduction and Advanced modules) training for Older Persons Mental Health clinicians. This training reflects the requirements of the 'Treatment and Care of Consumers with Suicidal Behaviour' policy. Monitoring of compliance is a function of the Older Persons Mental Health Community Daily Clinical meeting that is expected to review all assessments or the regular reviews completed in Older Persons Mental Health Inpatient Unit for person admitted following assessment.*

Feedback on the importance of documentation of accurate, timely and relevant information in the appropriate areas in the Mental Health Assessment Generation Information Collection is provided as a part of regular internal auditing cycle. This feedback is provided to the Team Leader for discussion with the individual clinicians.

Recommendation 14 (Chapter 6)

ACT Health should:

a) analyse and report on the impact of *admission blocks* to staffing requirements, and to other potential consumers of the Older Persons Mental Health Inpatient Unit; and

b) use the information to effectively manage *admission blocks*.

ACT Health's response:

Agreed. *Admission block in this localised context refers to high occupancy of the Older Persons Mental Health Inpatient Unit. At times occupancy is at 100 percent or exceeds 100 percent due to high demand. The planned increase in the availability of Older Persons Mental Health Inpatient Unit beds in the next six months is anticipated to alleviate circumstances where a bed is required and the unit is at full capacity. The year to date average occupancy of the Older Persons Mental Health Inpatient Unit is currently 83.3 percent. In the past two years, occupancy has been above 98 percent. The Older Persons Mental Health Community team are able to re-prioritise referrals to facilitate admission for the highest priority individual and to negotiate with the Older Persons Mental Health Inpatient Unit.*

Recommendation 15 (Chapter 7)

ACT Health should:

a) consistently conduct the required three-monthly reviews for all long term Older Persons Mental Health Services' consumers;

b) monitor the three-monthly reviews; and

c) provide support to the Older Persons Mental Health Community Team, particularly when there is unplanned staff leave, to ensure that all mandatory tasks are being undertaken.

ACT Health's response:

Agreed. *Mental Health ACT has policy, guidelines and professional development as a framework to articulate the expectations in relation to the completion of three monthly reviews. As the Case Review proforma is not embedded into the Mental Health Assessment Generation Information Collection (MHAGIC), the monitoring reports generated from that system are not as reliable as for other reports. Team Leaders supplement the MHAGIC report on Case Review completion as a component of the monthly Finance and Performance Committee meetings. As indicated in the response to Recommendation 6, this Committee is examining the content of Team Leader reports and will review the Older Persons Mental Health reports linking clinical activity and workforce capacity. Backfill for unplanned leave is a challenge nationally and across ACT Health.*

Recommendation 16 (Chapter 7)

ACT Health should:

a) ensure that the Older Persons Mental Health Community Team comply with the implementation and use of all outcome measures relevant to the Older Persons Mental Health Services; and

b) enhance the current system to accurately report on mental health outcome measures.

ACT Health's response:

Agreed. *Mental Health ACT acknowledges the need to improve the level of compliance with the collection of the relevant Older Persons Mental Health outcome measures. The national e-training module and resources support standardised training and practice. Training has been and will continue to be a focus. The greater challenge is to embed the outcome measures into discussion and informing clinical decision-making. Mental Health ACT will focus on fostering medical leadership and gradually building participation rates. Monitoring occurs monthly and Older Persons Mental Health will be expected to have achieved the target in 2011-2012.*

At an individual consumer level, the outcomes measure data is functional and useful for assessment, case review and case closure discussions. Redevelopment to improve the reporting capacity of Mental Health Assessment Generation Information Collection of more meaningful aggregated data concerning outcome measures for the team level is planned to be implemented as soon as practicable.

2. INFORMATION ON MENTAL HEALTH SERVICES FOR OLDER PERSONS

INTRODUCTION

2.1 Clear, well defined entry and exit criteria or screening guidelines are essential in all aspects of mental health services. Having a streamlined, simplified referral process is equally important. Communicating these two processes effectively to a consumer, carer or referrer is critical to ensure that:

- the intended consumers are kept aware of the services available;
- the consistency of the message/information is maintained; and
- the expectations align with what will be delivered.

KEY FINDINGS

- The Older Persons Mental Health Services do not have well defined screening guidelines (i.e. entry and exit criteria). Guidelines on the current exemption to the age criteria and issues of ageing are vague.
- The screening guidelines (i.e. entry and exit criteria) of the Older Persons Mental Health Services were not well communicated to, or well understood by related agencies, peak bodies, community organisations and service providers.
- There was inadequate communication and engagement with consumers, carers and other external stakeholders in relation to dementia-related illnesses that can be assessed and treated by the Older Persons Mental Health Services.
- There was a strong view expressed by community groups that the Older Persons Mental Health Services' acceptance of consumers with dementia was arbitrary and inconsistent, that some consumers with dementia-related illnesses were able to access treatment while others were not.

THE OLDER PERSONS MENTAL HEALTH SERVICES ENTRY AND EXIT CRITERIA[11]

2.2 Mental Health ACT (MHACT) provides specialist treatment and support to people experiencing moderate to severe mental illness. This support requires co-operation with other community agencies to ensure the individual needs of the consumers are met.[12] Information regarding assistance that can be provided to older persons who have mental health needs is available on the ACT Health website.[13] Further, the *Mental Health ACT Directory of Services* (June 2009), details the range of assessment and treatment services being offered and identifies its target consumers for Older Persons Mental Health Services (OPMHS) who are:

[11] ACT Health advised that the OPMHS entry and exit criteria will be re-named to s*creening guidelines* in all relevant documentation that will be made available to the public. Work is currently underway to reflect this change.

[12] http://health.act.gov.au/c/health?a=&did=10051295 [Accessed 1 July 2010]

[13] Ibid.

(a) people who are aged 65 and over; (b) with issues of ageing; and (c) who reside in the ACT.[14]

Exemption to the age criteria

2.3 The OPMHS' criterion of 'aged 65 and over' is clearly indicated on the ACT Health website, and in its hard copy brochures and pamphlets. However, MHACT readily acknowledges that OPMHS also takes in consumers who are under 65 years of age, and exhibiting moderate to severe mental illnesses. Further, OPMHS documentation indicate that the Services will treat:

> Patients under 65 years with a mental illness (e.g. presenile dementia) where Older Persons Mental Health Service involvement may be warranted.[15]

2.4 The OPMH Community Team confirmed there have been, and still are, consumers in their fifties who are being treated for mental illnesses. Audit found that the exemption to the age criterion is not well known in the community. It is not included on the ACT Health website or in the hard copy brochures. To ensure that consumers are not falling through the gaps, the age exemption needs to be incorporated in information made available to the public. This is particularly relevant for older persons who may self-refer or community organisations that rely on public information. Further, ACT Health should clarify the specific medical or other conditions that need to be present for a consumer who is under 65 years of age to have access to OPMHS.

Issues of ageing

2.5 In Audit's discussions with MHACT's external stakeholders, Audit was advised that there is confusion with regards to the entry criteria or screening guidelines for older people who require access to OPMHS. For example, the criterion of an older person presenting with 'issues of ageing' is seen to be vague. There is a strong view in the community that some consumers who meet the other general criteria, such as 'aged 65 and over' and presenting with 'moderate to severe mental illness', but do not exhibit 'issues of ageing' are not accepted for assessment and treatment by OPMHS. Further discussions between Audit and the Older Persons Mental Health Community Team suggest that even clinicians are unclear on the criteria of 'issues of ageing' currently used by OPMHS.

2.6 Internal OPMHS documentation states that its protocol focuses more on 'issues of ageing' rather than the 65-year demarcation point. Ageing issues identified include:

> Complex physical and medical disorders, cognitive and sensory impairments, disability and frailty and/or need for aged residential care.[16]

2.7 The OPMHS criterion on 'issues of ageing' is not well communicated and known in the community. There is a risk that potential consumers may be falling through the gaps. Examples of what constitutes 'issues of ageing', the conditions that need

[14] ACT Health Mental Health ACT, *Directory of Services,* June 2009, p. 27.

[15] MHACT Older Persons Mental Health Community Team, *Staff Orientation and Procedure Manual*, May 2010, p. 25.

[16] MHACT Older Persons Mental Health Community Team, *Staff Orientation and Procedure Manual*, May 2010, p. 22.

to be present for these issues to be acceptable to OPMHS, should be clarified and included in information made available to the public or the community.

Understanding of the eligibility criteria

2.8 In discussions with relevant external stakeholders, Audit was also advised of instances where consumers/carers who would call and make a referral to OPMHS were advised to call the Crisis Assessment and Treatment Team (CATT) instead. When the potential consumers or carers called CATT, they were referred back to OPMHS. Frustrated consumers or carers would sometimes call the ACT Public Advocate's Office to seek assistance, and it was only through the ACT Public Advocate's advice or intervention that the consumer or carer got clarification as to where to go to in order to seek help, which sometimes ended back with OPMHS.

2.9 The *National Standards for Mental Health Services* provide guidance relating to criteria that need to be in place for mental health services (MHS). Standards 11.2.1 and 11.2.2 state that,

> The process of entry to the MHS is made known to the defined community.
>
> The MHS has documented policies and procedures describing its entry process, inclusion and exclusion criteria and means of promoting and facilitating access to appropriate ongoing care for people not accepted by the service.[17]

2.10 Since the audit, new *National Standards for Mental Health Services* of September 2010 have been released. Standards 10.3.1 and 10.3.2 state that,

> The MHS has a written description of its entry process, inclusion and exclusion criteria and means of facilitating access to alternative care for people not accepted by the service.
>
> The MHS makes known its entry process, inclusion and exclusion criteria to consumers, carers, other service providers, and relevant stakeholders including police, ambulance services and emergency departments.[18]

2.11 To avoid ambiguity, information on well-defined entry and exit criteria or screening guidelines for OPMHS need to be disseminated to other mental health or general health service providers in the community. Further, the information should be made available to other ACT Health related agencies, all community organisations, peak bodies and service providers in the community to avoid confusion and uncertainty as to where to go to in seeking mental health assistance for older persons.

[17] Australian Health Minister's Advisory Council, *National Standards for Mental Health Services,* January 1997, p.29.

[18] Australian Government, National Mental Health Strategy, *National Standards for Mental Health Services,* September 2010, p. 23.

Recommendation 1

ACT Health should develop well defined screening guidelines (i.e. entry and exit criteria) for Older Persons Mental Health Services. This should include, at a minimum:

a) clarification as to the exemption to the age criteria, and issues of ageing; and

b) arrangements to ensure that other ACT Health related agencies, peak bodies, community organisations and service providers have access to, and are familiar with, the entry and exit criteria of Older Persons Mental Health Services.

Specific services need to be clearly articulated, particularly with dementia related illnesses

2.12 As indicated above, the range of services offered to older persons who have mental health needs is included in the MHACT Directory of Services. However, the Directory does not clearly specify the psychiatric, emotional or behavioural disturbances that are **not** covered or included in its services. This creates confusion among some of MHACT's community stakeholders and frustration to consumers and carers in the community.

2.13 For example, one of the services provided by OPMHS is to provide

> assessment, treatment and clinical management for older persons experiencing psychiatric, emotional or behavioural disturbance including: depression; anxiety; psychosis; chronic or aged related psychiatric illnesses; and behavioural and psychological problems which may be related to dementia and memory loss.[19]

However, it does not clearly denote the types of dementia that OPMHS will treat such as 'presenile dementia',[20] or ones that it will **not** treat such as the Wernicke Korsakoff's syndrome.[21]

2.14 In Audit's consultations and discussions with MHACT's external stakeholders, Audit found that a number of consumers, carers, and community organisations were unclear as to what dementia related mental health illnesses the OPMHS would accept and treat. Currently, there is confusion and a perceived inconsistency in terms of dementia-related illnesses that are accepted for treatment by OPMHS.

The importance of communicating dementia related illnesses that are accepted and treated by OPMHS

2.15 Dementia is defined as

> the loss of intellectual abilities (medically called cognitive function) of sufficient severity to interfere with social or occupational functioning. Intellectual capability is a complex function consisting of many individual components, such as memory,

[19] Ibid.

[20] *Presenile dementia* is an organic, symptomatic mental disorder, an unspecified dementia.

[21] *Wernicke Korsakoffs syndrome* is an alcohol-induced dementia, a less common type of dementia in which brain function deterioration is associated with excess alcohol consumption, particularly in conjunction with a diet low in Vitamin B1 (thiamine).

problem solving, calculation, speech, ability to find the way, analyse problems, etc.[22]

2.16 Dementia is not a single specific disease and will affect people differently with varying impacts to families and carers. Although not a natural part of ageing, most people with dementia are older.[23] With Australia's ageing population, there has been growing recognition that dementia represents a significant challenge to health, aged care and social policy. In its 2007 report on dementia, the Australian Institute of Health and Welfare estimated that the number of people with dementia will grow from over 175,000 in 2003,[24] to almost 465,000 by 2031.[25]

2.17 In Access Economics' 2005 report, *Dementia Estimates and Projections: Australian States and Territories,*[26] projections were made with regards to the prevalence of dementia in States/Territories across Australia. These projections for years 2000 to 2050 are shown in Table 2.1 below.

Table 2.1: Dementia prevalence ('000) by State/Territory, 2000-2050

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
2000	60.3	44.3	29.2	16.1	14.5	4.6	0.4	1.8	171.2
2005	71.4	52.5	36.2	18.8	17.7	5.4	0.5	2.3	204.9
2010	83.2	61.9	44.3	21.8	21.6	6.2	0.7	2.9	242.5
2020	110.3	83.6	65.6	28.0	31.8	8.2	1.0	4.3	332.9
2030	149.5	114.0	99.0	36.8	47.3	11.0	1.6	6.3	465.5
2040	194.8	149.8	138.7	46.2	65.5	13.6	2.2	8.3	619.1
2050	227.2	176.1	171.1	50.7	79.2	14.3	2.7	9.6	731.0
2000-50*	3.8	4.0	5.9	3.2	5.5	3.1	6.1	5.4	4.3
Growth rank*	6	5	2	7	3	8	1	4	
Share 2000	35.2%	25.9%	17.1%	9.4%	8.5%	2.7%	0.3%	1.0%	100.0%
Share 2050	31.1%	24.1%	23.4%	6.9%	10.8%	2.0%	0.4%	1.3%	100.0%
% pop'n 2000	0.93%	0.94%	0.82%	1.07%	0.77%	0.97%	0.23%	0.56%	0.89%
% pop'n 2050	2.72%	2.84%	2.68%	3.42%	2.76%	3.67%	0.88%	2.45%	2.77%

Notes: * 2000-50 is the prevalence in 2050 divided by the prevalence in 2000 (i.e. the factor of growth over the period). The *growth rank* ranks States/Territories according to the factor of growth from the fastest (1) to slowest (8).

