Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF AUDITOR-GENERAL OF VICTORIA

1. I, Andrew Greaves, Auditor-General, of The Victorian Auditor-General's Office, Level 31, 35 Collins Street, Melbourne, VIC 3000, say as follows:

Background

Background and experience, including qualifications

2. I have over 30 years' experience in public sector external and internal audit at the federal, state and local government levels. Before my appointment as Auditor-General of Victoria I was the Auditor-General of Queensland from 2011 to 2016. Prior to that, from 2003 to 2011, I held various roles at the Victorian Auditor-General's Office (VAGO), including Assistant Auditor-General, Performance Audit; and Assistant Auditor-General, Financial Audit.

3. I am a Fellow of both CPA Australia and the Institute of Chartered Accountants Australia and New Zealand. I hold a Bachelor of Economics degree from the Australian National University.

Current role and responsibilities.

4. I am the Auditor-General of the State of Victoria. I was appointed in September 2016.

5. The Auditor-General is an independent officer of the Victorian Parliament appointed to provide assurance to Parliament and the Victorian community about how effectively public sector agencies are providing services and using public money.

The role of the Auditor-General (and his or her office):

(a) status as a statutory appointee

6. The Auditor-General is appointed under section 94A of the *Constitution Act 1975*. The *Constitution Act 1975* places conditions on the Auditor-General's appointment, including that the Audit-General must take an oath of office before the Executive Council before undertaking the duties of the office.

(b) relationship with Parliament including interactions with the Public Accounts and Estimates Committee

7. The Auditor-General is accountable to the Victorian Parliament through the Public Accounts and Estimates Committee (PAEC). I must consult the PAEC when developing my annual plan and annual budget. The annual plan outlines the proposed financial and performance audit work program for the coming year that is to be delivered by the Victorian Auditor-General's Office.

8. I must also consult PAEC when developing the objectives and scope for particular performance audits:

    i. collaborative audits

    ii. audits that were not listed in my Annual Plan

iii. 'follow-the-dollar' performance audits

iv. when PAEC requests it be consulted

v. when the performance audit appears in my annual plan and is subject to a material change to the objectives of the audit, the entities included in the audit, or the particular issues (if any) to be considered.

9. The Auditor-General must report to PAEC on assurance reviews – a new function recently enabled through amendments to the *Audit Act 1994*.

10. In addition, PAEC:

i. may alter the annual reporting obligations of the Auditor-General or VAGO

ii. recommends the Auditor-General's appointment

iii. recommends a suitably qualified person to conduct an annual independent financial audit of VAGO

iv. recommends a suitably qualified person to conduct an independent performance audit of VAGO every four years.

(c) independence from the executive arm of government

11. The *Constitution Act 1975*, section 94B establishes the Auditor-General's independence. It states:

> "The Auditor-General is an independent officer of the Parliament." and "...., the Auditor-General has complete discretion in the performance or exercise of his or her functions or powers and, in particular, is not subject to direction from anyone in relation to—
>
> (a) whether or not a particular audit is to be conducted;
>
> (b) the way in which a particular audit is to be conducted;
>
> (c) the priority to be given to any particular matter."

The purpose of a 'performance audit' under section 14(1) of the Act

12. The Act provides that a performance audit is undertaken to determine whether public bodies, or the operations or activities of the whole or any part of the Victorian public sector, are achieving their objectives effectively, economically and efficiently and in compliance with all relevant Acts.

13. Performance audits are carried out according to Standards on Assurance Engagements issued by the Auditing and Assurance Standards Board. ASAE 3500 *Performance engagements* provides that the objective of a performance audit is to obtain reasonable assurance about an activity's performance against identified criteria and to express a reasonable assurance conclusion in a written report.

14. Against this background the two primary purposes of a performance audit can be characterised as:

i. providing assurance to the Parliament and the public about the subject matter of the audit, so that Parliament can discharge its oversight responsibility of the Executive

ii. providing recommendations to the audited agencies to seek to improve deficiencies and weaknesses in operations identified during an audit.

Please confirm our understanding that, by convention, the Auditor-General does not comment on the merits of policy, but can conduct a performance audit to determine whether a government authority is implementing policy 'effectively, economically and efficiently, and in compliance with all relevant Acts'.

15. Response to 4. and 5. above

16. Section 63 of the *Audit Act 1994* specifically states that the Auditor-General must not question the merits of policy objectives of the Government in a report.

17. It is by convention that this explicit prohibition is extended to any public commentary by the Auditor-General.

Statement

18. VAGO has published two performance audits relevant to mental health in 2019: *Access to Mental Health Services*, Independent assurance report to Parliament, Parl Paper No 19, Session 2018-19 (March 2019) (the Access Report) and *Child and Youth Mental Health*, Independent assurance report to Parliament, Parl Paper No 36, Session 2018-19 (June 2019) (the CAYMH report).

19. Attached to this statement and marked 'AG-1' is a copy of the Access Report. Attached to this statement and marked 'AG-2' is a copy of the CAYMH report.

The Access Report

20. The objective of this audit was to determine if people with mental illness have timely access to appropriate treatment and support services.

21. We concluded overall that DHHS has done too little to address the imbalance between demand for, and supply of, mental health services in Victoria.

22. We found in substance:

i. a lack of sufficient and appropriate system-level planning, investment, and monitoring over many years

ii. the current 10 Year Mental Health Plan (the Plan) outlines few actions that demonstrate how DHHS will address the demand challenge that the 10-year plan articulates

iii. the priority reform areas identified in the Plan do not adequately reflect the underlying issue of lack of system capacity and, as a result, DHHS has made almost no progress in addressing the supply and demand imbalance

iv. there are few measures in the outcomes framework for the Plan that directly capture performance against providing access to services or increasing service reach

v. there is sufficient evidence that there are not enough mental health beds in Victoria to meet current, or future, demand

vi. advice from DHHS to government, supported by multiple DHHS-commissioned reviews, clearly articulates the existing funding and infrastructure gaps but DHHS's progress has been slow, and the most important elements of change such as funding reform, infrastructure planning, catchment area review, and improved data collection have only just, or not yet commenced

vii. DHHS has made little progress closing the significant gap between area mental health services' (AMHS) costs and the price they are paid by DHHS to deliver mental health services; and in addressing historical inequities in funding allocations that do not align to current populations and demographics

viii. the bed day costs of AMHSs are higher than the price DHHS pays, and the AMHSs do not receive the necessary funding to meet demand

ix. there are shortcomings in the data collection system including lack of functionality and low useability, which often results in duplication of data collection

x. DHHS's approach of approximating demand, gives rise to a significant risk that, without the inclusion of data from the triage system and unregistered clients, DHHS does not adequately capture the extent of mental health illness in the population and the true unmet demand for services

xi. Victoria's public mental health services are subject to an input-based funding model, which is not sensitive to unmet demand, the needs and complexity of the mental health services' client cohort, contemporary population data, nor demographic changes

xii. the introduction of activity-based funding in mental health services has been on the agenda in Victoria for over five years and, although some reform has been proposed, without an adequate quantum of funding (and the staff and infrastructure to deliver the services) there is risk that the intended outcomes will not be achieved.

The CAYMH Report

23. The objective of this audit was to determine whether child and adolescent mental health services effectively prevent, support and treat child and youth mental health problems. The audit focused on clinical mental health services for young people with moderate to severe mental health problems.

24. We concluded that not all Victorian children and young people with dangerous and debilitating mental health problems receive the services that they and their families need.

25. We found in substance:

i. Specialist child, adolescent and youth mental health services do not meet service demand or operate as a coordinated system

ii. There is no strategic framework to guide and coordinate DHHS or health services that are responsible for CYMHS

iii. Problems with the CYMHS performance monitoring system create oversight gaps for DHHS, which leaves it unable to address significant issues that require a system-level response

iv. DHHS does not sufficiently understand the CYMHS system and the challenges it faces. Its lack of understanding contributes to a climate of uncertainty and distrust, which inhibits systemic improvement and creates significant variability and inequity in the care that children and young people receive.

v. DHHS has predominantly taken a one-size-fits-all approach to the mental health system's design and monitoring, which does not adequately identify and respond to the unique needs of children and young people.

Root cause analysis

26. The recommendations made in both reports look to directly address and correct the issues we observed in our audits. These issues however are often symptomatic of some deeper causal problem.

27. For the purpose of my submission I have used these and other reports relating to DHHS, and my experience more generally, to analyse systemic factors that in my opinion contribute in some way to the present situation. To the extent that these systemic factors are found to be an initiating (or root) cause, they bear close consideration.

28. From this perspective I believe two matters warrant scrutiny:

    i. the role of DHHS (the department) in a devolved service delivery environment

    ii. performance measurement frameworks and systems.

The role of DHHS

29. DHHS is responsible for ensuring the delivery of good-quality health services to the community on behalf of the Minister for Health and the Minister for Mental Health. DHHS plans services, develops policy, and funds and regulates health service providers and activities that promote and protect the health of Victorians.

30. As system manager, DHHS has a responsibility to ensure service access by supporting the foundations of the system: funding, capital infrastructure and service distribution, and understanding demand and system performance to guide proper investment.

31. In the CAYMH audit we found that DHHS has not provided the strategic leadership necessary nor met the obligations of its role as a system manager—to set clear strategic directions and service expectations for CYMHS, to establish a transparent and equitable funding model, and to ensure service design supports the infrastructure and service accessibility that children and young people need.

32. DHHS has not identified priority populations for CYMHS nor enabled health services to prioritise access at the local level. DHHS advises that it is not its role to identify priority populations for CYMHS, but that individual health services in Victoria's devolved health system are responsible for managing access and any priority populations at the local level.

33. In both the Access and the CAYMH reports we observed variously 'a patchy and often reactive approach to system oversight'; 'no clear method for monitoring the performance of the CYMHS system within broader health service and mental health system performance monitoring and oversight'; 'no effective governance arrangements to provide oversight of CYMHS'; and 'a lack of routine, senior level oversight of, and reporting against, the 10-year plan within DHHS'.

34. The CAYMH Report found also that a lack of effective overarching governance has created a performance monitoring system which duplicates some performance monitoring but leaves oversight gaps in critical areas.

35. Problems with system leadership and service oversight have been recurring themes in past and more recent audits, and other pertinent reviews.

36. In our report on *Managing Private Medical Practice in Public Hospitals* - Parliamentary Paper No 39, Session 2018–19, June 2019 we observed that DHHS does not guide or oversee the development of private medical practice arrangements in public hospitals. It therefore does not know whether private practice is achieving its intended outcomes of attracting and retaining specialist medical practitioners and providing additional health services, as well as more revenue for services.

37. In our report on *Patient Safety in Victorian Public Hospitals* – Parliamentary Paper No. 149, Session 2014-16, March 2016 – we found that there have been systemic failures by DHHS, indicating a lack of effective leadership and oversight which collectively pose an unacceptably high risk to patient safety. Some of these issues were identified over 10 years ago in our 2005 audit (*Managing patient safety in public hospitals* – Parliamentary Paper No. 121, Session 2003-05, March 2005).

38. That these systemic issues have been evident for many years was notably also confirmed as part of the Review of Hospital Safety and Quality Assurance in Victoria chaired by Stephen Duckett (the Duckett report) *Targeting zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*:

> "6. The panel found that the department's oversight of hospitals is inadequate. It does not have the information it needs to assure the Minister and the public that all hospitals are providing consistently safe and high-quality care...
>
> 7. The department's overarching governance of hospitals is also inadequate…
>
> 8. Finally, the department's support of hospitals to discharge their responsibilities with respect to safety and quality improvement has been inadequate...
>
> 9. Our review is not the first to identify these problems. Since 2005 the Victorian Auditor-General's Office has conducted three performance audits on patient safety. The most recent found that the department is not effectively providing leadership or oversight of patient safety, is failing to adequately perform important statewide functions and is not prioritising patient safety. Some of the systematic failures noted in its 2016 audit were first identified over a decade ago in the 2005 audit."

39. These findings speak to an ingrained culture, developed and reinforced over two decades, of not fulfilling the responsibilities that properly pertain to a system manager – either they are understood and accepted but not acted on, or there remains debate and uncertainty as to what the proper role of the department is vis a vis health services.

40. In my view, where a coordinated system response is needed it is not appropriate to assign responsibility for such responses to individual health services. Further, it is incumbent on the system manager to understand what is happening – how are its policies, plans and their associated actions, being implemented and funding being applied; and what impact are they having? Both are necessary if the system owner is to obtain feedback about efficiency and effectiveness of service delivery, so as to be able to fully advise government and to inform investment decisions that meet government and legislated objectives.

Performance measurement

41. DHHS' mental health KPIs do not assess whether consumers are accessing appropriate mental health services or track the performance of their 10-year plan in terms of the access Victorians have to mental health services.

42. DHHS has aligned five of the mental health KPIs against the outcome related to access: whether the treatment and support that Victorians with mental illness, their family and carers need is available in the right place at the right time. Those KPIs include:

    i. Rate of pre-admission contact – reflecting whether the person is appearing for the first time to an acute facility

    ii. Rate of readmission within 28 days – indicating that the discharge from inpatient services may have been too soon, or the treatment or discharge planning may not have fully addressed the issue.

    iii. Rate of post-discharge follow-up – an important service to support transition back into the community

    iv. New registered clients accessing public mental health services (no access in the last five years)

    v. Proportion of consumers reporting the effect the service had on their ability to manage their day-to-day life was very good or excellent – indicating general consumer satisfaction with the outcomes of the care provided.

43. These indicators mainly assess whether the client received the right service, rather than whether they received it at the right time. While the indicator measuring new registered clients could show the system's capacity to support access, the information is presented as a percentage of total clients and does not give information on whether the numbers of new clients are growing.

44. As outlined in my report, KPIs that appropriately assess whether consumers can access mental health services at 'the right time' may include:

    i. wait times for services

    ii. the numbers of consumers declined or delayed service due to capacity constraints

iii. consumer-reported experience of service accessibility.

45. I note that the performance measurement framework used in the Report on Government Services (https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/approach/performance-measurement) provides for specific access indicators under both effectiveness (how easily the community can obtain a service) and equity (how well a service is meeting the needs of particular groups that have special needs or difficulties in accessing government services). Presently it reports among other metrics the proportion of mental health-related emergency department presentations seen within clinically recommended wait times.

46. Getting the right service performance indicators is only part of the equation. If they are to be used to drive strategy and evaluate the effectiveness of planned actions, they must have targets against which progress can be compared.

47. In the public sector not for profit context they also take on the status of pre-eminent measures of service performance, supplanting the traditional financial measures such as operating result and net assets utilised in the private sector. But like the private sector, these non-financial measures must be publicly reported so that agencies can discharge their accountability obligations to the community.

48. DHHS has not articulated any targets for the mental health KPIs, which means it is difficult to understand the improvement that DHHS is aiming for or whether they are on track to achieving their objectives.

49. With respect to public reporting it was observed in the Duckett report that:

> "The establishment of a Mental Health Annual Report, the first of which is to be tabled later this year in Parliament, is an important opportunity to focus attention on the problems in access, pressure on services, and safety and quality, and provide the basis for a broader discussion with the community on safety and quality in mental health services." p.138

50. It is debatable whether the Mental Health Annual Report has fulfilled this ambition. There is little clarity about access performance and its structure, layout and content make it difficult to readily assess service performance.

51. Systemically, I note the lack of a mature outcome measurement and reporting framework has been, and remains, a feature of the Victorian public sector. While reporting on outputs is important, the output-based budgetary framework has not fostered, and is in many respects antipathetic to, measuring and reporting on outcomes.

52. In the mental health space this has helped to enable the fragmented and duplicative output performance reporting across various agencies exemplified by Figure 3A in the CAYMH report; with no clear mechanism to rationalise this. It also means there is less capacity and capability across the sector in outcomes measurement than needed.

53. The government has now embarked on outcomes reform (https://www.vic.gov.au/outcomes-reform-victoria).

54. In its own words:

> "Good public policy and service delivery must demonstrate its value to the community. In the past, government has measured what it does, and not necessarily what it achieves.
>
> Often government focuses on outputs (what activities, products or services it is providing) and how much it costs to provide them. Just monitoring and reporting on outputs doesn't provide evidence of the impact of our work.
>
> Focusing on outcomes instead of outputs allows us to better identify what we want to achieve for Victoria. It connects our work with communities, experts and service delivery sectors. It also provides flexibility and enables us to communicate what we want to achieve in a way that is meaningful for Victorians."

55. In my estimation this is long overdue. A top down, strategic, consistent, whole of government approach to setting priorities and associated outcomes should, if delivered as intended, overcome the deficiencies we observed in performance measurement and monitoring of access to mental health.

sign here ►

print name Andrew Greaves

date 19 July 2019

Royal Commission into
Victoria's Mental Health System

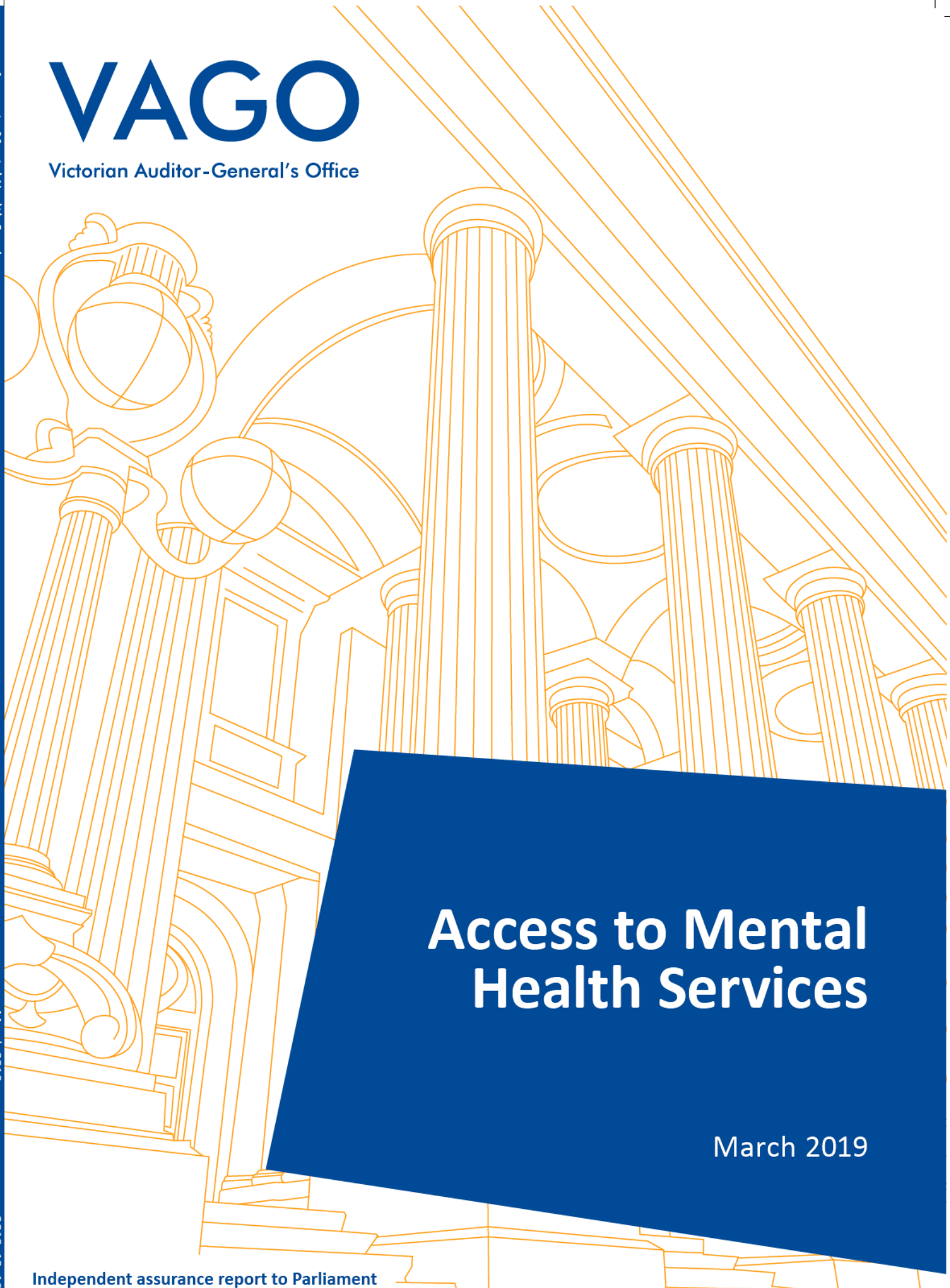
ATTACHMENT AG-1

This is the attachment marked 'AG-1' referred to in the witness statement of Andrew Greaves dated 19 July 2019.

https://www.audit.vic.gov.au/report/access-mental-health-services

VAGO

Victorian Auditor-General's Office



Access to Mental Health Services

March 2019

Independent assurance report to Parliament
2018–19: 16

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VAGO
Victorian Auditor-General's Office

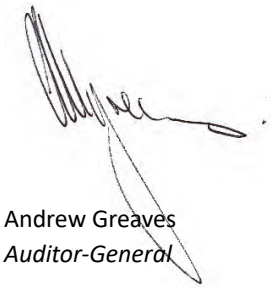
The Hon Shaun Leane MLC
President
Legislative Council
Parliament House
Melbourne

The Hon Colin Brooks MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my report *Access to Mental Health Services*.

Yours faithfully



Andrew Greaves
Auditor-General

21 March 2019

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Acronyms

AMHS	area mental health service
AIHW	Australian Institute of Health and Welfare
CCU	community care unit
CMI/ODS	Client Management Interface/Operational Data Store
DHHS	Department of Health and Human Services
ED	emergency department
LOS	length of stay
KPI	key performance indicator
MHCSS	Mental Health Community Support Services
MHET	Mental Health Expert Taskforce
MHNIP	Mental Health Nurse Incentive Program
PHN	primary health network
NDIS	National Disability Insurance Scheme
PAPU	psychiatric assessment and planning unit
PARC	prevention and recovery care
PBS	Pharmaceutical Benefits Scheme
SECU	secure extended care unit
SoP	statements of priorities
VAGO	Victorian Auditor-General's Office

Audit overview

One objective of the *Health Services Act 1988* is to 'ensure that an adequate range of essential health services is available to all persons resident in Victoria, irrespective of where they live or whatever their social or economic status'. Mental health care is one such service.

Mental illness affects not only an individual's wellbeing and quality of life, but also their physical health and engagement in employment, education and community; with flow-on effects to the human services, general health and justice systems.

With 45 per cent of the Victorian population experiencing mental illness in their lifetime, ensuring access to mental health care is vital to supporting a healthy and productive Victorian population. The demand for mental health care is growing, driven by multiple factors—including population growth, a reduction in stigma around seeking help, changes in legal and illegal drug use patterns, and increasing levels of social isolation in our community.

In 2009 the imminent gap in meeting demand for mental health services was forecast in the previous decade-long mental health plan titled *Because mental health matters: Victorian Mental Health Reform Strategy 2009–2019*, which stated that:

> Action is needed not only to address the current needs of the Victorian population but to plan for the projected numbers of people likely to be seeking help for mental health problems in ten years' time.

In 2015, the Department of Health and Human Services (DHHS), the agency responsible for managing Victoria's public mental health system, acknowledged in *Victoria's 10-year mental health plan* (10-year plan), that:

> …increasing and sustained demand pressure on services has not been matched with increasing resources. Shifting population and growth has left some services under even greater pressure. The result is longer waiting times to access services and higher thresholds for entry. The increased pressure on services creates a risk that people may receive treatment that is less timely, less intensive and shorter in duration than they want or need.

Given this acknowledgement, in this audit we assessed whether DHHS's current 10-year plan and supporting activities have started to address known access problems. Our audit objective was 'to determine if people with mental illness have timely access to appropriate treatment and support services'.

Conclusion

DHHS has done too little to address the imbalance between demand for, and supply of, mental health services in Victoria.

The lack of sufficient and appropriate system-level planning, investment, and monitoring over many years means the mental health system in Victoria lags significantly behind other jurisdictions in the available funding and infrastructure, and the percentage of the population supported.

While DHHS understands the extent of the problem well and has been informed by multiple external reviews, the 10-year plan outlines few actions that demonstrate how DHHS will address the demand challenge that the 10-year plan articulates:

- there are no clear targets or measures to monitor progress in improving access
- there are no forward plans for the capital infrastructure needed
- the workforce strategy does not address the particular issues in regional and rural areas and fails to articulate specific targets
- there is no work to address barriers to access created by geographic catchment areas.

DHHS has made little progress closing the significant gap between area mental health services' (AMHS) costs and the price they are paid by DHHS to deliver mental health services; and in addressing historical inequities in funding allocations that do not align to current populations and demographics. This means many people wait too long or miss out altogether on services, and for those that do receive services, their clinical care can be compromised by the need to move them quickly through the system.

Real progress is unlikely within the life of the plan unless DHHS accelerates and directs effort towards the fundamentals: funding, workforce and capital infrastructure. Until the system has the capacity to operate in more than just crisis mode, DHHS cannot expect to be able to make meaningful improvements to clinical care models or the mental health of the Victorian population.

The Royal Commission into Mental Health will undoubtedly highlight many areas for improvement across the system. However, the need for planning and investment to meet demand is already known and as such work to address this should not await the Commission's recommendations. Further delay will only amplify the problems the Commission seeks to address.

Findings

Victoria's 10-year mental health plan

Developing and implementing the 10-year plan

DHHS developed the 10-year plan through thorough sector and consumer consultation. The Mental Health Expert Taskforce (MHET) oversaw implementation. The group consisted of expert representatives from service providers, peak bodies, consumer groups, and academia.

Health services consistently raised that difficulty accessing services and coping with demand was a challenge. The 10-year plan reflects this and stresses the issue of 'higher demand and unmet need'. One of the 10-year plan's four focus areas is 'the service system is accessible, flexible and responsive to people of all ages, their families and carers and the workforce is supported to deliver this'.

However, little within the 10-year plan directly addresses improving access. It talks largely about the way services should be designed and delivered, such as through co-production with consumers, focusing on early intervention, integrating services, and implementing evidence-based practice. The AMHSs we audited expressed their disappointment in the plan because it is generic and lacks clear actions to address the demand and supply imbalance.

A role of the MHET was to inform 'waves of reform'—areas for DHHS to prioritise. The priority reform areas do not adequately reflect the underlying issue of lack of system capacity. Of the nine priority areas for the first two waves of reform, only two clearly relate to improving access; the development of a workforce strategy, and an action around 'managing clinical demand'. As such, while focusing action on useful activities—such as the development of frameworks for suicide prevention and supporting Aboriginal mental health, forensic service planning, and setting outcome measures—DHHS has made almost no progress in addressing the supply and demand imbalance.

DHHS has completed and released its workforce strategy, and through the 2018–19 budget secured funding for some new mental health workers. However, the workforce strategy does not include targets for the types or numbers of workers it aims to attract or retain and does not set action to address the significantly greater staffing challenges that regional and rural areas face. Further, the strategy is not integrated with service or infrastructure planning.

DHHS also completed a draft Clinical mental health services action plan 2018–2023, which better addresses the need of AMHSs and stakeholders to understand DHHS's direction in improving supply and access. The action plan informed DHHS's 2018–19 budget bid for mental health services, which secured growth funding for the sector. However, despite the investment of three-years' work in the plan, DHHS does not intend to release it publicly, which misses an opportunity to communicate DHHS's work in this area to the sector and stakeholders, and for stakeholders to hold DHHS to account for completing the work the action plan outlines.

Monitoring and reporting on progress

Other functions of the MHET were to develop a work program and advise the Minister for Mental Health on performance measures and targets. The MHET, though it considered and advised on progress indicators, did not develop a clear work program of actions, timeframes, or targets and subsequently neither the MHET nor DHHS have monitored plan progress against any agreed deliverables.

The MHET was disbanded in February 2018 as intended. The 10-year plan progress oversight now sits with the DHHS mental health branch. The mental health branch has reported only once to the DHHS Executive Board via the Health Reform Sub Committee—on the draft Clinical mental health services action plan 2018–2023. The lack of timely internal progress reporting significantly reduces accountability for achievement against the 10-year plan.

There are few measures in the outcomes framework for the 10-year plan that directly capture performance against providing access to services or increasing service reach—this is despite the acknowledged performance problems in this area—which shows a lack of focus on the most pressing issue the system faces.

Understanding and meeting demand

As system manager, DHHS has a responsibility to ensure service access by supporting the foundations of the system: funding, capital infrastructure and service distribution, and understanding demand and system performance to guide proper investment. In each of these areas, DHHS has done too little and now requires significant, prompt action if it is to make real progress against the 10-year plan.

Funding

Australian Institute of Health and Welfare (AIHW) data shows that between 2011–12 and 2015–16 national recurrent expenditure per capita on specialised mental health services grew an average of 0.7 per cent annually, while over that time in Victoria it declined by 0.3 per cent annually. In 2015–16, Victoria's per capita recurrent expenditure was $197.30, the lowest in Australia, with a national average of $226.52.

AMHSs advise that the allocation of growth funding over the last three state budgets has been partially directed to closing the existing gap between their service costs and the price DHHS pays, therefore AMHSs are not fully providing additional services. DHHS is aware of the price gap. A DHHS-commissioned review showed that DHHS pays 65 per cent of AMHS bed costs compared with more than 80 per cent of costs for general health beds.

DHHS has commenced funding reform, funding 'packages of care' to incentivise AMHSs to provide more community-based treatment services. However, without an adequate quantum of funding, the intended outcome is at risk.

DHHS's advice to government states that the new funding reform and four-year growth funding from 2018–19:

- provides each new community-based client with a maximum of six hours treatment per annum—the nationally recommended level is 72 hours
- enables DHHS to provide mental health services to 1.2 per cent of the population—a marginal improvement on the current 1.16 per cent—compared to the estimated 3.1 per cent of the Victorian population with a severe mental illness
- increases the price paid to only 67 per cent of AMHSs' costs.

DHHS also advises that the budget provides additional services for the most unwell patients, to be achieved within five years, but has not quantified this additional service provision.

DHHS has also moved bed funding to a slightly higher single price for all beds regardless of location or severity of illness, with the aim to begin addressing historical funding inequities. However, this does not account for the inherently higher operating costs that rural AMHSs face.

Planning to meet demand

Increasing demand combined with current service shortfalls are placing the whole mental health service under substantial stress. In 2017, DHHS commissioned an external review of the mental health system and the resultant report, Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System: Developing excellence in clinical mental health care for Victoria (Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System), highlights that:

- emergency department (ED) presentations have increased 9 per cent from 2015–16
- acute hospital admissions have grown at an annual rate of 2.4 per cent
- length of stay (LOS) in hospital trends down from 14.7 days to 11.2 days from 2009 to 2017 (with LOS stay in 2017–18 at 9.6 days)
- unplanned readmission rates for adult mental health patients at 14.4 per cent in 2017–18
- community mental health contacts per 1 000 people declining at a rate of 2.5 per cent per annum over the last 10 years.

These demand pressures have lifted the thresholds for access to services so that AMHSs only see the most unwell, which creates a flow on effect. AIHW reports the number of Victorian mental health patients that accessed acute services through police, ambulance and self-presentations to hospital EDs increased from 28 757 in 2004–05 to 54 114 in 2016–17.

To understand and respond to demand and access issues, DHHS needs data to reflect current service capacity and to calculate unmet demand. While it has developed a model to forecast service demand, it relies largely on historical activity data, which creates significant limitations to its use. DHHS is missing available information to understand unmet demand. It does not collate, assess and input to its forecasting model:

- data from mental health triage services to identify the number of people who contact triage but are not provided access to services
- people accessing services that are not registered with an AMHS.

Given DHHS acknowledges there is significant unmet demand, estimating this demand is critical to inform any future planning for the mental health system.

Capital infrastructure

Victoria has one of the lowest mental health bed bases nationally. As a result, all major acute psychiatric units continually operate at or above 95 per cent capacity—well above desirable levels of 80 to 85 per cent that would permit AMHSs to admit acutely ill patients as needed. A review commissioned by DHHS advised that Victoria's bed base needs to grow by 80 per cent over the next decade to reach levels of service provision of other Australian jurisdictions.

There are 53 new acute adult beds funded in 2018–19, with 21 now open and 34 in planning. There are also 24 sub-acute beds in the planning phase, and 10 mother and baby unit beds will operate seven rather than five days a week. While helpful, the additional beds will not meet the unmet demand nor shift Victoria towards the recommended bed numbers.

There are no further new beds in the capital pipeline, and while DHHS aims to complete a 'Detailed services and infrastructure plan for Victoria's clinical mental health system over the next 20 years' it will likely take DHHS some time to complete the plan; secure and allocate funding; and then plan and build infrastructure. DHHS should anticipate that Victorians with mental health issues will continue to face barriers accessing mental health beds across the remaining life of the 10-year plan, and that this will impact the effectiveness of any changes to funding or the service delivery model.