Source: Access Economics, February 2005 report for Alzheimer's Australia, *Dementia Estimates and Projections: Australian States and Territories.*

[22] World Health Organization, *Alzheimer's Disease: The Brain Killer* http://www.searo.who.int/en/Section1174/Section1199/Section1567/Section1823_8057.htm [Accessed 9 August 2010].

[23] Australian Institute of Health and Welfare, *Dementia in Australia – National data analysis and development,* January 2007. p. xii.

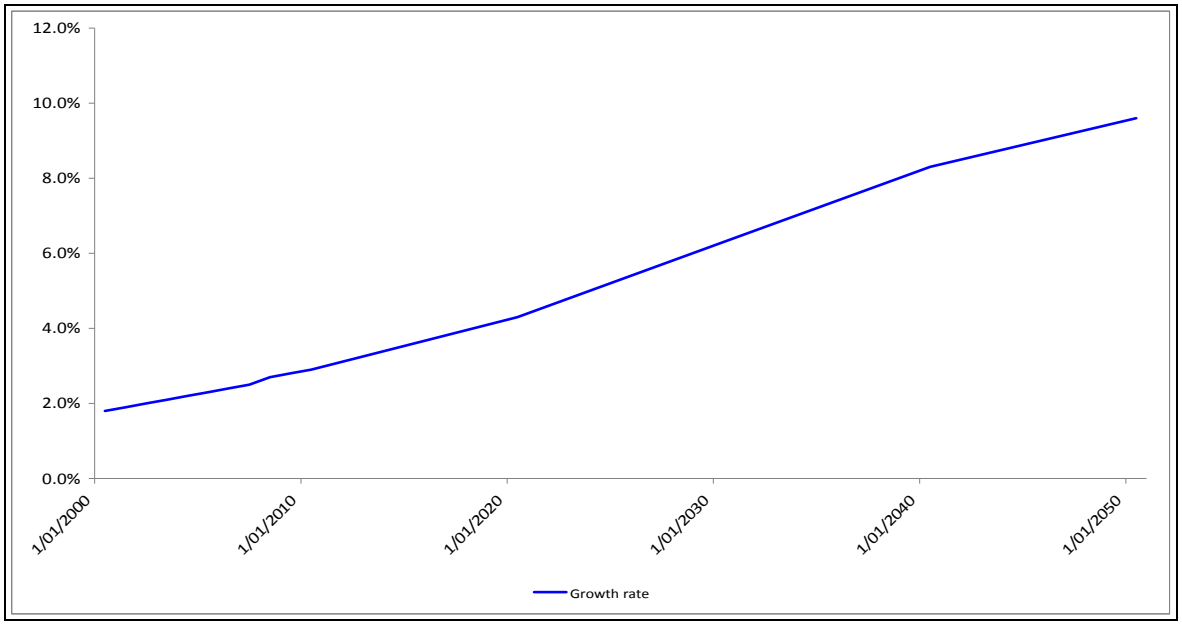
[24] Of the 175 000, 64 percent were female and 81 percent were 75 years and older.

[25] Australian Institute of Health and Welfare, *Dementia in Australia – National data analysis and development,* January 2007. pp. xii-xiii.

[26] This report was prepared for Alzheimer's Australia.

2.18 The 50-year projected growth trend of dementia in the ACT is illustrated in Figure 2.1 below.

Figure 2.1: Projected growth rate of dementia in the ACT, from year 2000 to 2050



Source: ACT Auditor-General's Office based on Access Economics February 2005 report for Alzheimer's Australia, *Dementia Estimates and Projections: Australian States and Territories.*

2.19 The percentage of the ACT population that will have dementia in 2050 is forecasted to be 2.45 percent, almost five times the percentage of the population in 2000, which was at 0.56 percent. As shown in Table 2.1 above, the forecast growth of dementia in the ACT ranks fourth as compared to other jurisdictions in Australia.

2.20 Consistent with information in Table 2.1 and Figure 2.1, Audit's discussions with the Older Persons Mental Health Community Team and its external stakeholders such as community groups and non-government organisations confirmed that the number of dementia patients being referred or presenting themselves to OPMHS is growing. However, it is not feasible for OPMHS to service all older persons with dementia. OPMHS is not able, nor is it resourced adequately, to assess and treat all consumers with dementia related illnesses.

2.21 There are a number of older persons in the ACT who have varying types and degrees of dementia. Audit found there is a strong view expressed by community groups that the OPMHS' acceptance of consumers with dementia is arbitrary and inconsistent, that some consumers with dementia-related illnesses are able to access treatment while others are not. As indicated in paragraph 2.13 above, publicly available information on OPMHS does not include the specific dementia-related illnesses that can be assessed and treated and those that cannot.

2.22 Since the audit, ACT Health advised that the agency has been trying to develop clinical guidelines relating to dementia-related illnesses that can be assessed and treated. With the expected growth of dementia patients in the ACT, it is important for OPMHS to engage and communicate with consumers, carers and other external stakeholders in the community the dementia-related illnesses that can (or

cannot) be assessed and treated by OPMHS. Better communication of these parameters will assist in ensuring consistency of approach and transparency in dealing with consumers with dementia related illnesses.

Recommendation 2

ACT Health should engage and communicate with consumers, carers and other external stakeholders in relation to dementia-related illnesses that can (or cannot) be assessed and treated by the Older Persons Mental Health Services.

3. MANAGEMENT OF THE REFERRAL PROCESS

INTRODUCTION

3.1 The Older Persons Mental Health Services (OPMHS) comprises several distinct service components, including:

- Older Persons Mental Health Community Team (OPMH Community Team);
- Older Persons Mental Health Inpatient Unit (OPMHIU) with a capacity of up to 20 beds at Calvary Hospital;
- Outpatient Clinic (located at OPMHIU – Calvary Hospital); and
- Consultation Liaison.[27]

KEY FINDINGS

- Referrals to the Older Persons Mental Health Services are accepted from other government agencies or community organisations; families and carers; health professionals and General Practitioners (GPs) and self-referrals.
- The Older Persons Mental Health Services' orientation and procedural manual, the key document used by the Older Persons Mental Health Community Team, provides guidance on the various stages of the intake and referral process. However, this manual did not contain nor was it linked to clear guidance on urgent and non-urgent referrals and prioritisation of consumers contained in other policy documents.
- The Older Persons Mental Health Services does not have a good feedback mechanism to provide information, when permitted, to referrers (such as community organisations), on a consumer's status with the Older Persons Mental Health Services. Such information is important to the community organisation for the ongoing care of their consumers.
- Most referrals made to the Older Persons Mental Health Community Team come from GPs. However, GPs in the community, particularly the newer ones, have a low general awareness of the Older Persons Mental Health Services.

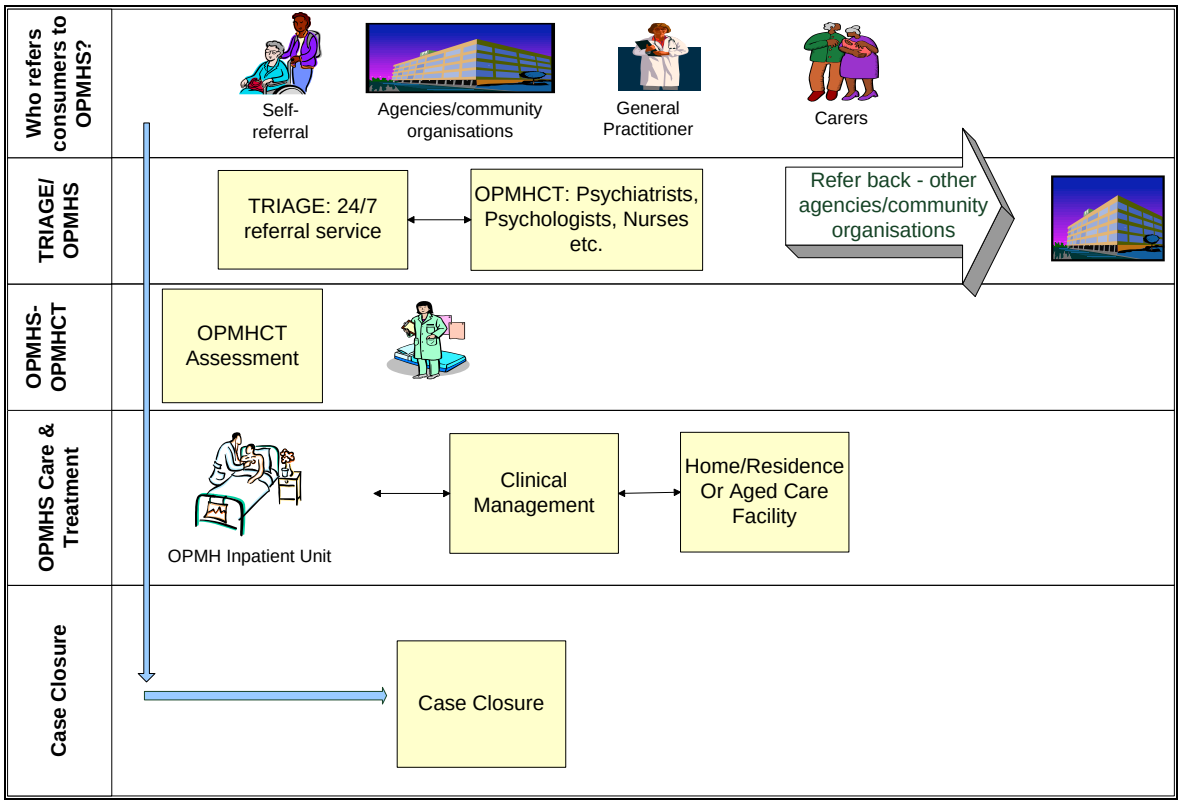
REFERRALS TO THE OLDER PERSONS MENTAL HEALTH SERVICES

3.2 Referrals to OPMHS are accepted from other government agencies or community organisations; families and carers; health professionals and General Practitioners (GPs) and self-referrals. Referrals endorsed by GPs are preferred, as the model of care adopted by OPMHS is shared with the GPs.[28] The referral pathway of a potential consumer is illustrated in Figure 3.1 on the following page.

[27] MHACT Older Persons Mental Health Community Team, *Staff Orientation and Procedure Manual*, May 2010, p. 24.

[28] Ibid.

Figure 3.1: Referral pathways for the OPMHS



Source: ACT Auditor-General's Office based on OPMHS documentation.

THE INTAKE AND REFERRAL PROCESS

A need for more specific guidelines

3.3 The guidelines for the intake and referral process specific to the Older Persons Mental Health Services are stipulated in the Older Persons Mental Health Services Staff Orientation Manual and Procedure Manual of May 2010.

3.4 Intake by the OPMH Community Team involves taking referrals over the phone or handling referrals that are either sent in manually or faxed in.[29] The Clinical Co-ordinator (Intake Officer) is allocated on a daily basis and undertakes all referral management responsibilities. The OPMH Community Team meets each morning for clinical allocation and review. Referrals come in through triage, or directly to a clinician within the OPMH Community Team. All referrals are discussed and allocated to the OPMH Community Team during the daily morning intake meeting.[30]

3.5 The OPMHS manual provides general and wide ranging instructions that cover the OPMH Community Team's responsibilities in various stages of the intake and referral process. However, Audit found that directives relating to 'urgent referrals' or in management of 'large numbers of referred consumers' need to be more specific. For example, on 'urgent referrals', the OPMHS manual states that:

[29] MHACT Older Persons Mental Health Community Team, *Staff Orientation and Procedure Manual,* May 2010, p.13.

[30] Ibid.

> If an urgent referral is made that cannot wait until allocation, it is the responsibility of the clinical coordinator of the day taking the referral to arrange contact as appropriate. This may involve liaising with other team members, the crisis team, inpatient units or alternative agencies to respond. The consumer, and the crisis response provided, will then be presented and discussed at the next allocation meeting.[31]

3.6 Detailed and more explicit guidelines on 'urgent referrals' need to be in place, including:

- defining what entails an 'urgent referral'- identifying scenarios or examples of when a referral is considered critical or urgent; and
- specifying 'arranging contact as appropriate' – what kind of liaising arrangements should be made? For example, will provision of the critical consumer's details and history to another agency (the receiving agency) be sufficient? Are further follow-up or liaison arrangements needed? These need to be clearly identified.

3.7 The OPMHS Manual also provides general guidance in managing 'large numbers of referred consumers'.[32] However, Audit found that the information provided is broad and may be subject to interpretation. The Manual states that:

> If there are a large number of referred consumers to be managed, then the most urgent will require priority and non-urgent referrals may be left until the next day. However, no referral shall wait longer than 48 hours from the time they contacted Triage or OPMHS until they receive contact from the OPMHS allocated clinical manager.[33]

3.8 Similar to 'urgent referrals', in managing 'large numbers of referred consumers', specific and unambiguous guidelines need to be provided, that include:

- when is the number of referred consumers considered too large to manage? Is it related to the clinician-consumer ratio? These need to be specified. There is no current MHACT policy on a clinician-consumer ratio, although members of the OPMH Community Team acknowledge an 'unwritten rule' on the matter. Further, members of the OPMH Community Team members indicate that individually, they are managing a large number of consumers at certain times.

  At the time of audit, MHACT advised that policy on this was still being developed. In the interim, clear guidance should be provided to the OPMH Community Team as to the appropriate allocation of consumers per clinician, which is dependent on the clinician's work level and experience in his/her particular discipline.

- what differentiates the 'urgent referrals' that require priority from the 'non-urgent referrals' that can wait the following day? There needs to be a system for prioritising referrals according to risk, urgency, distress,

[31] Ibid.

[32] Ibid.

[33] Ibid.

dysfunction and disability.[34] Audit was advised that clinicians within the OPMH Community Team conduct their own prioritisation or risk assessment in managing referrals, and acknowledged that existing consumers being clinically managed may be ignored for weeks as a result. The prioritisation of referrals needs to be clearly identified in the OPMHS guidelines.

3.9 Since the audit, ACT Health advised that the OPMHS Staff Orientation and Procedure Manual was an 'informal' document, notwithstanding that it was the main document used or referred to by the OPMH Community Team. Further, ACT Health advised that other internal documentation describes, and provides directives on, urgent and non-urgent referrals, including:

- Mental Health ACT's *Clinical Processes and Documentation*, July 2008 (was under review at the time of audit); and
- Mental Health ACT's *Triage Category of Response Policy*, June 2008.

Neither of these documents was linked or referred to in the OPMHS Staff Orientation and Procedure Manual.

3.10 ACT Health also advised that it is currently in the process of updating all localised orientation manuals of various mental health services, including the OPMHS Staff Orientation and Procedure Manual. A project is underway to ensure that all local orientation/procedure manuals are standardised and comply with legislative and corporate requirements.

Recommendation 3

ACT Health should ensure that orientation and procedure manuals for Older Persons Mental Health Services are consistent with other relevant policies and provide clear directives or guidance on:

a) urgent and non-urgent referrals;

b) prioritisation of consumers;

c) definition of a 'large number of referred consumers'; and

d) the acceptable clinician-consumer ratio.

Referrers unsure of what happened to consumers whom they referred to OPMHS

3.11 Referred consumers who are found not to be appropriate for allocation within the OPMH Community Team may be referred to other agencies, as Mental Health ACT adopts a 'no wrong door' policy.[35] When needed, the referral to other agencies may involve a clinical manager, within the OPMH Community Team, to contact the other agencies and make appointments/referrals in consultation with the consumer.[36]

[34] Australian Health Minister's Advisory Council, *National Standards for Mental Health Services,* January 1997, p. 30.

[35] MHACT Older Persons Mental Health Community Team, *Staff Orientation and Procedure Manual,* p.13.

[36] Ibid.

3.12 MHACT's external stakeholders advised Audit they receive little feedback from Mental Health ACT. For example, referrers, such as community organisations, will not receive feedback as to what happened to a consumer referred to OPMHS. This information is important to the community organisations for the ongoing care of their consumers. Some older people referred to OPMHS are already existing consumers of community organisations. A holistic approach is adopted in caring for a consumer, and community organisations would like information as to what happened to their consumers when referred to OPMHS. Audit was also advised that OPMHS would not discuss clinical problems of consumers with non-clinicians, which may be pertinent information to case workers in the community organisations.

3.13 Audit appreciates that there are legitimate concerns regarding privacy and the rights of consumers who were assessed or treated by OPMHS, and information relating to their clinical problems may not be relayed back to the referrer, even if the consumer was already an existing consumer of the community organisation. For example, Standard 5.4 of the *National Standards for Mental Health Services* that applied at the time of audit stipulate:

> Consumers give informed consent before their personal information is communicated to health professionals outside the mental health service, to carers or other agencies or people.[37]

3.14 The recently released *National Standards for Mental Health Services 2010* provide further guidance on personal and health related information of consumers. Standard 1.4 state that:

> The MHS enacts policy and procedures to ensure that personal and health related information is handled in accordance with Commonwealth, State/Territory privacy legislation when personal information is communicated to health professionals outside the MHS, carers or other relevant agencies.[38]

3.15 The OPMHS ability (or its inability) to share information of a consumer needs to be communicated back to the community organisation that makes the referral. There needs to be a clear understanding of what consumer information can (or cannot) be shared between both parties, and process in place to improve co-ordination of care, when possible.

Recommendation 4

ACT Health should:

a) develop a feedback mechanism to referrers, that includes community organisations, of the consumer's status with the Older Persons Mental Health Services; and

b) ensure a clear understanding with the referrer as to what consumer or clinical information can be shared.

[37] Australian Health Minister's Advisory Council, *National Standards for Mental Health Services,* January 1997, p.12.

[38] Australian Government, *National Standards for Mental Health Services 2010,* p.8.

Relationship with General Practitioners (GPs) is sound, but there is room to improve awareness and usefulness of services provided by OPMHS

3.16 It is estimated that 80 to 90 percent of referrals made to the OPMH Community Team come from GPs. As discussed above, referrals endorsed by GPs are preferred, as the model of care adopted by OPMHS is shared with the GPs. Audit found that the OPMHS has a better relationship with the GPs who refer their patients to the service, compared to other sources of referrals. However, a recent survey showed that the *usefulness* to, and *awareness* of, the OPMHS to the GPs could be strengthened.

3.17 A survey on the performance of service delivery to consumers across the interface between GPs and ACT health services in the ACT, including hospitals, mental health and community services, was conducted by the ACT Division of General Practice and the Australian Medical Association in late 2009 (released in early 2010).[39] In terms of usefulness of service and awareness of GPs, the OPMHS ranked fourth out of 15 service areas that were sampled for the survey. The *usefulness* of OPMHS to GPs was rated to be around 65 to 67 percent, while their *awareness* of OPMHS was rated to be around 55 to 57 percent.[40]

3.18 Since most OPMHS referrals come from GPs, and given the growing trend in the number of older persons with mental health illnesses in the community, it is essential for GPs to have a higher level of awareness of the services provided by the OPMHS. As the GPs are the primary providers of health services for older persons, their services can be further supported with better awareness and communication with specialised psychiatric services such as OPMHS.

Recommendation 5

ACT Health should strengthen its general awareness programs relating to Older Persons Mental Health Services, and particularly target these to new General Practitioners in the community.

[39] ACT Division of General Practice, *ACT Health Interaction Survey,* 2010.

[40] Ibid.

4. RESPONSIVENESS TO DEMAND

INTRODUCTION

4.1 Knowing your consumer base is a fundamental premise in any service organisation. Mapping-out the demand to services, whether it is increasing or decreasing, and a continuous assessment of consumer needs will assist in making informed management decisions.

KEY FINDINGS

- The number of older persons requiring mental health services has been growing. The Older Persons Mental Health Services has recorded a 400 percent increase in the number of consumers that had occasions of service since 2000–01.
- ACT Health collects good data, in that it monitors the number of consumers or older persons who avail of mental health services. ACT Health also monitors the diagnosis given to older consumers with mental health illnesses, and tracks the consumers that have been referred on or consumers that have not yet been diagnosed.
- There was inconsistent reporting on the actual number of consumers availing of the Older Persons Mental Health Services and a lack of reporting on the impact of demand on the services being delivered.
- There is an 'annual performance review' process that looks at various mental health data sets collected by ACT Health. However, this process is informal and does not include an analysis of various mental health diagnosis, or their prevalence and impact to the Older Persons Mental Health Services.
- ACT Health (Mental Health ACT) did not routinely consult or collaborate with the community including peak bodies, service providers, and other community organisations that deal with older persons in the community.
- Importantly, ACT Health has not communicated or collaborated effectively with relevant stakeholders to determine the extent of 'unmet needs'of older persons with mental health illnesses in the community.
- In general, the timeliness of the Older Persons Mental Health Services' response to demand was good. However, there was no clear process to monitor cases where the Older Persons Mental Health Services response was delayed, or where needs of at-risk groups are not met.

OPMHS' increasing number of consumers

4.2 ACT Health monitors the number of consumers who avail of mental health services for older persons by tracking each month: the total number of consumers who are clinically managed; the new allocations; and the number of case closures. These are reported in the program activity reports prepared by the Team Leader of the OPMH Community Team.

4.3 Audit examined the program activity reports and found that for years prior to 2010, the reports did not include actual number of consumers for the service. It was not until 2010 that consumer numbers for older persons were reported. From January 2010 to July 2010, the total number of consumers for OPMHS was averaging close to 290 each month, with March 2010 reporting a low of 228 consumers, and July 2010 reporting a high of 344 consumers. New allocations from January 2010 to July 2010 averaged from 30 to 35 consumers each month, while case closures reported for the same period varied from a high of 61 closures for January 2010, to a low of 8 closures for July 2010.

4.4 Assessing demand trends is difficult given that previous consumer numbers have not been reported or recorded for monitoring purposes. The collection of demand data will assist OPMHS to provide an accurate picture of actual numbers of consumers, new allocations and case closures per month. Although the collection of this data complements other indicators used by ACT Health, such as the *occasions of service*, it is useful to ACT Health management if OPMHS consistently report on the actual number of consumers who use or avail of the OPMHS.

Occasions of service

4.5 Another indicator used by ACT Health in monitoring and reporting its growing consumer base for OPMHS is through the number of consumers who have *occasions of service* (OOS). OOS is ACT Health's measure for the provision of service to non-admitted patients.[41] OOS can either be a single encounter or a group encounter. An OOS 'single encounter' is defined as any examination(s), consultation(s), treatment(s) or other direct clinical care[42] attended by a non-admitted patient,[43] while a 'group encounter' involves any significant contact with a consumer and his or her family.[44] Audit analysed OPMHS' consumers that had *occasions of service* over a ten-year period, from July 2000 to July 2010, as illustrated in Figure 4.1 on the following page.

4.6 As shown in Figure 4.1, the average number of consumers who had OOS in 2000-01 was 52, whereas 216 consumers were recorded for 2009-10,[45] a 400 percent increase from 2000-01 levels. The diagnosis for older persons who have mental health illnesses has become varied and more complex, and this has further complicated the demand for OPMHS,

[41] Non-admitted patient is someone who is not admitted to hospital.

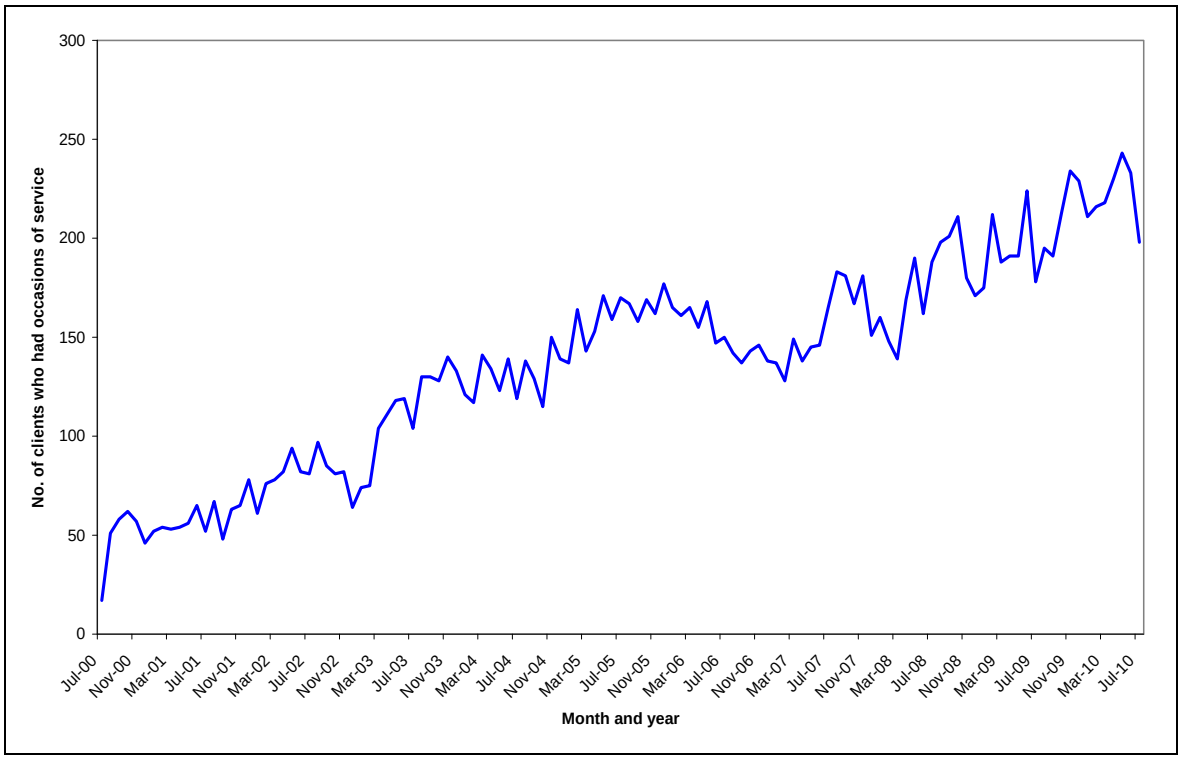
[42] Direct clinical care is when patient contact is made either face to face, via telephone or email for clinical care or intervention and a file notation is made in the health record

[43] ACT Health Data Dictionary, 27 June 2007.

[44] Ibid.

[45] An average for the 12-month period.

Figure 4.1: OPMHS occasions of service, July 2000 to July 2010



Source: ACT Auditor-General's office using data from ACT Health

Consumers' varying and complex mental health illnesses

4.7 ACT Health monitors the diagnosis given to older consumers with mental health illnesses, and also tracks consumers referred on or consumers who have not yet been diagnosed. Diagnoses are classified as shown in Table 4.1.