Catchment areas

Clinical mental health services are provided in geographic catchment areas that were established in the 1990s. The consumer's place of residence determines which service or services they can access, which causes practical problems that hinder service access:

- the catchment areas are not aligned with other health and human service areas, or local government area boundaries, which makes service coordination difficult
- the geographic catchments do not align with age-based service groupings
- there is a lack of coordination between catchment areas when patients need to access services across catchment borders
- there is misalignment between service levels and types within a catchment and population growth and demographic changes in that area.

Despite understanding these issues for many years, and commissioning work to examine them and make recommendations, DHHS has taken no action to address them.

Figure A
Key numbers about the Victorian mental health system

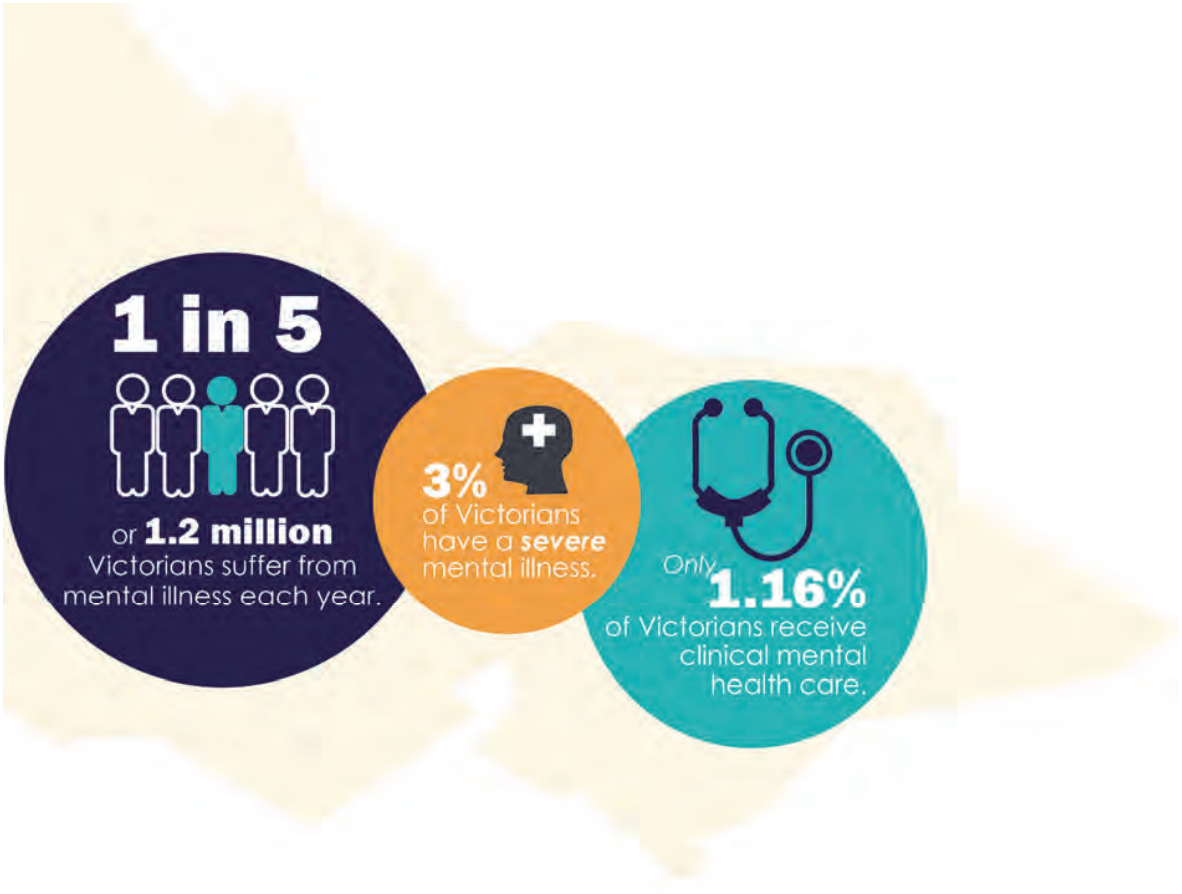
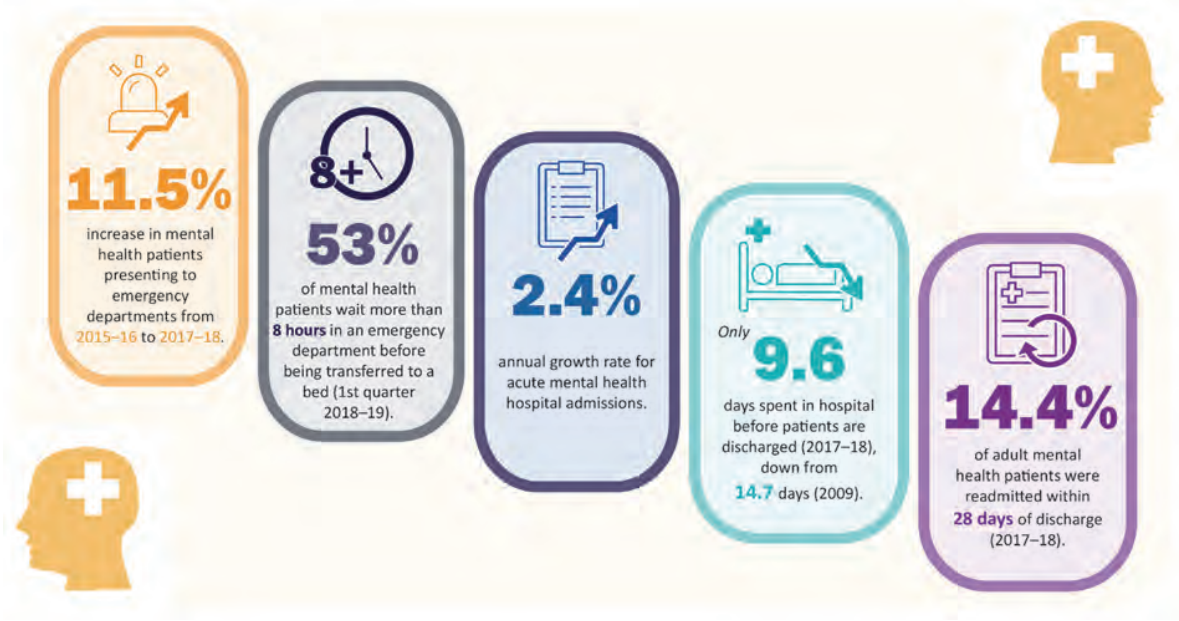


Figure A
Key numbers about the Victorian mental health system—*continued*



Source: VAGO.

Recommendations

We recommend that the Department of Health and Human Services:

1. complete a thorough system map that documents its capacity, including capital and workforce infrastructure, geographical spread of services, and estimated current and future demand, including current unmet demand
2. use this map to inform a detailed, public, statewide investment plan that integrates service, capital and workforce planning; setting out deliverables and time frames
3. set relevant access measures with targets, which reflect the intended outcomes of the investment plan, and routinely report on these internally and to the public
4. undertake a price and funding review for mental health services, which includes assessing funding equity across area mental health services, and provide detailed advice to the Minister for Mental Health on the results and use this information to inform funding reforms
5. resolve the known catchment area issues of misaligned boundaries that prevent people from accessing services
6. re-establish routine internal governance and reporting against mental health system priorities, activities and performance that ensures senior executive level oversight and accountability.

Responses to recommendations

We have consulted with the DHHS, Bendigo Health, Melbourne Health, Monash Health, Latrobe Regional Hospital, Peninsula Health, and South West Healthcare and we considered their views when reaching our audit conclusions. As required by section 16(3) of the *Audit Act 1994*, we gave a draft copy of this report to those agencies and asked for their submissions or comments. We also provided a copy of the report to the Department of Premier and Cabinet.

DHHS provided a response. The following is a summary of its response. The full response is included in Appendix A.

DHHS accepted each of the six recommendations, with two accepted in-principle pending the outcomes of the Royal Commission into Mental Health. The department will undertake statewide mapping and assessment of current and future demand, develop a performance and accountability framework for mental health services, undertake a price review of clinical mental health services, and re-establish the MHET.

1 Audit context

1.1 Overview of Victoria's mental health services system

Nearly half (45 per cent) of Victorians will experience mental illness in their lifetime. Annually, one in five Victorians, or 1.2 million, suffer from a mental illness[1]. Of these 1.2 million people, based on 2017 population figures:

- 11 per cent will experience mild mental illness (670 000)
- 6 per cent will experience moderate mental illness (346 000)
- 3 per cent will experience severe mental illness (184 000).

The Victorian Government funds public mental health services covering clinical assessment, treatment, and case management in community and inpatient settings as Figure 1A shows.

A number of publicly funded specialist clinical mental health services are also delivered on a statewide basis, such as mother and baby services, eating disorder services, and forensic mental health services.

1.2 Agency roles and responsibilities

The Department of Health and Human Services

In relation to mental health services, DHHS is responsible for:

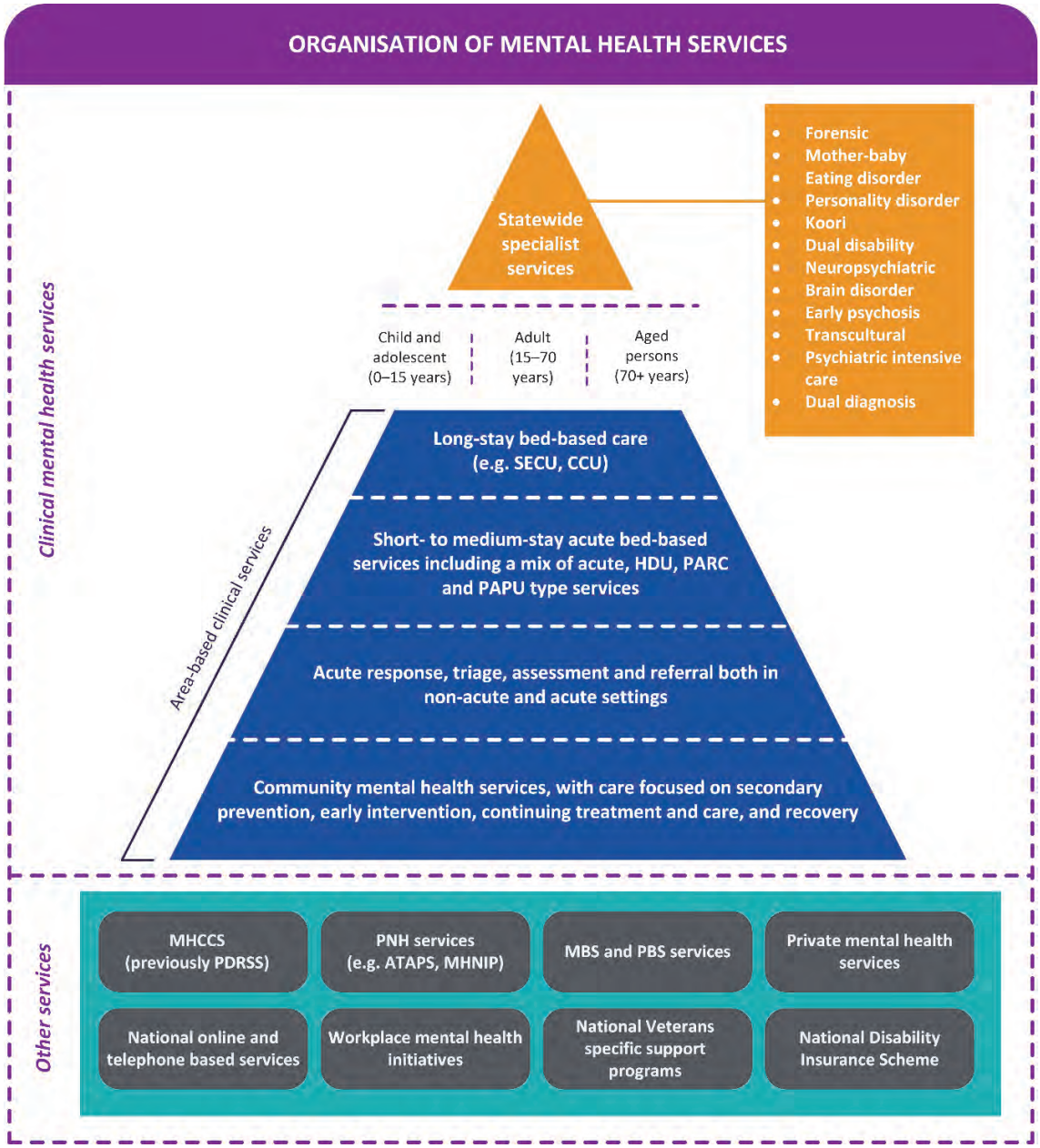
- funding
- developing policies and plans
- encouraging safety and quality of care
- monitoring and reviewing service provision
- developing performance measures to enable service comparison
- collecting and analysing data to support these functions.

These functions are undertaken by the mental health branch and other business units within DHHS.

1 Reform of Victoria's specialist clinical mental health services: Advice to the Secretary, Department of Health and Human Services, by A.Cockram, S.Solomon, H.Whiteford, 2017, page 20.

Figure 1A

Organisation of mental health services



Note: CCU = community care unit, SECU = secure extended care unit, HDU = high dependency unit, PARC = prevention and recovery care, PAPU = psychiatric assessment and planning unit, MHCSS = Mental Health Community Support Services, PHN = primary health network, ATAPS = Access to Allied Psychological Services, MHNIP = Mental Health Nurse Incentive Program, MBS = Medicare Benefits Schedule, PBS = Pharmaceutical Benefits Scheme.

Note: Services such as CCU, SECU and PAPU are described further in the next section.

Source: VAGO, based on Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System, DHHS, 2017.

DHHS's 2018–19 mental health services budget was $1 605.7 million, or 6.4 per cent of its total budget. DHHS distributes the funding as set out in its annual policy and funding guidelines and annual statements of priorities (SoP)—the key accountability agreements between the government and health service providers. SoPs outline expected services and activity levels, performance measures and targets, and policy directions and requirements. DHHS monitors health services' performance against their SoP.

DHHS groups Victoria's clinical mental health services into age and regional cohorts. Aged-based service groupings are: child and adolescent mental health services (0–18 years), adult mental health services (16–64 years), and mental health services for older people (65+ years). Geographically, DHHS arranges services within catchments. The consumer's place of residence determines which service(s) they can access. The current range of services provided throughout Victoria includes:

- 13 child and adolescent mental health services, provided in five metropolitan and eight rural catchments
- 21 adult mental health services, provided in 13 metropolitan and eight rural catchments
- 17 aged persons mental health services provided in nine metropolitan and eight rural catchments.

Area mental health services

AMHSs provide a range of clinical mental health assessment and treatment services, and are managed by general health facilities such as hospitals. This audit focuses on the mental health services provided through these general health facilities—including:

- acute community intervention services (ACIS)—urgent response service providing telephone triage, community outreach, and support to EDs
- acute inpatient services—bed-based care for people acutely unwell, often provided within general hospitals
- community care units (CCU)—clinical care and rehabilitation in a home-like environment
- secure extended care units (SECU)—inpatient treatment and rehabilitation for people with unremitting and severe mental illness
- prevention and recovery care (PARC) services—short-term residential treatment services with a recovery focus
- psychiatric assessment and planning units (PAPU)—short-term (up to 72 hours) specialist psychiatric assessment and treatment for people experiencing an acute episode of mental illness
- clinical mental health services delivered in the community.

Figure 1B shows where the AMHSs are located across Victoria.

Figure 1B
Spread of AMHSs across Victoria against local government area boundaries

Regional and rural services

Metropolitan services

Source: Victoria's Clinical Mental Health System Plan, DHHS, 2016.

1.3 Relevant legislation and policies

Mental Health Act 2014

The *Mental Health Act 2014* (the Act) provides a legislative framework for the assessment of Victorians who appear to have a mental illness, and for the treatment of people with mental illness. The Act requires that people receive assessment and treatment with as few restrictions on human rights and dignity as possible. The Act has core principles and objectives, including:

- assessment and treatment is provided in the least intrusive and restrictive way
- people are supported to make and participate in decisions about their assessment, treatment and recovery
- individuals' rights, dignity and autonomy are protected and promoted at all times
- priority is given to holistic care and support options that are responsive to individual needs
- the wellbeing and safety of children and young people is protected and prioritised
- carers are recognised and supported in decisions about treatment and care.

Policies

Several policies enable the provision of services to respond to the intent of the Act.

Victoria's 10-year mental health plan

DHHS published the 10-year plan in November 2015 in response to government election commitments. It is a long-term plan that sets the mental health agenda for the next decade that is intentionally ambitious, and outcome focused. The 10-year plan's goal is that all Victorians experience their best possible health, including mental health. The 10-year plan is not designed to document all the activities and initiatives needed to address the issues in the mental health system, but it aims to give strategic direction in mental health policy, funding and program development.

Victorian Government Suicide Prevention Framework 2016–25

The *Victorian Government Suicide Prevention Framework 2016–25* aims to halve Victoria's suicide rate by 2025 and supports the Commonwealth's *Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan).

Balit Murrup: Aboriginal social emotional wellbeing framework 2017–2027

Balit murrup, meaning 'strong spirit' in the Woi-wurrung language, aims to reduce the health gap attributed to suicide, mental illness and psychological distress between Aboriginal Victorians and the general population. The framework sets out principles, strategic priorities and new investments to achieve this. In relation to access, one of four 'domains' included in the framework is 'improving access to culturally responsive services', with priorities for more Aboriginal people to engage in appropriate treatment and care, and for those services to be culturally safe and free from racism.

1.4 Why this audit is important

Mental health is an integral part of a person's capacity to lead a fulfilling life, including the ability to form and maintain relationships, to study, work, pursue recreational interests, and to be able to make a positive contribution to society by making day-to-day decisions about education, employment, housing or other choices.

Disturbances to a person's mental wellbeing can negatively impact their capacity and the choices they make, leading not only to diminished functioning at the individual level but also to broader societal and welfare losses. There is significant flow on effect to other services if the mental health system is not functioning well, such as housing, justice and other health and community services.

Victoria's mental health system faces significant challenges and the 10-year plan is intended to set a pathway to address them. As DHHS is currently three years into this plan, it is timely to assess its progress in meeting one of the key challenges to the system: providing timely access to services in the face of increasing demand.

1.5 What this audit examined and how

Our audit objective was to determine if people with mental illness have timely access to appropriate treatment and support services.

DHHS and the broader mental health sector notes that Victorians with a mental illness do not have timely access to appropriate treatment and support services as expressed in the 10-year plan. For this reason, our audit focused on analysing whether the 10-year plan and supporting activities will start to address the existing access problem.

We examined how DHHS oversees the mental health system and whether it promotes increased accessibility. We examined DHHS's mental health policies, strategies and plans, the data it collects, and how this informs planning.

Alongside DHHS, we gathered evidence from six health services:

- Bendigo Health
- Melbourne Health
- Monash Health
- Latrobe Regional Hospital
- Peninsula Health
- South West Healthcare.

Pursuant to section 20(3) of the *Audit Act 1994*, unless otherwise indicated, any persons named in this report are not the subject of adverse comment or opinion.

We conducted our audit in accordance with Section 15 of the *Audit Act 1994* and the Australian Auditing and Assurance Standards. The cost of this audit was $760 000.

1.6 Report structure

The rest of this report is structured as follows:

- Part 2—Victoria's 10-year mental health plan
- Part 3—Meeting demand for mental health services.

2 Victoria's 10-year mental health plan

DHHS published the 10-year plan in November 2015 in response to government election commitments. Service accessibility is one of the primary considerations within the 10-year plan. Accessible mental health services mean they are available in the right place, at the right time and delivered by the right people with the right skills.

Demand for mental health services in Victoria is rising. The number of Victorians who require services, and the severity of illness, has increased. Population growth, different legal and illegal drug use patterns, and better mental health awareness are all driving this increased demand.

Without high quality and accessible services, many Victorians with mental illness are unlikely to receive timely help and support. Alongside the significant human cost, the lack of timely access to services has a substantial economic impact, and negative flow-on effects to other government services such as housing and justice services.

This part examines the extent to which the 10-year plan focuses on addressing demand.

2.1 Conclusion

While the 10-year plan clearly outlines the significant service demand and access issues facing the system, little within it directly addresses these issues. While effort has been directed to worthy activities such as new frameworks for suicide prevention and Aboriginal mental health and planning for forensic mental health services neither these initiatives, nor core services, can succeed while the system is overwhelmed. The priorities established in the 10-year plan do not reflect the most pressing challenges facing mental health services and their users.

DHHS's draft Clinical mental health services action plan 2018–2023, building on the 10-year plan, goes some way to addressing the challenges. The action plan details system changes to improve access to mental health services. However, while DHHS is using elements of the draft action plan to inform new initiatives, many of which government funded as four-year initiatives from 2018–19 onwards, it advises it is unlikely to finalise and release it. This misses the opportunity to communicate to stakeholders, who are in need of support, DHHS's goals for improving access, and also limits the ability of AMHSs, service users, and the public to hold DHHS to account in achieving its aims.

A completed 10-year plan priority action relevant to access is DHHS's workforce strategy. It includes new approaches to recruitment advertising and professional development, and helped inform a successful bid to government for funding for new mental health workers in 2019. However, the strategy has no concrete actions to address regional and rural workforce gaps, is isolated from service and capital planning, and has no measures or targets to show what DHHS hopes to achieve.

DHHS has not articulated any targets to measure progress against the 10-year plan's key challenge—providing timely access to the right services in the face of growing demand. Current measures that DHHS has aligned to the outcome of 'right services at the right time' either indirectly measure access, or do not measure access at all. While the measures focus on providing the 'right service', there are no measures addressing the 'right time' part of the outcome. If the focus of effort is truly to be on improving access, then DHHS must set relevant access measures and targets to drive performance and against which to publicly report progress. Compounding the lack of targets and measures is a lack of routine, senior level oversight of, and reporting against, the 10-year plan within DHHS, limiting senior executive attention to this high priority service.

2.2 Developing and implementing the 10-year plan

10-year plan aims

Victoria's 10-year plan is a high-level, outcome-focused framework for mental health service reform. DHHS's vision for mental health as outlined in the 10-year plan is that 'all Victorians experiencing mental illness get the best possible treatment and support, so they can live meaningful and fulfilling lives of their choosing'. The vision reflects one of the main objectives of the *Health Services Act 1988*, that 'an adequate range of essential health services is available to all persons, resident in Victoria irrespective of where they live or whatever their social or economic status'.

The 10-year plan aims to achieve its vision through four focus areas that contribute to sixteen outcomes as per Figure 2A.

Figure 2A
10-year plan focus areas and outcomes

Vision	ALL VICTORIANS EXPERIENCE THEIR BEST POSSIBLE HEALTH, INCLUDING MENTAL HEALTH
Domains	**Outcomes**
Victorians have good mental health and wellbeing	1. Victorians have good mental health and wellbeing at all ages and stages of life 2. The gap in mental health and wellbeing for at-risk groups is reduced 3. The gap in mental health and wellbeing for Aboriginal Victorians is reduced 4. The rate of suicide is reduced
Victorians promote mental health for all ages and stages of life	5. Victorians with mental illness have good physical health and wellbeing 6. Victorians with mental illness are supported to protect and promote health
Victorians with mental illness live fulfilling lives of their choosing, with or without symptoms of mental illness	7. Victorians with mental illness participate in learning and education 8. Victorians with mental illness participate in and contribute to the economy 9. Victorians with mental illness have financial security 10. Victorians with mental illness are socially engaged and live in inclusive communities 11. Victorians with mental illness live free from abuse or violence, and have reduced contact with the criminal justice system 12. Victorians with mental illness have suitable and stable housing
The service system is accessible, flexible and responsive to people of all ages, their families and carers, and the workforce is supported to deliver this	13. The treatment and support that Victorians with mental illness, their families and carers need is available in the right place at the right time 14. Services are recovery-oriented, trauma-informed and family-inclusive 15. Victorians with mental illness, their families and carers are treated with respect by services 16. Services are safe, of high quality, offer choice and provide a positive service experience

Source: Victoria's Mental Health Services Annual Report 2016–17, DHHS, 2017.

The fourth focus area, describing an accessible system, is particularly relevant to meeting demand. The 10-year plan links these outcomes to the statements:

- Universal access to public services—people with mental illness and their families and carers have access to high-quality, integrated services according to their needs and preferences.
- Access to specialist mental health services—people with mental illness, their carers and families have access to the public treatment and support services they need and choose, appropriate to their age and other circumstances, where and when they need them most.

While the 10-year plan articulates these overarching goals, the outlined approaches focus on the way services are provided and developed and do not highlight actions to address the unmet demand that the plan acknowledges exists.

Stakeholder engagement

DHHS consulted with a wide range of stakeholders in developing the 10-year plan, including six rural and regional public workshops and gathering input from more than 1 000 consumers, carers, workers and other sector stakeholders. Our review of the records of public consultations notes diverse issues and opinions. Access to mental health services was a key issue highlighted in all public consultation records reviewed, including the gap between the number of people needing public mental health services and the capacity of specialist clinical services and community mental health support services to meet those needs.

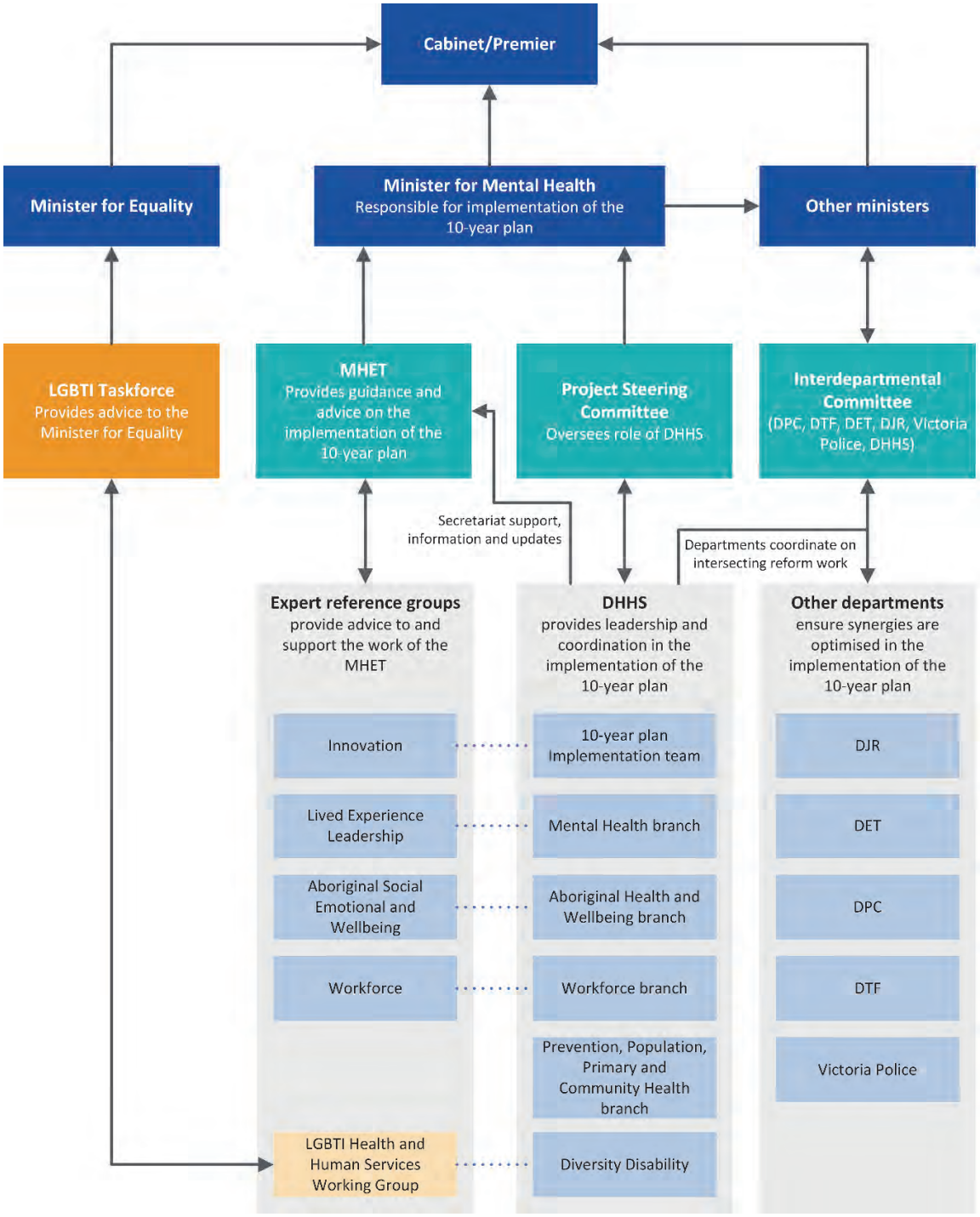
DHHS prepared discussion papers to assist with developing the 10-year plan that included diverse groups, including Aboriginal communities, refugees and asylum seekers, and lesbian, gay, bisexual, transgender and intersex persons. Consultation questions included 'How do we configure the way specialist mental health treatment services are delivered to improve access and responsiveness to the needs of…'. However, though access was a key issue put forward during these consultations, improving access, including for diverse groups, has not been adequately reflected in the 10-year plan.

Each of the audited mental health services were critical of the 10-year plan. These stakeholders all said that while the 10-year plan includes many relevant issues, there are too many generic statements in response to these issues. Each service would like practical guidance and a plan that clearly outlines the key deliverables. They indicated they would like DHHS to engage more with them and develop a plan that is achievable and aligned with contemporary practice. Access and demand issues were discussed strongly by each of the audited AMHSs, with issues such as workforce capacity and geographic reach identified as barriers to addressing access.

Governance arrangements

The MHET was established to monitor the 10-year plan's progress, as outlined in Figure 2B, and to provide guidance and advice on its implementation in the first two years.

Figure 2B
Initial governance structure for the 10-year plan



Note: LGBTI = lesbian, gay, bisexual, transgender and intersex; DJR = Department of Justice and Regulation; DET = Department of Education; DPC = Department of Premier and Cabinet; DTF = Department of Treasury and Finance.
Note: On 1 January 2019, a number of machinery of government changes came into effect, and consequently the Department of Justice and Regulation (DJR) became the Department of Justice and Community Safety.
Source: VAGO, based on information from DHHS.

The MHET included members representing service providers, peak bodies and other stakeholder organisations. The MHET's terms of reference included to:

- advise the minister on actions to achieve intended outcomes
- identify priorities and develop a work program of actions
- advise the minister on measures and targets to demonstrate achievement towards intended outcomes
- plan implementation activities.

Minutes from the MHET's meetings show discussion of a range of mental health issues, including taskforce priorities and updates on government activity. However, these documents do not show substantive discussion about access and demand. The taskforce also did not develop a clear work program of actions, with timeframes, and subsequently did not monitor progress against any agreed deliverables. The MHET, while considering and advising on progress indicators, did not set targets for them.

The MHET was disbanded in February 2018, at the completion of its fixed two-year term. Oversight for progress against the plan now sits with the mental health branch within DHHS, which reports only to higher levels within DHHS—the Executive Board via the Health Reform Sub Committee—on an ad hoc basis. Since the MHET disbanded, the mental health branch has reported to the executive once about just one of the four priority areas within the 10-year plan. This lack of internal progress reporting significantly reduces accountability for achieving against the plan.