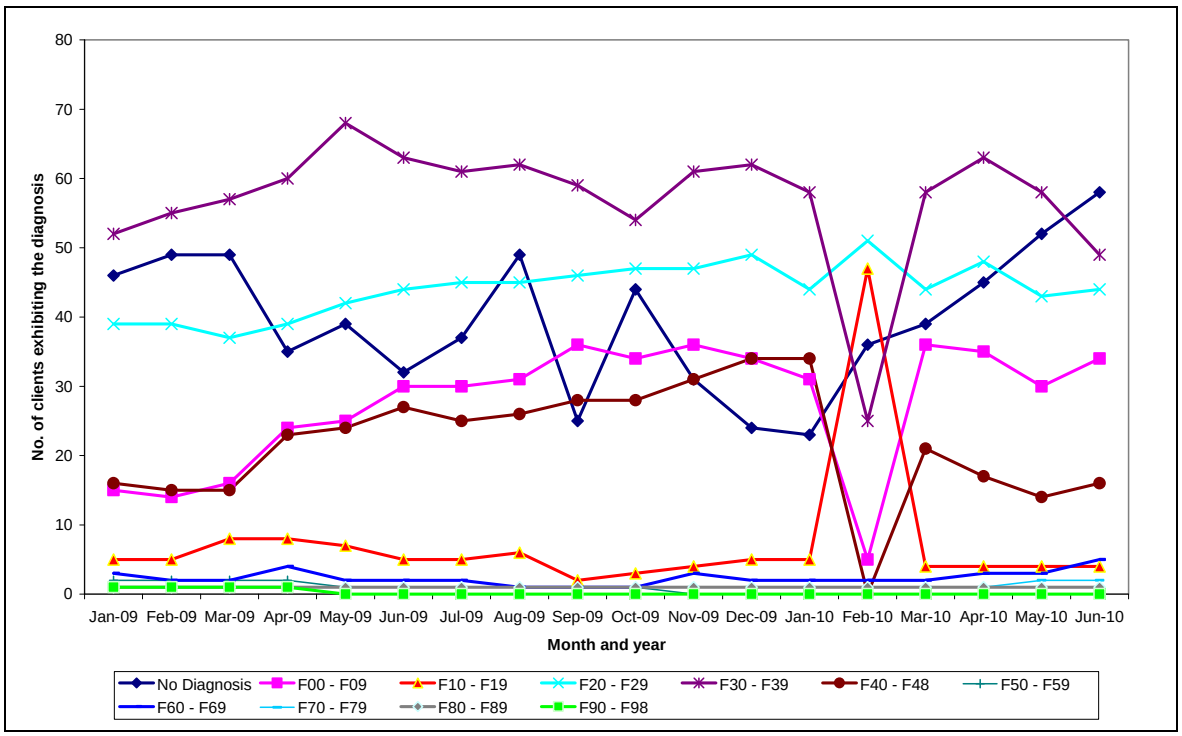
Table 4.1: Diagnosis classification and what they mean

Diagnosis classification	What it means
No Diagnosis	Consumers referred on and consumers not yet diagnosed
F00 - F09	Organic, including symptomatic, mental disorders
F10 - F19	Mental and behavioural disorders due to psychoactive substance abuse
F20 - F29	Schizophrenia, schizotypal and delusional disorders
F30 - F39	Mood (affective) disorders
F40 - F48	Neurotic, stress related and somatoform disorders
F50 - F59	Behavioural syndromes associated with physiological disturbances and physical factors
F60 - F69	Disorders of adult personality and behaviour
F70 - F79	Mental retardation
F80 - F89	Disorders of psychological development
F90 - F98	Behavioural emotional disorders with onset usually occurring in childhood or adolescence

Source: ACT Auditor-General's Office, as extracted from ACT Health's master reports.

4.8 Figure 4.2 illustrates the consumer diagnosis breakdown from January 2009 to June 2010.

Figure 4.2: Consumer diagnosis breakdown, January 2009 to June 2010



Source: ACT Auditor-General's Office using data from ACT Health's Master Reports.

4.9 Of the classifications shown in Table 4.1, the top four diagnosis given to consumers of OPMHS from January 2009 to June 2010 were:

- mood (affective) disorders (F30-F39) – total of 1 025;
- schizophrenia, schizotypal and delusional disorders (F20-F29) – total of 793;
- organic, including symptomatic, mental disorders (F00-F09) – total of 496; and
- neurotic, stress related and somatoform disorders – a total of 394.[46]

4.10 As illustrated in Figure 4.2, in February 2010, there was a marked spike in 'mental and behavioural disorders due to psychoactive substance abuse' (F10-F19), and similarly, a noticeable decline in: 'mood affective disorders' (F30-F39); 'organic including symptomatic, mental disorders' (F00-F09); and 'behavioural emotional disorders with onset usually occurring in childhood or adolescence' (F90-F98) in the same month. Audit found no analysis or report of why this occurred.

4.11 The number of 'no diagnosis', who were consumers referred on to another organisation and consumers who had not yet been diagnosed, totalled to 713 for the same 18-month period as above. OPMHS' consumer diagnosis breakdown is

[46] Totals provided are for the 18-month period, from January 2009 to June 2010.

included in Mental Health ACT's Master Report that is submitted to MHACT management. As this classification represents a significant number, it is useful for management, particularly for business and strategic planning to:

- ascertain and report the exact number of consumers referred on, and why they have been referred on; and
- establish and report the number of consumers not diagnosed, and why these consumers have not yet been diagnosed.

While ACT Health collects good data, further analysis on the reasons or trends behind the data will further assist its delivery of services.

Are there consumers with unmet needs?

4.12 In Audit's engagement with one of ACT's leading non-government organisations that represent older persons in the community, Audit was informed of older persons with mental illnesses in the community whose mental health needs are not being met. In particular, ongoing concerns/issues were raised and these include:

- a strong view in the community that there is a high degree of undiagnosed depression with the elderly, with older persons having major acute episodes;
- an observation in the community that when an elderly person causes harm to himself/herself and to others, that it has to occur several times before OPMHS becomes involved;
- ACT Health has no clear policy framework for older persons who are living independently or at home after the onset of dementia – intervention, if it occurs, is minimal, ad hoc and often late; and
- ACT Health's mental health framework is 'supply driven', not 'demand driven'.

4.13 Audit was also advised that the current environment of older persons with mental health illnesses in the community is similar to that of a 'pyramid', with the base representing the consumers with unmet needs, while services are currently concentrated on the top of the 'pyramid' which represents consumers whose mental health needs have been identified and are being treated.

4.14 Audit considers that a collaborative, co-ordinated planning with relevant key stakeholders in the community will assist ACT Health management in:

- making plans for the future of older persons' mental health; and
- ensuring it is adequately equipped, funded and resourced to meet the growing mental health needs of older persons in the community.

4.15 Since the audit, ACT Health advised that it has an informal 'annual performance review' where services within Mental Health ACT get together and as a group, discuss the relevance of their various data sets.

Recommendation 6

ACT Health should put in place robust arrangements to ensure that current and future mental health needs are met by:

a) consistently reporting the actual number of consumers availing of the Older Persons Mental Health Services and its likely impact to the services being delivered;

b) enhancing and formalising the 'annual performance review' process to include an analysis of various mental health diagnosis, their prevalence and the impact on the Older Persons Mental Health Services; and

c) collaborating with relevant stakeholders to identify and service the 'unmet needs' of older persons with mental health illnesses in the community.

FUNDING

Cost of mental health services to the Territory

4.16 In 2008–09, the ACT Government allocated $66.694 million for mental health services in the Territory, which equated to 7.5 percent of the total ACT budget. Of the budget for mental health services, 12.6 percent was allocated to the community sector.[47] Current ACT budget figures show the estimated outcome for the total cost for mental health services for 2009–10 to be $75.426 million, a 13 percent increase from previous year's budget. Figure 4.3 on the following page shows the ACT budget for mental health services from 2004–05 to 2008–09.

4.17 As illustrated in Figure 4.3, the ACT Health's budget and actual spending for mental health services in the Territory have been increasing in recent years. This highlights the growing trend and the importance of the provision of mental health services in the Territory, provided primarily by MHACT.

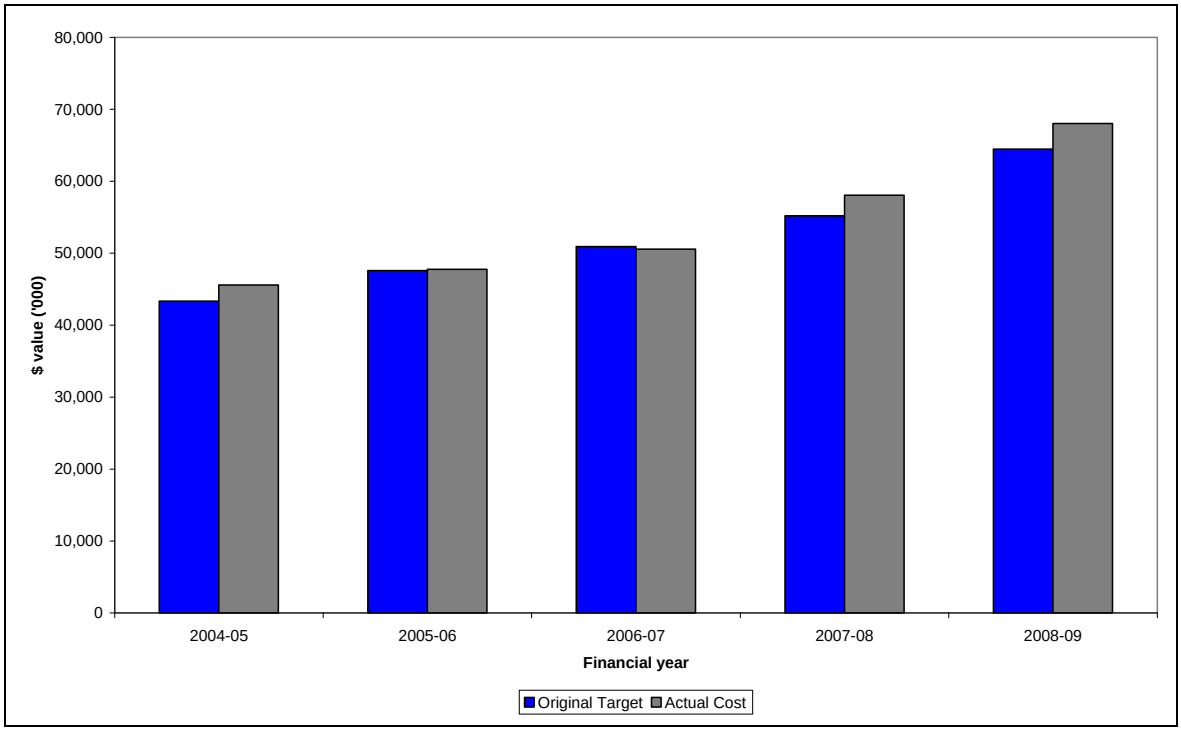
4.18 Audit was informed that currently, ACT Health adopts an incremental approach to its funding arrangements. Funding for the past few years have been based on growth of services rather than any new policy initiatives.

4.19 In 2009-2010, the net operating costs for mental health services to older persons were around $6.8 million. This included net operating costs incurred by ACT Health's 'rehabilitation services'.

4.20 In February 2010, a restructuring of Mental Health ACT services have seen costs for older persons mental health services bundled with 'adult community mental health services', which used to comprise the most number of mental health services in the Territory as shown in Figure 1.1 (Chapter 1).

[47] ACT Health annual report 2008—09.

Figure 4.3: ACT budget for mental health services from 2004–05 to 2008–09



Source: ACT Auditor-General's Office analysis using data from ACT Health annual reports.

TIMELINESS OF RESPONSE

4.21 Improving responsiveness of health services is essential to ensure the needs of specific at-risk groups, such as older persons with mental health illnesses, are met. Responsiveness is assessed based on the actual time it takes for the service to respond to an initial referral, and its overall responsiveness to the mental health needs of the targeted consumers in the community.

Based on its own standards, OPMHS' response times are generally good

4.22 Standard 11.2.12 of the *National Standards for Mental Health Services* that applied at the time of audit state that:

> the mental health service 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 within 24 hours of initial contact.

This may be commenced with initial history taking, risk assessment, or needs assessment over the telephone by appropriately qualified health professional.[48]

4.23 The recently released *National Standards for Mental Health Services 2010* provide current guidance on the timeliness of assessment. In particular, Standard 10.4 and 10.4.2 state that:

> Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carer(s). Assessments are conducted during the consumer's first contact with the MHS by appropriately

[48] Australian Health Minister's Advisory Council, *National Standards for Mental Health Services,* January 1997, p. 30.

> qualified staff experience and trained in assessing mental health problems, and where possible in a consumer's preferred setting with consideration of safety for all involved.[49]

4.24 The OPMHS manual states that the response times from the time of the initial call until the initial assessment of a consumer is conducted within 48 hours of the date on the original referral.[50] If a consumer is not contactable by phone, a letter is sent before the 48-hour period has expired.[51]

4.25 To assess the response times of the OPMH Community Team, Audit examined 56 individual consumer files/cases of OPMHS for the period January 2009 to July 2010.[52] Of the 56 cases, the response to the referral, through a phone call or an initial assessment, was made either on the same day of the referral or the day after the consumer was referred. This is a positive indication that the 48-hour standard set by OPMHS is being met. However, Audit was also advised of instances where OPMHS was not as responsive to referrals made to them.

Examples of when OPMHS has not been as responsive

4.26 Audit was aware of instances where OPMHS was not as responsive to referrals made to them. Examples of these are shown in the following case studies (names and personal circumstances have been changed to protect the privacy of the consumers).

Case Study 4.1 A 75 year old man who was disorientated and confused

On 2 May 2009, an external agency referred Mr A, a 75 year old man who had history of being disorientated and confused, to OPMHS for admission to the OPMH Inpatient Unit. The OPMH Inpatient Unit was full, so Mr A was referred to Calvary Hospital's Emergency Department (ED) where he was admitted. Mr A was eventually discharged from ED and was later re-admitted to another ward in the hospital on 5 May 2009.

Following 5 May 2009, Mr A was admitted to the OPMH Inpatient Unit and was case managed by the OPMH Community Team.

Better practice would require OPMHS, through the OPMH Community Team, to follow-up the consumer when the first referral was made on 2 May 2009, not waiting for his admission to the OPMH Inpatient Unit.

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[49] Australian Government, *National Standards for Mental Health Services 2010,* September 2010, p.24.

[50] MHACT Older Persons Mental Health Community Team, *Staff Orientation and Procedure Manual,* May 2010, p. 15.

[51] Ibid.

[52] Files/cases of consumers were generated from MHACT's consumer management document system called the 'Mental Health Assessment Generation Information Collection' (MHAGIC).

Case Study 4.2 An 80 year old man who had violent outbursts

On 3 April 2010, an external agency referred Mr C who had violent outbursts toward his wife, made threats to wife's safety, and had difficulty finding words when speaking, to OPMHS by telephone. The referrer advised that the matter was considered urgent. The referrer followed-up the phone call with an email that included her request for assessment by OPMHS, and a mental state examination and information on brief cognitive testing.

On 9 April 2010, the first response was received from the OPMH Community Team advising that they contacted Mr C's son on 7 April 2010 (four days after the first referral was made) without success, and left a message.

Mr C's son advised that he did not receive any message from the OPMH Community Team.