Implementing the 10-year plan

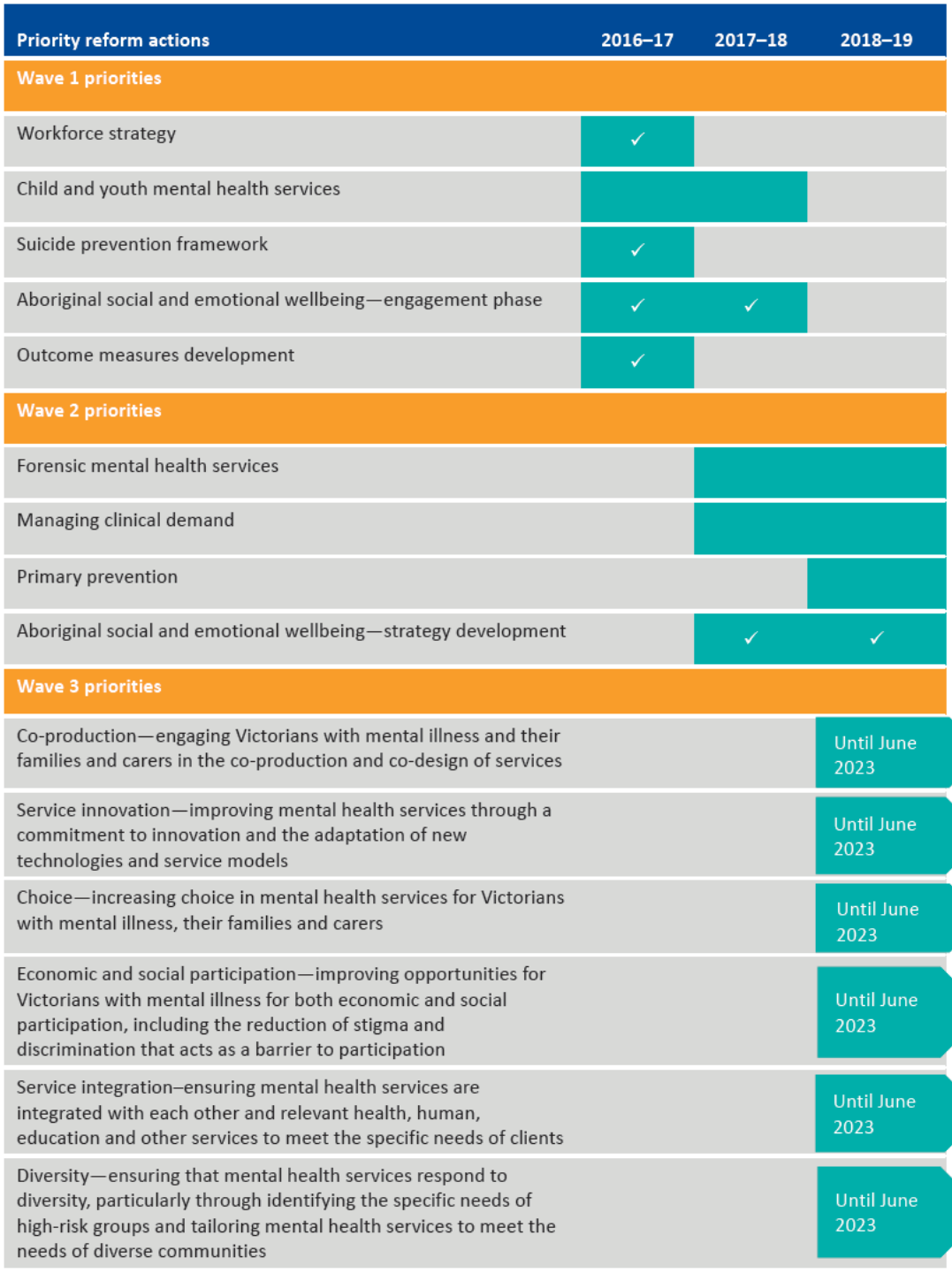
DHHS and other stakeholders have directed significant resources to implementing the activities underpinning the 10-year plan; however, there is no evidence of activity milestones, nor these being met.

A key DHHS focus was to create short and long-term implementation activities to achieve the plan's outcomes by identifying waves of reform that operate alongside other reform activities, shown in Figure 2C. The waves describe the order of priority actions over the first three years of the 10-year plan, as set out by the MHET. Key focus areas that are particularly relevant to access include the Workforce Strategy (Wave 1), Managing Clinical Demand (Wave 2), and in Wave 3, 'Diversity—ensuring that mental health services respond to diversity, particularly through identifying the specific needs of high-risk groups and tailoring mental health services to meet the needs of diverse communities'. *Victoria's Mental Health Services Annual Report 2017–18* (2017–18 Annual Report), published by DHHS, outlines several actions commenced to support access for diverse consumers including:

- the development of guidelines for interpreters working in mental health settings
- work to engage and support young people from refugee and asylum seeker backgrounds
- a grants programs to fund initiatives that support lesbian, gay, bisexual, transgender and intersex young people.

Figure 2C shows the priorities by wave, when DHHS identifies that it started to act on them, and priorities they report as completed (shown with a tick).

Figure 2C
Waves of reform



Source: VAGO, based on information from MHET planning material and interviews with DHHS staff.

We developed this progress report as DHHS does not track and report progress against the wave priorities.

2.3 Monitoring progress of the plan in improving access

DHHS's outcomes framework for the 10-year plan sets indicators against the planned outcomes. Figure 2D shows the indicators DHHS has aligned to the outcome related to access: 'the treatment and support that Victorians with mental illness, their families and carers need is available in the right place at the right time', and results against these indicators, as reported publicly by DHHS.

Figure 2D

Results against mental health 'access' indicators 2014–15 to 2016–17

Indicator	2014–15	2015–16	2016–17	2017–18
Rate of pre-admission contact—reflecting whether the person is appearing for the first time to an acute facility	59.4%	57.2%	51.8%	59.4%
Rate of readmission within 28 days—indicating that the discharge from inpatient services may have been too soon, or the treatment or discharge planning may not have fully addressed the issue	13.8%	13.9%	13.4%	13.8%
Rate of post-discharge follow-up—an important service to support transition back into the community	85.7%	84.2%	77.7%	87%
New registered clients accessing public mental health services (no access in the last five years)	36.3%	35.7%	36.6%	36.8%
Proportion of consumers reporting the effect the service had on their ability to manage their day-to-day life was very good or excellent—indicating general consumer satisfaction with the outcomes of the care provided	N/A	N/A	53.5%	55.2%

Note: No data is available for the 'consumer' indicators for 2014–15 and 2015–16.

Note: The result for post-discharge follow up for 2016–17 was impacted by industrial issues.

Source: Victoria's Mental Health Services Annual Report 2016–17 and the 2017–18 Annual Report, DHHS.

Except for the measure regarding new registered clients, these indicators only provide an indication of whether consumers received the 'right service'. The lack of improvement in the readmission rate suggests ongoing challenges in providing the 'right service', though there are improvements in the most recent year data for consumer experience, pre-admission contact and discharge follow up, which likely reflects recent increases in funded service hours. However, none of the measures are truly relevant to access, which considers the 'right time' part of the intended outcome. There are no measures of wait times for services, the numbers of consumers declined or delayed service due to capacity constraints, or consumer-reported experience of service accessibility. The measure of new registered clients could provide an indication of the system's capacity to support access; however, measured as a percentage of total clients, it gives no information on whether actual numbers of new clients are growing.

Further, DHHS has not articulated any targets for the measures that it has set. Without targets, it is unclear what level of improvement DHHS is aiming for.

As shown in Figure 2E, available service usage and capacity data for 2014–15 to 2017–18 shows recent improvements in the numbers of people accessing public mental health services; however, this reflects only a marginal increase in the proportion of people receiving care. The large gap against the target for timely access to a mental health inpatient bed from an ED persists. DHHS could use the information it already collects to set targets for improvements to access.

Figure 2E
Alternate indicators of mental health service accessibility

Indicator	2014–15	2015–16	2016–17	2017–18
Community service contacts (number)	2 058 909	1 935 262	1 675 772	2 407 730
Community service contacts (hours)	1 011 396	971 965	881 950	1 288 028
Total numbers of people accessing clinical mental health services[(a)]	67 030	67 559	66 487	72 859
Proportion of population receiving clinical care[(b)]	1.13%	1.12%	1.08%	1.16%
	Jul–Sep 2017	**Oct–Dec 2017**	**Jan–Mar 2018**	**Apr–Jun 2018**	**Jul–Sep 2018**
Audit mental health ED presentations transferred to a mental health bed within eight hours—target is 80%	55%	56%	56%	59%	53%

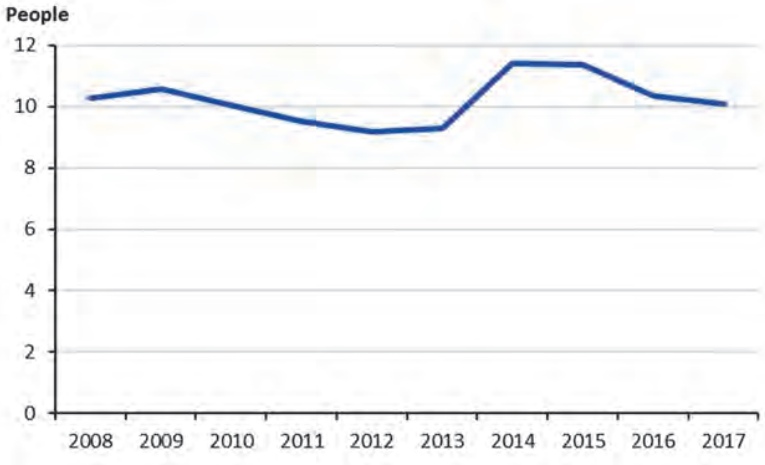
(a) 2015–16 and 2016–17 data collection was affected by industrial activity. The collection of non-clinical and administrative data was affected, with impacts on the recording of community mental health service activity and client outcome measures.
(b) Population estimate is based on *Victorian in Future 2014* projections.
Source: VAGO, based on information from *Victoria's Mental Health Services Annual Report 2016–17*, the 2017–18 Annual Report, and the Victorian Health Services Performance website www.performance.health.vic.gov.au, DHHS.

Suicide rates, while determined by multiple environmental factors, in part reflect the quality and availability of clinical supports. The only stated outcome of the 10-year plan with a clear target relates to the aim to halve the Victorian suicide rate by 2025.

The 2017–18 Annual Report states there has been a reduction in the number of suicides from 654 in 2015 to 621 in 2017. However, 10-year data available from the Australia Bureau of Statistics shows that there is no significant reduction. As shown in Figure 2F, the suicide rate has been relatively stable, varying slightly around 10 per 100 000 with an increase between 2013 and 2014 due to a change to incorporate cause-of-death post coroners' enquiries[2]. To halve the 2015 rate of suicides these numbers will need to decline to around 418 in 2025 based on current Victorian population projections.

[2] Australian Bureau of Statistics technical note 2 CAUSES OF DEATH REVISIONS, 2013, http://www.abs.gov.au/ausstats/abs@.nsf/Previousproducts/3303.0Technical%20Note22015?opendocument&tabname=Notes&prodno=3303.0&issue=2015&num=&view=, 2018.

Figure 2F
Victorian suicide rate per 100 000 population, by year, 2008 to 2017



Source: VAGO, based on Australian Bureau of Statistics data.

DHHS has not completed an evaluation framework to support the 10-year plan; however, DHHS's Centre for Evaluation and Research is planning a formal evaluation of the 10-year plan by 2020, five years into the plan. To properly complete this task, performance indicators relevant to improving access to services and more importantly, targets are necessary, particularly to ensure DHHS and AMHSs collect the right data for the evaluation.

2.4 The draft Clinical mental health services plan 2018–2023

The draft Clinical mental health services action plan 2018–2023 is a blueprint for transforming clinical mental health services in Victoria to address demand for, and access to, mental health services. The action plan supports the 10-year plan implementation. The action plan's focus areas are:

- transforming adult community-based services by:
  - increasing their capacity to treat more people and respond at earlier stages of illness
  - supporting clinicians to deliver evidence-based and best practice interventions
  - streamlining and improving service entry processes so that people can get timely assessment of their needs and referral to mental health or other services
- introducing new responses to help people experiencing a mental health crisis
- providing a balanced system of high-quality bed-based services, included enhanced sub-acute services to relieve pressure on acute inpatient units
- building links with and support for other services, with alcohol and other drug services prioritised for immediate action
- responding effectively to people with complex needs who present risks to community safety
- strengthening services for children and young people.

The key enablers are:

- a new funding model that incentivises health services to accept more patients and direct resources to the highest need patient groups
- a new Mental Health Performance and Accountability Framework that reflects the intended funding reform and creates greater transparency about service performance and consumer outcomes
- support for the mental health workforce, including in the delivery of evidence based and best practice treatment
- service and infrastructure planning to identify the optimum mix of community-based, sub-acute and acute inpatient services, taking account of the need for infrastructure to reflect demographic changes
- high-quality government policies, legislative frameworks and guidance for the sector
- strategic investment in research and evaluation to create a system that is continually learning.

Currently, this document is in draft form. It takes a step towards supporting AMHSs and their stakeholders by outlining more direct actions to reform the system and address capacity issues. While it took three years to develop, DHHS advises that it is unlikely to be finalised and released. DHHS is using elements of the draft action plan to inform new initiatives, many of which were funded as four-year initiatives from 2018–19; however, it is a missed opportunity for DHHS to not release the plan, particularly given the clear need of AMHSs for more communication about DHHS's intentions in this area.

2.5 Workforce strategy

Currently, there are over 5 000 people working in mental health, predominantly in roles such as psychiatry, mental health nursing, social work, psychology and occupational therapy, and increasingly, lived-experience workers (both consumers and carers) and other allied health professionals (such as speech pathologists). We found through our consultations with AMHSs that recruiting, retaining and managing their workforce is one of their most significant obstacles to providing access to services. They cited low morale and an ageing, stretched workforce as key challenges, in addition to stigma and negative community perceptions. The mental health workforce is impacted by:

- insufficient workers, particularly in rural and remote areas
- a change in service delivery needs from community mental health services to acute mental health services and the different skills needed
- risks to safety and wellbeing
- a lack of development opportunities
- inadequate undergraduate and other training opportunities.

DHHS is aware of these workforce challenges and has been actively trying to address them through a range of initiatives. The workforce strategy is a key focus area under wave 1 of the 10-year plan. DHHS published the new workforce strategy in June 2016, which builds on *Victoria's specialist mental health workforce framework: strategic directions 2014–24* and the previous 10-year plan *Because mental health matters: Victorian Mental Health Reform Strategy 2009–2019*. The workforce strategy outlines five key objectives, with the first being most relevant to access:

- workforce availability and skill—right person, right place, right skill
- worker safety and satisfaction—places people want to work
- workforce integration—learning together, working together
- co-design and co-delivery with consumers and carers—shaping the future together
- workforce innovation—exploring and sharing new ways of working.

Initiatives within the workforce strategy that aim to support workforce availability and skill include:

- the provision of learning and development in priority areas through DHHS's new Centre for Mental Health Learning (see sidebar)
- a targeted mental health recruitment campaign, Hello Open Minds, to attract and retain a skilled and sustainable workforce (launched in July 2017)
- workforce planning, informed by routine workforce data collection, to highlight where development and growth need to be focused
- a range of actions to attract and retain Aboriginal people to the mental health workforce
- expansion of the paid 'lived-experience' workforce to provide consumers with more choice in the types of services they receive, including peer support and advocacy
- a commitment for further work to address issues of occupational violence that affect attraction and retention.

The Centre for Mental Health Learning will act as an umbrella organisation, coordinating and leveraging current mental health investments by partnering with statewide trainers, Mental Health Workforce Learning and Development Clusters, health services, clinical academics and other stakeholders.

A number of activities relate to addressing access by increasing the mental health workforce with initiatives such as Hello Open Minds—a strategy to support recruitment—and the Centre for Mental Health Learning—aimed at improving the retention of the workforce through professional development and enhancing their ability to care for clients with complex needs. DHHS also requested and received funding to support workforce initiatives aimed at increasing the number of mental health staff. In 2019, additional clinical nurse consultants and mental health engagement workers will be recruited.

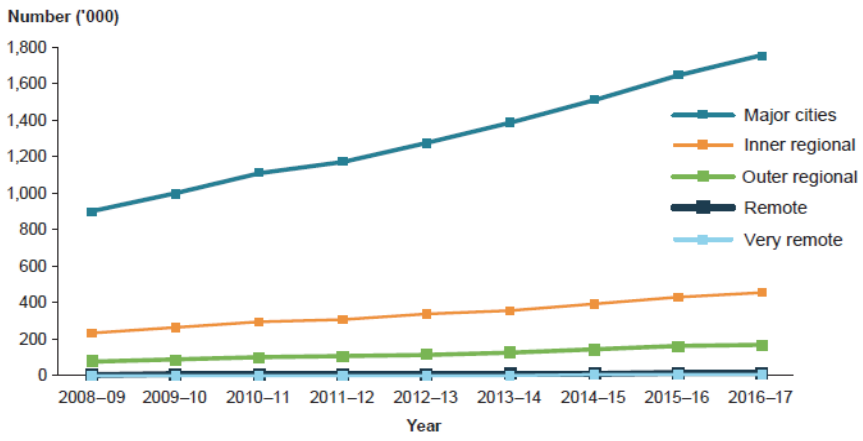
Despite this range of workforce activities, it is not clear what DHHS aims to achieve through its workforce strategy and initiatives, as it has not set quantifiable performance indicators or targets, and there are no plans for a formal evaluation. DHHS advice to government through its 2018–19 business case to 'Reform clinical mental health services', does articulate the need for growth funding, additional and different services and additional staff, but does not explain their interdependencies. DHHS requires a clear understanding of the numbers and types of staff needed, and where and when they are needed, to enable its broader service reforms to occur. This in turn, would inform specific targets. Without such ways to measure progress, DHHS cannot track whether its investment in the workforce strategy and initiatives is growing and supporting the mental health workforce. The strategy also does not directly address the identified issue of higher workforce gaps in regional and rural areas.

3

Understanding and meeting demand

Demand for mental health services in Victoria is increasing, not just in relation to the number of people who need services, but also in the severity of illness. The drivers of the increased demand include population growth, legal and illegal drug use, and heightened community awareness of mental health issues. The number of people experiencing mental illness in Australia has increased significantly in the last 10 years, as Figure 3A shows, and Victoria is consistent with this trend.

Figure 3A
Growth in number of Australians experiencing mental illness by area of residence



Source: Mental health services: In brief 2018, AIHW.

DHHS's intention for the mental health system is that, where possible, people are supported to remain in the community—which is often the best environment for the individual, and also reduces demand on bed-based services. However, achieving this aim relies on a system with the capacity to provide timely access to services.

This part examines the aspects of the mental health service system that underpin the provision of access to services; funding, demand, infrastructure and service distribution.

3.1 Conclusion

DHHS's 10-year plan includes 'enabling greater access to high quality, integrated services'—Outcome 13. Victorians have a right to expect this level of service from their public mental health services and to achieve this outcome, the system needs funding and infrastructure that matches demand and a service model that promotes, rather than impedes, access. Recent advice from DHHS to government, supported by multiple DHHS-commissioned reviews, clearly articulates the existing funding and infrastructure gaps. However, DHHS progress has been slow and the most important elements of change, such as funding reform, infrastructure planning, catchment area review, and improved data collection have only just, or not yet commenced. There is real risk that achievements intended within the 10-year plan's lifespan will not occur. Considerable acceleration of effort is required.

3.2 Funding

Victoria's public mental health services are subject to an input-based funding model. In this model, DHHS allocates a block of funding to AMHSs based on their number of inpatient beds or previous year's client numbers, which is indexed at 1.6 per cent per annum. The allocation is not sensitive to unmet demand, the needs and complexity of the mental health services' client cohort, contemporary population data, nor demographic changes.

AIHW data shows that between 2011–12 and 2015–16 national recurrent expenditure per capita on specialised mental health services grew an average of 0.7 per cent annually. Over that time in Victoria it declined by 0.3 per cent annually. In 2015–16, Victoria's per capita recurrent expenditure was $197.30, the lowest in Australia, against a national average of $226.52.

Funding for the mental health system since the 10-year plan was issued increased by $100.0 million in 2017–18 and $106.8 million in 2018–19. The Victorian State Budget 2018–19 provides $1 605.7 million in mental health funding, which will assist Victoria to address the funding disparity with other states and territories.

DHHS will spend $83.7 million during the 2018–19 financial year to begin clinical mental health services reform with a number of initiatives to help address access including:

- redesigning community-based mental health services
- strengthening the mental health workforce
- six new mental health and alcohol and drug service hubs
- growth in community mental health service hours
- increasing clinical capacity in sub-acute services.

Impact of funding shortfalls

Despite mental health system growth funding allocation over the last three state budgets, the lack of funding for more than 10 years has forced AMHSs to focus on acute and crisis treatment at the expense of earlier intervention services in the community. While community mental health received a share of growth funding, 2.3 per cent in 2016–17 and 7 per cent in 2017–18, AMHSs advise that this growth funding was largely directed to filling the existing gap between their service costs and the price DHHS pays, rather than providing additional services.

Because AMHSs often redirect resources from community to hospital settings to support consumers who need a higher level of care, AHMSs have limited capacity to intervene in the earlier stages of mental illness or deliver high quality interventions in the community to promote recovery. This limitation contributes to an increase in the number of people admitted to acute care without prior community contact. Between 2009 to 2016 acute admissions grew by 19 per cent, while community mental health contacts decreased by 17 per cent, which contributes to a cycle of increasing demand for costly emergency and inpatient services and further impacts AMHSs' ability to provide effective interventions during earlier stages of illness. Recent increases in funding for community services, however, have seen more people have preadmission contact, which begins to address this problem.

The audited AMHSs also advised that their bed day costs are higher than the price DHHS pays, and that they do not receive the necessary funding to meet demand. DHHS costings of acute mental health inpatient funding found that the price paid by DHHS meets only around 62 per cent of full costs to AMHSs, compared to 82 per cent of the price paid for general acute hospital beds. A DHHS commissioned review advised that the price paid should be 80 to 85 per cent of the full cost. All the audited AMHSs advised that, because of the current gap, AMHSs cross-subsidise their inpatient mental health services from other areas within the health service, which risks a negative impact on those services.

The case for funding reform

The introduction of activity-based funding in mental health services has been on the agenda in Victoria for over five years—DHHS's 2016–17 Acute Funding Review identified the need for mental health funding reform. DHHS's commissioned review 'Reform of Victoria's specialist clinical mental health services December 2017' (2017 review) also recommends that a future funding model should include output, input, block and outcome funding. Alongside this model is national health funding reform and the need for Victoria to align with the new Australian Mental Health Care Classification (AMHCC). The AMHCC is designed to provide consistency across health services, support integrated service delivery across services, and enable mental health services to be priced and funded on an activity basis.

Packages of Care—patients are classified into one of 13 levels by the complexity of their issues, phase of care and social connectedness, with funding matched to the needs of each classification level.

DHHS intends to provide AMHSs with a single annual payment based on their patient mix. Over time, DHHS will bundle funding for community care and acute care to provide the strongest incentive to substitute community mental health services for acute care where clinically possible.

In the interim, DHHS has started funding packages of care for high needs patients.

DHHS is now implementing funding reform for clinical mental health services that will move away from an input-based model towards bundling bed and community hours funding through 'packages of care' that are informed by the complexity levels of the client mix at an AMHS. The aim is to improve the support for clients most in need of mental health services and to incentivise AMHSs to assist people to remain well within the community setting. This is consistent with the findings and recommendations in DHHS's 2017 review which emphasises the need to increase community-based mental health treatment to reduce the demand on acute services. The four-year funding reform began in 2018–19 with a 'shadow' year to allow AMHSs to adjust to the changes. If this funding distribution method is successful, it will enable greater early access for consumers in need of mental health services and eventually alleviate demand for acute mental health services.

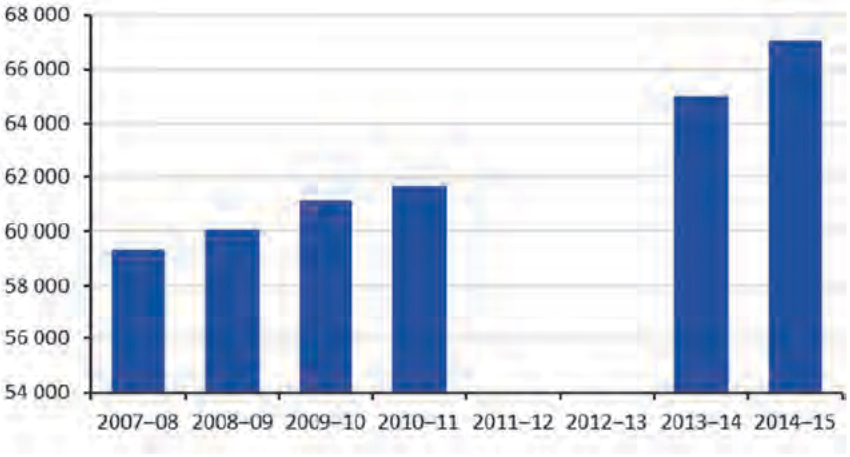
While the new funding model is well aligned to the intent to incentivise more community-based treatment, without an adequate quantum of funding (and the staff and infrastructure to deliver the services) there is risk that the intended outcomes will not be achieved. DHHS advice to government states that the new funding reform model aims to provide each new community-based client with a maximum of six hours treatment per annum and that the nationally recommended level is 72 hours per annum. DHHS also notes that the four-year growth funding will enable DHHS to provide mental health services to 1.2 per cent of the population in 2018–19 and thereon, only a marginal improvement on the current 1.16 per cent coverage compared to the estimated 3.1 per cent of the Victorian population with a severe mental illness. This growth funding also only increases the price paid to 67 per cent of AMHSs' costs.

Another change is that DHHS has moved bed funding to a single price for all beds regardless of location or severity of illness. It is unclear how DHHS is addressing the risk of disadvantaging some service providers such as rural AMHSs that have inherently higher operating costs.

3.3 Understanding and planning to meet demand

Demand for mental health services in Victoria has increased over the last 10 years, and this trend is likely to continue, as indicated by Figure 3B. This demand is exceeding population growth, as shown in Figure 3C.

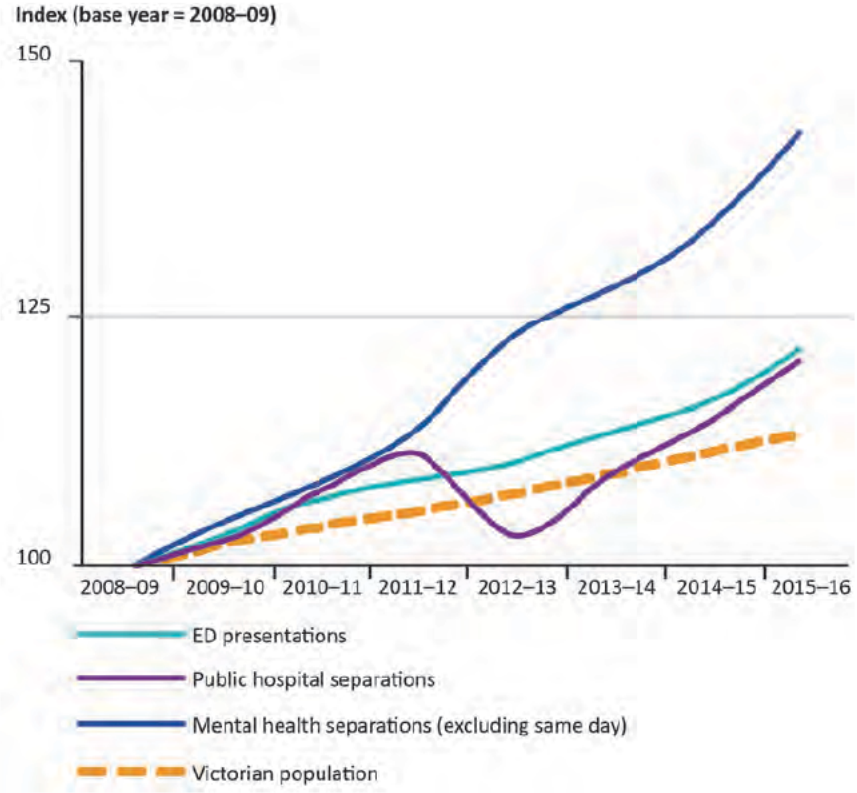
Figure 3B
Number of people receiving mental health services in Victoria



Note: Data was not available for 2011–12 and 2012–13.
Source: VAGO, based on *Report on Government Services*, Productivity Commission, 2017.

Mental health separations—when a patient formally admitted to hospital, receives at least one episode of care (and is in hospital for more than one day). Same-day services are counted separately.

Figure 3C
Indexed growth in Victorian health service-related events versus population



Note: Between 2011–12 and 2012–13 the negative growth in public hospital separations was due to a change in admissions policies (patients accommodated in the ED only were no longer counted as admitted). Once hospitals reconfigured their ED/inpatient interface, growth in separations has consistently increased.
Source: VAGO, based on information from DHHS using internal and Australian Bureau of Statistics data.

DHHS's 2017 review estimates that close to one million Victorians have a mental illness, with around 184 000 having a severe mental illness, as Figure 3D shows.

Figure 3D
Estimated number of Victorians with a mental illness

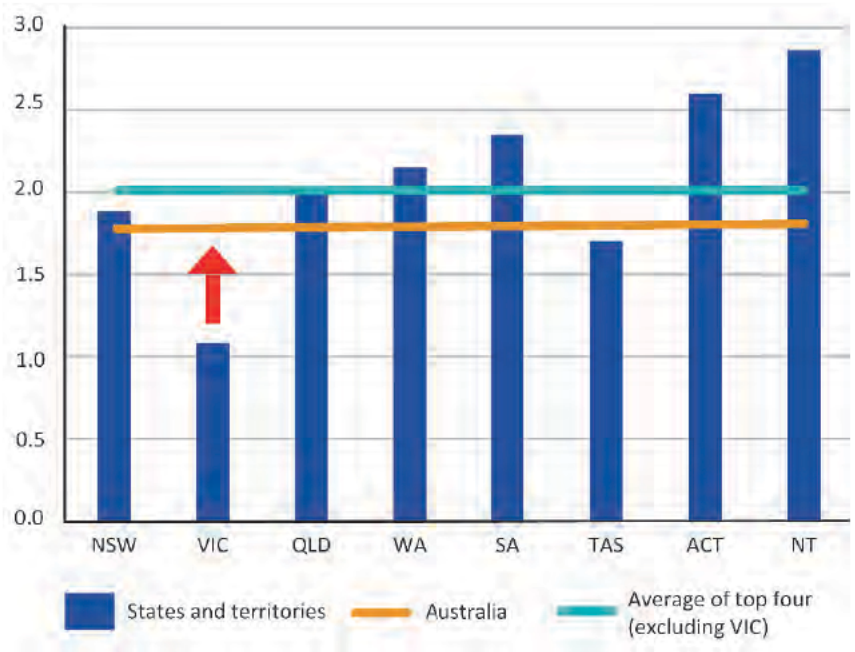
Severity of illness	Percentage of Victorians with a mental illness (%)	Number (thousands)	Percentage requiring treatment	Number needing treatment (thousands)	Primary government responsibility
Mild	9.0	537	50	268.5	Commonwealth
Moderate	4.6	272	80	217.6	State/Commonwealth
Severe	3.1	184	100	184	State
Total with mental illness	**16.7**	**993**		**670.1**	

Source: 2017 review, DHHS.

The table highlights the unmet demand for services in Victoria. In 2017–18 there were 72 859 registered users of mental health services, compared to the estimated 184 000 with severe mental illness that DHHS's 2017 review states need treatment.

Victoria falls significantly behind other jurisdictions and the national average in the proportion of the population receiving clinical mental health services, as Figure 3E demonstrates.

Figure 3E
Percentage of the Victorian population receiving clinical mental health services compared to other jurisdictions and the national average



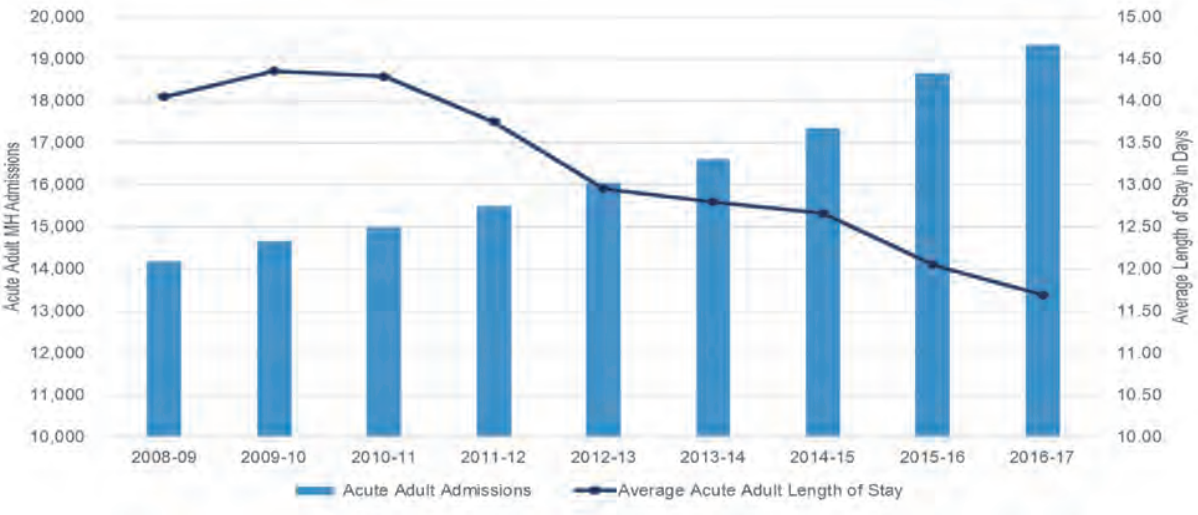
Source: VAGO, based on information from AIHW's *Mental health services in Australia 2013–14* cited in Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System, DHHS, 2017.

Increasing demand combined with current service shortfalls are placing the whole mental health service under considerable stress. The DHHS-commissioned Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System report states that increased demand has placed pressure across the mental health system over the last 10 years, which includes:

- ED presentations increasing 9 per cent from 2015–16
- acute hospital admissions growing at an annual rate of 2.4 per cent
- LOS in hospital trending down from 14.7 days to 11.2 days from 2009 to 2017—potentially not providing enough time for patients to become well
- unplanned readmission rates for adult mental health patients at 14.4 per cent in 2017–18
- community mental health contacts per 1 000 people declining at a rate of 2.5 per cent per annum over the last 10 years.

Figure 3F shows the increase in adult mental health admissions from 2009 to 2017. The increased number of presentations coupled with a shortage of mental health beds affects patients' LOS, meaning some patients likely do not receive the length of treatment they need. The 2017–18 Annual Report states LOS for adult acute mental health patients is just 9.6 days, a further decrease from that reported in the 2017 DHHS-commissioned review.