Better practice would be for the OPMH Community Team to contact the referral agency within 24 hours to determine the status of this urgent case and any further action required.

4.27 A service provider's responsiveness is imperative to ensure the needs of at-risk groups are met. Equally important is the measurement of how responsive the service is, and the reasons behind cases where the service has not been as responsive, or was not able to meet the standard set by ACT Health. A regular appraisal of its responsiveness will assist the agency in determining whether the services being provided align with the needs of its target consumers.

Recommendation 7

ACT Health should ensure that it effectively manages cases where the Older Persons Mental Health Services' responses were delayed, or where needs of at-risk groups are not met. Instances where the expected response times are not met should be closely monitored.

Overall responsiveness of OPMHS is hard to measure, and communication and engagement with the community need to be strengthened

4.28 Mental Health ACT strives to work in partnership with key stakeholders and community agencies within the ACT, to provide a high quality mental health service that expands across the community and inpatient services. A yearly survey is distributed to key stakeholders and community agencies that work with mental health to review the quality of partnerships.[53]

4.29 The most recent stakeholder survey conducted by MHACT was in 2008, where questions relating to the 'timeliness' and 'responsiveness' (among others), of MHACT were included. Stakeholder responses to timeliness and responsiveness

[53] ACT Health, *2009 Staff Survey on Evaluation of Mental Health Services and Comparison Analysis to the 2008 Key Stakeholder Survey*.

were generally low, 45.8 percent ('agreed somewhat') and 50 percent ('agreed somewhat') respectively.[54]

4.30 Audit was not able to use the results of MHACT's 2008 stakeholder survey to assess the responsiveness specific to OPMHS.

- The survey was not specific to OPMHS - the 2008 stakeholder survey was for MHACT's overall mental health services, and did not delineate or segregate mental health services provided to older persons specifically; and
- There was a limited number of respondents that dealt directly with older persons with mental health illnesses - the 2008 stakeholder survey was sent to a total of 53 stakeholders, of which some were ACT government agencies, and only five or six of the 53 were confirmed community agencies that may deal with older persons.

4.31 Nevertheless, results on 'communication' and 'participation of external agencies' for Mental Health were quite low with only 25 percent of the respondents 'agreeing strongly' for both categories.[55] These results were consistent with the advice provided to Audit in relation to OPMHS' communication and engagement with the community. In its discussions with OPMHS external stakeholders, such as community organisations and peak bodies, Audit was informed that there is a strong need for OPMHS to better engage with the community.[56] The external stakeholders want active consultation and collaboration with OPMHS. Engagement needs to go beyond the conduct of a regular/yearly survey, which is a helpful tool on its own, but is not sufficient.

Recommendation 8

ACT Health should strengthen its engagement with its external stakeholders, through regular consultation and collaboration with the community including peak bodies, service providers, and other community organisations that deal with older persons in the community.

[54] Ibid.

[55] Ibid.

[56] ACT Auditor-General's Office, *Minutes of Stakeholder Discussions,* 12 July 2010.

5. STAFFING, TRAINING AND DEVELOPMENT

INTRODUCTION

5.1 This Chapter examines ACT Health's staffing arrangements for the delivery of mental health services to older persons and analyses the training and development provisions that are in place.

KEY FINDINGS

- There was no regular analysis and evaluation of staffing data in the Older Persons Mental Health Services that could provide input to workforce planning and future recruitment strategies.
- There was no clear plan for the provision of specialised training for the Older Persons Mental Health Community Team. The Team did not have ready access to information regarding developments in the assessment and treatment of older persons with mental health disorders.
- The Older Persons Mental Health Community Team did not fully comply to the requirements regarding the use of the agency's mental health data collection system. As a result, the relevant data on older persons mental health services were not always complete or up to date.
- The Older Persons Mental Health Community Team relied on corporate knowledge when identifying external agencies or aged care facilities that consumers may be referred to. There was no consolidated list maintained by ACT Health (Mental Health ACT) for this purpose. Consequently, the approach used in 'referring on' consumers was inconsistent.

STAFFING

The Older Persons Mental Health Community Team

5.2 The OPMH Community Team is the core team that services older persons with mental health illnesses in the community. The 21-person team is made up of workers from various disciplines. At the time of audit, the team comprised of:

- a Team Leader;
- five Psychiatrists (one full-time and the remainder are part-timers);
- three Registrars;
- two Psychologists;
- five Registered Nurses;
- two Social Workers;
- an Occupational Therapist; and
- two Administrative personnel.

5.3 The OPMH Community Team is currently based at the Calvary Hospital where the Older Persons Mental Health Inpatient Unit (OPMH Inpatient Unit) is also located.

Is there enough staff with the right mix of disciplines?

5.4 Getting the right number of staff with the right mix of skills is essential to provide quality service to someone with a mental health problem. This is why different mental health professionals work in teams. A good team should have workers from different professions, who understand each other's different skills and ways of approaching problems.[57]

5.5 At the time of Audit, of the 21-person team indicated in paragraph 5.2 above, 14 were full-time staff and seven were part-timers. Audit was advised that previously, OPMH Community Team also engaged a part-time medical officer who was no longer with the team and was not replaced. Audit conducted discussions with members of the OPMH Community Team, and identified that staffing is an ongoing issue. Team members' comments included 'being over-stretched', 'consumers allocated for the OPMH Community Team are manageable but stressful at times' and of circumstances where the team was 'bulging at the seams'. There is significant pressure when the OPMH Community Team staff numbers are down, this occurs when staff members go on leave or resign, and the remaining staff need to take-over their existing consumers.

5.6 Senior team members are also uncertain as to whether the current composition of the OPMH Community Team is adequate. The previous set-up where a part-time medical officer was engaged was considered ideal, as members of the team could easily and readily consult with someone who had medical expertise. Although the OPMHS has five Psychiatrists, the full-time specialist doctor is based at the Older Persons Mental Health Inpatient Unit, and the remaining four come in on a part-time basis.

5.7 Workforce or resource planning is essential in service environments as it assists management in making sound decisions on human resources. There is no clear workforce planning or analysis of staffing data within OPMHS, which links staff numbers and the specific disciplines required with the growing number of older persons with varying mental illnesses. In a resource constrained environment such as the OPMHS, these need to be determined to ensure that the OPMH Community Team is adequately and appropriately staffed, and able to meet the growing, complex mental health needs of older persons in the community.

5.8 ACT Health advised that the current composition of the OPMH Community Team reflects the full-range of disciplines required of a multi-disciplinary team in a mental health service that caters to older persons. Further, a Planning and Development Officer - Mental Health Workforce Strategy, has recently been recruited and will be responsible for workforce and resource planning, among other duties.

[57] http://www.rcpsych.ac.uk [Accessed on 15 August 2010].

Recommendation 9

ACT Health should regularly analyse and evaluate staffing data to:

a) identify trends and process improvements in a resource constrained environment; and

b) provide input to workforce planning and future recruitment strategies.

TRAINING AND DEVELOPMENT

Generic training is well received by the OPMH Community Team

5.9 ACT Health offers a variety of training and development opportunities to its officers and staff. The agency has a learning management system, *Capabiliti*, to book onto courses and administers employees' learning and development. MHACT employees are also required to attend essential training specific to their role. This includes essential education for administration officers, health service/technical officers, directors, clinicians, and team leaders.[58]

5.10 The OPMH Community Team is generally satisfied with the training provided to them. In particular, staff members who are new to the team and to MHACT commented that 'there is a good range of courses or modules on offer' and 'there is good training provided'. However, Audit's discussions with senior members of the team, who have been with OPMHS for a number of years and have extensive experience dealing with older persons in the ACT, indicated the need for more specialised training that focuses on the growing and complex mental health needs of the elderly in the community.

Specialised training that reflects the needs and demands of older persons with mental health illnesses is needed

5.11 With Australia's ageing population, there will be an increasing demand for expert clinicians and mental health workers who are well equipped to assist older people and their families or carers who deal with late life mental disorders and mental health problems. Specialised training is paramount. MHACT's 'essential education' for its staff, such as the mental health clinicians and health service/technical officers for example, includes a variety of general topics relating to mental health, a broad range of processes and protocols, and specific mental health illnesses that are prevalent in the community. These include modules on:

- working with mental health consumers;
- Aboriginal and Torres Strait Islander cultural awareness training;
- the *Mental Health Act;*
- expectations and standardisation of clinical processes;
- suicide assessment and management;
- schizophrenia;

[58] ACT Health, *MHACT Organisational Development Essential Education*, 2009.

- depression;
- anxiety disorders;
- borderline personality disorder; and
- bipolar disorder.[59]

5.12 Although mental illnesses are included in many of the offered modules, old age specific illnesses such as dementia and other related illnesses are not included. As discussed earlier, there has been a growing recognition that dementia represents a significant challenge to health, aged care and social policy.

5.13 Audit found that ACT Health allows its interested officers/staff to attend ad hoc conferences/workshops relating to specific mental health illnesses that affects older persons. For example, early in 2010, a number of senior staff members of the OPMH Community Team attended a two-day conference in Melbourne that related to psychogeriatric services.[60] To supplement the current development and learning opportunities, basic education and specialised training relating to dementia, its various types or categories and the way it presents itself, need to be routinely provided to ACT mental health workers who work with older patients. Ideally, this will form part of their regular education/training program to enable them to recognise dementia related illnesses and be able to deal with them appropriately.

What other specialised training is provided externally?

5.14 Audit investigated external bodies that also provide specialised training to older persons with mental health illnesses, these include:

- the Royal Australian and New Zealand College of Psychiatrists (RANZCP); and
- the New South Wales Institute of Psychiatry.

5.15 The RANZCP's Psychiatry of Old Age offers the Advanced Training Program in Psychiatry of Old Age, which focuses on the study, treatment and prevention of mental disorders and mental health problems in older people.[61] However, this certification is only offered to psychiatrists or to people intending to take psychiatry. The RANZCP does not offer training relating to older persons mental health to non-psychiatrists.

5.16 The New South Wales Institute of Psychiatry (the Institute) offers a Graduate Mental Health Program that is a professional skills-based program for people working in the mental health field.[62] It offers multidisciplinary education that includes specific training to the mental health of older persons and can be accessed by mental health workers who are not psychiatrists. These include

[59] ACT Health, *Mental Health ACT Essential Education,* 2009.

[60] Psychogeriatric services are specialist mental health services for older people.

[61] The Royal Australian and New Zealand College of Psychiatrists *Advanced Training in Psychiatry of Old Age.* http://www.ranzcp.org/fellowhip/vocational-training.html [Accessed 16 August 2010].

[62] http://www.nswiop.nsw.edu.au [Accessed 16 August 2010].

nurses, social workers, occupational therapists and the like. Specific old age training or programs offered by the Institute include:

- the *Certificate Program in Mental Health of the Older Person* — this program provides an overview of mental illness and disorders in old age. Content includes assessment, treatment, types of services and current research. Students are expected to gain theoretical knowledge and practical skills for assessment and management of consumers in the field of aged care psychiatry.
- the *Graduate Diploma of Mental Health (Older Person)* — this program builds in the Graduate Certificate program of study and develops students' critical thinking, analytical, diagnostic, intervention, evaluation and research skills in relation to mental illness in the older person.
- *Master of Mental Health (Older Persons)* — this program is designed to enhance specialised skills in the mental health of the older person. Candidates elect to specialise in either research or clinical streams. Current, complex and diverse (sensitivity to socio-cultural issues) factors that influence clinical presentation and continuum of care are covered.[63]

5.17 The above are just a few examples of specialised training, or further education that can be considered and offered to ACT mental health workers who deal with older persons with mental health illnesses. It is useful to establish a regular, specialised training program for the OPMH Community Team, not only to enhance their skill set but also to ensure that they remain up-to-date with current developments in the assessment and treatment of older persons with mental health disorders.

Recommendation 10

ACT Health should:

a) develop a plan that includes arrangements for the provision of specialised training in the mental health of older persons; and

b) provide the Older Persons Mental Health Community Team good access to information regarding current developments in the assessment and treatment of older persons with mental health disorders.

Specific guidance and training on the administrative and operational processes and procedures are required

5.18 It is beneficial to provide guidance and training on the administrative processes and procedures to ensure efficiency and consistency of approach, particularly in a health service environment such as the OPMHS. Having clear, concise guidelines is a key factor to the success of the service.

5.19 As discussed in paragraph 3.5 above, the OPMHS orientation manual for the OPMH Community Team provides detailed and wide-ranging instructions on the

[63] Ibid.

team's responsibilities. However, guidance and training relating to important operational processes and procedures such as monitoring of consumers and other tasks, particularly on the use of the agency's information collection system, the Mental Health Assessment Generation Information Collection (MHAGIC), are fragmented. For example, the procedures relating to the three-month monitoring of consumers, a critical function for the OPMH Community Team, are not detailed in the orientation manual. There is no cohesive documentation or reference document that details all the important operational processes/procedures that need to be adhered to in the OPMHS.

5.20 In Audit's discussions with the OPMH Community Team, Audit was advised that 'processes and procedures are not nailed down', 'there were no briefings conducted on day-to-day tasks', and that 'the orientation was not done well'. Further, Audit found that there is widespread negative sentiment regarding adherence to administrative requirements, particularly concerning the completion of outcome measures that require the use of MHAGIC. Audit was advised that the 'paperwork has increased', 'it is laborious', 'an added burden', 'there is more focus on compliance/accountability rather than the actual treatment of consumers' and 'a lot of time that could have been spent with consumers was spent doing paperwork'.

MHAGIC and the importance of updating it

5.21 The Mental Health Assessment Generation Information Collection (MHAGIC) is ACT Health's consumer management system. It provides a snapshot of a consumer's clinical history and information that include contact/s with the agency;[64] assessments; diagnosis; treatment and relevant plans, such as a consumer's recovery plan. All members of the OPMH Community Team have access to MHAGIC, and all clinicians and case workers are able to update files of their consumers.

5.22 Audit was informed by senior members of the OPMH Community Team that MHAGIC is a 'very good tool', 'it is a superior consumer management system as compared to similar systems in other jurisdictions' and that 'it is very useful'. Similarly, Audit found that MHAGIC is also a useful tool to senior management of ACT Health, in that it is used to extract data or information that assists management in making informed decisions. However, the updating of required fields in MHAGIC is not consistent. For example, the updating of 'outcome measures' (as discussed in detail in Chapter 7), is critical to the agency as it provides perspectives from both the clinician and the consumer, as to whether mental health services are effective in achieving improvements. Audit found that this is done poorly.