Figure 3F
Acute adult mental health admissions and average length of stay, 2009 to 2017



Source: Reform of Victoria's specialist clinical mental health services: Advice to the Secretary, Department of Health and Human Services, by A.Cockram, S.Solomon, H.Whiteford, 2017.

DHHS's 2017 review found demand pressures have also increased the threshold for access to community-based services so that AMHSs only see the most unwell, which creates a flow on effect with AIHW reporting the number of mental health patients accessing acute services through police, ambulance and self-presentations to hospital EDs increasing from 28 757 in 2004–05 to 54 114 in 2016–17.

Mental health patients are also staying in EDs longer. Between 2015 to 2017 their average wait time in EDs has gone from 7.6 hours to 9.5 hours, well over the national target of 4 hours. Mental health patients are the most represented when wait times for movement from the ED to a bed exceed 24 hours—79 per cent of patients compared to 30 per cent five years ago. For patients experiencing acute mental illness, the ED environment is often clinically inappropriate, and at times the presence of acutely unwell patients in the ED presents risks to the patient and others around them.

Collecting data to understand the system

To understand and respond to demand and access issues, DHHS needs systems that capture necessary data to reflect current service capacity and use statistical techniques to calculate unmet demand.

DHHS's key data tool is its Client Management Interface/Operational Data Store (CMI/ODS). AMHSs use it to record the core data elements of their service provision as mandated under the Act.

Mental health triage is the first point of system entry for potential consumers, or people seeking assistance on behalf of another.

A triage clinician assesses whether a person is likely to have a mental illness and the nature and urgency of the response required. Where an AMHS is not the most appropriate option for the person, they are referred to another organisation or given other advice. When specialist mental health services are likely to be suitable, the triage clinician comprehensive intake assessment is done.

The intake assessment may result in referral to another organisation and/or in the person being treated within the specialist mental health service. Only clients that receive treatment are recorded in CMI/ODS.

All the audited AMHSs use CMI/ODS as part of their data collection. They input data up to three times a day and this data links to quarterly reporting against KPIs that measure, for example, the rate a patient is readmitted, use of seclusion, and rates of post-discharge follow-ups.

However, while DHHS and AMHSs consider the data recorded to be accurate, five of the six audited AMHSs reported shortcomings in the CMI/ODS system including lack of functionality and low useability. Due to this shortcoming, the audited AMHSs use their own bespoke systems in addition to CMI/ODS for collecting and analysing data, duplicating effort in what is an already stretched workforce.

DHHS's 2017 review highlights the lack of comprehensive mental health triage data at a statewide level. The review notes the limitations the lack of data places on understanding the people who AMHSs do not accept into the mental health system and the reasons. The report states there has been a 63 per cent increase over the last four years in the number of people seeking access to, but not accepted by, AMHSs. This is also supported by DHHS's data analytics work undertaken in 2017, which used some triage information to demonstrate service demand increased by 43 per cent between 2010–11 and 2016–17.

DHHS is aware of the gaps in its triage data collection and the need to review triage services. While DHHS has decided to delay triage reform until after funding reforms, there is still an opportunity to improve data collection and analysis now to better inform future change.

In 2017, data analytics work by the Victorian Data Linkage Centre within DHHS in conjunction with external consultants noted limitations in the current data set and made several recommendations, including:

- incorporating data on unregistered clients into CMI/ODS to give a more complete picture of service activity and demand

- integrating mental health triage (see sidebar) data into CMI/ODS to give a better picture of service demand and analysis of how quickly services are provided as is done in other jurisdictions
- including information about mental health clients that present to EDs for treatment to allow for analysis of preventable ED presentations
- including information about people that contact mental health triage and do not go on to receive services but later present at an ED.

Forecasting demand

Having an estimate of future mental health system demand is crucial to ensuring adequate future service access and to advise government of funding needs. DHHS lacks a comprehensive view of current mental health service demand, and until recently DHHS utilised only basic forecasting.

Capture-recapture is a statistical method to estimate the population of a subset of a population.

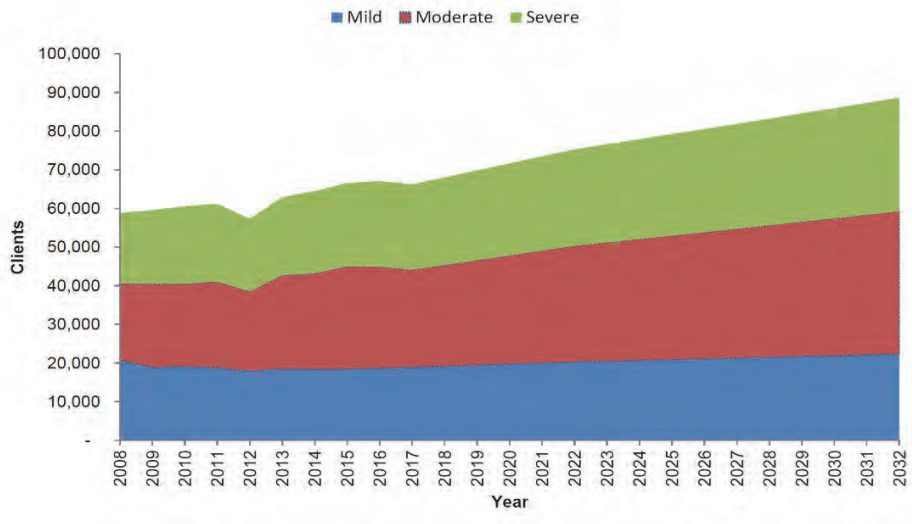
Typical applications include estimating the number of people needing particular services, or with particular conditions.

DHHS's current forecasting tool is available on its intranet and DHHS has committed to using this tool for its mental health work. It provides forecasting for system indicators including registered client numbers, acute admissions, community contacts and case length by taking historical data and aligning this with forecast population growth.

DHHS applies a statistical method of approximating demand known as 'capture-recapture', which informs its forecasting model that helps to estimate unmet demand by utilising DHHS data sources including ED presentations and information from its drug and alcohol, disability and child protection datasets. However, without the inclusion of data from the triage system and unregistered clients there remains a significant risk that using this statistical method, DHHS does not adequately capture the extent of mental health illness in the population and the true unmet demand for services.

Figure 3G is an example of forecasts using this tool, it projects the number of registered mental health clients will increase from 62 000 in 2017 to 80 000 in 2031—a 29 per cent increase—with the proportion of clients with moderate illness increasing from 38 per cent in 2017 to 42 per cent in 2032 and clients with severe illness being relatively stable at 33 per cent. Given the model limitations, the projection should be considered conservative, particularly as the number of registered clients for 2017–18, 72 859, already exceeds the projection for that year.

Figure 3G
Past and forecast registered active clients by illness severity



Source: DHHS, 2017.

3.4 Capital infrastructure

The other foundational factor needed to meet demand for mental health services is capital infrastructure: namely inpatient beds, including separate facilities for female inpatients. Responding to this need requires significant forward planning as new facilities take around five years to plan and build and, without accurate demand forecasting, can be already at or over capacity when they open.

Victoria's acute mental health beds are under significant pressure. There is sufficient evidence from the recent reviews that there are not enough mental health beds in Victoria to meet current, or future, demand. A DHHS review found that all major acute psychiatric units are continually operating at or above 95 per cent capacity, well above desirable levels of 80 to 85 per cent that allow AMHSs to admit acutely ill patients as needed.

The audited AMHS confirmed the capacity issue during our site visits. The impact on patients of high bed capacity is that AMHSs must make difficult decisions to manage bed availability. Audited AMHSs informed us that strategies used to manage bed availability include increasing the LOS in EDs, discharging the least unwell, and utilising other wards such as aged care, potentially placing a patient's care at risk.

In most facilities, males with acute mental health issues mix with female inpatients, which places women at significant risk of sexual abuse. Victoria's Mental Health Complaints Commissioner's *The Right to be Safe: Ensuring sexual safety in acute mental health inpatient units: sexual safety project report* (The Right to be Safe: Sexual Safety Project Report) found that 74.4 per cent of sexual safety complaints from 2014 to 2017 related to mixing males with acute mental health issues with female inpatients as shown in Figure 3H. AMHSs cite challenges to separating males and females because of ageing infrastructure.

Figure 3H
The Right to be Safe: Sexual Safety Project Report

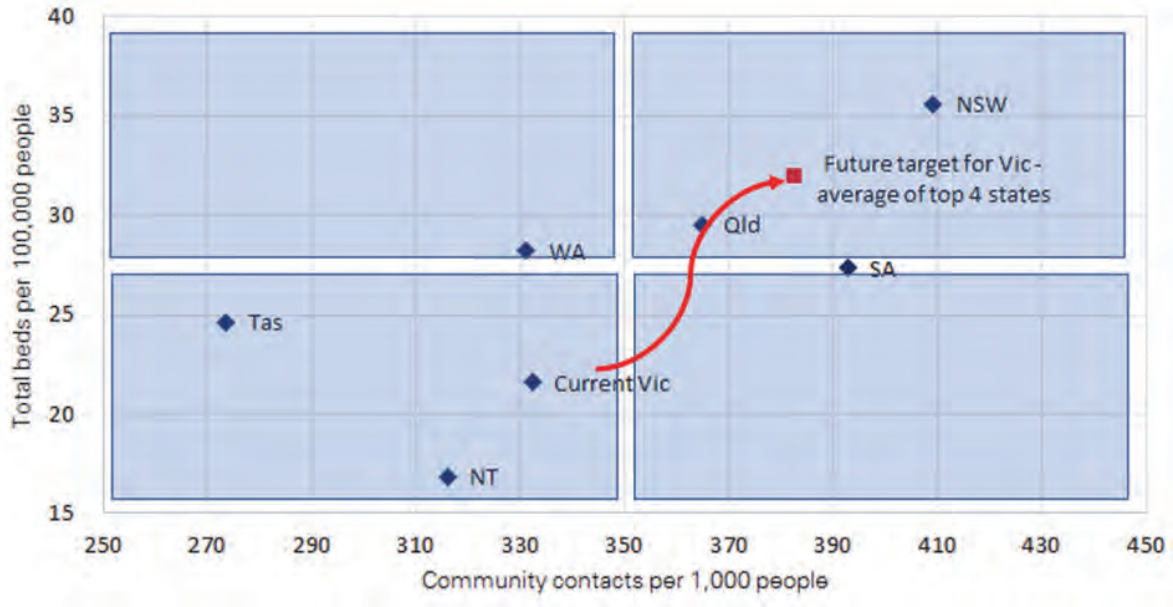
Victoria's Mental Health Complaints Commissioner's The Right to be Safe: Sexual Safety Project Report assessed 90 complaints from 1 July 2014 to 30 June 2017 that related to the sexual safety of acute mental health inpatients. The Commissioner found that most complaints related to breaches that occurred in the high dependency units or intensive care areas of the ward (40.4 per cent) or in bedrooms (34 per cent). The commissioner found that while most health services have some type of separate gender area, six cases occurred in women's only areas and for a further 22 cases, the health services reported that the service infrastructure (including gender separate areas) was not being adhered to. During our audit, all audited health services reported that they struggled to separate males and females due to a lack of appropriate infrastructure.

Source: VAGO, based on The Right to be Safe: Sexual Safety Project Report, Victoria's Mental Health Complaints Commissioner, 2018.

The availability of acute mental health beds is different across geographic areas, with outer suburban areas not keeping pace with population increases in growth corridors. Demographic changes in regional areas also impact bed requirements, for example at least two of the four regional AMHSs audited cited the ageing population in their catchment area and the need for more aged mental health beds.

To service current unmet need as well as future demand and to adequately support community-based treatment and care, the mental health bed base across Victoria must be increased. Victoria currently has the lowest bed base nationally as well as a comparatively low bed base globally. A review commissioned by DHHS advised that Victoria's bed base should increase in line with the bed base provided by other comparable states. The review estimates that the bed base would need to grow by 80 per cent over the next decade, which highlights the existing low bed base per head of population in Victoria shown in Figure 3I.

Figure 3I
Comparison of states and territories on per capita utilisation of mental health beds and community contacts



Note: Excludes forensic mental health beds.
Source: AIHW's *Mental health services in Australia 2013–14,* cited in DHHS-commissioned consultant report, Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System, 2017.

There are 53 new acute adult beds funded in 2018–19; with 21 now open and 34 in planning. There are also 24 sub-acute beds in the planning phase, and 10 mother and baby unit beds will now operate seven rather than five days a week. No further new beds are in the capital pipeline and given population growth, current and planned beds will not meet the unmet demand nor move Victoria towards the recommended bed base. Delivering mental health facilities requires significant planning and construction time—around five years—in part due to the need for reinforced walls, egress and seclusion areas, outside space, and anti-ligature features.

DHHS intends to complete a 'Detailed services and infrastructure plan for Victoria's clinical mental health system over the next 20 years' and update it every five years to support the 'Statewide design, service and infrastructure plan for Victoria's health system 2017–2037'. However, given it will likely take DHHS some time to complete this plan, secure and allocate funding, and then plan and build infrastructure, DHHS should anticipate and plan for Victorians with mental health issues to continue to experience problems accessing mental health beds at least across the remaining life of the 10-year plan, and that this will impact the effectiveness of any changes to funding or the service delivery model.

3.5 Catchment areas

Clinical mental health services are provided in geographic catchment areas that were established in the 1990s. The consumer's place of residence determines which service or services they can access. DHHS's internally commissioned reviews highlight practical problems with the current area-based clinical mental health system that impact Victorians' ability to access services, which include:

- the catchment areas are not aligned with other health and human service areas, or local government area boundaries, which makes service coordination difficult for consumers and carers, many of whom need support from multiple services
- lack of alignment between geographic catchments and age-based service groupings
- lack of coordination between catchment areas when patients need to access services across catchment borders
- misalignment between service levels and types within a catchment and population growth and demographic changes in that area.

In August 2013, DHHS reviewed the mental health catchments. The review states that 'reconfiguring the catchment areas under which clinical mental health services are organised is a key step in delivering the kind of seamless, easy-to-navigate system that consumers and carers expect. It is also important for achieving optimal efficiency and effectiveness across the state'. Commitment to changing the catchment areas was included in the then Department of Health's strategy document, *Victoria's priorities for mental health reform 2013–15*. Despite this, DHHS has not implemented the changes to catchment areas.

In 2017, DHHS commissioned external consultants to develop the Design, Service and Infrastructure Planning Framework for Victoria's clinical mental health system. The framework recommended the following principles in reconfiguring service regions:

- Design service regions for populations between 500 000 to 1 000 000 people forecast by 2036, where appropriate and practical taking into consideration geographic placement of services and other factors.
- Improve access, outcome and demand management in growth corridors, including that sensible access to services overrides artificial geographical boundaries where appropriate.
- Align catchment areas with contemporary local government areas.

DHHS has not yet implemented these recommendations. While issues relating to catchments are complex and challenging, it is a critical piece of work that will contribute to improved access for consumers and we recommend that DHHS direct resources to this issue.

Appendix A
Audit Act 1994 section 16—submissions and comments

We have consulted with DHHS, Bendigo Health, Melbourne Health, Monash Health, Latrobe Regional Hospital, Peninsula Health and South West Healthcare and we considered their views when reaching our audit conclusions. As required by section 16(3) of the *Audit Act 1994*, we gave a draft copy of this report to those agencies and asked for their submissions or comments. We also provided a copy of the report to the Department of Premier and Cabinet.

Responsibility for the accuracy, fairness and balance of those comments rests solely with the agency head.

Responses were received as follows:

RESPONSE provided by the Secretary, DHHS

Department of Health and Human Services

CPES UNIT
RECEIVED
07 MAR 2019
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Mr Andrew Greaves
Auditor-General
Victorian Auditor-General's Office
Level 31, 35 Collins Street
MELBOURNE VIC 3000

Dear Mr Andrew Greaves

Thank you for your letter dated 22 February 2019, providing the proposed performance audit report on the accessibility of mental health services.

The Department of Health and Human Services (the department) has reviewed the report and accepts the recommendations. Enclosed with this letter, I present the department's action plan to address the report's recommendations. You note that, some of the recommendations will also be informed by the work of the Royal Commission into Mental Health.

That said, the department is committed to maintaining the momentum of efforts initiated under *Victoria's 10 Year Mental Health Plan*, to deliver safe, quality clinical mental health services. The audit provides a timely opportunity for the department to build on this foundation and strengthen the benefits of Royal Commission recommendations delivered in the years to come.

I would like to take this opportunity to thank your staff for their work, and the professional manner with which they engaged with department staff.

Yours sincerely

Kym Peake
Secretary

7 / 3 / 2019

VICTORIA State Government

RESPONSE provided by the Secretary, DHHS—continued

Access to Mental Health

Department of Health and Human Services response to VAGO recommendations

No	Recommendation	Proposed action	Proposed start date	Proposed end date
1	That the Department of Health and Human Services complete a thorough system map documenting its capacity, including capital and workforce infrastructure, geographical spread of services, and estimated current and future demand, including current unmet demand.	**The department accepts this recommendation.** The department will undertake a state-wide mapping and assessment of current and future demand that will be aligned to locality planning already scheduled to take place as part of the *Statewide Design, Service and Infrastructure Plan for Victoria's Health System, 2017 - 2037.* This will be supported by a comprehensive workforce strategy, which will plan for the workforce required for new and repurposed capital infrastructure.	June 2019	November 2020
2	That the Department of Health and Human Services use this map to inform a detailed, public, state-wide investment plan, that integrates service, capital and workforce planning, setting out deliverables and time frames.	**The department accepts this recommendation in-principle.** The department will use this map to inform funding allocations within the program area's budget, and to inform annual budget planning and business case processes Implementation of this recommendation will also be informed by recommendations arising from the Royal Commission.	Following the delivery of the Royal Commission's recommendations in its final report.	Within a year of the Royal Commission's recommendations in its final report.
3	That the Department of Health and Human Services set relevant access measures with targets, which reflect the intended outcomes of the investment plan, and routinely report on these internally and to the public.	**The department accepts this recommendation.** The department will consider the suite of available measures that to respond to known issues around access in the context of existing work to develop a performance and accountability framework for mental health services, and within the context of national reporting directions. The department recognises the need to be consider any unintended	May 2019	May 2022

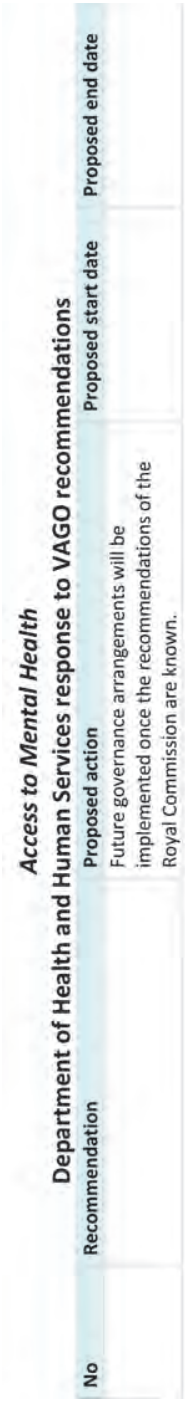
RESPONSE provided by the Secretary, DHHS—continued

Access to Mental Health

Department of Health and Human Services response to VAGO recommendations

No	Recommendation	Proposed action	Proposed start date	Proposed end date
		consequences that could occur as a result of changes to public reporting arrangements.		
4	That the Department of Health and Human Services undertake a price and funding review for mental health services, that includes assessing funding equity across Area Mental Health Services, and provide detailed advice to the Minister for Mental Health on the results and use this information to inform funding reforms.	**The department accepts this recommendation.** The department will undertake a price review of clinical mental health services. The department will establish a Mental Health Pricing Steering Committee, which will lead consultation with the sector. This work will inform the implementation of funding reforms currently underway.	July 2019	October 2020
5	That the Department of Health and Human Services resolve the known catchment area issues of misaligned boundaries that prevent people from accessing services.	**The department accepts this recommendation in-principle.** In the short to medium term, the department will work with health services with respect to known catchment issues. Implementation of this recommendation will also be informed by recommendations arising from the Royal Commission.	Following the delivery of the Royal Commission's recommendations in its final report.	Within two years of the Royal Commission's recommendations in its final report.
6	That the Department of Health and Human Services re-establish routine internal governance and reporting against mental health system priorities, activities and performance that ensures senior executive level oversight and accountability.	**The department accepts this recommendation.** In the short term, the Mental Health Expert Taskforce will be re-established to provide external input into the work of the department on mental health system priorities. The department will continue to report to the Health Reform subcommittee of the department's Executive Board on progress against Victoria's 10 Year Mental Health Plan.	June 2019	Following the delivery of the Royal Commission's recommendations.

RESPONSE provided by the Secretary, DHHS—continued



Access to Mental Health

Department of Health and Human Services response to VAGO recommendations

No	Recommendation	Proposed action	Proposed start date	Proposed end date
		Future governance arrangements will be implemented once the recommendations of the Royal Commission are known.		

RESPONSE provided by the Chief Executive, Melbourne Health

MELBOURNE HEALTH

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Australia

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5 March 2019

Mr Andrew Greaves
Victorian Auditor General's Office
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35 Collins Street
Melbourne VIC 3000

Dear Mr Greaves

Thank you for providing a copy of the proposed report on Access to Mental Health Services and for your worksheet acquitting your consideration of the comments we made regarding an earlier draft.

We do not wish to provide further comment.

Yours sincerely

Christine Kilpatrick
Chief Executive

First in Care, Research and Learning

The Royal Melbourne Hospital | NorthWestern Mental Health | Doherty Institute

Auditor-General's reports tabled during 2018–19

Report title	Date tabled
Local Government Insurance Risks (2018–19:1)	July 2018
Managing the Municipal and Industrial Landfill Levy (2018–19:2)	July 2018
School Councils in Government Schools (2018–19:3)	July 2018
Managing Rehabilitation Services in Youth Detention (2018–19:4)	August 2018
Police Management of Property and Exhibits (2018–19:5)	September 2018
Crime Data (2018–19:6)	September 2018
Follow up of Oversight and Accountability of Committees of Management (2018–19:7)	September 2018
Delivering Local Government Services (2018–19:8)	September 2018
Security and Privacy of Surveillance Technologies in Public Places (2018–19:9)	September 2018
Managing the Environmental Impacts of Domestic Wastewater (2018–19:10)	September 2018
Contract Management Capability in DHHS: Service Agreements (2018–19:11)	September 2018
State Purchase Contracts (2018–19:12)	September 2018
Auditor-General's Report on the Annual Financial Report of the State of Victoria: 2017–18 (2018–19:13)	October 2018
Results of 2017–18 Audits: Local Government (2018–19:14)	December 2018
Professional Learning for School Teachers (2018–19:15)	February 2019

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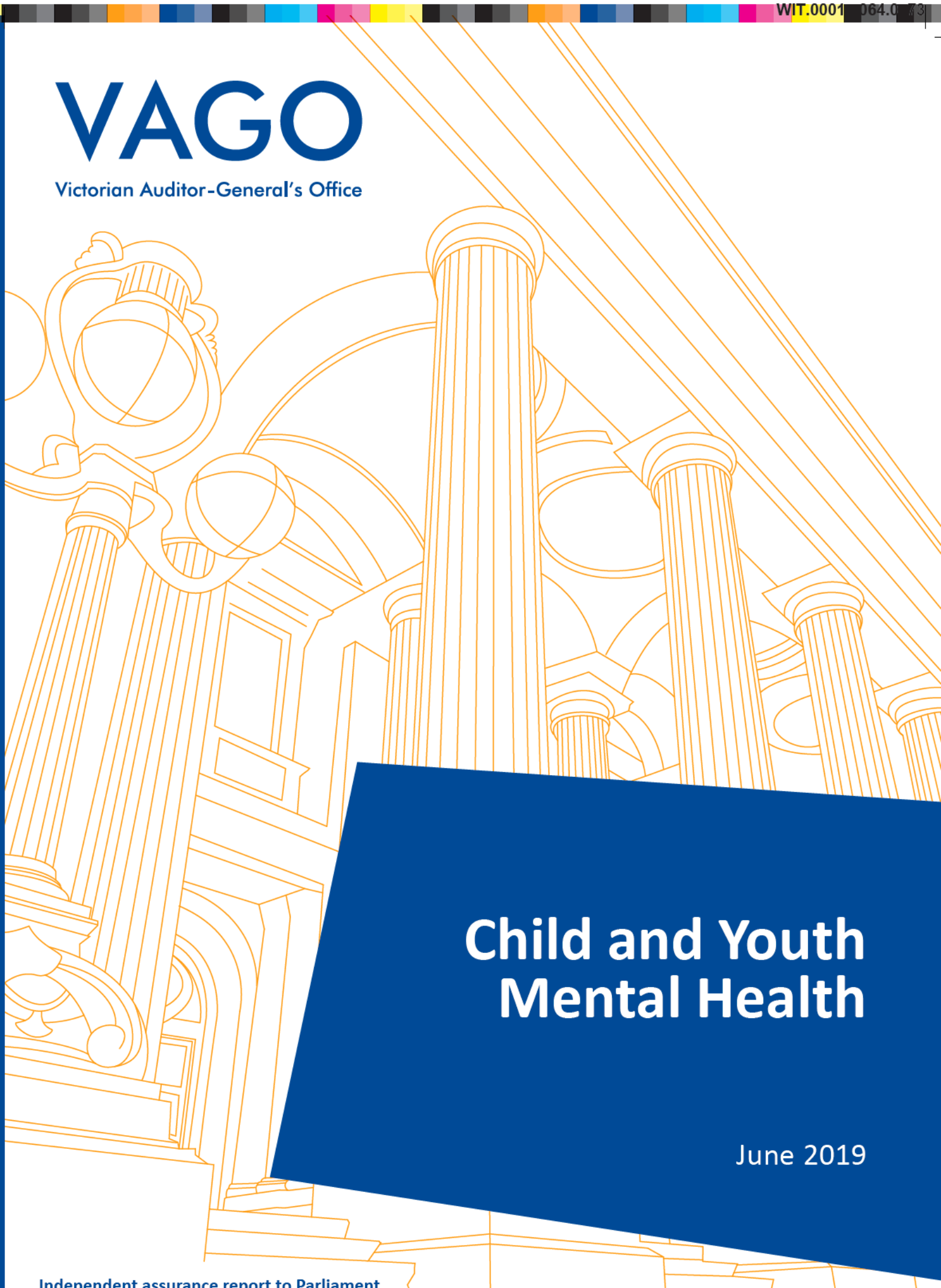
Attachment AG-2

This is the attachment marked 'AG-2' referred to in the witness statement of Andrew Greaves dated 19 July 2019.

https://www.audit.vic.gov.au/report/child-and-youth-mental-health

VAGO

Victorian Auditor-General's Office



Child and Youth Mental Health

June 2019

Independent assurance report to Parliament
2018–19: 26

VAGO

Victorian Auditor-General's Office

Child and Youth Mental Health

Independent assurance report to Parliament

Ordered to be published

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Victorian Auditor-General's Office

The Hon Shaun Leane MLC
President
Legislative Council
Parliament House
Melbourne

The Hon Colin Brooks MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my report *Child and Youth Mental Health.*

Yours faithfully

Andrew Greaves
Auditor-General

5 June 2019

Contents

Acronyms

AWH	Albury Wodonga Health
CAMHS	child and adolescent mental health services
CAP	child and adolescent psychiatrists
CEO	chief executive officer
CMI	Client Management Interface
CYMHS	Child and youth mental health services
DHHS	Department of Health and Human Services
DJCS	Department of Justice and Community Safety
DTF	Department of Treasury and Finance
ECT	electroconvulsive treatment
KPI	key performance indicator
MACNI	Multiple and Complex Needs Initiative
MHIDI	Mental Health and Intellectual Disability
NDIS	National Disability Insurance Scheme
NOCC	National Outcomes and Casemix Collection
OCP	Office of the Chief Psychiatrist
ODS	operational data score
PCP	Primary Care Partnership
PHN	Primary Health Networks
PRISM	*Program Report for Integrated Service Monitoring*
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCH	Royal Children's Hospital
SCV	Safer Care Victoria
SDQ	Strengths and Difficulties Questionnaire
SoP	Statement of Priorities
VAGO	Victorian Auditor-General's Office
VAHI	Victorian Agency for Health Information
Y-PARC	Youth Prevention and Recovery Centres

Audit overview

There are many different terms used for children and young people in different contexts. In this report:

- 'infants' are 0–4 years of age
- 'children' are 4–12 years of age
- 'adolescents' are 13–18 years
- 'youth', 'young people' or 'young persons' are 13–24 years, ending on the individual's 25th birthday.

'Children and young people' is used in this report as a generic term that has no specific age grouping or may refer to several different groupings that are later specified.

Mental health problems are the most common health issues facing young people worldwide, according to the *Global Burden of Disease Study 2017*. Mental health problems encompass mild and short-term problems to severe, lifelong and debilitating, or life-threatening problems.

Three-quarters of all mental health problems manifest in people under the age of 25. One in 50 Australian children and adolescents has a severe mental health problem. Severe mental health problems include acute psychiatric disorders, such as schizophrenia, that are persistent and make daily tasks difficult. Some severe mental health problems can be triggered by trauma such as abuse or neglect, or by developmental disorders or physical trauma that leads to disability.

The likelihood of mental health problems increases exponentially where there are other indicators of vulnerability such as unstable housing and poverty, neglect and abuse, intergenerational trauma or developmental disabilities.

Intervention early in life, and early in mental illness, can reduce the duration and impact. Early intervention is especially important for children and young people because many mental health problems can affect psychosocial growth and development, which can lead to difficulties later in life.

Victoria's public mental health services focus on the treatment of more severe mental health problems and support infants, children, and young people through a mix of community, outreach, and inpatient hospital services. They also provide education, upskilling and leadership on managing mental health problems to the services and agencies that involve children and young people, which include schools, child protection, and disability services.

There has never been an independent review of clinical mental health services for children and young people in Victoria, despite significant changes in the service system with the introduction of the National Disability Insurance Scheme (NDIS) and headspace centres (youth-specific community mental health services).

This audit assessed the effectiveness of public child and youth mental health services (CYMHS) in one regional and four metropolitan health services. After our planning process identified the most significant risks for CYMHS, we focused on whether the services have been designed appropriately, and whether the Department of Health and Human Services (DHHS) is administering them effectively. The audit did not investigate the clinical effectiveness of individual patient care.

Conclusion

Not all Victorian children and young people with dangerous and debilitating mental health problems receive the services that they and their families need. This can lead to ongoing health problems, increasing the risk that children and young people will disengage from education and employment and be more likely to be involved with human services and the justice system.

Specialist child, adolescent and youth mental health services do improve many of their clients' outcomes, but they do not meet service demand or operate as a coordinated system. This can lead to significant deterioration in the health and wellbeing of some of Victoria's most vulnerable citizens.

DHHS has neither established strategic directions for CYMHS nor set expected outcomes for most of its CYMHS funding. This key issue inhibits service and program managers from realising efficiencies and improvements to service delivery such as working to a common purpose, sharing lessons or benchmarking progress.

Problems with the CYMHS performance monitoring system create oversight gaps for DHHS, which leaves it unable to address significant issues that require a system-level response. These issues include clinically unnecessary stays in inpatient mental health wards, and the admission of children and young people to adult mental health beds.

Health services express that due to DHHS's limited engagement with them, and monitoring systems that do not accurately reflect services' performance, DHHS does not sufficiently understand the CYMHS system and the challenges it faces. DHHS's lack of understanding contributes to a climate of uncertainty and distrust, which inhibits systemic improvement and creates significant variability and inequity in the care that children and young people receive.

DHHS has predominantly taken a one-size-fits-all approach to the mental health system's design and monitoring, which does not adequately identify and respond to the unique needs of children and young people.

Findings

Design of child and youth mental health services

There is no strategic framework to guide and coordinate DHHS or health services that are responsible for CYMHS, which is evident in a range of issues with the CYMHS design:

- DHHS lacks a rationale for the programs and services it funds and there has been a lack of transparency in how some programs and services have been funded.
- Some health services receive funding for programs that technically have ceased, and health services that provide similar activities receive different funding.
- DHHS does not set expectations for service delivery for most funded programs and does not monitor what programs and activities health services deliver.

- DHHS has not adequately considered the geographic distribution of services relative to the population, which creates inequities in service provision.
- There is a confusing mix of age eligibility arrangements across services—some treat young people up to the age of 25 and some up to 18. This is because in 2006, DHHS began increasing service eligibility to 25, but stopped the rollout midway through when the government changed.
- DHHS has not considered CYMHS's particular workforce challenges and needs that can vary from the adult sector, and the recent DHHS mental health workforce strategy does not specifically address CYMHS workforce issues. DHHS advises that the new Centre for Mental Health Learning is now mapping workforce needs, including for CYMHS.

While the cause of this lack of a strategic approach to CYMHS is unclear, high staff turnover in leadership roles and lack of specific performance oversight of CYMHS are likely contributing factors.