[64] Made either through the OPMHS, the OPMHIU, and other bodies within ACT Health.

Recommendation 11

ACT Health should:

a) ensure the Older Persons Mental Health Community Team complies with the requirements regarding the use of the agency's mental health data collection system (the Mental Health Assessment Generation Information Collection); and

b) highlight the importance of completing and updating all required information.

Comprehensive referral document to support the OPMH Community Team

5.23 When a referral is made to the OPMHS or to the OPMH Community Team and it is clear that the referral is not appropriate, that is, the consumer does not have issues of ageing or may not be exhibiting moderate to severe metal illness, then that consumer will be referred by OPMHS to a more appropriate service provider externally. As well, existing consumers of the OPMHS who may have complex needs and requirements may be referred to another external agency (such as a community organisation/service provider) who can better service them. To make an appropriate referral externally, the OPMH Community Team relies on an updated list of community organisations, non-government organisations (NGOs) or carers in the community, that the team can call upon and make the referral to. A readily available, uniform and updated 'referral list', although important and useful to the OPMH Community Team, does not exist.

5.24 Audit found that the OPMH Community Team relies on a senior member of the team who has been with the OPHMS for a number of years as a 'very good source' of information on community organisations, NGOs or aged-care facilities. Another member of the OPMH Community Team stays informed of organisations or NGOs in the community that caters to older persons by attending a 'respite care network', and has a directory of various community organisations and service providers in the ACT.

5.25 There was no consistent approach adopted when external referrals were made. In general, the OPMH Community Team relies on 'corporate knowledge' of senior staff for information relating to external agencies or organisations. Various lists produced by other agencies or other sources are used. There is no updated, documented, single 'referral list' available for use by all staff. Having a comprehensive and up to date 'referral list' is fundamental to the reliability and consistency of the referral process.

5.26 Since the audit, ACT Health advised that in December 2009, Adult Community Mental Health Services has developed and introduced a system, the *Care Coordination Links*, a compilation of external agencies, resources and other information that mental health consumers can be referred or have access to. Audit considers that this is a good model or approach that can be similarly adapted to the Older Persons Mental Health Services.

Recommendation 12

ACT Health should ensure that a consistent approach is adopted in 'referring on' consumers, by:

a) developing a consolidated list of external agencies, including aged care facilities, and community service providers, that can be used uniformly and consistently by the Older Persons Mental Health Community Team; and

b) keeping the list updated.

6. SUICIDE PREVENTION AND THE OLDER PERSONS MENTAL HEALTH INPATIENT UNIT

INTRODUCTION

6.1 Every year, nearly two thousand Australians from all ages and all walks of life take their own life. The causes often appear to be a complex mix of adverse life events, social and geographical isolation, cultural and family background, socio-economic disadvantage, genetic make up, mental and physical health, the extent of support of family and friends, and the ability of a person to manage life events and bounce back from adversity.[65]

6.2 In 2007, the most recent year for which mortality data was available, there were 1 881 registered deaths, with suicide representing an overall rate of 9.0 per 100,000.[66] The highest age-specific suicide death rates for males occurred in those aged 85 years (22.8 per 100,000), while the rate for males aged 65-74 year olds was slightly lower (12.2 per 100,000). For females, the age-specific death rates were highest for those aged 45-54 years and 55-64 years (both 5.7 per 100,000) and, by contrast to males, lowest for elderly females aged 75-84 years and 85 years and over (3.3 and 3.9 per 100,000).[67]

KEY FINDINGS

- ACT Health had comprehensive policy and guidelines on suicide prevention. However, these were not well implemented.
- ACT Health did not conduct suicide risk assessment in all cases as required by its policy. In the sample of cases examined by Audit, only 52 percent of cases had the required risk assessments done.
- There was no clear monitoring of the implementation of the suicide risk assessments.
- *Admission blocks* occur when consumers for a variety of reasons stay for a long period of time in the Older Persons Mental Health Inpatient Unit. There was no clear strategy to address the impact of *admission blocks* to the Older Persons Mental Health Services' staffing requirements and to other potential consumers of the Older Persons Mental Health Inpatient Unit.

SUICIDE IN JURISDICTIONS ACROSS AUSTRALIA

6.3 The Australian Bureau of Statistics' combined data for five years allows a comparison of suicide rates across the States and Territories. Figure 6.1 below

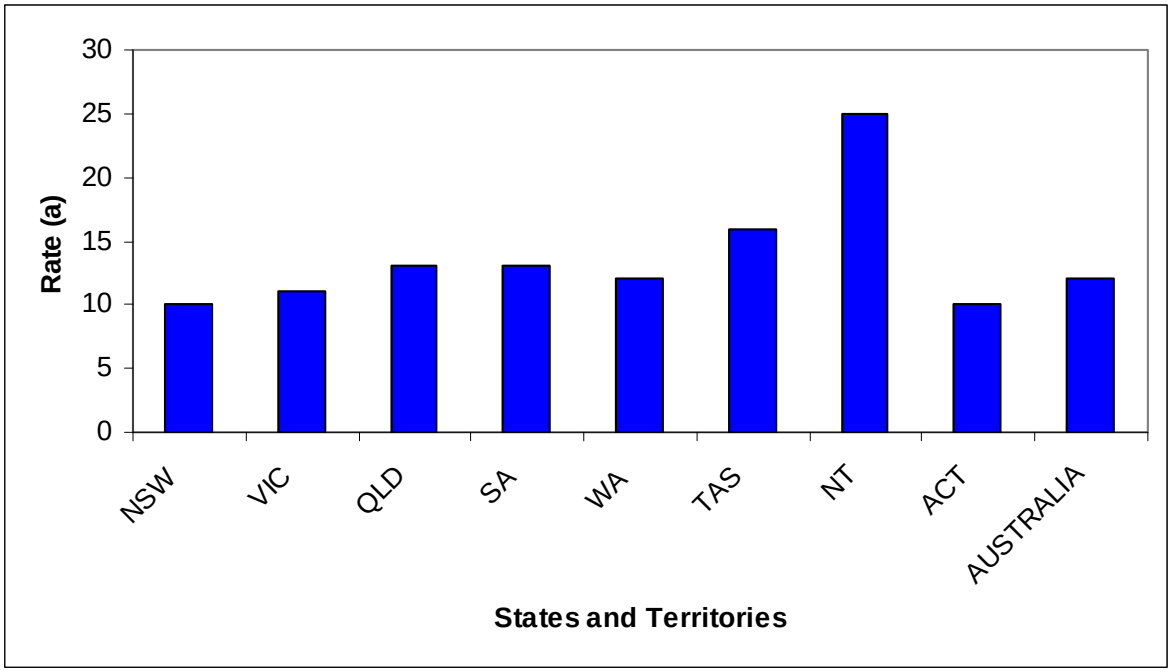
[65] http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/national-suicide-prevention-strategy-1 [Accessed 2 August 2010].

[66] Ibid.

[67] http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/national-suicide-prevention-strategy-1 [Accessed 2 August 2010].

illustrates age-standardised suicide rates for the States and Territories using the most recent five years of data, registration years 2001 to 2005 combined.

Figure 6.1: Suicide by State and Territory 2001—2005



Source: ACT Auditor-General's Office recreation of the original bar graph from the Australian Bureau of Statistics.

(a) Age-standardised rate per 100,000. Standardised using direct method and estimated resident population for Australia (persons) at 30 June 2001 as standard population.

6.4 For this period, high rates of suicide were evident in the Northern Territory (more than double the national rate), followed by Tasmania (39 percent above the national rate) and Queensland and South Australia (14 percent above the national rate). New South Wales, Victoria and the ACT all had lower rates than the national rate.[68]

ACT HEALTH'S INITIATIVES ON SUICIDE PREVENTION

6.5 ACT Health has a number of initiatives to help prevent suicide in the community that include:

- *Building a Strong Foundation*, the agency's framework for promoting mental health and wellbeing in the ACT for 2009—2014; and
- *Managing the Risk of Suicide*, the agency's suicide prevention strategy for the ACT for 2009—2014.

6.6 ACT Health recently conducted its 'Let's Talk' Suicide Prevention Campaign from 16 August to 12 September 2010. The Campaign aimed to:

- raise awareness about suicide and suicide prevention for residents of the ACT;

[68] http://www.abs.gov.au/ausstats/abs@.nsf/mf/3309.0 [Accessed 31 May 2010].

- provide information about where residents of the ACT can obtain assistance if they, or someone they know, is at the risk of suicide; and
- reduce the stigma associated with suicide.[69]

6.7 Further, ACT Health has a breadth of internal documentation, including policies that provide guidance to its relevant staff on the treatment and care of consumers with suicidal behaviour, and detailed clinical processes and documentation that need to be followed.[70]

ACT policy and guidance on suicidal behaviour

6.8 MHACT staff, including the OPMH Community Team, is required to treat every suicide attempt as a significant and imminent threat.[71] ACT Health's current policy on suicidal behaviour, *Treatment and Care of Consumers with Suicidal Behaviour* of June 2010, provides extensive guidance on procedures and protocols in managing consumers with possible suicidal behaviour. The roles and responsibilities of clinical staff tasked with the assessment and treatment of consumers with suicidal behaviour are clearly identified. A mandatory task that needs to be undertaken by MHACT staff is the 'suicide risk assessment'. This is conducted when a consumer presents or phones with suicidal behaviour/deliberate self harm, or when a third party presents or refers suicidal behaviour.

Assessment of older persons who are at the risk of suicide are not conducted consistently

6.9 Audit examined OPMHS' assessment of older persons who are at the risk of suicide. MHACT's old and new policies on suicidal behaviour state that,

> All consumers with suicidal or possible suicidal behaviour have a responsive, evidence based intervention that will attempt to minimise any harm and provide the maximum appropriate support. The intervention **must** include an assessment, risk rating and the development of a recovery plan, all to be clearly documented in the clinical record.[72]

6.10 Further, MHACT's policy states that its purpose is:

> to provide a basis for ensuring that regardless of the context, the management of consumers with possible suicidal behaviour, must be integrated and coordinated across health services.[73]

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69 <http:www.health.gov.act.au/suicideprevention> [Accessed 23 August 2010].

70 These include the old and new policy on *Suicidal Behaviour: Treatment and care of Consumers with Suicidal Behaviour Policy* (issued in August 2008), *Suicidal behaviour: Treatment and Care of Consumers with Suicidal Behaviour Policy* (issued in June 2010), Policy: Clinical Care Review (issued in July 2008), and the Mental Health ACT Clinical Processes and Documentation, 3rd edition (still under review at the time of audit).

71 ACT Health, Mental Health ACT Policy, *Suicidal behaviour: Treatment and Care of Consumers with Suicidal Behaviour Policy,* June 2010.

72 ACT Health Mental Health ACT Policy, *Suicidal behaviour: Treatment and Care of Consumers with Suicidal Behaviour Policy*, June 2010

73 Ibid.

Audit found that inconsistent practices were adopted when conducting suicide risk assessments for older persons who were referred, or presented themselves, to OPMHS.

6.11 Audit examined 56 individual files/cases that were referred or presented to OPMHS. Of the 56 consumers, 21 (38 percent) exhibited suicidal tendencies or behaviour, that is, the consumer explicitly stated that he/she 'wanted to die', or had just harmed himself/herself physically (that is, inflicted several cuts on his/her wrist etc) prior to the referral. Of these 21 cases, Audit found inconsistencies in OPMHS' practices in conducting suicide risk assessments,

- only 11 (52 percent) of the 21 cases had suicide risk assessments conducted;
- eight (38 percent) had no suicide risk assessment at all; and
- two cases (nine percent) had incomplete suicide risk assessments, that is, no suicide risk ratings were provided.

6.12 As discussed in paragraphs 6.8 and 6.9 above, and as illustrated in MHACT's policy documents, conducting the 'suicide risk assessment' and the allocation of an appropriate risk rating are obligatory tasks for all clinical staff, working within or outside MHACT settings, where staff provide services.[74] This includes the OPMH Community Team. Suicide risk assessments need to be conducted, and appropriate risk ratings allocated and documented to ensure that:

- a consistent approach is adopted to all consumers of OPMHS;
- the right interventions and treatments are provided to consumers with suicidal behaviour; and
- the provision of service to the consumer is integrated and coordinated across all health services in the ACT.

Recommendation 13

ACT Health should:

a) ensure that suicide risk assessments are conducted consistently across Older Persons Mental Health Services, and that risk ratings are allocated accordingly; and

b) regularly monitor the implementation of the suicide risk assessments.

THE OLDER PERSONS MENTAL HEALTH INPATIENT UNIT

6.13 In 2001, the OPMHS established a partnership with Morshead Hostel (now known as Morshead Home) to provide 10 low-level care beds for the long term older consumers with mental health illnesses.[75] These people were case managed by the OPMH Community Team. Currently, there are just four OPMHS consumers

[74] ACT Health Mental Health ACT Policy, *Suicidal behaviour: Treatment and Care of Consumers with Suicidal Behaviour Policy*, June 2010, pp. 1 and 6.

[75] ACT Health's objective in setting-up the OPMHIU is to provide interdisciplinary assessments and a comprehensive range of multidisciplinary treatment for mental health disorders in the elderly.

remaining at Morshead Home and no new consumers will take those places if existing consumers leave or pass away.

6.14 With the growing demand for a psychogeriatric inpatient unit in the ACT, the OPMH Inpatient Unit was established at Calvary Hospital. It opened in March 2007, and provides inpatient services for up to 20 people aged 65 years and over. The OPMH Inpatient Unit is a partnership between Calvary Health Care and Mental Health ACT.