DHHS's commitment to reform the mental health funding model into activity-based funding has not progressed for CYMHS. DHHS has taken no action to address the known problems with transparency and equity in the current funding model.

Monitoring performance, quality and outcomes

DHHS's performance monitoring of CYMHS comprises seven separate systems that are conducted in silos. The different areas that hold responsibility for monitoring within DHHS do not coordinate to identify common or systemic issues, nor do they share the information they collect. The current arrangement offers significantly limited oversight of CYMHS:

- The Mental Health Branch's program meetings discussed CYMHS only once in four years for four health services.
- Key performance indicators (KPI) to measure CYMHS differ from the national mental health performance framework limiting performance benchmarking.
- The two CYMHS KPIs that inform DHHS’s quarterly performance discussions with chief executive officers (CEO) only concern services provided to patients who have had an inpatient admission.
- There are no KPIs or monitoring of some significant issues in CYMHS, such as long inpatient stays, accessibility, service coordination or family engagement in care.

The lack of service performance expectations and the limitations of DHHS's performance monitoring systems for CYMHS also hinder its ability to accurately advise government on how this important system performs, or what improvements are needed.

Monitoring the quality and safety of service delivery

The Chief Psychiatrist has legislated responsibilities to monitor service quality and safety in CYMHS. The Office of the Chief Psychiatrist (OCP) has delivered a large program of activities to review and improve service quality across mental health services; however, there has been no attention to the unique issues in CYMHS. Rather, the monitoring is reactive and crisis-driven, with limited focus on systemic issues.

DHHS does not routinely monitor the quality of CYMHS service delivery. Further, DHHS has commissioned two significant evaluations and reviews of new CYMHS services that have not been publicly released, and their findings have not been communicated to the CYMHS that were reviewed. A further nine reviews and analyses that DHHS conducted internally include information about CYMHS that could contribute to broader service quality improvement; however, these have not been provided to health services.

Access for vulnerable populations

DHHS has not identified priority populations or enabled health services to provide priority access to those most in need. Only one of the five audited health services has implemented the Chief Psychiatrist's 2011 guideline to prioritise children in out-of-home care. DHHS has not reviewed the guideline or its implementation since its release. Furthermore, DHHS's data does not record a client's legal status, which means there is no mechanism to reliably identify children in out-of-home care in the CYMHS system.

DHHS has not reviewed its triage scale since its introduction in 2010. DHHS is aware that the triage scale is not optimal for children and young people because it does not consider developmental risks and does not enable prioritisation of access for high-risk population groups.

Service coordination around multiple and complex needs

Young people are routinely getting 'stuck' in CYMHS inpatient beds when they should be discharged, because they cannot access family or carer support and/or services such as disability accommodation or child protection and out-of-home care. DHHS does not monitor this issue of inpatient stays that are clinically unnecessary despite health services having raised it repeatedly.

Current data systems prevent definitive monitoring of clinically unnecessary stays in CYMHS inpatient beds. However, the five audited health services provided to this audit 29 case studies from the prior 12 months that show at least 1 054 bed days used by patients without clinical need to be mental health inpatients. While some of the drivers of this problem are complex social and family issues, DHHS has not taken strategic action to address systemic issues with service coordination that they have the authority to resolve.

Monitoring long inpatient stays would provide a partial indicator of clinically unnecessary stays. DHHS could not explain why it monitors long stays over 35 days for the adult mental health system, but not for CYMHS, despite our data analysis showing that there have been 228 long stays in four health services over three years, of which 107 were children under 18 years.

In one region, there has been a long-running dispute between two service providers over referral and discharge processes. DHHS has acted to resolve this issue, which caused longer inpatient stays for approximately 300 adolescents per year, by advising the health services to meet monthly and to escalate matters that cannot be resolved to the Chief Psychiatrist.

Clients with intellectual or developmental disabilities complicated by mental health problems account for many long and/or clinically unnecessary inpatient stays. DHHS has not responded adequately to CYMHS's reports about the service gap for young people with dual disability and the significant negative impacts on CYMHS's resources, workforce and the young people and their families.

DHHS and the Department of Justice and Community Safety's (DJCS) shared Multiple and Complex Needs Initiative (MACNI) provides case management for people aged 16 and over with mental illness, complex needs, and dangerous behaviours. Eligibility criteria are too narrow and processes too slow for this service to assist CYMHS with complex clients who are 'stuck' in inpatient units.

A $5.5 million pilot project that DHHS funded three years ago, and another CYMHS's independent service development, have lessons and resources that DHHS has not shared with other CYMHS. DHHS has not responded to either of these services' recommendations to address gaps in accommodation and service coordination for these young people, nor taken any action to support other CYMHS with providing services to clients with dual disability who have complex needs.

Recommendations

We recommend that the Department of Health and Human Services:

1. in conjunction with child, adolescent and youth mental health services and consumers, develop strategic directions for child, adolescent and youth mental health services that include objectives, outcome measures with targets, and an implementation plan that is supported by evidence-based strategies at both the system and health service levels (see Section 2.2)
2. when implementing the six recommendations from the VAGO audit *Access to Mental Health Services*, ensure that the needs of children, adolescents and young people as well as child, adolescent and youth mental health services are considered and applied, wherever appropriate (see Section 1.4)
3. establish and implement a consistent service response for 0–25 year-olds in regional Victoria that need crisis or specialised support beyond what their local child, adolescent and youth mental health services' community programs can provide, including reviewing the extent to which the six funded regional beds are able to provide an evidence-based child and adolescent service (see Sections 2.4 and 3.2)

4. establish and implement a transition plan towards achieving a consistent service response for 19–25 year-olds with moderate and severe mental health problems (see Section 2.5)
5. develop and implement a child, adolescent and youth mental health workforce plan that includes understanding the specific capability needs of the sector and specifically increasing capabilities in the area of dual disability, that is, intellectual or developmental disabilities complicated by mental health problems (see Section 2.7)
6. refine, document and disseminate the performance monitoring approach for child and youth mental health services so it consolidates current disparate reporting requirements and includes:
    - measures that allow monitoring of long inpatient stays, priority client groups, clinical outcomes and accessibility of child and youth mental health services
    - introducing quality and safety measures of child and youth mental health services community programs in the Victorian Health Services Performance Monitoring Framework
    - the role of the Chief Psychiatrist in performance monitoring, and how the information it receives from mandatory reporting informs the Department of Health and Human Services' performance monitoring
    - documenting in one place all reporting requirements for child and youth mental health services from all areas of the Department of Health and Human Services, including administrative offices Safer Care Victoria and the Victorian Agency for Health Information
    - how the Department of Health and Human Services will respond to performance issues (see Sections 3.2 and 3.6)
7. ensure that six-monthly mental health program meetings occur and information received is consolidated to identify systemic and persistent issues (see Section 3.4)
8. initiate negotiations with the Department of Treasury and Finance during the state budget process to ensure that Budget Paper 3 performance measures include monitoring of child, adolescent and youth mental health services (see Section 3.6)
9. disseminate evaluations and reviews of child, adolescent and youth mental health service projects and services to all child, adolescent and youth mental health service leaders (see Section 3.7)
10. formally respond to all recommendations made in the 2016 review of the role of the Chief Psychiatrist and advise the Minister for Mental Health on intended actions (see Section 3.7)
11. in consultation with health services, ensure that the Chief Psychiatrist's guidelines and directions are effectively communicated to those responsible for their implementation in child, adolescent and youth mental health services and that their implementation is supported and monitored (see Section 3.7)

12. benchmark the performance of child, adolescent and youth mental health services in Victoria at the system level against other jurisdictions, and national and international targets, and report the findings and opportunities for improvement subsequently identified in the Mental Health Annual Report (see Section 3.8)
13. ensure that the data that the Department of Health and Human Services and/or health services need to collect about child and youth mental health services for their reporting and monitoring obligations, including the outcome measures and targets developed through Recommendation 1, is consistent with what is collected and recorded in the Client Management Interface database and develop a single and comprehensive source of guidance and business rules about data reporting requirements (see Section 3.9)
14. update the triage scale and process so it is developmentally appropriate for children, adolescents and young people, and considers how triage can be provided at peak periods of demand such as evenings and weekends (see Section 4.2)
15. ensure the registration forms that the Department of Health and Human Services issues to health services can record a child, adolescent or young person's legal status with regards to guardianship, out-of-home care, and restrictive interventions or compulsory treatment under the *Disability Act 2006,* that the information can be entered into central databases, that business rules exist for doing so and data entry is monitored to ensure it is occurring (see Section 4.2)
16. provide written guidance to child and youth mental health services' leaders about both the Department of Health and Human Services' Complex Care Panels and the Multiple and Complex Needs Initiative, which includes how to refer clients to each, how to contact the necessary staff in each Department of Health and Human Services geographic area for information and advice, which clients are eligible for each, and is updated at least annually (see Section 4.3)
17. consider establishing a High-Risk Complex Care Child and Youth Panel, with executive representation from out-of-home care, disability services, and mental health areas of the Department of Health and Human Services, with remit to:
    - allow health services to rapidly escalate cases to the panel when a local service response is not meeting a young person's needs, to prevent a clinically unnecessary inpatient stay that may cause deterioration of the young person's health and wellbeing
    - identify and address service gaps and service coordination challenges that are contributing to clinically unnecessary inpatient stays
    - liaise with the National Disability Insurance Agency, as required (see Section 4.4)

18. create a channel for the Chief Psychiatrist to independently brief the Minister for Mental Health or the Secretary, if they deem it necessary (see Section 4.4)
19. establish and implement a consistent service response for 0–25 year-olds who have intellectual or developmental disabilities and moderate to severe mental health problems (see Section 4.5)
20. establish a mechanism for operational and clinical leaders of all child, adolescent and youth mental health services to collaborate with each other and with the Department of Health and Human Services to improve service response consistency, and strengthen pathways between services for clients and families, including reviewing catchment boundaries and access to specialised statewide programs (see Section 4.5).

Responses to recommendations

We have consulted with DHHS, Albury Wodonga Health (AWH), Austin Health, Eastern Health, Monash Health and the Royal Children's Hospital (RCH) and we considered their views when reaching our audit conclusions. As required by section 16(3) of the *Audit Act 1994*, we gave a draft copy of this report to those agencies and asked for their submissions or comments. We also provided a copy of this report to the Department of Premier and Cabinet.

DHHS provided a response. The following is a summary of its response. The full response is included in Appendix A.

DHHS accepted each of the 20 recommendations, noting that implementation of the recommendations will be informed by the outcomes of the Royal Commission into Mental Health, particularly recommendations relating to system design. DHHS will develop strategic directions and refine the performance monitoring approach for services, share reviews and evaluations, update triage and registration processes, provide guidance around complex care panels, consider establishing a High-Risk Complex Care Child and Youth Panel, establish a mechanism for health services to collaborate and create a means for the Chief Psychiatrist to independently brief the Secretary or Minister for Mental Health.

1

Audit context

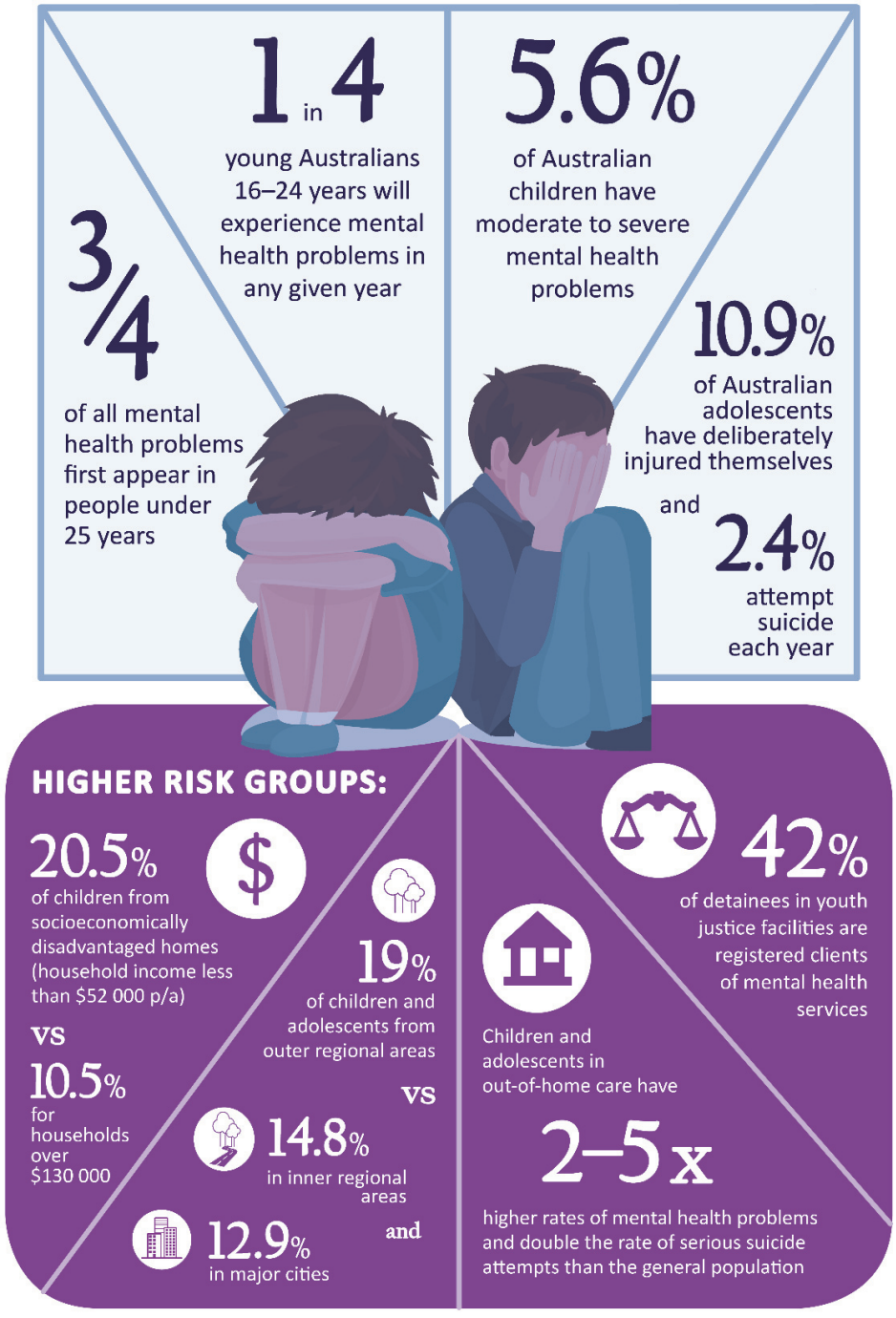
Mental health problems are the most common health issues facing young people worldwide, according to the *Global Burden of Disease Study 2017*. Three-quarters of all mental health problems manifest in people under the age of 25. One in four Australians aged 16–24 years will experience mental health problems in any given year, while 2.1 per cent of Australian children and adolescents have a severe mental health problem and a further 3.5 per cent have moderate mental health problem. One in 10 Australian adolescents (10.9 per cent) have deliberately injured themselves, and each year one in 40 (2.4 per cent) attempt suicide.

The Australian Government's national survey of child and adolescent mental health defines the most common and disabling mental health problems that children and young people in Australia experience as:

- major depressive disorder
- attention-deficit/hyperactivity disorder
- conduct disorder
- social phobia
- separation anxiety
- generalised anxiety
- obsessive-compulsive disorder.

Figure 1A summarises the most recent data on children and young people's mental health problems. This data references various years and sources, and highlights that some children and young people are at higher risk of having a mental health problem. For example, children and young people from socio-economically disadvantaged families have higher rates of mental health problems. Children living in out-of-home care experience two to five times higher rates of mental health problems and more than double the rate of serious suicide attempts.

Figure 1A
Prevalence of mental health problems in Australian children and young people



Note: A serious suicide attempt is a suicide attempt that required medical treatment.
Source: VAGO with information from Lawrence D, et al, (2015), *The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*; Department of Health, Canberra; Sawyer, M. et al (2007), 'The mental health and wellbeing of children and adolescents in home-based foster care', *Medical Journal of Australia*, 186:4; Kessler RC, et al, (2005), *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication*; Australian Institute of Health and Welfare, (2007), *Young Australians: their health and wellbeing*; DHHS (2018), Mental Health 2018–2023 Services Strategy analysis – Draft, Linkage, Modelling and Forecasting Section.

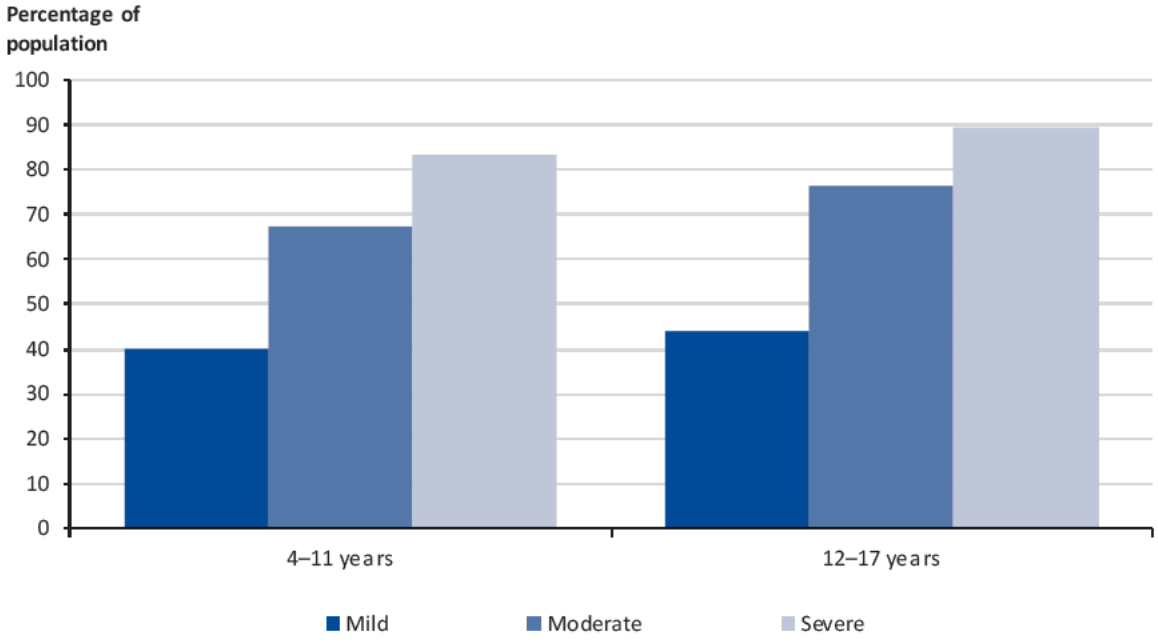
Services used by children and young people with mental health problems

In 2017–18, there were 11 945 registered clients of CYMHS, 331 058 contacts and 2 014 inpatient stays.

For children and young people, intervention early in life and at an early stage of mental health problems can reduce the duration and impact of the problems. Services that recognise the significance of family and social support are particularly important for children and young people. These principles informed the Australian Government's *National Mental Health Plan*, published in 2003.

A national survey by the University of Western Australia and Roy Morgan Research for the Australian Government in 2013–14 (published in 2015) on mental health of children and adolescents estimated that 3.3 per cent of Australian children and young people with mental health problems access clinical mental health services. However, 12 per cent with severe mental health problems do not access any services, including those provided through schools, general practitioners, telephone helplines or online. For children and young people with moderate or severe mental health problems, this figure rises to 27.5 per cent. Service use varies by age as well as the severity of problems, as shown in Figure 1B.

Figure 1B
2015 Australian Government report of service use by 4–17 year-old Australians with mental health problems by age group and severity of problem



Note: Services include any service provided by a qualified health professional regardless of where that service was provided including in the community, hospital inpatient, outpatient and emergency, and private rooms; school or other educational institution; telephone counselling; online services that provided personalised assessment, support or counselling.

Source: VAGO based on information from the Australian Government's 2015 report, *The mental health of Australian children and young people: Report on the second Australian child and adolescent survey of mental health and wellbeing*.

1.1 Agency roles and responsibilities

Department of Health and Human Services

DHHS is responsible for ensuring the delivery of good-quality health services to the community on behalf of the Minister for Health and the Minister for Mental Health. DHHS plans services, develops policy, and funds and regulates health service providers and activities that promote and protect the health of Victorians.

The Secretary of DHHS is responsible for working with, and providing guidance to, health services to assist them on matters relating to public administration and governance.

The Mental Health Branch of DHHS has 84 staff who carry out the duties prescribed to the Secretary.

The Chief Psychiatrist

The Secretary of DHHS appoints a Chief Psychiatrist, who has legislated responsibilities under the Victorian *Mental Health Act 2014* (the Act) for:

- providing clinical leadership and advice to public mental health services
- promoting continuous improvement in quality and safety
- promoting the rights of persons receiving treatment
- providing advice to the minister and the Secretary about the provision of mental health services.

The Chief Psychiatrist is subject to the general direction and control of the Secretary of DHHS in the exercise of their duties, functions and powers under the Act. The Secretary has specific powers to request the Chief Psychiatrist take action, for example, to conduct a clinical audit. The Chief Psychiatrist also has statutory obligations to the Secretary to provide a report of any investigation undertaken. Operationally, the Chief Psychiatrist reports to DHHS's Director of Mental Health.

Child and Youth Mental Health Services

Clinical mental health services targeting people up to 18 years only are known as **child and adolescent mental health services (CAMHS)** and those who have expanded their models to 0–25 years refer to themselves as child and youth mental health services (CYMHS). The subtle difference in terminology creates frequent confusion in discussions around these services.

In this report, '**child and youth mental health services (CYMHS)**' is used to refer to all clinical services that the Victorian Government funds to support children, adolescents and youth aged 0–25 years who have moderate to severe mental health problems, and includes services named CAMHS.

CYMHS support children and adolescents through a mix of community-based or outpatient programs and inpatient treatment in hospitals, as well as a small number of community residential programs. They also provide education, upskilling and leadership on managing mental health problems to the services and agencies that care for children and young people, which includes schools, child protection and disability services. Health services manage CYMHS and are responsible for ensuring compliance with relevant legislation, regulations and policies.

DHHS provides $11.4 million per year for an early psychosis program to target young people aged 16–25 who are experiencing their first episode of psychosis. The program provides case management, medication, psychological therapies, social, educational and employment support, and family work.

In addition to accessing CYMHS, some young people in Victoria use adult mental health services because eligibility for the adult stream commences at 16 years. DHHS funds specialist perinatal mental health services, mother and baby units, and a statewide program that aims to reduce the impact of parental mental illness on family members through the adult mental health system. While these programs directly impact children and young people, this audit does not examine them.

Mental health problems have many causes, including abuse and neglect in childhood, developmental disorders, and physical disability. Children and young people who access clinical mental health services commonly also need services such as child protection or disability support. Coordinating these different services is an important and complex part of best-practice care for many children and young people with mental health problems.

Figure 1C shows one CYMHS's description of the service system for its clients and their role within it.

Figure 1C
Other services that clients of CYMHS routinely require

Source: RCH response to DHHS's *10-Year Mental Health Plan*, 2016.

Commonwealth-funded services

There are 27 headspace centres around Victoria that offer enhanced primary care services, which include mental health, physical and sexual health, and life skill support around work and study in an accessible, youth-friendly environment.

Children and young people can access Commonwealth-funded services to support their mental health needs. The Australian Government funds Primary Health Networks (PHN), which provide early-intervention services for young people with, or at risk of, severe mental illness, alongside its funding of primary care through general practitioners and headspace centres. Victoria has six PHNs that provide 28 different services. CYMHS are involved with supporting some Commonwealth-funded initiatives. Many CYMHS have active roles in managing and supporting their local headspace centres.

Workforce challenges

Attracting, training and retaining a sufficient and appropriately skilled mental health workforce, and making mental health services safe places to work, is a major challenge for health services and DHHS.

The Royal Australian and New Zealand College of Psychiatrists' (RANZCP) review of workforce issues, which it publicly reported in 2018, noted a shortage of Victorian child and adolescent psychiatrists (CAP). Victoria has 31 CAP training positions, of which two are in regional areas. RANZCP says that Victoria urgently needs 12 additional CAP training positions.

A 2016 study by the University of Melbourne and the Health and Community Services Union, published in the *International Journal of Mental Health Nursing*, found that 83 per cent of 411 surveyed staff in Victoria's mental health workforce had experienced violence in the prior 12 months, mostly comprising verbal abuse (80 per cent) followed by physical violence (34 per cent) and bullying (30 per cent). One in three victims of violence rated themselves as being in psychological distress, 54 per cent of whom reported being in severe psychological distress. The survey did not report on these matters specific to CYMHS.

1.2 Relevant legislation

In 2014, the Act came into effect. The Act prescribed many changes to the mental health system including ensuring that treatment is provided in the least restrictive way possible.

Under the Act, mental illness is defined as 'a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory'.

The Act mandates that health services report to the Chief Psychiatrist on the use of electroconvulsive treatment (ECT), results of neurosurgery, the use of restrictive interventions, and any deaths that meet the *Coroners Act 2008*'s definition for a reportable death.

The Act sets out roles and responsibilities for the Chief Psychiatrist and the Secretary of DHHS.

The 'Mental Health Principles' in the Act state that:

> Children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible.

The Act does not specify an age grouping for children and young persons to which this principle would apply.

1.3 Why this audit is important

There have been considerable changes to the environment in which CYMHS operate in recent years. The types and complexity of mental health problems that children and young people seek support for is increasingly challenging for health services. Demand for services is growing rapidly due to interconnected factors including reduced stigma around mental health problems, and more youth-friendly access points for young people to seek help, such as headspace centres.

This is the first Victorian Auditor-General's Office (VAGO) audit of Victoria's child and youth mental health system, and there has been no other substantial public, external review of this topic. VAGO's 2019 audit *Access to Mental Health Services* found that DHHS has not done enough to address the imbalance between demand for, and supply of, mental health services in Victoria. VAGO made six recommendations to DHHS about investment planning, monitoring access, funding reforms, catchment boundaries, and internal governance.

During VAGO's audit, the Victorian Government established a Royal Commission to inquire into mental health, which is due to provide an interim report to the Governor of Victoria in November 2019 and a final report in October 2020. The terms of reference released in February 2019 give the Royal Commission an extensive brief to report on how to improve many matters in the mental health system, including access, governance, funding, accountability, commissioning, infrastructure planning, workforce, and information sharing.

The Productivity Commission is currently conducting an inquiry into The Social and Economic Benefits of Improving Mental Health, which will focus on the largest potential improvements, including for young people and disadvantaged groups. This audit adds a detailed review of this particular part of the mental health system to these larger and broader inquiries.

1.4 What this audit examined and how

The objective of this audit was to determine whether child and adolescent mental health services effectively prevent, support and treat child and youth mental health problems. We considered whether the services are appropriately designed and whether DHHS administers them effectively. The audit focused on clinical mental health services for young people with moderate to severe mental health problems.

We selected five health services for the audit, alongside DHHS, in order to sample the varied services in Victoria's devolved health system:

- AWH
- Austin Health
- Eastern Health
- Monash Health
- RCH.

The audit focused on current service delivery, with some reference to significant changes over the past three to five years.

We conducted our audit in accordance with section 15 of the *Audit Act 1994* and ASAE 3500 *Performance Engagements*. We complied with the independence and other relevant ethical requirements related to assurance engagements. The cost of this audit was $530 000.

In accordance with section 20(3) of the *Audit Act 1994*, unless otherwise indicated, any persons named in this report are not the subject of adverse comment or opinion.

1.5 Report structure

The remainder of this report is structured as follows:

- Part 2 examines the design of CYMHS.
- Part 3 examines how DHHS monitors performance, quality and outcomes of child and youth mental health services.
- Part 4 examines access and coordination of care for the most vulnerable and complex clients.

2

Design of child and youth mental health services

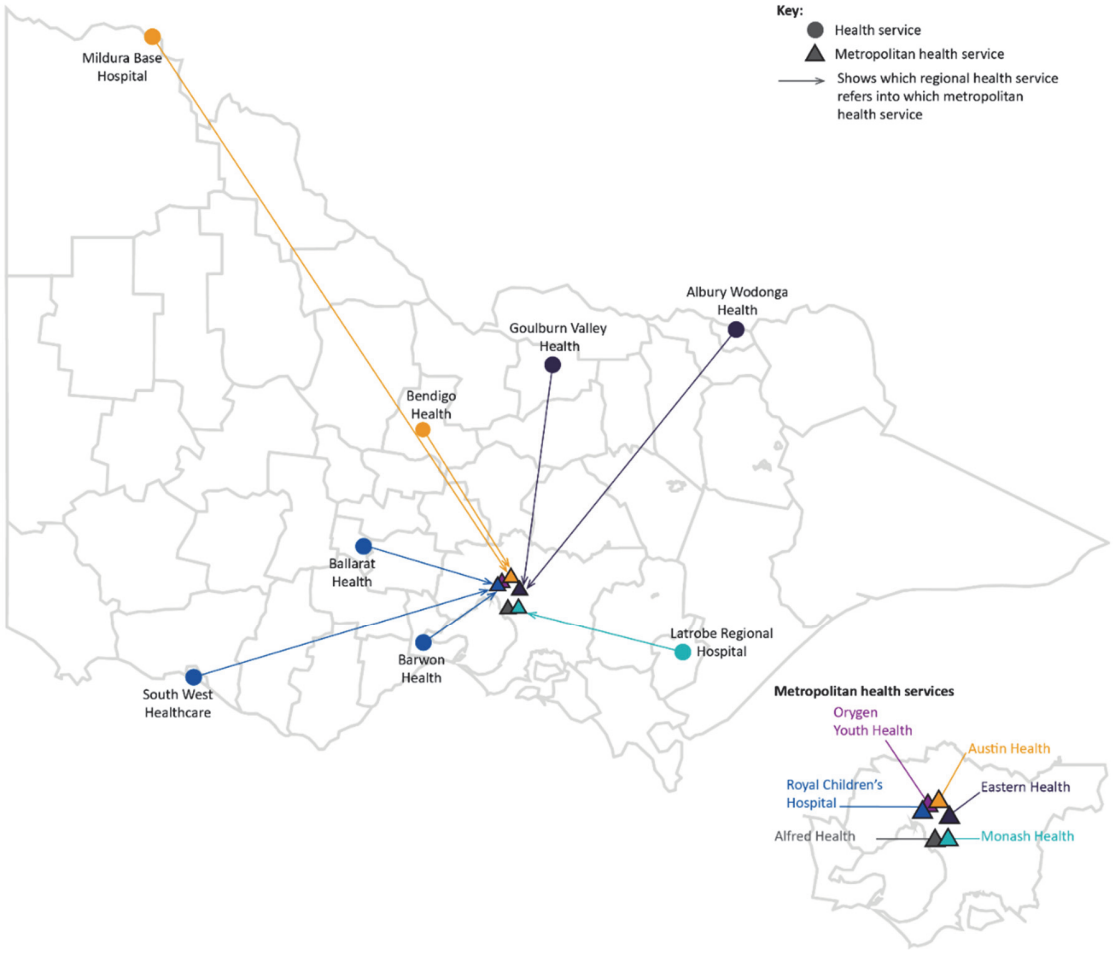
The Victorian Government funds 17 health services to provide clinical services to children or young people with moderate to severe mental health problems.

In 2017–18, clinical mental health services in Victoria treated 11 945 children and young people up to the age of 18 years—an 11.5 per cent increase on the previous year—and admitted 2 014 to hospital, a 9.8 per cent increase. DHHS was not able to provide any information about young people aged 19–25 years in either the adolescent or adult mental health system.

There are six CYMHS in metropolitan Melbourne and eight in regional Victoria, as shown in Figure 2A. Clients must attend the CYMHS located in the catchment where they live, unless they require a specialised service that is not provided or available in their own catchment. Regional CYMHS are attached to one of four metropolitan services as their primary referral option for specialist or inpatient support that is not available locally, as illustrated by Figure 2A.

Three provide limited, specialised services to children and adolescents such as forensic services and treatment of eating disorders. The remaining 14 provide a general service, often alongside a suite of specialised programs. Eight of these provide inpatient services, of which two include inpatient services specifically for children under 12 years of age. One of these services is specifically 'youth-focused', providing both inpatient and community services to 15–24 year-olds in its catchment area.

Figure 2A
Location of CYMHS and their partner agencies for inpatient and specialised service referrals



Source: VAGO mapping of DHHS information.

2.1 Conclusion

DHHS has not provided the strategic leadership necessary to effectively plan, fund and manage CYMHS. Consequently, the system consists of a collection of fragmented and overstretched health services. DHHS has created a system that cannot effectively work together even when client need requires it.

DHHS has not met the obligations of its role as a system manager—to set clear strategic directions and service expectations for CYMHS, to establish a transparent and equitable funding model, and to ensure service design supports the infrastructure and service accessibility that children and young people need. Where health services have made innovative attempts to improve services, there are no mechanisms for sharing or collaborating.

This lack of leadership and strong communication and collaboration with the CYMHS sector has created a culture of distrust, and has impeded knowledge sharing among health services and between health services and DHHS. All of this results in a service system that is not meeting the needs of some vulnerable children and young people.

2.2 Strategic direction

In 2015, DHHS published *Victoria's 10-year Mental Health Plan* (the 10-year plan), which is a high-level framework for mental health service reform. There is one action in the plan that is relevant to child and youth clinical mental health services:

> strengthening collaboration between public specialist mental health services for children and young people and paediatricians, other social and community services and schools

The 10-year plan does not provide a strategic framework for child and youth mental health. DHHS formed the Mental Health Expert Taskforce (the taskforce) to advise on the 10-year plan and its implementation. The taskforce identified child and youth mental health as one of the highest priority areas for action; however, no plan was developed on what that action should be.

DHHS's *Clinical Mental Health Services Improvement Implementation Plan*—endorsed internally in December 2018—commits to developing a 'child and youth service framework' with immediate priorities identified by June 2019 and the framework complete by June 2020. DHHS has not progressed this work and has not determined the framework's scope, purpose or how it will be developed. In early 2019, DHHS took a decision to not progress this work until the Victorian Government's Royal Commission into Mental Health concludes.

During the audit, DHHS became aware of a proposal by RCH for a strategic direction for CYMHS, which calls for bringing all Victorian CYMHS together into a network that undertakes shared work on quality improvement, workforce development and practice innovation. The proposal identified nine priority areas for this work, which are:

- development with consumers and carers of a central dataset that monitors clinical needs, accessibility, collaboration with child and family service providers, and outcome evaluation to allow benchmarking and collaboration across mental health services
- workforce development
- establishing a research forum
- clinical pathways between services
- policy directions to specify the role of public mental health services
- expanding targeted interventions for dual disability, gender dysphoria, eating disorders, Aboriginal and Torres Strait Islander children, trauma, children in out-of-home care, and refugees
- clinical guidelines commencing with psychopharmacology, dual disability, and children involved with child protection
- implementation research

- engaging with schools.

Given our observations of a fragmented system and the lack of strategic direction, RCH's proposal has merit. DHHS should consider this proposal and provide a response to RCH at the earliest opportunity.

The only evidence that DHHS provided strategic guidance to CYMHS about how they should operate is the following statement in the Clinical Specialist Child Initiative program guidelines issued in 2016:

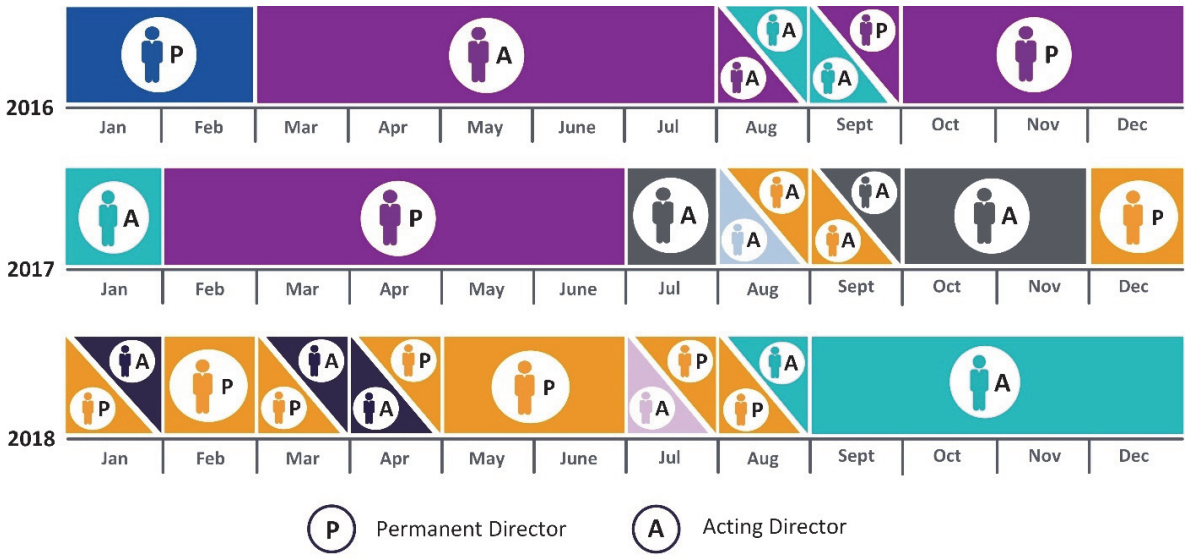
> It is expected that the new, expanded and existing services will work together to form a comprehensive response to the mental health needs of children aged 0–12. It is expected that the local operation of these services will interlink and not be delivered in isolation.

Despite giving these directions, DHHS has not taken action to enable services to achieve them and it has not monitored progress.

There has been significant change in the position of Director of Mental Health at DHHS. In the three years from 2016 to 2018, eight people have held the role, as illustrated in Figure 2B. Three permanent appointments covered 15 months out of the three years. Five other individuals held the role in acting positions, and two of the permanent appointees began their tenure with temporary secondments. For 537 days, or 49 per cent, of the three years, there was a temporary appointee in the role.

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

Figure 2B
Individuals who have held the Director of Mental Health role at DHHS in 2016–18, by month



Note: Each colour represents a different individual, with an 'A' or a 'P' indicating whether that individual was in an acting or a permanent role at that time.
Source: VAGO analysis of information supplied by DHHS from 'SAP Organisational Management' database, December 2018.

It is also unclear what resources are dedicated to DHHS's oversight and monitoring of CYMHS, as this is predominantly embedded within positions responsible for broader performance monitoring of individual health services and/or the mental health system more generally. There is one position within the Mental Health Branch whose responsibilities include the 'child and adolescent portfolio' alongside being the lead contact for monitoring performance for several health services. Portfolio responsibilities include program development, service planning and system oversight. These portfolio responsibilities form approximately 20 per cent of the workload in the position, dependent on other responsibilities.

2.3 Funding model

DHHS has not acted to address the transparency and equity problems with the current funding model, and there has been no progress towards introducing activity-based funding for CYMHS.

Mental health is funded through a block funding model, where a sum of funding is provided by DHHS for the health service to deliver an agreed number of services—a number of 'beds' for inpatient services and 'service hours' for community-based services.

DHHS determines each year's funding allocation by considering the previous year's funding, some analysis of services provided in the previous year, and any new government commitments in the State Budget.

As noted in a 2018 report to DHHS's Audit and Risk Committee, *Hospital Budget Governance Framework – Internal Audit Report*, there is a 'medium-level' risk that models of funding that are not activity-based have 'a lack of governance and documentation of decisions taken'. Figure 2C shows the funded units that are relevant to CYMHS.

Figure 2C
Mental health—funded units applicable to clinical bed-based services 2018–19

Service element	Funded unit	All health services ($)
Admitted care		
Acute Care—child/adolescent, adult, aged[(a)]	Available bed day	712.00
Youth Prevention and Recovery Centre	Available bed day	600.13
Clinical community care		
Ambulatory	Community service hour	402.58

Note: (a) Supplement grant provided to support the acute care unit price.
Source: VAGO based on *DHHS Policy and Funding Guidelines 2018–19*.

DHHS's internal analysis shows that its funding covers 65 per cent of the costs of inpatient mental health beds while other health services are funded at more than 80 per cent of the actual cost. Audited health services confirmed that they 'cross-subsidise' from their community CYMHS funding to cover the costs of meeting demand for their inpatient beds.

In addition to the 'available bed day' funding unit, Monash Health receives $1 092 774 per year labelled 'child bed supplement' in DHHS's funding system. DHHS advises that the extra funding is to support Monash Health to provide inpatient services for children. However, we found that Austin Health does not receive this supplement despite also providing inpatient beds for children. DHHS's explanation for the funding discrepancy is that each health service provides a different model of care and that if Austin Health transitioned to the same model as Monash Health, it would also receive the supplement. DHHS has not communicated this to Austin Health, which demonstrates an example of the risk raised in the internal audit report of a lack of transparency and clarity around block funding arrangements.

DHHS provides a total of $9.3 million for eating disorder services to seven health services. As we were unable to determine what proportion of this funding is spent in CYMHS, we have only included eating disorder funding for RCH in our funding analysis as this health service only treats children and young people.

Activity-based funding is used for most other services provided through Victorian hospitals—the amount paid reflects a service's complexity and cost with some additional loadings for especially complex and high-risk patient groups. In its *Policy and Funding Guidelines 2018–19*, DHHS states its commitment to introducing an activity-based funding model, also noting its benefits:

> There will be a focus on developing a new mental health funding model for specialist community-based adult mental health services in 2018–19. The new model will link funding to the delivery of services and will provide different levels of funding depending on the complexity of the consumer needs. The reforms, and related and revised performance and outcomes monitoring, will improve the transparency and drive improvements in services' performance and consumer outcomes.

During the audit, DHHS was in the early stages of planning a trial of activity-based funding for one adult mental health program. DHHS advises that in future, it will consider using activity-based funding for CYMHS.

2.4 Services funded

DHHS does not have a transparent and clear rationale for the suite of programs and services that it funds, or how it determines the distribution of funding across programs, regions and health services.

DHHS specifies the number of inpatient beds for children and adolescents, but for community or outpatient programs it provides guidance only on how health services should use the funding for two of the 14 funded programs. Health services must deduce what DHHS expects them to deliver and develop their own rationale for what they will deliver with the funding.

In 2018–19, DHHS is providing $127.7 million to Victorian health services for a range of clinical mental health services targeted at children and young people with mental health problems, which is a significant increase in funding. In 2016–17, the Victorian Government committed $73.8 million over four years, primarily to increase accessibility to CYMHS for children under 13 years. In the same year, the government also provided $59 million to support the construction of a new facility to house Orygen, the National Centre of Excellence in Youth Mental Health, which opened during this audit, in Parkville.

The programs delivered by each of the 17 funded health services vary significantly. Four receive more than $15 million per year each for a large array of different programs and services. A fifth receives $7.7 million for services specifically targeted at young people aged 15–24 years. Nine are in regional areas with either no inpatients or two inpatient beds and funding between $2 and $5 million per year each. Funding by service type and health service is shown in Appendix B.

Each service has different client eligibility arrangements—some accept children and young people up to the age of 25 years, while others only accept those up to 18 years. Eligibility also varies by age for specific programs provided within CYMHS. In one region, the client's age determines whether the same service that provides inpatient care will provide ongoing care or whether they need to be referred to another service in the catchment.

DHHS currently distributes funding across seven different types of services, as shown in Figure 2D.

Figure 2D
Distribution of CYMHS funding by type of service

Type of services	Proportion of total funding (%)
Community-based assessment and treatment services	43.9
Inpatient services	25.6
Other specialised community programs	14.6
Early psychosis services	8.9
Eating disorders specialised services	1.1
School outreach program	5.0
Autism coordinators	0.8

Source: VAGO, with information provided by DHHS.

Inpatient beds

DHHS determines how many inpatient mental health beds each health service provides and whether these beds are for children (0–12 years), adolescents (13–18 years) or young people (15–25 years). DHHS could not provide a clear rationale for how it determines the location and number of these beds, and there is no evidence that DHHS consults with CYMHS when making these decisions.

Figure 2E shows DHHS distribution of inpatient mental health beds for children, adolescents and young people.

Figure 2E

Number of inpatient mental health beds for children, adolescents and young people funded by DHHS

Health service	Children aged 0–12	Adolescents aged 13–18	Young people aged 15–24	Funding ($ million)
Monash Health	8	15	*	7.07
Austin Health	12	11		5.98
Melbourne Health (as auspice of Orygen Youth Health)			16	4.16
RCH		16		4.16
Eastern Health		12		3.12
Ballarat Health		2		0.52
Latrobe Regional Hospital		2		0.52
Ramsay Healthcare (as managers of Mildura Base Hospital)		2		0.52
Total	**20**	**60**	**16**	**26.06**

Note: * Monash Health operates a youth inpatient service for 18–25 year-olds that is not included in this table because DHHS does not fund it as part of its child and youth mental health funding. Monash Health created the dedicated youth service as part of its adult mental health service.

Source: VAGO from *DHHS Policy and Funding Guidelines 2018–19* and DHHS website.

There are complex catchment arrangements across the system. DHHS has acknowledged the catchment arrangements are problematic because they are not aligned with the catchments that other government services use. Clients must attend the CYMHS located in the catchment area they live in, unless they require a specialised service that is not provided or available in their own catchment. Figure 2A shows how regional CYMHS are attached to one of four metropolitan services as their primary referral option for specialist or inpatient support. DHHS has not yet taken action to improve or resolve the catchment issues.

If a child or young person urgently requires inpatient care, health services may admit them 'out-of-area' for care at a CYMHS in another catchment, when one or more of the following occurs:

- Their local CYMHS does not have an available bed.
- Their local CYMHS does not provide inpatient services.
- The health service that their local CYMHS refers to for inpatient services does not have an available bed.

These scenarios can require a child or young person to be transferred to a health service located several hours from their home. Once treatment has ended, the child or young person is 'repatriated' to the CYMHS within their catchment for follow-up care. Health services do not have a consistent process for repatriation. Each repatriation varies depending on the clinical needs of the child or young person, and the availability of their catchment CYMHS service to engage in the repatriation process. Given services are stretched across all CYMHS, it can be difficult for health services to effect repatriations effectively and efficiently.

Children and young people in adult inpatient beds

There are systemic conflicts around inpatient services for young people, which DHHS acknowledges, but has not acted to address:

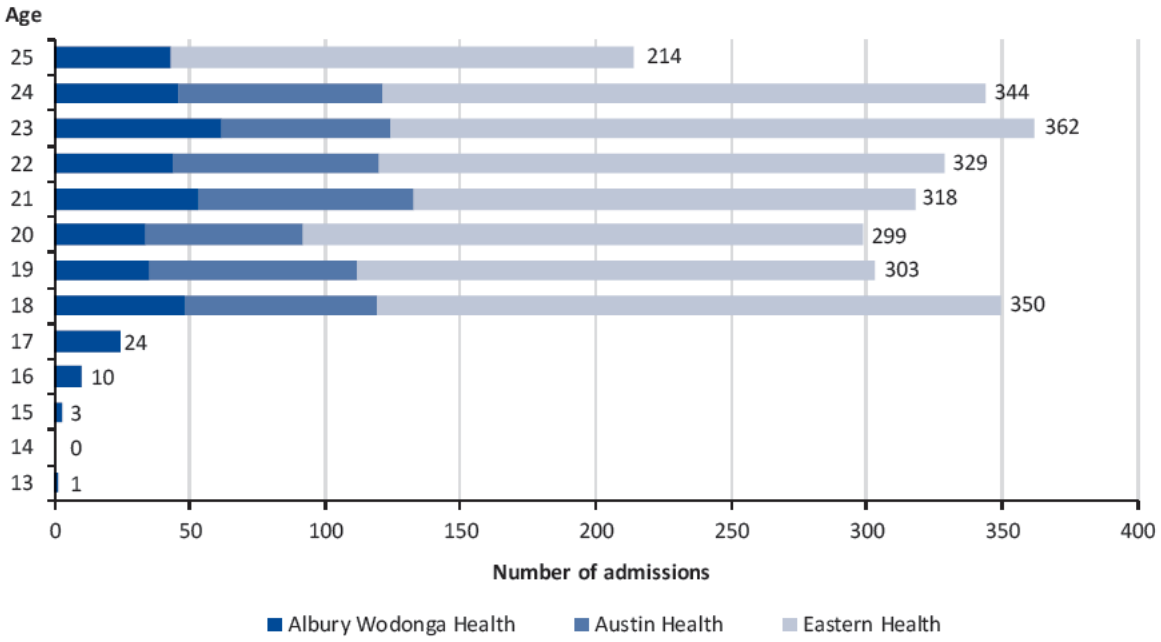
- The Act says 'children and young people' should receive separate services from adults wherever possible. The Act does not define the age of 'young people' though this terminology is commonly understood to include people aged approximately 18–25 years of age.
- DHHS does not define eligibility for CYMHS adolescent inpatient beds beyond a description on its website stating that 'CAMHS inpatient units … mostly admit young people aged 13–18 years' and that RCH admits young people 13–15 years and Orygen Youth Health 15–24 years.
- Audited health services received guidance from DHHS that eligibility for CYMHS adolescent beds ceases on a young person's 18th birthday, but they can use the beds for 18-year-olds if clinically appropriate—there is no written evidence of this guidance.
- DHHS only funds dedicated inpatient beds for young people aged 18–24 in one metropolitan catchment.
- DHHS defines eligibility for adult inpatient beds as 16 years and over.

DHHS has never analysed the use of adult inpatient beds for children and adolescents and does not monitor the issue despite it being clinically inappropriate, inconsistent with legislation, and a potential indicator of significant demand pressures on CYMHS.

When we analysed inpatient admissions data over three years (2016–18) for our audited health services, we found young people admitted to adult mental health services as young as 13 years, as shown in Figure 2F.

RCH is excluded from this table because it is a paediatric hospital. Monash Health was also excluded as the data could not distinguish between inpatient wards and Youth Prevention and Recovery Centres (Y-PARC) that are designed for 16–25 year-olds.

Figure 2F
Adolescents and young people in adult mental health services at audited health services during 2016–18, by age at admission



Note: This assumes that all 18–25 year-olds at Austin Health and Eastern Health are in their adult service, but a small but undetermined number are known to be admitted to adolescent beds based on clinical assessments of individual need and availability of beds.

Source: VAGO analysis of Client Management Interface data provided by five audited health services. See Appendix D for data analysis scope and methodology.

Austin Health and Eastern Health had 2 154 admissions of young people aged 18–25 years in the three years between 2016 and 2018. These health services routinely place these patients in adult mental health beds because their age limit for adolescent beds is a child's 18th birthday.

Monash Health recorded 3 131 admissions of young people aged 18–25 years; however, they have established a separate youth ward of 25 beds within their adult service and they also have a Y-PARC community residential facility. It was not possible through our data analysis to confirm that all of the 18–25 year-olds were treated in the separate youth ward or the breakdown between the Y-PARC and the hospital inpatient services.

Monash Health's service development work to create a youth ward within an adult service without dedicated resources is an important initiative. DHHS should review and monitor this youth ward to identify opportunities to share the learnings with other CYMHS and inform service development that could increase compliance with the Act's principle to provide services for young people separate to adults wherever possible.

AWH admitted 403 mental health inpatients aged 0–25 years to its adult mental health ward. This included 86 admissions for adolescents aged 13–18 years. Some were admitted more than once. Sixty-nine individual adolescents had inpatient admissions to an adult facility.

Our analysis considered four health services. It is likely that admission of children and young people to adult mental health beds has occurred in other health services, particularly in regional and rural areas. This warrants broader review by DHHS.

During this audit, AWH undertook a snapshot audit of 13 adolescents admitted to its adult inpatient facility and found that the reasons for admission across the different cases included:

- a family who refused a referral to the metropolitan adolescent inpatient unit due to the costs and time of travel involved, including a prior experience of having to arrange return transport without assistance
- a patient who was scheduled for transfer to the metropolitan adolescent unit the following day, and spent one night 'contained' in the adult mental health bed while transport was arranged
- a patient's residence being out-of-area for AWH CYMHS, but who was admitted after a crisis assessment
- the crisis assessment team admitting a patient with no explanation in the notes of why a referral to the metropolitan adolescent service was not considered.

AWH has committed to investigate these adolescent admissions to the adult inpatient unit to understand and address the underlying issues.

DHHS has not reviewed, and does not monitor, the effectiveness and appropriateness of transfers between regional areas and metropolitan CYMHS and has not taken action to understand or alleviate the challenges this poses for both families and health services.

Access to inpatient beds for regional areas

At three regional health services, DHHS provides funding for two CYMHS inpatient beds. DHHS has not reviewed the use of these beds and does not monitor the extent to which CYMHS allocate them to children and young people. It would be challenging for the three regional health services to run a separate, dedicated child and adolescent inpatient service given the small number of CYMHS-funded beds. Not only do the beds need to be physically separate from their adult mental health service to meet the principle of care in the Act, but the clinical staff also need to be trained in the child and youth mental health specialty.

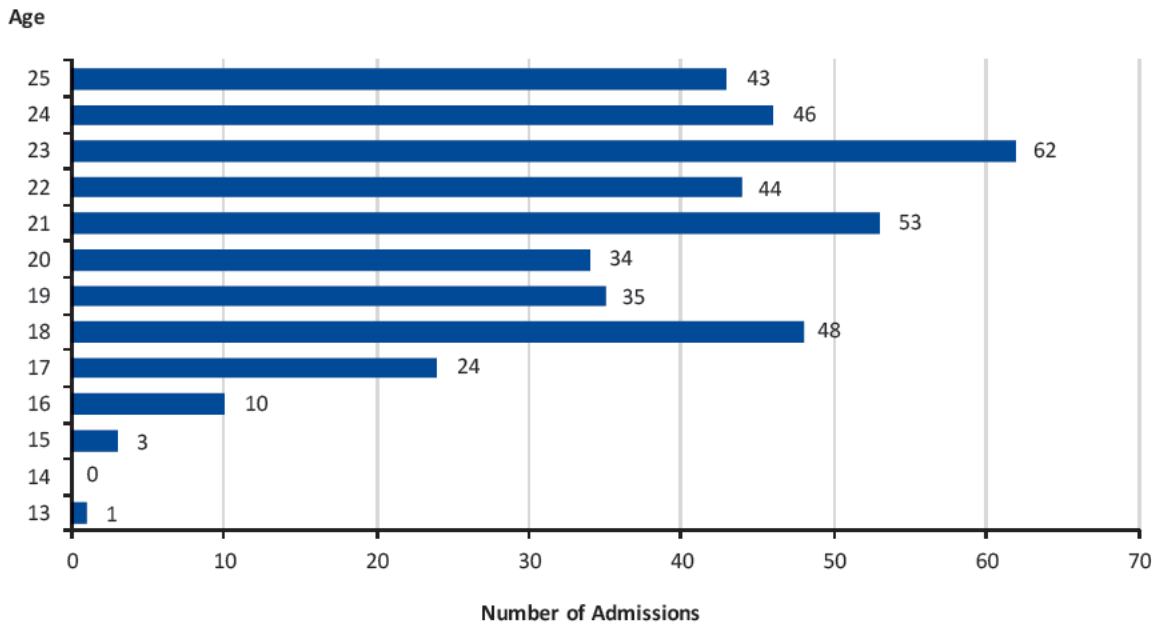
Given the significant demand pressures that we reported in our March 2019 audit *Access to Mental Health Services* together with the workforce challenges of attracting sufficient child and adolescent psychiatrists to regional areas, as described in Sections 1.2 and 2.7, it is unrealistic to expect these services to deliver appropriate CYMHS inpatient services. There is a high risk that the beds are used for adult mental health patients instead, which could mean that CYMHS funding is diverted from children and young people. In 2018–19, these beds represented $1.56 million of the ongoing CYMHS funding.

All regional CYMHS, including those with their own inpatient bed funding, are designated one of four metropolitan services to refer their clients to if they require inpatient or other specialised care that is not available locally, as shown in Figure 2A. For example, AWH CYMHS refers to Eastern Health's CYMHS.

Over the three years between 2016 and 2018, our analysis of health services' data shows that Eastern Health and AWH shared 59 clients.

AWH believes it may have enough demand for its own CYMHS inpatient service. As shown in Figure 2G, AWH had 86 admissions for adolescents aged 13–18 years and a further 317 admissions for young people aged 19–25 years during the three years between 2016 and 2018. In addition, AWH keeps a manual record of transfers to other health service inpatient units, which shows 44 transfers for admission elsewhere, mostly to Eastern Health, between 2016 and 2018. DHHS has advised that services can submit a business case to DHHS requesting additional resources, but this process is not documented anywhere and AWH was not aware of this process.

Figure 2G
Number of mental health inpatient admissions at AWH for 0–25 year-olds, 2016–18, by age at admission



Source: VAGO analysis of DHHS information, February 2019.

Youth Prevention and Recovery Centres

In addition to the inpatient beds located in hospitals, Y-PARCs offer short-term, subacute, intervention and recovery-focused clinical treatment services in residential settings. They are a voluntary program sometimes described as a 'step up, step down' service for young people aged 16–25 years who are unwell, but not so unwell that they need to be in hospital, or who have been released from hospital, but would benefit from further recovery before going home.

There are currently three Y-PARCs—in Bendigo, Frankston and Dandenong—with 10 beds in each. Each received $2.19 million funding from DHHS in 2018-19. In 2018–19, DHHS allocated $11.9 million over three years to Melbourne Health to establish a fourth Y-PARC in Parkville. DHHS cannot demonstrate how it determined where the Y-PARCs should be located.

The University of Melbourne evaluated the Frankston Y-PARC and found that it had positive impacts on reducing client crisis episodes and reducing emergency department presentations.

In addition to Y-PARCs, young people use adult Prevention and Recovery Centres (PARC) of which there are 23 in Victoria. All the audited health services except RCH manage at least one PARC. Our data analysis found that for the audited agencies, 212 young people up to 25 years had spent time in an adult PARC in the past three years, of which five were aged 16–18 years.

Community programs

The majority of CYMHS services are delivered to people living in the community through outpatient clinics at hospitals, or outreach programs at other community locations (community programs). These programs represent 74.4 per cent of CYMHS annual funding—$95 million in 2018–19.

DHHS does not advise health services on the intent or deliverables for eight of the 14 CYMHS community programs it funds—totalling over $19 million.

DHHS's lack of guidance on what community programs health services should deliver makes it impossible to understand funding distribution across programs and to monitor performance of health services against program objectives, where they exist. We discuss this further in Section 3.2.

DHHS asserts that health services are best placed to determine local need; however, it should still articulate what it expects health services to deliver based on statewide analysis of need and demographics. Without such guidance, DHHS cannot hold health services to account for the funding they receive and assure itself that the right services are provided in the right places.

Under the current devolved system, children and young people receive different services and care based on the catchment they live in, which leads to inequity across the system and can also mean that clients who move between catchments may lose services that were previously available to them.

With a lack of any other guidance on what they are expected to deliver with their community funding, some health services have developed their own internal systems based on how DHHS provides their CYMHS funding through up to 14 'funding lines' in their financial system. Figure 2H shows how DHHS's financial system identifies 14 'funding lines' and the availability of guidance for each.

Figure 2H
DHHS funding in 2018–19 and guidance to health services for clinical mental health services for children and young people, by funding line

Program	Total program funding 2018–19 ($)	Number of health services receiving this program funding	Guidelines available	Program description in policy and funding guidelines
Child and adolescent treatment services	56 042 170	13	No	Yes
Early psychosis	11 425 522	15	No	Yes
CAMHS and Schools Early Action (CASEA)	6 440 097	13	Yes	No
Youth integrated community service	5 650 860	7	No	No
Intensive youth support	4 807 444	9	No	Yes
Child clinical specialist initiatives	2 115 152	13	Yes	No
Gender dysphoria	2 047 896	1	No	No
Mental health output eating disorders funding	1 432 591	1	No	Yes[(a)]
Mental health and intellectual disability initiative (MHIDI)	1 321 000	1	No	No
Autism coordinator	1 071 258	14	No	No
Homeless youth dual diagnosis initiative (one-off funding)	1 004 272	8	No	No
Community forensic youth mental health	752 019	2	No	No
Youth justice mental health	724 711	5	No	No
Refugee	200 000	1	No	No

(a) There is a program description for 'Community Specialist Statewide Services – Eating Disorders', which we have assumed to be the same program as 'Mental health output eating disorders' funding.
Source: VAGO analysis of DHHS information, February 2019.

Lack of program guidelines or expectations

DHHS commissioned the *Reform of Victoria's specialist clinical mental health services: Advice to the Secretary, DHHS* in 2017. It provided advice on future directions for Victoria's specialist clinical mental health services. The report has not been released to health services or the public.

The 2017 *Reform of Victoria's specialist clinical mental health services* review recommended that DHHS 'develop clinical guidelines that specify expectations of the level and mix of services', but DHHS disputes that it should develop program guidelines for mental health programs, and does not plan to develop guidelines for the remaining programs.

The *DHHS Policy and Funding Guidelines 2018–19* provides a one or two-sentence 'program description' for six mental health community programs that mention children and young people, but only four align with the CYMHS funded programs. The brief program descriptions, where they exist, do not provide sufficient guidance to health services about the intent or expected deliverables for their funded programs.

Some funding lines are historical and reflect programs that have ceased while the funding has continued. For example, the youth integrated community service funding line provides $5.7 million per year to seven CYMHS. DHHS advises that this was originally funding to trial new Youth Early Intervention Teams in 2010 and that DHHS did not continue that program after a change in policy directions in 2013. DHHS does not know why it has continued to provide CYMHS with this funding given the program does not exist, nor could it provide guidance on how health services should use this funding.

2.5 Inconsistency in treatment age

When requiring inpatient care, all 18–25 year-olds must use the adult mental health system with the exception of the 16 beds at Orygen Youth Health in the Western region and the youth inpatient service at Monash Health. Only four of 13 CYMHS provide youth-targeted community programs for young Victorians aged 18–25 years, as shown in Figure 2I.

Historically, all health services treated children only to age 18 years. However, it is now commonly understood that it is not in the best interests of young people to transfer to the adult system at 18 years, as this is a vulnerable time in their life. This is especially true for adolescents in out-of-home care, who must manage the significant transition to independent living at this age.

Figure 2I
Age eligibility for programs, by CYMHS

Health service	Child inpatient	Adolescent inpatient	Youth inpatient/ residential	Community programs
AWH	No	No—refers to Eastern Health	No	0–18
Alfred Health	No	No—refers to Monash health	No	0–18 for residents of Bayside and Kingston 0–25 for residents of Port Phillip, Stonnington and Glen Eira
Austin Health	Yes—up to age 13	Yes—ages 13–18	No	5–18 for community teams Three specialist/outreach teams extend to 24 or 25 years
Ballarat Health	No	Two local beds and also refers to RCH	No	0–14 Child and infant 15–25 Youth
Barwon Health	No	No—refers to RCH	No	0–15
Bendigo Health	No	No—refers to Austin Health	Y-PARC—ages 16–25	0–18
Eastern Health	No	Yes—ages 13–18	No	0–25
Goulburn Valley Health	No	No—refers to Eastern Health	No	0–18
Latrobe Regional Hospital	No	Two local beds and also refers to Monash Health	No	0–18

Figure 2I
Age eligibility for programs, by CYMHS—*continued*

Health service	Child inpatient	Adolescent inpatient	Youth inpatient/ residential	Community programs
Melbourne Health (Orygen)	No	Yes—ages 15–24	Yes—ages 15–24	15–24
Monash Health	Yes—ages 0–12	Yes—ages 12–18	Yes—Youth mental health service for 19–25 years Y-PARC—ages 16–25	0–18 Early in Life Mental Health Service 19–25 Youth mental health service
Ramsay Healthcare (Mildura)	No	Two local beds and also refers to Austin Health	No	0–18
RCH	No	Yes—ages 13–18	No	0–14 (15+ referred to Melbourne Health) 0–18 (some statewide services)
Southwest Healthcare	No	No—refers to RCH	No	0–18

Source: VAGO interviews and document review with audited health services; public websites service descriptions for other services.

The inconsistencies exist because DHHS introduced, then ceased midway, a suite of pilot projects to increase the age eligibility to 25 at some health services. DHHS has taken no action to address the subsequent differences in age eligibility across the system.

The Victorian Government introduced a reform strategy for mental health services in 2009, *Because Mental Health Matters,* which included a specific commitment to 'redeveloping services within a 0–25 years framework'. The government provided $34 million for the following projects to progress this commitment:

- child and youth mental health service redesign—two demonstration projects
- youth early intervention teams—six sites
- youth justice mental health initiative—six sites
- youth crisis response team—two sites
- Y-PARCs—two sites.

This reform strategy ceased in 2013, during its fourth year of implementation, following the change of government. No alternative strategic direction or policy replaced it. Despite this, DHHS continues to provide funding for defunct programs, but does not tell health services what to do with it.