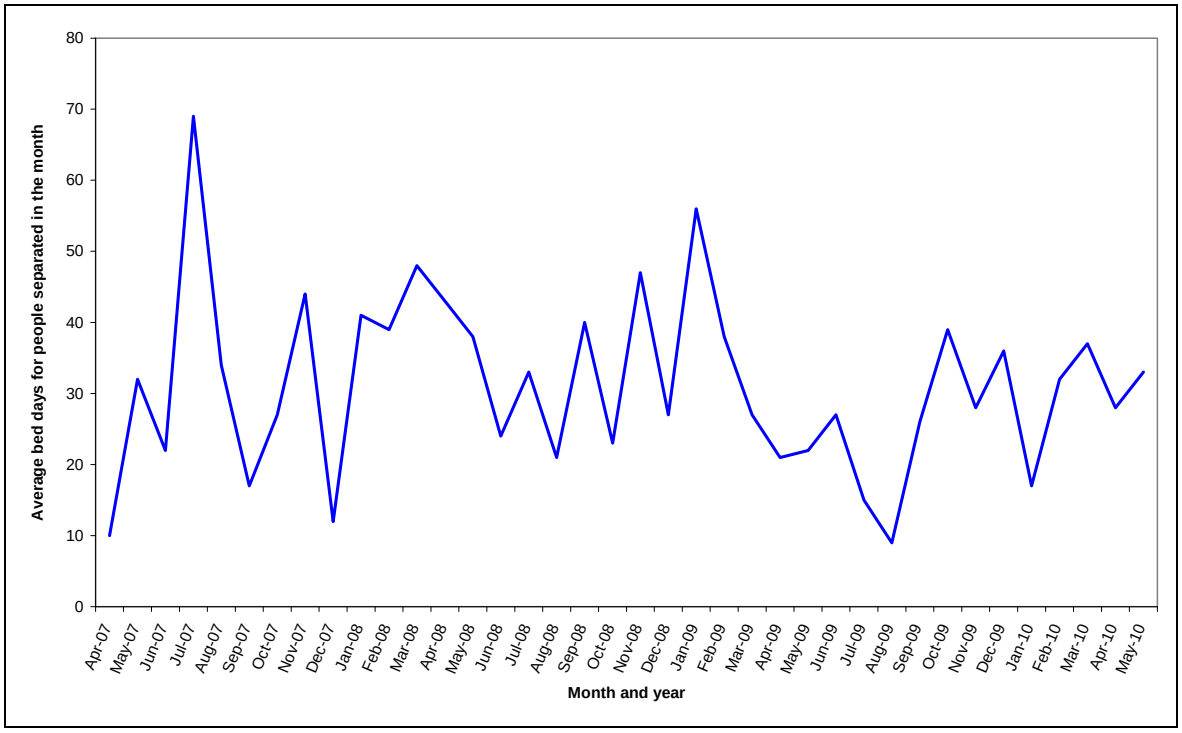
6.15 Audit examined the referral process and relationship between the OPMHS and the OPMH Inpatient Unit. Audit found that, currently, as both services are co-located at Calvary Hospital, the referral and communication linkages are efficient and seamless. However, Audit was advised of concerns that these linkages may falter once the OPMH Community Team is physically separated from the Inpatient Unit. Audit understands that plans are underway to create two older persons mental health community teams, possibly one in the northside of Canberra and the other in the southside. To ensure the effective linkage between the OPMH Community Team and the OPMH Inpatient Unit, it is important for ACT Health to consider any potential impact of the physical locations of the community teams.

6.16 Audit was also advised of issues regarding *admission blocks*. In ACT Health's Older Persons Mental Health, an *admission block* is characterised by an extended stay above the expected length of stay due to complex physical, behavioural and psychological presentations and to the inability to access appropriate placement. Delays in discharging patients from the Inpatient Unit are caused by a number of reasons that include, among others:

- the lack of GPs who can, or are willing to, visit consumers in the nursing homes when they get discharged (this is a pre-condition before a patient is discharged from the Inpatient Unit);
- delays in guardianship decisions and/or hearings. This also causes delays in referring consumers to other facilities who can service them better in the long term.

6.17 One consequence of delaying the discharge of consumers from the OPMH Inpatient Unit is that other consumers in the community who may need immediate mental health assistance or treatment may be turned away. To examine whether the OPMH Inpatient Unit was being used as an acute unit, and not as a long stay unit, Audit analysed the 'length of stay' of patients. Figure 6.2 on the following page illustrates the average bed days for people separated during the months of July 2007 to May 2010.

Figure 6.2: Average bed days for people separated in the month, July 2007 to May 2010



Source: ACT Auditor-General's Office using data from ACT Health.

6.18 The OPMH Inpatient Unit activity, specifically the 'number of separations and occupied bed days on separation by month' is closely monitored by ACT Health. However, as shown in Figure 6.2 above, the average stay of patients in the OPMH Inpatient Unit has been exceeding 30 days, and there have been instances where a consumer of the OPMH Inpatient Unit stayed for a long period of time, that is, several months at a time. In particular, Audit found an example of a consumer who could not be 'referred on' and was staying at the OPMH Inpatient Unit for at least six months.

6.19 The issue of *admission blocks* and its likely impact on staffing requirements and on incoming patients/consumers of the OPMH Inpatient Unit need to be assessed. There was no evidence of ACT Health developing strategies to effectively address these issues.

Recommendation 14

ACT Health should:

a) analyse and report on the impact of *admission blocks* on staffing requirements, and on other potential consumers of the Older Persons Mental Health Inpatient Unit; and

b) use the information to effectively manage *admission blocks*.

7. MONITORING AND REVIEW PROCESSES

INTRODUCTION

7.1 Monitoring and review of services delivered is a fundamental element of sound governance and quality management. It informs management decisions and contributes to improvements of service delivery.

KEY FINDINGS

- In general, the Older Persons Mental Health Services had good processes in place to monitor and review its consumers. The Older Persons Mental Health Community Team routinely conducted clinical meetings where new referrals are presented and allocated, and feedback on current cases was discussed.
- However, the Older Persons Mental Health Services did not consistently conduct the required three-monthly reviews of long term consumers.
- There was no assurance that all mandatory tasks were being undertaken by the Older Persons Mental Health Community Team, particularly when unplanned staff leave occurred.
- ACT Health closely monitored and reported on its 'accountability indicators', which provide an accurate picture of the patient activity, accommodation rates and others. However, the monitoring and reporting of 'outcome measures' were inadequate. The Older Persons Mental Health Community Team did not fully comply with the implementation and use of outcome measures relevant to the Older Persons Mental Health Services.

QUALITY MANAGEMENT

7.2 Quality management relating to mental health services is conducted by Mental Health ACT's Service and Sector Development, a new program under Mental Health ACT that was created in February 2010. One of its key components is quality improvement, where clinical audits are conducted, which provides assurance regarding 'accreditation compliance' to the *National Standards for Mental Health* and the *Australian Council of Health Standards*. The Service and Sector Development also looks into reporting and analysis; workforce development; safe practice and environment; service and practice standards and capacity building. Audit considers the Service and Sector Development Program is a good framework to ensure that quality of services, particularly clinical services, are monitored, reviewed and reported to ACT Health management.

7.3 The Service and Sector Development Program also produces 'Clinical Documentation Audit Reports' that provide an indication of an increase or decrease in the standards of documentation as implemented by various mental health services within ACT Health. Audit examined the findings of the recent 'Clinical Documentation Audit Report', dated July to December 2009, relating to 'Adult Community and Older Persons Mental Health Services'. An area of concern identified in the report was that the documentation of risk assessment by OPMHS had decreased by 40.1 percent. This is consistent with the weaknesses

identified by Audit, as discussed earlier in Chapter 6, regarding the conduct of suicide risk assessments. Audit considers that findings in the report should be taken account when developing business or strategic plans for the OPMHS.

Individual consumer monitoring and review

7.4 In general, the OPMHS has good processes in place to monitor and review its consumers. For example, the OPMH Community Team conducted clinical meetings where new referrals are presented and allocated, and feedback on current cases is discussed. Audit observed this process, in both morning intake meetings and in multidisciplinary team review meetings. Audit found that the monitoring and review of consumers were undertaken as stipulated in the OPMHS clinical guidelines.

7.5 Reminders are also provided by the administration staff or the Team Leader of the OPMH Community Team to ensure that the monitoring and review of individual consumers allocated to individual clinicians or case workers are conducted regularly. However, there is a risk that if reminders are not made, then the monitoring and review will not occur. As discussed earlier, some members of the OPMH Community Team acknowledged that at times, due to resource constraints, they were not able to monitor or follow-up consumers for weeks.

Three-monthly reviews of consumers require closer monitoring

7.6 Guidance relating to consumer review that applied at the time of audit is stipulated in The *National Standards for Mental Health Services.* Standard 11.3.17 states that:

> All active consumers, whether voluntary or involuntary, are reviewed at least every three months. The review should be multidisciplinary, conducted with peers and more experienced colleagues and recorded in the individual clinical record.[76]

7.7 The new *National Standards for Mental Health Services* of September 2010 provide current guidance on three-monthly reviews that need to be conducted. Standard 10.4.6 states that:

> The MHS conducts assessment and review of the consumer's treatment, care and recovery plan, whether involuntary or voluntary, at least every three months (if not previously required).

When the OPMH Community Team was fully staffed, three-monthly reviews were conducted consistently. However, when members of the OPMH Community Team left or went away for a period of time, the reviews were not conducted as regularly.

7.8 Audit conducted random tests using MHACT's information collection system to determine whether three-monthly reviews were undertaken consistently. Audit found that:

- when the Team Leader role was occupied permanently, three-monthly reviews of consumers were conducted 100 percent of the time; however

[76] Australian Health Minister's Advisory Council, *National Standards for Mental Health Services,* January 1997, p. 32.

- when the Team Leader role was filled-in temporarily, or when a senior member, such as a Psychiatrist, of the OPMH Community Team was away on leave, the three-monthly reviews were not conducted regularly. Audit noted, for example, that three consumers of OPMHS had not been seen for three months. This will increase the risks of appropriate care not being provided and timely action not being taken to assist consumers.

7.9 The following case studies illustrate two examples of consumers that have not had three-monthly reviews as at 2 September 2010.

Case Study 7.1 70 year old man who has bipolar disorder

Mr A is a known consumer to OPMHS. He was initially referred to OPMHS in November 2006. A year later, he was diagnosed with 'bipolar affective disorder, current episode mixed'. He has been in and out of the Older Persons Mental Health Inpatient Unit. Mr A's last case review was in May 2010, where he was recommended for 'ongoing case management'. Mr A has not been seen for three months.

Case Study 7.2 80 year old woman who has dementia in Alzheimer's disease

Mrs B is also a known consumer to OPMHS. She was initially referred to OPMHS in April 2007. In July 2009, she was diagnosed with 'dementia in Alzheimer's disease, atypical or mixed type'. Her last case review was in June 2010, where a recommendation was made for case closure. Mrs B's case has not been closed and her case file has not been reviewed for three months.

Source: Extracted from Mental Health ACT's information collection system, MHAGIC.

7.10 Recently, Audit was advised that a full-time, permanent Team Leader for the OPMH Community Team has been recruited. However, when team members go on unplanned leave or are absent from work, there is no assurance that all of his/her responsibilities will be taken over by another team member. Team members who fill-in are still required to fulfil their own job functions, expected to perform multiple roles or tasks, in a resource-constrained environment.

7.11 Closer monitoring by management in these circumstances is crucial to ensure that key functions are being performed and adequate services are still being delivered. Closer monitoring will also provide assurance to management that staff members who are performing multiple tasks are not fatigued or burnt-out.

Recommendation 15

ACT Health should:

a) consistently conduct the required three-monthly reviews for all long term Older Persons Mental Health Services' consumers;

b) monitor the three-monthly reviews; and

c) provide support to the Older Persons Mental Health Community Team, particularly when there is unplanned staff leave, to ensure that all mandatory tasks are being undertaken.

PERFORMANCE INFORMATION

7.12 The collection of performance information provides ACT Health management with the ability to monitor progress in its delivery of mental health services. It also assists in assessing whether outcomes, outputs and targets are achieved, and determining any changes that need to be made.

7.13 ACT Health's 'accountability indicators', or performance indicators, for mental health services include:

- cost weighted separations;
- admitted patient separations;
- adult services;
- children and youth services;
- older persons services;
- psychogeriatric services bed days;
- psychogeriatric inpatient episodes of care;
- supported accommodation bed occupancy rate;
- proportion of clients seen at an ACT Health community facility during the seven days post discharge from the inpatient services; and
- percentage of clients with outcome measures completed.[77]

7.14 Audit found that ACT Health closely monitors and reports on its 'accountability indicators' that provide a picture of the patient activity, accommodation rates and others. However, the monitoring and reporting of outcome measures have been an issue that ACT Health has been trying to resolve.

[77] ACT Health Budget Paper No. 4, p. 227

Outcome measures

What they are and why they are important

7.15 The Australian Government has supported the establishment of a standardised system for the regular, routine monitoring of consumer outcomes. This has been the focus of extensive activity in State and Territory-funded mental health services. The goal has been to develop standard measures of a clinical status and functioning, and apply these at entry to, and exit from, care. This enables change to be measured. For consumers who require longer term care, the measures are applied at three monthly review points.[78]

7.16 Outcome measures provide perspectives from both the clinician and the consumer/carer, as to whether mental health services are effective in achieving improvements to consumers' wellbeing.[79] The purpose of measuring clinical outcomes is to see whether consumers of public mental health services are getting better as a result of the services they receive.[80]

7.17 In December 2003, the Australian Government established the Australian Mental Health Outcomes and Classification Network (AMHOCN) to provide leadership to the mental health sector to support the sustainable implementation of the outcomes and case mix collection as part of routine clinical practice.[81] Routine measurement of consumer outcomes is now in place in an estimated 85 percent of public mental health services and 98 percent of private hospitals. Over 12,000 clinicians have received training.[82]

OPMHS' uptake of outcome measures

Poor uptake requires management to communicate the importance of outcome measures

7.18 ACT Health advised that training on outcome measures has been conducted across all Mental Health ACT services, including the Older Persons Mental Health Services. The Australian Mental Health Outcomes and Classification Network (AMHOCN) has provided training materials including online web training for clinicians.[83] Training materials and resources have been provided to all mental health teams and services across Mental Health over a long period of time. Further, a specialist consultant was engaged to train all mental health staff on outcome measures. However, Audit found that with OPMHS, there was generally a low uptake of outcome measurement, as discussed below.

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78 Council of Australian Governments (COAG) National Action Plan on Mental Health – Progress Report 2008—09, pp. 27-29.