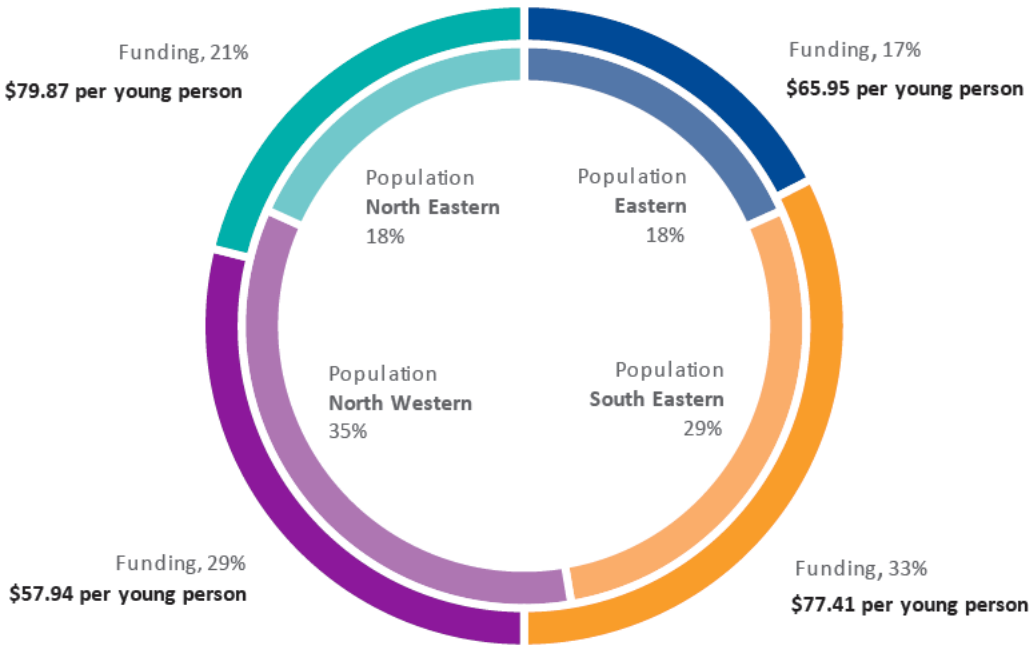
The reform strategy introduced fundamental changes to the whole service system; however, DHHS did not advise health services whether they should continue with the changes or revert to the previous system. This has resulted in inconsistency as some CYMHS chose to continue with the reforms independently while others did not.

DHHS commissioned external consultants to undertake two formal evaluations of the reform projects in 2012 and 2013. These reports contain valuable lessons about effective strategies for undertaking the reforms and delivering services to 0–25 year-olds. The reports would be particularly beneficial for the CYMHS that were part of the projects, as well as those that have chosen to, or are considering, reforming their services to a 0–25 year-old framework. DHHS has not shared this information with those CYMHS and has no plans to do so.

2.6 Geographic distribution of services

Our analysis of CYMHS funding by geographic area compared to the population of 0–24 year-olds shows substantial variation in funding distribution per head, with the South Western area of the state receiving $57.94 per child and young person compared to the North Eastern's $79.87. This analysis does not include forecasts of population growth and includes several statewide services that should not be directly mapped to regions. DHHS should investigate these funding discrepancies.

Figure 2J
Geographic distribution of 2018–19 CYMHS funding compared to population of 0–24 year-olds



Note: Funding was assigned to a geographic area based on the CYMHS referring relationships as shown in Figure 2A. The three health services delivering a limited program were assigned to an area based on which CYMHS catchment they are located in. Our analysis does not account for exact residence of clients receiving services in each region, such as where one CYMHS delivers a specialised, statewide program and the clients receiving that service may reside in other regions—we have assumed in this analysis that the funding provided into each region is serving that same region's population.

Source: VAGO analysis of Australian Bureau of Statistics (ABS) 2016 Census data, DHHS 2018–19 funding to health services information and DHHS catchment areas.

DHHS has advised that it carries out demand forecasting and considers population size and socio-economic issues when distributing new funding. However, it could provide only one example—the $4.1 million ongoing funding to expand clinical services to children under 12 in 2016–17.

Our examination of DHHS's analysis shows that it distributed most of that funding according to a model that considered the number of children living in each CYMHS catchment, the current funding, and the catchment's socio-economic disadvantage. DHHS applied this model to $3.7 million of the funding and then made some adjustments to the model, which are only partly explained in their working papers.

Monash Health received $100 000 more than the modelling allocated it, which appears to be related to its new inpatient service for children. DHHS allocated the remaining $232 410 to RCH because its funding (per head of catchment population) was significantly lower than all other CYMHS.

DHHS's modelling in 2016 showed that RCH received $38.28 community funding per head of population in its catchment, compared to an average across all CYMHS of $72.42. The second-lowest funded CYMHS was significantly higher than RCH, at $58.88 per head of population. RCH confirmed that it had been operating for many years under very challenging resource constraints and while DHHS had never explained to them the rationale for the substantial increase in funding for 2016–17, it did relieve some of its resource pressures in meeting its population's demand.

Despite carrying out modelling in 2016, DHHS still does not monitor geographical equity of CYMHS funding and has not acted to address the ongoing inequities in geographic distribution that our analysis indicates.

2.7 Workforce development

DHHS's *Mental Health Workforce Strategy* (the workforce strategy), which it published in 2016, notes age-appropriate and developmentally focused care as a principle, but does not address how the CYMHS workforce's needs might be met.

Although the workforce strategy provides a clear future direction around general mental health workforce issues, it lacks timelines, milestones and mechanisms to keep DHHS accountable for its implementation—such as targets and performance measures. The Workforce Strategy was informed through consultations with members of the workforce, service providers, education and training providers, professional bodies, unions, and peak bodies including consumers and carers. However, DHHS did not specifically consult with CYMHS on the strategy. It advised that this was not possible in its available budget.

The 2018–19 Victorian Budget invested $32.5 million towards implementing the workforce strategy, with a focus on reducing occupational violence against the mental health workforce in inpatient units. This investment included the six Clinical Nurse Consultants appointed to implement quality improvement initiatives in CYMHS inpatient wards—these are described further in Section 3.2. However, it did not include other initiatives to consider or address the specific workforce challenges that CYMHS experiences.

A major workforce challenge for CYMHS is filling clinical positions that require specialised skill sets such as working with children and young people who have a disability and mental health problems. After advertising repeatedly, the MHIDI pilot project at Alfred Health changed its recruitment approach. Alfred Health advertised for mental health clinicians, and committed to train them in working with disability on commencement. The process took two years, which naturally created a delay in initiating the project and the service it created. As DHHS never circulated lessons from the MHIDI project, other CYMHS have not had the opportunity to replicate Alfred Health's solution, risking repetition of the challenges and delays they experienced, as discussed further in Section 4.5.

In 2017, DHHS commissioned RANZCP to conduct a review of workforce issues for psychiatrists in Victoria, which included child and adolescent psychiatry. DHHS has not responded to the review's findings that relate to child and adolescent psychiatry or CYMHS, which included:

- a shortage of child and adolescent psychiatrists in Victoria
- a shortage of training positions for child and adolescent psychiatrists in Victoria, especially in regional areas
- workload issues for child and adolescent psychiatrists in regional areas.

The number and location of psychiatry training positions is determined by federal funding to RANZCP to provide the training, and health services' local decisions to create the training positions within their medical workforce. DHHS has taken no action to encourage health services that it funds to increase their child and adolescent psychiatry training places.

3 Monitoring performance, quality and outcomes

Government departments have a core responsibility to monitor the performance of their funded agencies and to understand what services or other public value is being delivered with the funding that it provides, and ideally to also understand what outcomes are achieved.

The processes and information that departments use to make decisions about funding and the performance of funded agencies—often described as performance and accountability frameworks—should be clear and transparent to all relevant stakeholders. In most cases they should also be transparent to the public and the recipients of services.

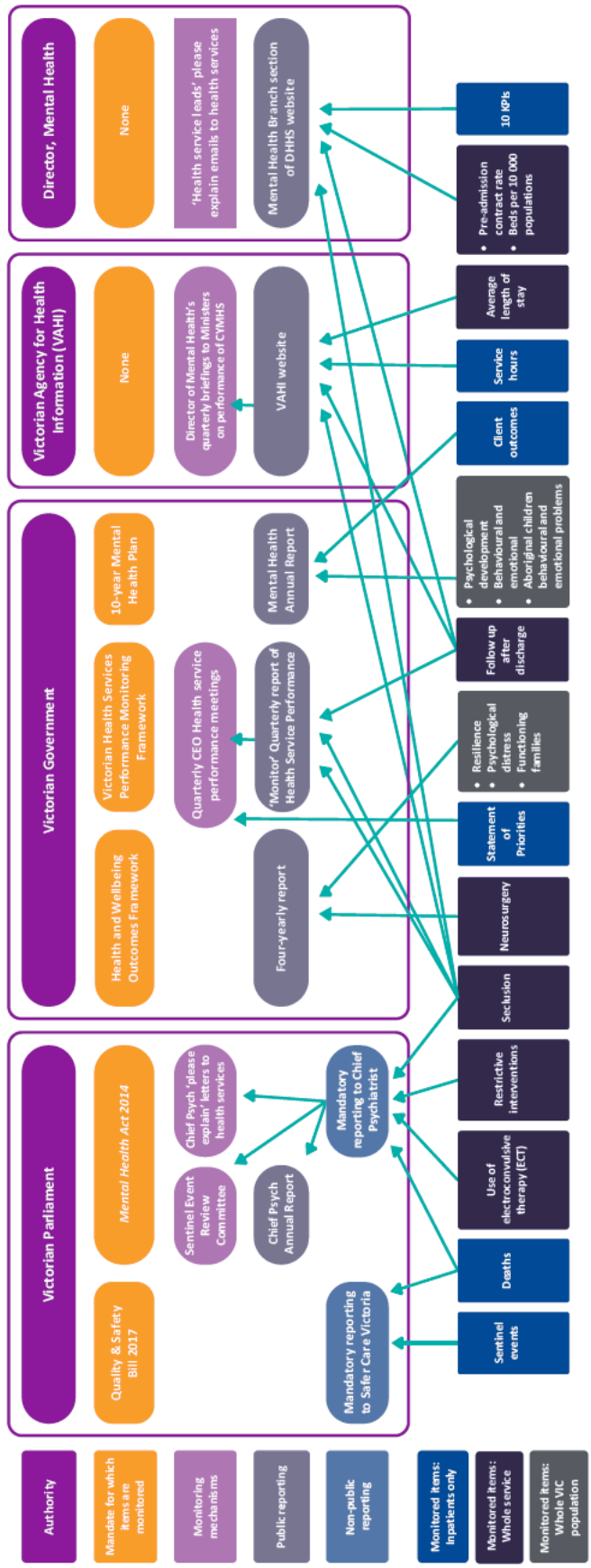
3.1 Conclusion

DHHS does not have a clear method for monitoring the performance of the CYMHS system within broader health service and mental health system performance monitoring and oversight. Without this, DHHS cannot fulfil its role to advise government on the system's performance, its resourcing needs, or the challenges patients and health services face in engaging other necessary social services. An example of this is that the current performance monitoring system has not highlighted the significant number of young people regularly 'stuck' in inpatient mental health services. Legislated mechanisms to protect the most vulnerable Victorians are also impeded by bureaucratic hierarchies and silos within DHHS.

3.2 Monitoring performance

DHHS has no effective governance arrangements to provide oversight of CYMHS, as CYMHS monitoring is embedded within broader performance monitoring and system oversight, as seen in Figure 3A. Legislation mandates some of the Chief Psychiatrist's and Secretary's monitoring but other components of the monitoring would benefit from a more systemic approach.

Figure 3A
DHHS performance monitoring agreements for CYMHS, their oversight bodies and mechanisms, the KPIs and other items



Key to 'Monitored items' section: Dark grey = population-level health outcomes. Blue = consider only inpatient services. Dark purple = monitor either community programs or CYMHS as a whole.

Note: Regarding reporting of deaths, Safer Care Victoria and the Chief Psychiatrist each require reporting of certain types of deaths only. Different criteria are legislated/mandated for each reporting requirement.

Source: VAGO, with information provided by DHHS.

DHHS does not have mechanisms to identify and address consistent issues in CYMHS in order to proactively prevent safety breaches or improve the quality of CYMHS.

When the performance monitoring that occurs around CYMHS is presented together, as in Figure 3A, it is evident that a lack of overarching governance and coordinated monitoring of CYMHS creates an unnecessary reporting burden on health services.

There are 29 components of CYMHS service delivery or outcomes that are monitored, by mandate or request, through seven different systems that are managed by DHHS and overseen by four different authorities with different roles and responsibilities in monitoring the performance of CYMHS. There are also six public reports produced by six different agencies or groups about different aspects of CYMHS performance.

This section examines the effectiveness and appropriateness of each of the seven different systems for performance monitoring of CYMHS, which are:

- the *Victorian Health Services Performance Monitoring Framework*, published by DHHS's Health Services Performance and Regulation Branch, which also convenes the primary performance monitoring discussions between DHHS and health service CEOs each quarter
- 15 KPIs on CYMHS service delivery and outcomes, collected and publicly reported by the Mental Health Branch
- legislated responsibilities of the Chief Psychiatrist to monitor five components of service delivery and the quality of services more broadly
- the *Quality and Safety Bill 2017* by which Safer Care Victoria (SCV) was established as an administrative office of DHHS with a range of functions, including monitoring sentinel events
- public reporting on five components of CYMHS service delivery by the Victorian Agency for Health Information (VAHI), another administrative office of DHHS
- the *Mental Health Services Annual Report*, which the Secretary of DHHS has a legislated responsibility to produce
- the Victorian Government's *Health and Wellbeing Outcomes Framework*, which monitors three components of Victorian children and young people's mental health.

Sentinel events are defined by SCV as 'unexpected events that result in death or serious harm to a patient while in the care of a health service'.

Three items are reported and monitored by multiple mechanisms and agencies, as follows:

- Some deaths must be reported as a sentinel event to SCV and the Chief Psychiatrist also requires notification of 'reportable deaths'. The two mechanisms use different definitions of what needs to be reported and have different processes for how they are reported and analysed.
- The rate of seclusion events is monitored by the Chief Psychiatrist; the *Monitor* report, which makes it a topic of the quarterly CEO health service performance meetings; and public reporting on both the VAHI website and the Mental Health Branch's section of the DHHS website.

- The rate of follow-up after discharge is similarly reported in *Monitor* and therefore CEO health service performance meetings as well as public reporting on VAHI and DHHS websites.

The latter two items relate only to inpatients and DHHS could not provide any rationale for why the most actively monitored items neglect the largest component of CYMHS clients, those receiving community programs.

In addition to the performance monitoring arrangements described above, both the Public Advocate and the Mental Health Complaints Commissioner, which was established under the new Act in 2014 as an independent authority, undertake investigations around mental health services. These entities require health services to provide information about incidents, which can duplicate what they provide to DHHS.

DHHS could not provide evidence that it had taken any action to understand the complexity and duplication that exists within the performance monitoring arrangements. It has taken no action to streamline or resolve conflicts and confusion caused by the overlapping reporting requirements for health services or its own duplicated monitoring arrangements, except for discussions around sentinel event reporting, which resulted in a joint OCP and SCV sentinel event review process.

During the audit, DHHS commenced a project to develop a new performance and accountability framework for mental health, with an initial focus on adult services. DHHS should ensure the inclusion of CYMHS in this work and also consider health services' reporting burden under current and future accountability arrangements.

DHHS has advised that 'quality and safety reporting and monitoring requirements will continue to be managed by the Office of the Chief Psychiatrist'. DHHS needs to ensure that there is clarity and transparency about the role of the Chief Psychiatrist in performance monitoring, and the accountability framework should articulate the Chief Psychiatrist's role.

There is no single source of information for CYMHS about either reporting requirements or DHHS's performance monitoring activities. The *DHHS Policy and Funding Guidelines 2018–19* contain only an incomplete description of reporting and monitoring for CYMHS.

During the audit, the Director of Mental Health proposed some additions to the 2019–20 version of the DHHS Policy and Funding Guidelines to detail all of health services' mandatory reporting requirements to the Chief Psychiatrist.

Even if the proposed changes to the DHHS Policy and Funding Guidelines 2019–20 proceed, there remains no single source of information on the reporting requirements and performance monitoring arrangements for CYMHS. This reflects a siloed approach within DHHS and within the Mental Health Branch itself (between its performance monitoring area and the OCP), which inhibits DHHS from effective and efficient performance monitoring. It also inhibits DHHS's capability to provide accurate advice to government on CYMHS and the needs of Victorian children and young people with serious mental health problems. Although during the audit, DHHS finalised an Operational Model, which outlines a more integrated approach to performance monitoring that details the roles of the performance monitoring area and the OCP.

The *Victorian Health Services Performance Monitoring Framework*

The *Victorian Health Services Performance Monitoring Framework* describes DHHS's roles, responsibilities and processes for monitoring the performance of health services across all areas of quality of care, governance, access to care, and financial management. It specifies two KPIs for CYMHS that health services' CEOs are held accountable for by DHHS, through its quarterly performance meetings.

Figure 3B
***Victorian Health Services Performance Monitoring Framework* KPIs for child and youth mental health**

KPI	Target
Rate of seclusion events relating to a child and adolescent acute mental health admission	15 seclusions per 1 000 bed days
Percentage of child and adolescent mental health inpatients with post-discharge follow-up within seven days	80 per cent 75 per cent prior to 1 July 2018

Source: VAGO, from the *Victorian Health Services Performance Monitoring Framework 2018–19*.

DHHS could not provide a rationale for why it chose these two KPIs as the measures of CYMHS performance at a high level. Each KPI addresses areas that are important to monitor, but we found critical weaknesses in how the follow-up rate is calculated and how the seclusion rate is reported. It is a significant concern that these KPIs apply to inpatients only. The *Victorian Health Services Performance Monitoring Framework* therefore does not monitor the largest cohort of CYMHS clients, those in community or outpatient programs, which represent 74.4 per cent of CYMHS funding and a greater, though undetermined, proportion of people receiving CYMHS services.

Monitoring seclusion

If a health service exceeds DHHS's target for seclusions in CYMHS, DHHS brings this to the attention of the health service CEO and Board through the *Monitor* report and the quarterly health service performance meetings. CYMHS leaders are subsequently asked to explain the breach of the target to their hospital executive and Board. The explanation requires significant time and resources because of the required detail, which includes the background of the young people involved, and the complex and rapid clinical decisions that led to seclusions.

Quality improvement activities must accompany monitoring activities, otherwise a punitive culture can develop, which can worsen the practice the KPI is seeking to improve.

International literature shows that effectively reducing seclusion requires a comprehensive set of actions including training, debriefing and leadership on organisational change, alongside monitoring data. DHHS should consider reporting a health service's engagement in evidence-based activities to improve seclusion practices alongside the KPI in the *Monitor* report.

Figure 3C
Definition of seclusion in mental health care

Seclusion is the confinement of a patient at any time of the day or night alone in a room or area from which free exit is prevented.

The purpose, duration, structure of the area and awareness of the patient are not relevant in determining what constitutes seclusion. Seclusion also applies if the patient agrees to or requests confinement and cannot leave of their own accord.

While seclusion can be used to provide safety and containment at times when this is considered necessary to protect patients, staff and others, it can also be a source of distress; not only for the patient but also for support persons, representatives, other patients, staff and visitors. Wherever possible, alternative, less-restrictive ways of managing a patient's behaviour should be used, and hence the use of seclusion minimised.

Source: Australian Institute of Health and Welfare, *Mental Health Services in Australia*, 2019.

Since 2013, the Office of the Chief Mental Health Nurse within DHHS has led important work to introduce systems-oriented quality-improvement practices focused on seclusion and other restrictive practices across Victorian mental health services, including CYMHS.

Safewards is a UK-developed model with a set of 10 interventions designed to reduce conflict and containment in inpatient services. The trial of Safewards in Victoria in 2013 included two youth and one adolescent ward, as well as an adult ward that receives funding for two adolescent beds. A comprehensive evaluation by The University of Melbourne, published in 2015, showed that the rate of seclusion in the three adolescent/youth wards reduced significantly from 19 seclusions per 1 000 occupied bed days before the 12-week trial to 9.5 seclusions at the 12-month follow-up. The trial also showed promising, though less significant, improvements in adult services.

A 2016 expansion of Safewards engaged all but one of the adolescent and youth CYMHS wards. One of the child wards did not yet exist and the other was deemed out of scope for the project.

In 2018–19, another initiative to expand the Safewards program saw eight of the 11 CYMHS inpatient wards funded to employ a Clinical Nurse Consultant whose responsibilities include implementing Safewards and other activities to reduce restrictive interventions. A ninth CYMHS, Orygen Youth Health, had recently established a similar position at the time that the Victorian Budget provided this new funding, so it did not receive the funding but is doing the same work. Figure 3D shows the CYMHS wards that have been engaged in each of these three components of the Safewards program. DHHS needs to ensure that all CYMHS inpatient wards are engaged with Safewards.

Figure 3D
Participation in the three components of the Safewards program, by CYMHS wards

Ward	Trial, 2013	Expansion, 2016	Clinical Nurse Consultant funded, 2018–19	Any of the three components
Metropolitan services				
Austin—adolescent	×	✓	✓	✓
Austin—child	×	×	✓	✓
Eastern—adolescent	×	✓	✓	✓
Monash—youth	✓	✓	✓	✓
Monash—adolescent	✓	✓	✓	✓
Monash—child	n/a	n/a	✓	✓
Orygen Youth Health	✓	✓	self-funded	✓
RCH	×	✓	✓	✓
Regional services				
Ballarat Health	×	✓	✓	✓
Latrobe Regional Hospital	✓	✓	×	✓
Mildura Base Hospital	×	×	×	×
Total	**4**	**8**	**8–9**	**10**

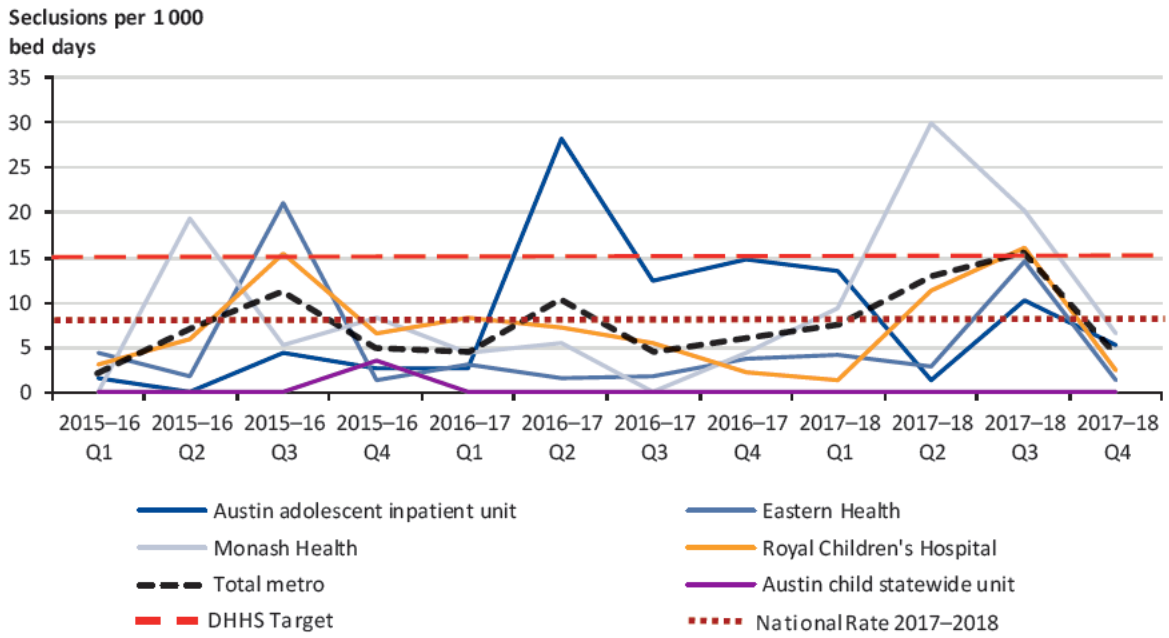
Note: Monash Child ward opened in 2018.
Note: The sites in Figure 3D were nominated for the expansion of the project but their actual participation varied due to staged implementation based on service capability.
Note: Monash Health and Austin Health both have one Clinical Nurse Consultant position split across their child and adolescent wards, making the total number of Clinical Nurse Consultants across CYMHS six.
Source: VAGO, based on information from DHHS.

Despite the significant work with Safewards, the rates of seclusion in CYMHS continue to exceed DHHS's target of 15 seclusions per 1 000 bed days and the national rate in 2017–18 of 8.1 seclusions per 1 000 bed days. DHHS advises that the national rate is lower than the Victorian rate due to a stricter definition of seclusion in Victoria, and therefore higher rates of reporting in Victoria. However, DHHS has not conducted an audit or review to confirm this theory.

DHHS's rationale for setting the target at 15 seclusions per 1 000 bed days includes data from a report it published in 2018 that shows trends in seclusion rates in adult mental health services only. DHHS advises that its Restrictive Interventions Governance Group has considered the target on several occasions. This group decided against reducing the target, but DHHS could not provide evidence of these deliberations.

DHHS monitors and publicly reports the seclusion rate at individual health services and calculates the total rate for all metropolitan CYMHS, which has only exceeded the target in one quarter since 2015–16, as shown in Figure 3E.

Figure 3E
Seclusion rate for audited CYMHS per 1 000 bed days, 2015–16 to 2017–18



Note: In the graph Q refers to 'Quarter'.
Note: The target in the Victorian Health Performance Framework is 15 seclusions per 1 000 bed days.
Source: VAGO analysis of information available on DHHS website. National rate 2017–2018 as reported by Australian Institute of Health and Welfare in *Mental Health Services in Australia*, published 22 March 2019.

The Act defines seclusion as 'the sole confinement of a person to a room or any other enclosed space, from which it is not within the control of the person confined to leave'.

A variety of scenarios can occur when a young person in a mental health facility becomes agitated or aggressive. These can include a clinician leaving the room so that the young person is left alone. The door to the room where the young person is can be left open, closed or locked. There are different understandings among CYMHS clinicians about whether an open door, or a closed but unlocked door, must be reported and recorded as a seclusion.

An authorised psychiatrist is appointed by the board of a health service and has specific legislated responsibilities under the Act around compulsory assessment and treatment and other situations where a consumer's rights may be at risk.

In 2018, the Chief Psychiatrist wrote to authorised psychiatrists about a concern that seclusion was under-reported. There was debate about reporting practices at a forum of mental health nurses in November 2018, which was chaired by DHHS's Chief Mental Health Nurse, that included different interpretations of the 2018 correspondence from the Chief Psychiatrist.

Inconsistent reporting of seclusion reduces the validity of the KPI. DHHS needs to better understand whether there are variable reporting practices around seclusion in CYMHS and take strategic action to improve them.

Chief Psychiatrist monitoring of individual seclusions

Health services must report every case of seclusion to the Chief Psychiatrist through monthly reporting processes. Reports include the patient's date of birth, which allows the Chief Psychiatrist to identify seclusions of children and young people. Reports include the duration of seclusion, the reason for it, who secluded the patient, and who approved and authorised the seclusion. The Chief Psychiatrist's Data Review Working Group reviews all reports of seclusion monthly. Services are required to clarify the circumstances of episodes of seclusion and restraints that exceed thresholds. In circumstances where the clarification raises concerns regarding quality and safety, the matter is brought to the Chief Psychiatrist's Portfolio Governance meeting for assessment and review. This process is highly resource-intensive, with approximately 10 senior staff involved at least half a day every month.

DHHS could not provide evidence of how it decides that there is a 'concern' that requires action or analysis to identify trends or persistent issues to inform strategic action.

The current process is reactive and focuses on singular cases. DHHS advises that actions arising from the meetings include phone calls made by senior staff to the authorised psychiatrists in the health services concerned. They may also instigate visits to health services by the Chief Psychiatrist and/or the Chief Mental Health Nurse. DHHS should develop a more transparent, timely, and efficient mechanism for reviewing individual cases of seclusion.

To enable this, DHHS should consider analysis of individual seclusion reports that includes:

- identifying trends at health services over time
- identifying trends or clusters within vulnerable population groups
- collecting and analysing additional information about the secluded client such as indicators of vulnerability, which for children and young people would include legal status with regards to child protection, disability diagnoses and family and housing characteristics.

This form of analysis would be consistent with the 2016 external review of the OCP, to be discussed in Section 3.7, which recommended increasing data analysis capacity.

There is no evidence that this monitoring of individual seclusion cases by the OCP is coordinated with the monitoring of the seclusion rate by the performance monitoring areas of DHHS. When DHHS communicates a breach of the seclusion rate target to hospital CEOs through its performance monitoring, it should draw on the information it holds through the OCP's extensive monitoring processes to form consolidated and consistent advice to health services.

Monitoring seclusion in regional health services

DHHS does not report the seclusion rate—or any other KPI—for the six CYMHS inpatient beds it funds for regional health services in Ballarat, Mildura, and Gippsland as it does for metropolitan services. DHHS advises that it 'monitors all seclusions for all health services … against age-determined benchmarks', but it could not provide evidence of seclusion rates for these regional CYMHS beds nor for children and adolescents in these regional services. One example of a seclusion report received by the OCP for a young person in a regional service was provided, but there is no evidence that seclusion of children and young people in regional health services is monitored strategically.

DHHS has not taken action to investigate the rate of seclusion for children and adolescents in these or any other regional mental health services. In Section 2.4, we detailed the significant problems with the system design around these beds and the risk that health services are not able to use them as a child and adolescent inpatient service.

In Section 2.4, we also showed how there are significant numbers of both adolescents and young adults using adult inpatient services in the regional health service that we audited. DHHS has taken no action to monitor the seclusion rate for children and young people who are being admitted as inpatients to adult services.

Post-discharge follow-up

Continuity of care, especially after an inpatient admission, is a critical component of good-quality mental health care. It requires the discharging inpatient service to make appropriate referrals, and communicate with the 'receiving' community program as well as the client and family. It also requires the 'receiving' community program to participate in the discharge process and communicate effectively with the inpatient service, client and family.

The post-discharge follow-up KPI holds only the 'receiving' CYMHS accountable for follow-up, when the process is also highly dependent on the inpatient service communicating well during the discharge process.

This issue is significantly exacerbated in the Western metropolitan region, where CYMHS funding and service delivery is shared between two organisations. RCH provides an inpatient service for adolescents aged 13–18 years, but their community programs that offer follow-up care for younger clients cease at 15 years. For RCH inpatients aged 15 years or over who live in the Western metropolitan catchment—approximately 300 young people each year—follow-up care is provided by Orygen Youth Health.

DHHS's performance monitoring system does not account for this complexity through its KPI reporting. RCH is reporting against post-discharge follow-up within seven days for inpatients over 15 years, although this service is provided by Orygen Youth Health. Orygen Youth Health, which is funded to provide the follow up care, is only held accountable for following up its own inpatients, excluding those transferred from RCH. During the audit, DHHS committed to 'improve the transparency' around this matter, but did not advise how they plan to do this and whether it will rectify this error in its performance monitoring system.

DHHS advises that the follow-up target is set at only 80 per cent to allow for clients who may use services outside of the Victorian public mental health system for their follow-up care. It had not done any research or analysis to confirm what proportion of CYMHS clients receive their follow-up care in the private or other parts of the health system. The target is also consistently lower than the current data on follow-up, which shows an average of 90 per cent for metropolitan services and 87 per cent for rural services. DHHS increased the target from 75 per cent to the current 80 per cent on 1 July 2018, but could not provide a rationale for why the target was increased or why 80 per cent was chosen.

3.3 Mandatory reporting to the Chief Psychiatrist

The Act stipulates that health services must report to the Chief Psychiatrist on:

- use of ECT
- results of neurosurgery performed
- use of restrictive interventions
- reportable deaths under the *Coroners Act 2008.*

The Chief Psychiatrist has powers under the Act to request additional reporting to what is legislated. This is communicated to health services as a part of guidelines that address individual topics, such as the guideline on ECT, for which the Chief Psychiatrist requires reporting 'in advance' for children and adolescents. As another example, in 2018, the Chief Psychiatrist issued a new reporting instruction to health services to mandate reporting of sexual safety violations.

During the audit, the OCP provided us with some proposed changes to the *DHHS Policy and Funding Guidelines 2017–18* to include all mandatory reporting requirements to the Chief Psychiatrist. This is an important development if it proceeds, because while some of the mandatory reporting to the Chief Psychiatrist is contained in legislation, other requirements are issued through topic-specific guidelines or directives. There are currently 32 documents on the Chief Psychiatrist's website that health services need to review to identify whether they contain a reporting mandate.

A person with **dual disability** has a developmental disability, such as intellectual disability or autism spectrum disorders and also severe mental health problems.

During the audit, the OCP proposed a new requirement for health services to report long periods of seclusion and long stays in high-dependency units, which our audit has shown are important matters to monitor in CYMHS given the challenges with complex clients with dual disability. However, this is only proposed as a revision to the DHHS Policy and Funding Guidelines 2019–20. The OCP advises that they will consider whether a guideline or reporting directive is required after reporting has commenced. This creates another level of inconsistency in reporting guidance for health services where some reporting requirements have directives or guidelines from the Chief Psychiatrist to explain the context, rationale and reporting processes, but others do not.

Health services are confused about their reporting obligations and associated actions with regards to SCV and the Chief Psychiatrist having some overlapping responsibilities. DHHS has not taken any action to clarify or explain this.

Some of the information health services report to the Chief Psychiatrist is made public through their annual reports. The reports use age groupings or service type of child and youth, adult or aged which allows monitoring of these measures for CYMHS, but only at a statewide level. There are privacy issues that reasonably explain why the data should not be publicly reported at a health service level.

The last published annual report for 2016–17 reported:

- seclusion episodes per 1 000 occupied bed days, by clinical program
- bodily restraint episodes per 1 000 occupied bed days
- number of ECTs for people under 18 years, and for 18–29 year-olds, by gender.

Deaths reported to the Chief Psychiatrist are not stated in the annual report by age for privacy reasons, although they are carefully monitored by the OCP.