79 Ibid.

80 ACT Health Annual Report 2008—09, p.83.

81 < http://amhocn.org> [Accessed 16 August 2010].

82 Council of Australian Governments (COAG) National Action Plan on Mental Health – Progress Report 2008-09, pp. 27-29.

83 The Australian Mental Health Outcomes and Classification Network (AMHOCN) was established by the Australian Government in December 2003 to provide leadership to the mental health sector to support the sustainable implementation of the outcomes and casemix collection as part of routine clinical practice.

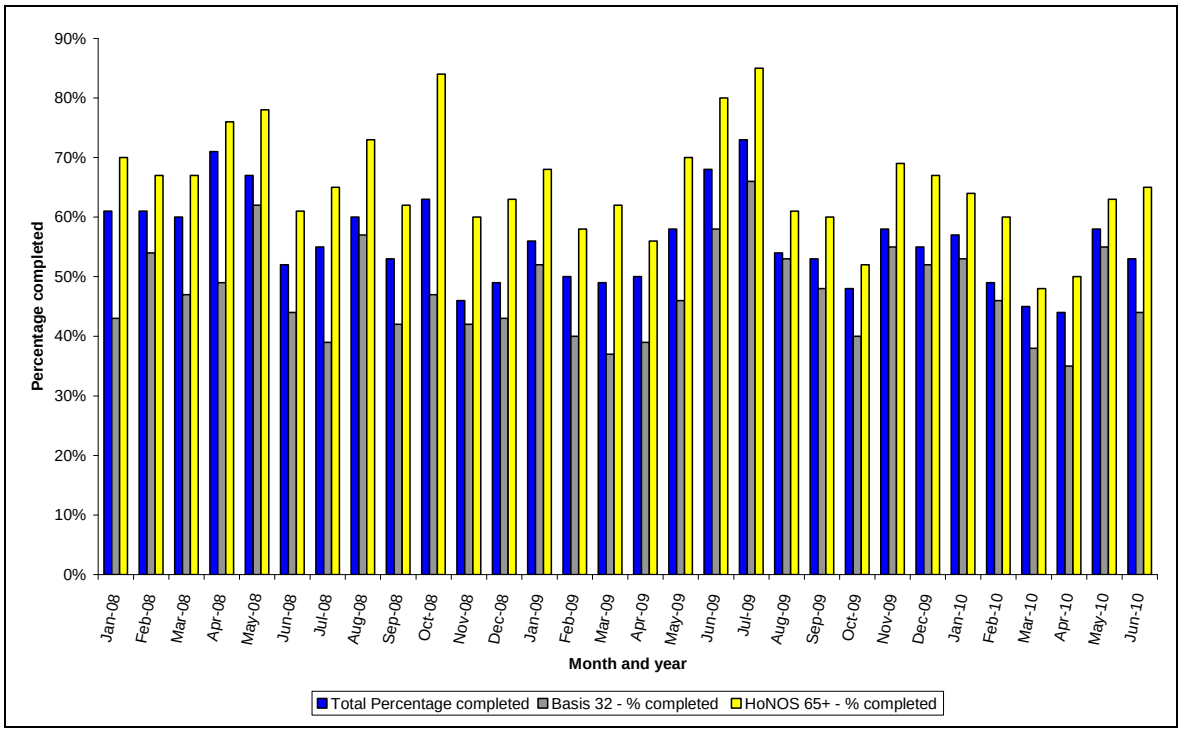
7.19 MHACT reports on the percentage of consumers with outcome measures completed. Its target for 2008–09 was 65 percent, with actual results of 72 percent. ACT Health reported that increased collections have occurred due to the focus on training and inclusion of outcome measures incorporated into recovery planning and multidisciplinary team reviews.[84]

7.20 Outcome measures that have been collected by the OPMHS include:

- *BASIS 32* – Behaviour and Symptom Identification Scale, where there are 32 queries;
- *Focus of care* – Clinicians are asked to identify which one of the four types of care focus (that is, either acute, functional gain, intensive extended or maintenance) best describes the goals of care provided to a consumer over the episodes of care;
- *HoNOS* – Health of the Nation Outcome Scales ;
- *HoNOS 65+* – Health of the Nation Outcome Scales for 65 years and over;
- *LSP16* – Life Skills Profile, a 16 question version; and
- *Primary Diagnosis*.

7.21 ACT Health, through its internal website, provides guidance on outcome measures that are mandatory. For OPMHS, compulsory measures are: HoNOS 65+ and BASIS 32. Audit analysed the outcome measures collected by OPMHS from January 2008 to June 2010, as shown in Figure 7.1.

Figure 7.1: Collection of outcome measures by OPMHS, January 2008 to June 2010



Source: ACT Auditor-General's Office using data from ACT Health

[84] ACT Health Annual Report 2008—09, p.83.

7.22 As illustrated in Figure 7.1, the uptake of outcome measurement by OPMHS was below, or just within, ACT Health's target. In particular, the average rate of total outcome measures collected over the two and a half year period was only 55 percent. In general, this is a poor uptake compared to the agency-wide target (65 percent) and actual result (72 percent) reported in 2008-09. The average rates for the mandatory outcome measures, BASIS 32 and HoNOS 65+, are 48 percent and 65 percent respectively.

7.23 Although BASIS 32 is a mandatory outcome measure, it is self-reported by consumers. Hence, the low reporting rate could mean that the consumer is reluctant to self-report or the clinician does not understand or see the importance of collecting the information. Some members of the OPMH Community Team viewed the outcome measures as an added burden to their numerous tasks. Most have acknowledged that they did not complete the outcome measures.

7.24 The ACT Health information collection system, MHAGIC, generates alerts or prompts on OPMHS consumers that have not had outcome measurements. As an example, case studies 5.1 and 5.2 cited above had alerts/prompts that outcome measures have not been undertaken for those consumers.

7.25 ACT Health advised that the uptake of outcome measures as reported (or as extracted) from MHAGIC is not accurate. Inconsistencies exist and technical issues are still being resolved. The agency is in the process of negotiating and planning for a system upgrade that could better reflect and report uptake of outcome measures.

7.26 In the Council of Australian Government's (COAG's) 2008—09 Progress Report on the National Action Plan for Mental Health, outcome measurement across Australia still represents a 'work in progress' that is considered imperfect and incomplete due to the following:

- the main outcome measurement tools being used describe the condition of the consumer from the clinician's perspective and do not address the 'lived experience' from the consumer's viewpoint;
- the uptake by public sector services is relatively low; and
- there are some technical and conceptual issues that remain unresolved.[85]

7.27 Nevertheless, the ACT Government is still part of a continued Government collaboration required to support the further development of the national approach to measuring and reporting mental health consumer outcomes. The OPMHS' uptake of outcome measures can be improved. Management needs to instil its importance, and adequate training and support be provided to ensure an improved uptake of outcome measurement.

[85] Council of Australian Governments (COAG) National Action Plan on Mental Health – Progress Report 2008-09, pp. 27-29.

Recommendation 16

ACT Health should:

a) ensure that the Older Persons Mental Health Community Team comply with the implementation and use of all outcome measures relevant to the Older Persons Mental Health Services; and

b) enhance the current system to accurately report on mental health outcome measures.

APPENDIX A: AUDIT CRITERIA, APPROACH AND METHODOLOGY

AUDIT CRITERIA

The efficiency and effectiveness of ACT Health's delivery of mental health services to older persons in the community were assessed against the following criteria:

Appendix Table 1: High-level criteria and sub-criteria statements

High-Level Criteria	High-Level Sub-Criteria Statements
1. Are Older Persons Mental Health Services effective?	• There is an adequate assessment of older persons mental health needs. • There are education and public awareness programs – adequate and reliable information is provided. • Older Persons Mental Health Services are available and accessible. The services are available when needed and can be reached by those who need it. • Response (or turnaround times) is timely and is reflective of consumer's needs. • There is co-ordination and integration of Older Persons Mental Health Services. Protocols are established, the referral service works, and there is a smooth transition.
2. Are Older Persons Mental Health Services efficient?	• Older Persons Mental Health Services provided to the community are cost-efficient. There is sufficient, adequate funding, and it is allocated according to the needs or requirements of the consumers. • Older Persons Mental Health Services provided to the community is time-efficient. • There is enough staff or workforce across the Territory to meet the demands of older persons with mental health needs. The workforce/staff are qualified and are adequately trained.
3. Is there continuous monitoring and evaluation of Older Persons Mental Health Services?	• There is a feedback mechanism in place. Relevant information is collected or gathered for future use. Feedback is recorded, assessed, and reported accordingly. • There is regular monitoring of mental health services provided to older persons by external stakeholders (that is, community groups, NGOs etc). • Assessment techniques are evaluated, and are current to reflect latest developments in mental health services. • There is a quality assurance mechanism in place.

AUDIT SCOPE

The audit examined the availability, adequacy and responsiveness of the OPMHS to meet the needs of the ACT community. In particular it examined:

- the assessment and management for older persons experiencing mental health problems;
- the referral process to generic aged care service providers, where needed;
- consultation and liaison services with external stakeholders;
- dissemination of information on aged mental health issues;
- risk assessment processes in place for older persons who are at the risk of suicide; and
- the 'stakeholder engagement' between ACT Health (through Mental Health ACT) and other external organisations such as community groups, non-government organisation and professional bodies.

The following topics are not included in this Audit:

- the quality of individual clinical care provided to older persons;
- the quality of clinical diagnoses or treatments provided to older persons;
- the broader ACT mental health service system;
- the National Health and Hospitals Network and its impact to the Territory; and
- services provided within the Older Persons Mental Health Inpatient Unit.

AUDIT APPROACH AND METHODOLOGY

The performance audit was conducted under the authority of the *Auditor-General Act 1996*, and in accordance with the principles, procedures, and guidance contained in Australian auditing standards relevant to performance auditing. These standards prescribe the minimum standards of professional audit work expected of performance auditors. Of particular relevance is the professional standard on assurance engagements - *ASAE 3500 Performance Engagements*.

The audit approach and methodology consisted of:

- interviewing ACT Heath and Mental Health ACT staff and external stakeholders, and reviewing files and document. This includes quantitative and qualitative analysis of strategies and plans, response times, financial data and reports, procedural guidelines, service standards, case studies, quality reporting system data, complaints and compliments data or feedback mechanisms in place, performance reports, monitoring tools and internal or external reviews;
- conducting focused discussions with relevant stakeholders to support an independent assessment of ACT Health and Mental Health ACT's delivery of mental health services to Older Persons, and to obtain feedback on the adequacy of these services;

- reviewing information on response or turnaround times, appropriateness of response or turnover and the outcomes (for example, a referral to the Older Persons Mental Health Inpatient Unit); and
- applying industry-recognised best practices, standards or benchmarks, the Commonwealth's best practices, and 'lessons learnt' from other States and Territories, where relevant.

APPENDIX B: LIST OF EXTERNAL STAKEHOLDERS CONSULTED

The ACT Auditor-General's Office would like to acknowledge the following external stakeholders who were consulted during the audit, and extends its appreciation for their co-operation, participation and contribution.

EXTERNAL STAKEHOLDERS CONSULTED

- ACT Mental Health Consumer and Carer Caucus;
- Baptist Community Care Centre;
- Belconnen Community Service;
- Carers ACT;
- Council on the Ageing (COTA) in the ACT;
- Dementia Behaviour Management Advisory Service (DBMAS) Alzheimer's Australia;
- Mental Health Community Coalition;
- Mental Health Consumer Network;
- Morshead Home;
- Northside Community Services; and
- Public Advocate of the ACT;

APPENDIX C: COMMONWEALTH HEALTH REFORMS

A number of recent Commonwealth health reforms will affect the delivery of mental health services to older persons in the Territory.

On 3 March 2010, the Commonwealth Government announced the structural health reform, the *National Health and Hospitals Network (*the *Network).* The *Network* is aimed at putting Australia's health care system on sustainable funding basis and implement major improvements in the frontline delivery of health care to Australians. The *Network* will be funded nationally and will run locally.[86]

For the first time, the Commonwealth Government will:

- guarantee that there will be no long 'waiting times' for elective surgery;
- a four hour National Access Target will be established for hospital emergency departments;
- personalised care for patients with one of Australia's most common chronic diseases, that is diabetes; and
- will assume full responsibility for aged care following immediate improvements to help older Australians and their families better navigate the aged care system.[87]

The Council of Australian Governments notes in the *National Health and Hospitals Network Agreement* of April 2010 *(*the *Network Agreement)* that the reforms are intended to be implemented from 1 July 2011. For a seamless transition, a clear delineation of roles and responsibilities for both States and Territories and the Commonwealth is required. In April 2010 and with the exception of Western Australia, all States and Territories agreed to the *Network* and signed the *Network Agreement*. These responsibilities comprise both funding responsibility and policy responsibility.

The *Network Agreement* lists the responsibilities of the Commonwealth and States and Territories that include GP and primary health care services. One of the 'GP and primary health care services' that will be transferred to the Commonwealth and most relevant to this audit is the 'primary mental health care services which target the more common mild to moderate mental illnesses'.

At the time of audit, it was unknown what 'primary health care services' and specifically, what particular 'primary mental health care services' will be included or excluded from the transfer of responsibilities to the Commonwealth. Under the *Network Agreement*, Tasmania was given the responsibility to provide guidance as to what will (and will not) entail 'primary mental health care services'. It is expected that Tasmania will provide the definition to COAG on 31 December 2010. Audit was advised by the Commonwealth's Department of Health and Ageing that the general definition of 'primary health care services' is still being negotiated between the Commonwealth and the States and Territories.

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[86] http://www.health.gov.au [Accessed 31 May 2010].

[87] Australian Government, *A National Health and Hospitals Network: Further Investments in Australia's Health,* 2010.

AUDIT REPORTS

Reports Published in 2010-11	
Report No. 8 / 2010	Delivery of Mental Health Services to Older Persons
Report No. 7 / 2010	Management of Feedback and Complaints
Report No. 6 / 2010	Annual Report 2009-10
Report No. 5 / 2010	Delivery of ACTION Bus Services
Reports Published in 2009-10	
Report No. 4 / 2010	Water Demand Management: Administration of Selected Initiatives
Report No. 3 / 2010	Delivery of Budget Initiatives
Report No. 2 / 2010	Student Support Services for Public High Schools
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