The *Chief Psychiatrist annual report* for the period ending June 2018 was not published until March 2019, nine months after the end of the reporting period. This data is less useful when it is reported with extensive delays.

The OCP analyses the data it receives and identifies trends that it acts on either by issuing statewide guidance or instigating investigations of specific services. However, we found that this guidance is not communicated to CYMHS leaders nor is it understood consistently by senior staff in CYMHS responsible for implementing it.

The Chief Psychiatrist also chairs a Sentinel Event Review Committee, which makes recommendations about themes and system issues.

3.4 Mental Health Branch's monitoring activities

DHHS's Mental Health Branch monitors the performance of CYMHS through a suite of 15 KPIs, allocation of 'health service leads' and convening program meetings with each health service.

Key performance indicators

DHHS has a broader suite of 15 KPIs for CYMHS, shown below in Figure 3F, which it publicly reports on four times per year on its website. These KPIs have significant problems with their appropriateness as a representation of performance.

There is no governance structure or performance monitoring framework that oversees the development or use of these KPIs. DHHS has never evaluated, reviewed or consulted health services nor other experts on these or other KPIs' appropriateness for monitoring the performance of CYMHS. DHHS advises that its plans to develop a performance and accountability framework for mental health include reviewing its KPIs. DHHS should ensure that this review extends to the CYMHS KPIs, and addresses the problems with validity and appropriateness that are described in this report.

DHHS's rationale for the selection of these KPIs is that they are 'based on the national KPIs', but it could not explain the rationale for many of the significant differences between the national KPIs and those that it uses.

The national KPIs are formally known as the *Key Performance Indicators for Australian Public Mental Health Services, Third Edition* ('the national KPIs'), which are developed and overseen by a subcommittee established to advise the Australian Health Minister's Advisory Council. The national KPIs contain 15 KPIs that DHHS reports against to the Australian Government annually. DHHS could not provide any evidence of their decision-making process to develop their own suite of KPIs and the changes made from the national KPIs, which had been developed by high-level committees of experts in the field.

DHHS does not have a corresponding KPI for six of the national KPIs, which are marked as red in Figure 3F, and its rationale for excluding each is either absent or incomplete for three of these KPIs as follows:

- 'Costs of services'—data is available because it is reported to the Australian Institute of Health and Welfare, but DHHS could not provide any rationale for excluding this KPI
- 'Accessibility—New client index'—no rationale
- 'Accessibility—Proportion of population receiving care'—excluded because 'the CAMHS population is very small', without further explanation.

A further eight of the DHHS KPIs can be aligned to their counterpart in the national KPIs, but DHHS has changed them substantially, which are those marked orange in Figure 3F. For example, 'change in consumers' clinical outcomes' is measured by DHHS only for community clients, whereas the national KPI does not prescribe this limitation. 'Comparative area resources' is measured only in metropolitan areas, when geographic proximity is a known issue for regional areas and the rates of mental health problems for young people in regional areas are greater. DHHS excludes regional areas from this KPI without a rationale.

DHHS has an additional KPI outside the scope of the national KPIs, which is for monitoring services provided to children under the age of 12 years.

Figure 3F
DHHS's KPIs compared to national KPIs

Domain	National KPIs	DHHS Mental Health Branch's CAMHS KPIs	VAHI Victorian Health Services Performance public report	Victorian Health Services Performance Framework
Effective	Change in consumers' clinical outcomes	Percentage of clients with significant improvement case end (community only)	×	×
		Change in mean number of clinically significant HoNOS items (community only)	×	×
		Mean HoNOS at episode start	×	×
	28-day readmission rate		×	×
Appropriate	National service standards compliance		×	×
Efficient—inpatient	Average length of acute inpatient stay	Trimmed average length of stay, excluding same day stays and stays over 35 days	✓	×
	Average cost per acute admitted patient day		×	×
Efficient—community	Average treatment days per three-month community care period	Average treatment days	×	×
	Average cost per community treatment day		×	×
		Average length of case (days)	×	×
		Case re-referral rate	×	×
Accessible	Proportion of population receiving clinical mental health care		×	×
	New client index		×	×
	Comparative area resources	Beds per 10 000 of population (metro only)	×	×
Continuous	Rate of preadmission community care	Preadmission contact rate—CAMHS	×	×
	Rate of post-discharge community care	Post-discharge contact rate—CAMHS	✓	✓

Figure 3F
DHHS's KPIs compared to national KPIs—*continued*

Domain	National KPIs	DHHS Mental Health Branch's CAMHS KPIs	VAHI Victorian Health Services Performance public report	Victorian Health Services Performance Framework
Responsive	Consumer outcomes participation	Percentage self-rating measures offered	×	×
		Percentage self-rating measures completed	×	×
Capable	Outcomes readiness	Percentage HoNOS compliant	×	×
Safe	Rate of seclusion	Seclusion per 1 000 occupied bed days	✓	✓
No domain in national KPIs	n/a	Percentage clients aged under 12	×	×
		Service hours	✓	×

Key: Red = very significant variation or omission; orange = substantial variation; green = consistent.
Note: HoNOS = Health of the National Outcomes Scale.
Note: 28 day readmissions: CAMHS services advised that the 28-day readmission rate is not a reliable indicator of service as clinicians need flexibility to readmit patients if needed, without being concerned about KPIs.
Note: National service standard compliance: this KPI is measured at a health service/organisational level.
Source: VAGO analysis of *Key Performance Indicators for Australian Public Mental Health Services (Third Edition),* DHHS Mental Health Branch quarterly reports to Ministers and public, VAHI's Victorian Health Services Performance public report and the Victorian Health Services Performance Framework.

Health services could use these KPIs to benchmark their performance against other services, but they advise that this is rarely useful given the measures do not appropriately represent their performance. They report that the KPIs do not sufficiently monitor client outcomes and monitor seclusion in a manner that is not useful to understand the problems and respond to any performance issues at the health service level.

DHHS has not reviewed the effectiveness or appropriateness of its KPIs in monitoring CYMHS performance, nor has it strategically consulted with CYMHS or acted on their advice that the KPIs are not a useful measure of performance.

Section 4.3 of this report details how long patient bed occupancy is a significant issue in CYMHS, but DHHS could not provide any rationale or evidence to explain why it does not monitor it for CYMHS.

Six-monthly program meetings

Six-monthly program meetings are attended by senior staff from the health service (at least the Director of Mental Health, and sometimes the CEO as well) and the DHHS Mental Health Branch, often including the Chief Psychiatrist.

DHHS report that these meetings are not for performance monitoring. However, audited health services consider them to be an important forum to seek and receive guidance from DHHS and to communicate challenges and opportunities they face. Some of the audited health services noted that these meetings are their sole opportunity to formally communicate with DHHS, and in some cases their only opportunity to communicate at all, as they did not know who to contact at DHHS if they need guidance.

The meetings are held inconsistently for all but one health service, and do not regularly cover any matters related to CYMHS, focusing instead on adult mental health services. The meetings occur significantly less frequently with regional health services.

Our analysis of DHHS's minutes of these meetings over the past four years for 13 health services that have CYMHS and/or a Y-PARC found that, on average across all health services, CYMHS had only been discussed on two occasions in four years and only half of the meetings held mentioned child and youth mental health—for regional services it was less often. For four health services, only one meeting in four years had addressed child and youth matters, as seen in Figure 3G. DHHS could not provide evidence of any program meetings at AWH or Ballarat Health.

It is unclear whether agreed actions are followed through by either party, as the structure of the meetings does not frequently include reference to progress against agreed actions.

During the audit, the Mental Health Branch finalised an Operational Model, which outlines a range of processes and protocols including for:

- engaging with health services
- monitoring programs
- escalating performance issues
- working across DHHS to address systems issues
- program meetings
- ensuring the follow up of agreed actions.

Figure 3G
Six-monthly program meetings held in 2015–18

	Meetings held	Meetings that included matters related to children and youth
Metropolitan services		
Alfred Health	6	6
Austin Health	8	7
Eastern Health	7	4
Melbourne Health (auspice of Orygen Youth Health)	5	1
Monash Health	7	3
RCH	5	5
Regional services		
AWH	0	0
Ballarat Health	0	0
Barwon Health	4	2
Bendigo Health	3	2
Goulburn Valley Health	3	1
Latrobe Regional Hospital	3	1
Mildura Base Hospital	3	1
Peninsula Health	7	2
South West Healthcare	4	2

Source: VAGO analysis of DHHS minutes of six-monthly program meetings held between 1 January 2015 and 31 December 2018.

The role of health service leads

DHHS's Mental Health Branch allocates a health service lead to each mental health service. They are primarily responsible for liaison between DHHS and the health service around mental health matters. One staff member may be the health service lead for one or two health services.

One of the tasks of the health service lead is to ask services to explain their KPI results to DHHS when they are released quarterly. There is no protocol for what does or does not trigger the health service lead to ask for these explanations, and there is no evidence that DHHS has taken any follow-up action on the responses.

DHHS has acknowledged weaknesses in its engagement model with health services and had commenced a review at the time of the audit, but this was in a very early stage so we cannot report on its appropriateness for addressing the issues identified in this audit.

3.5 Failing to monitor accessibility

The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) is a clinician-rated instrument comprising 15 questions measuring behaviour, impairment, symptoms, social problems and information problems for those under 18 years.

The only KPI for accessibility of services is limited to inpatient beds in metropolitan services, as shown in Figure 3F. Our March 2019 performance audit *Access to Mental Health Services* found that accessibility is a significant problem that DHHS needs to monitor more closely.

DHHS's KPI of a mean (average) HoNOSCA score does not allow it to monitor whether the most severe clients are accessing CYMHS. To do this, DHHS should monitor the distribution of outcome measures at admission and look at the proportion that are of a high severity. DHHS's KPI shows that CYMHS are collecting outcomes measures at a high rate, so it could commence more meaningful analysis and monitoring of accessibility immediately.

In 2012, the National Mental Health Performance Subcommittee considered adopting a new accessibility measure that would monitor whether the most seriously unwell clients were getting access to CYMHS. The measure was to look at what proportion of clients accessing CYMHS community programs had very high (95th percentile) scores on a self-rating measure that is routinely collected—the *Strengths and Difficulties Questionnaire (SDQ)—Parent versions*. While this measure did not become a national KPI, it is an example of a measure that DHHS could use to monitor access for CYMHS. DHHS has been collecting this data for many years, so changes over time could also be determined and monitored going forward.

The Strengths and Difficulties Questionnaire (SDQ) is a brief emotional and behavioural screening tool. The tool can capture the perspective of children and young people, their parents and teachers.

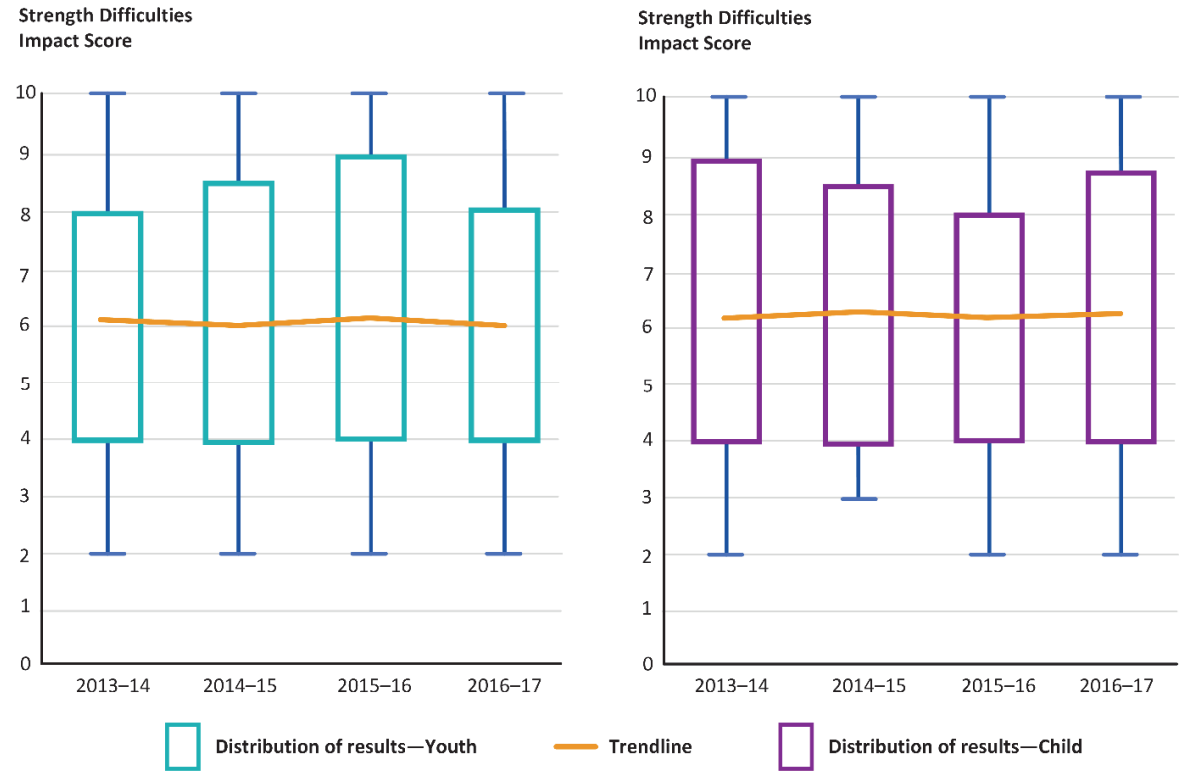
The SDQ can be used for various purposes, including clinical assessment, evaluation of outcomes, research and screening.

The most recent data from the Australian Mental Health Outcomes and Classification Network shown in Figure 3H demonstrates that clients admitted to CYMHS in Victoria in 2016–17 had an average SDQ impact score of between 6 and 6.1 out of 10 over the past four years. The most unwell 5 per cent of the population will have a score over 3. In 2016–17, 89 per cent of CYMHS clients in Victoria had an SDQ impact score over 3, putting them in the highest range of the most unwell 5 per cent of the population. This demonstrates that CYMHS are seeing the most unwell young people in the population.

Figure 3H shows that in 2015–16 the severity of CYMHS 'youth' clients was the highest of the four years of available data, while the severity of 'child' clients was lower than the other years. It also shows that in 2014–15, the minimum level for children accessing CYMHS was more severe than other years. These differences cannot be seen by the corresponding average figure, which is also shown on the chart in Figure 3H, and does not vary enough to identify changes.

Further analysis and monitoring of this data, which DHHS receives daily through its Client Management Interface (CMI) database, could show DHHS any changes over time and any variations between health services. There is no evidence that DHHS has ever reviewed the severity of clients accessing CYMHS nor taken any action where variation has occurred over time or between services.

Figure 3H
Severity of mental health problems as shown by the SDQ's impact scores for Victorian CYMHS clients at access to community programs, by year



Note: The box in each chart shows the upper and lower limits of the middle 50 per cent of all scores recorded, and the lines or 'whiskers' show the upper limits, the highest and lowest scores recorded.
Source: VAGO analysis of Australian Mental Health Outcomes and Classification Network information.

The measure DHHS uses as a KPI to monitor the severity of CYMHS clients is less precise and less useful as it does not identify the wide range of levels of severity of mental health problems seen in CYMHS. It therefore does not allow any determination around whether the intended client group—those with more severe problems—are accessing CYMHS.

3.6 Other DHHS areas and agencies' performance monitoring of CYMHS

There are four performance monitoring activities for CYMHS that are managed by areas of DHHS outside of the Mental Health Branch:

- quarterly health service performance meetings
- VAHI reporting of CMI data
- sentinel event reporting to SCV
- reporting to Department of Treasury and Finance (DTF).

Quarterly health service performance meetings

The primary mechanism for managing the performance of health services is a quarterly meeting between health service CEOs and DHHS. The inputs to this meeting are the KPIs in the Victorian Health Services Performance Monitoring Framework and the agreement made through the Statement of Priorities (SoP), which are described below.

The meetings cover performance of the entire health service, and DHHS was not able to provide advice about the extent to which they address mental health performance matters. A representative of the Mental Health Branch is invited to attend if a mental health program matter is on the agenda. This can be contributed by a health service or the Mental Health Branch can recommend agenda items relating to the health service's performance against KPIs.

Statements of Priorities

Each year, a SoP is developed as an agreement between each health service and the Minister for Health on what that year's priorities will be. We analysed the SoPs for all 17 Victorian health services that receive funding directed at children and youth with mental health problems (see Appendix B for funded agencies).

No SoPs in 2018–19 mention child and youth mental health, though two did in the previous year. In 2016–17, when there was a substantial investment of new funds and new programs, only five health services mentioned child and youth mental health in their SoP.

Victorian Agency for Health Information

VAHI was established as an administrative office within DHHS in 2017 after *Targeting zero: Report of the Review of Hospital Safety and Quality Assurance in Victoria* made 66 recommendations about improving quality and safety in Victorian hospitals.

VAHI produces a quarterly report on the performance of Victorian health services, which includes four items that allow performance monitoring of CYMHS. All are reported at the individual health service level. These are:

- service hours provided by community mental health services
- child and adolescent mental health average length of stay
- child and adolescent mental health post discharge follow-up rate
- child and adolescent mental health seclusion events per 1 000 bed days.

DHHS advises that 27 items that VAHI reports on relate to CYMHS. However, the four above are the only items where CYMHS data is separated from other parts of the mental health system and therefore used to monitor CYMHS performance. It is not possible to monitor the performance of CYMHS using data that does not distinguish between the different sectors of the mental health system.

VAHI's quarterly report is the primary source of evidence for advising the ministers for Health, Ambulance Services and Mental Health on the performance of CYMHS.

DHHS could not provide a rationale or evidence of the decision-making for how or why these four indicators were selected. These indicators do not adequately monitor the performance of community programs and critical issues for inpatients such as long stays, continuity of care for vulnerable groups and aspects of accessibility, as discussed in Section 3.5. The quality of DHHS's advice to its ministers is therefore impacted.

VAHI produces a range of reports with this information, which are distributed to different groups, as follows:

- *VAHI Board Quality and Safety Report* is sent quarterly to health service boards and CEOs.
- *Inspire* is sent directly to clinicians quarterly with special issues also produced for in-depth reporting on specific clinical areas. There have been two *Inspire* reports into mental health, which included data reported for children and youth.
- *Monitor* is sent to public health service boards, CEOs and DHHS quarterly, and reports performance information across measures contained in each health service's SoP.
- *Program Report for Integrated Service Monitoring* (PRISM) is sent to public health service boards, CEOs and DHHS quarterly, with a broader range of performance information to complement *Monitor*.

Sentinel event reporting to Safer Care Victoria

The *Health Legislation Amendment (Quality and Safety) Bill 2017* established SCV as an administrative office of DHHS to monitor and improve the quality and safety of care delivered across Victoria's health system. It also gave the Secretary of DHHS powers to request information from health services, which has been one of the enablers of SCV's mandatory reporting of sentinel events.

Health services must report sentinel events within three days and must complete and provide to SCV a 'root cause analysis' within 30 working days.

DHHS advises that it had received a report of one sentinel event in CYMHS since SCV was established three years ago, but it could not provide evidence to the audit about this event or its treatment. There is no evidence that this sentinel event report was shared with other areas of DHHS with responsibility for monitoring quality, safety or performance such as the Chief Psychiatrist or the Mental Health Branch, nor how these different areas coordinate their various monitoring activities.

Reporting to the Department of Treasury and Finance

DHHS must report to the DTF every year on the performance of the mental health system through Budget Paper 3.

The 14 performance measures and targets relate to the whole mental health system, and are not broken down by age, so none of measures that are used for this purpose allow DTF to monitor CYMHS or children and young people's mental health.

Budget Paper 3 performance measures can be changed through negotiations with DTF during the annual state budget process, but there is no evidence that DHHS considered giving DTF visibility of the performance of CYMHS.

Given the significant economic impact of addressing mental health problems early in life, DTF should be able to monitor the performance of CYMHS as a priority area.

3.7 Monitoring the quality of service delivery

The Act prescribes three functions to the Secretary of DHHS that relate to service quality and a further six service quality functions to the Chief Psychiatrist, as shown in Figure 3I. The activities we identified around monitoring or improving service quality for CYMHS were those undertaken by the OCP.

Figure 3I
Functions in the Act for the Secretary and the Chief Psychiatrist that relate to program quality

The Secretary's functions include:

(a) to develop and implement mental health strategies, policies, guidelines and Codes of Practice

(b) to plan, develop and promote a range of mental health services that are comprehensive, integrated, accessible, safe, inclusive, equitable, and free from stigma

(c) to promote continuous improvement in the quality and safety of mental health services.

The Chief Psychiatrist's functions include:

(a) to develop standards, guidelines and practice directions for the provision of mental health services and publish or otherwise make available those standards, guidelines and practice directions

(b) to assist mental health service providers to comply with the standards, guidelines and practice directions developed by the chief psychiatrist

(c) to develop and provide information, training and education to promote improved quality and safety in the provision of mental health services

(e) to assist mental health service providers to comply with this Act, regulations made under this Act and any Codes of Practice

(i) to conduct investigations in relation to the provision of mental health services by mental health service providers

(j) to give directions to mental health service providers in respect of the provision of mental health services.

Source: Excerpts from the *Mental Health Act 2014.*

Seven of the 15 KPIs that DHHS's Mental Health Branch monitors every quarter measure different aspects of service quality, which are clinical outcomes, seclusions, continuity of care and consumer participation in monitoring outcomes. However, all the KPIs have significant limitations, which we have detailed in Section 3.4.

The role of the Chief Psychiatrist

DHHS has assigned all responsibility for matters of service quality in mental health services to the OCP. The Chief Psychiatrist undertakes a wide range of activities that endeavour to improve service quality across mental health services for all children and young people, adults and aged people, such as issuing guidelines, forums, service reviews and correspondence.

Figure 3J shows the functions of the Chief Psychiatrist legislated in the Act that relate to service quality and evidence of action against each of these areas with relevance to CYMHS.

Figure 3J
OCP's actions against the Chief Psychiatrist's legislated functions that relate to service quality

Legislated function	Evidence of action in 2017–19
(a) to develop standards, guidelines and practice directions for the provision of mental health services and publish or otherwise make available those standards, guidelines and practice directions	• Sixteen current guidelines published. • Four new guidelines completed and released. • New reporting instruction on sexual safety violations. • Clinical practice framework for intensive mental health nursing. • Guideline and practice resource: Family violence.
(b) to assist mental health service providers to comply with the standards, guidelines and practice directions developed by the chief psychiatrist	• **Minimal.** New guidelines are sent to authorised psychiatrists by email. No guidance or support is provided on their implementation. Evidence that some are not implemented and no follow-up.
(c) to develop and provide information, training and education to promote improved quality and safety in the provision of mental health services	• Two *Quality and Safety* bulletins published. Note: Committed to two per year but only published one in each of 2017–18 and 2018–19. • CYMHS Senior Nurses Forum—three meetings held, plus monthly forums for all senior nurses. • CYMHS Clinical Leaders meeting—two meetings held during the audit in October 2018 and March 2019, after they were put on hold for two years commencing August 2016. • Quarterly forums for authorised psychiatrists. • Three quality and safety forums. • Safewards project—27 events, forums, workshops, meetings.
(d) to monitor the provision of mental health services in order to improve the quality and safety of mental health services	• Analysis of individual reports of seclusions and restrictive interventions. • Monitored implementation of the Hospital Outreach Post-suicidal Engagement (HOPE) program at six sites. • Review of inpatient deaths. • Review of community deaths.

Figure 3J
OCP's actions against the Chief Psychiatrist's legislated functions that relate to service quality—*continued*

Legislated function	Evidence of action in 2017–19
(e) to assist mental health service providers to comply with this Act, regulations made under this Act and any Codes of Practice	• Correspondence to authorised psychiatrists regarding restrictive interventions in CYMHS in July 2018, and subsequent discussions of same at CYMHS Clinical Leaders Network and CYMHS Senior Nurses forum.
(i) to conduct investigations in relation to the provision of mental health services by mental health service providers	• Eleven major investigations since 2016, including two relating to young people. • Recommended a review of whole mental health service at AWH, which the service accepted and commissioned. Chief Psychiatrist's role in the process unclear. Reasons for review also unclear. • Last review of CYMHS specifically was Goulburn Valley Health in 2016.
(j) to give directions to mental health service providers in respect of the provision of mental health services	• While it is clear that the Director of Mental Health cannot provide directions to health services on clinical care, the Chief Psychiatrist is consulted by the Director of Mental Health for ad hoc advice that informs directions to health services such as prioritising access to beds. The Chief Psychiatrist also provides their own directions on occasions where more collaborative improvement strategies have failed. The respective roles of the Chief Psychiatrist and the Director of Mental Health in providing directions to health services is unclear and lacks transparency.

Key: Green = actions have fully met the legislated functions; orange = actions have not completely met legislative functions.
Source: Mental Health Act 2014; VAGO analysis of Chief Psychiatrist Annual Report 2017–18 (draft) and other documentation provided to the audit.

The audited health services confirmed that the two areas noted as 'minimal' in Figure 3J are both lacking actions by the OCP and that the lack of guidance in these areas is a cause of significant challenges for CYMHS.

External review of the OCP

In 2016, DHHS commissioned an external review of the Chief Psychiatrist's role by two senior health service managers from New South Wales, one of whom was a psychiatrist. The review made 22 recommendations about organisational structure and resourcing, engagement with health services and stakeholders, internal business processes and several matters of scope and role definition.

The OCP's internal acquittal of the review in February 2019 shows that five of the recommendations were not supported. The OCP replaced one of them with an alternate response, but the remaining four, which relate to resourcing the OCP and its scope extending to oversight of the private sector, have no explanation as to the rationale or decision-making process for their dismissal, nor any alternative response proposed to deal with the underlying issues identified by the review.

Eight recommendations have been partially implemented three years after the review and one has not been implemented at all, which was about the Chief Psychiatrist providing regular independent briefings to the DHHS Secretary, the implications of which are discussed in Section 4.4.

For three of the eight recommendations that the OCP's internal acquittal notes as fully implemented, our audit has found evidence which contradicts these assertions, which relate to:

- clarifying respective roles around sentinel event reporting with SCV
- clarifying and communicating to mental health services the respective roles of the OCP and other parts of the Mental Health Branch
- contributing to health service performance discussions.

It is unclear why the OCP would acquit these recommendations as complete when they have not been. DHHS should more thoroughly respond to this review and increase its transparency by reporting against its progress to the Minister.

Chief Psychiatrist's Guidelines

The OCP develops and issues guidelines on a range of topics. The guidelines do not differentiate between different parts of the mental health system with different models of care. As such, their implementation in CYMHS can be complex and conflict with their own health service policies. There is insufficient interpretation or implementation support provided by the OCP or DHHS.

Audited health services report that it can be difficult to determine whether communication from the Chief Psychiatrist is a mandate or directive that must be implemented under legislation, or whether it is merely advice of recommended practice that can be adapted and implemented to suit local needs. This is an important distinction that should be made clear in all communications if the impact of the mandated directives is to be upheld. The OCP does not monitor the implementation of guidelines.

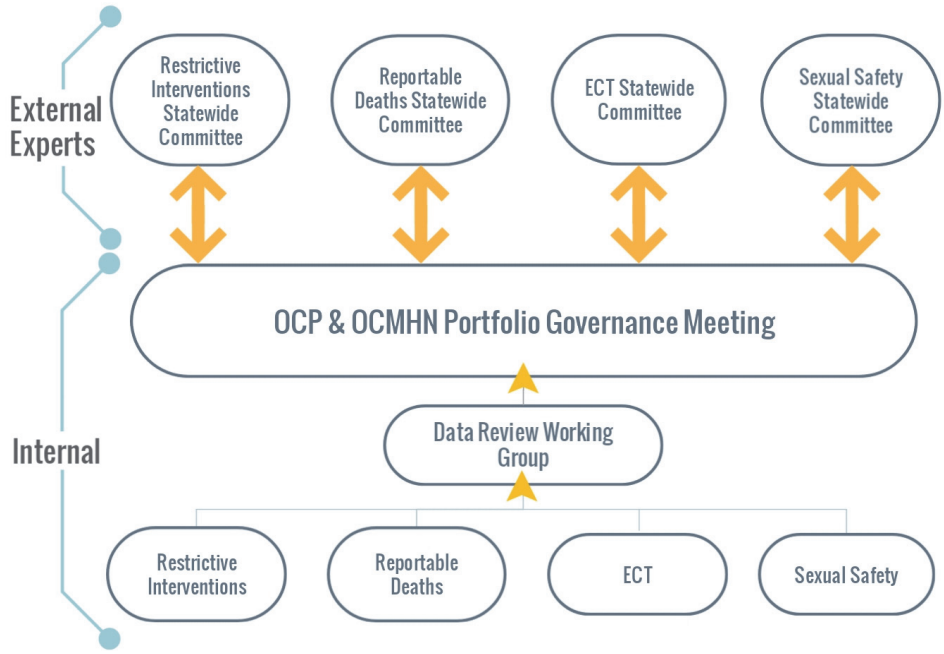
The guidelines are issued to only one person in each health service, the authorised psychiatrist, which can cause delays or, on occasion, failures in delivery to those who are responsible for implementing them in CYMHS. It is a simple administrative matter to ensure distribution of guidelines to senior staff. There is no evidence that these staff change frequently in CYMHS, so maintaining a database of the the relevant names and their email addresses would not be a significant resource burden for DHHS.

Governance and 'umpire' functions

Health services described the occasional need for an 'umpire' where there are disputes or differing policies and procedures between services. For example, where there are disputes about responsibility for patients and processes for transferring patients between catchments.

The Chief Psychiatrist convenes four external committees and six internal groups that provide governance around the functions in the Act, as shown in Figure 3K. There is no evidence that these committees have considered CYMHS specifically in the past year, as their meetings are fully occupied by matters in the adult mental health system.

Figure 3K
Governance of quality and safety issues in mental health services managed by the OCP



Source: OCP.

Unreleased evaluations and reviews

The Victorian Government invested $34 million over four years in child and youth reform initiatives in 2008. $200 000 was allocated towards evaluation, which internal correspondence noted as insufficient. $100 000 was spent to undertake an internal evaluation; however, competing priorities prevented the evaluation from being finalised. The remaining $100 000 was subsequently combined with some program delivery underspend, so that $453 963 was allocated towards evaluation of the 2008 reforms.

DHHS commissioned two external evaluations, but did not release either 'due to a change in government'. The reports were titled:

- *Evaluation of selected Victorian child and youth mental health reform initiatives. Stage 1 Preliminary Investigation Final Report*, 31 October 2012
- *Evaluation of selected child and youth mental health reform initiatives*, 29 May 2013.

Audited health services advise that the findings of these two evaluations are highly sought-after and would remain relevant and useful today.

There are another 10 reviews and reports that also provide data and lessons about program quality and improvement opportunities for CYMHS that have not been released for reasons that DHHS could not explain. These documents represent a considerable expenditure of government funds and resources. Where CYMHS have directly contributed to the evaluations and reviews, withholding these reports has eroded their trust in DHHS. It is also inconsistent with DHHS's organisational value to 'generously share our knowledge'.

The University of Melbourne evaluated the Frankston Y-PARC in 2017, but only an executive summary was published. DHHS did not commission this evaluation, and ownership sits with the university and the agency that manages the Y-PARC, Mind Australia. However, as the funding body for the service, DHHS could direct and enable this evaluation to be shared with the wider sector. Further, DHHS has not sought or reviewed either the unreleased full evaluation report or the publicly available executive summary.

DHHS has also not released a comprehensive report by Alfred Health on the establishment of a dual disability service there, which Alfred Health provided to DHHS in 2018. DHHS has taken no action to communicate the project's outcomes with other CYMHS. The report contains valuable lessons for improving service quality in CYMHS. The importance of this project is discussed further in Section 4.5. Alfred Health has presented at one conference about the project, but has not discussed it more widely.

The following eight reviews and analyses of clinical mental health services, conducted or commissioned by DHHS, include specific consideration of CYMHS, but have never been released or communicated to the sector:

- Mental Health Services Strategy Data Analysis Report—Draft Report, April 2018
- *Reform of Victoria's specialist clinical mental health services: Advice to the Secretary*, December 2017
- DHHS Linkage, Modelling and Forecasting Section, Mental Health 2018–23 Services Strategy analysis—Draft, 2018
- *Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System*, April 2017
- *Consultation paper Clinical mental health service catchments*, August 2013
- *Review of acute mental health assessment and treatment for Victorian children aged 0–12 Summary Report*, April 2010
- *Next steps 0–25 Next Steps in Mental Healthcare Reform for Children, Young People and their families: Guidance for state-funded specialist mental health services*, August 2012
- *Victorian Department of Health and Human Services' Expert Taskforce on Mental Health, 10-year mental health plan wave 2 priorities—discussion paper*, 28 June 2016.

All relevant lessons learned from these 12 evaluations and reviews, and where possible complete reports, should be released to CYMHS leaders, and more widely to consumers and the general public, so they can be used to inform service development and quality improvement.

3.8 Monitoring outcomes

Monitoring outcomes is a significant priority for all mental health services and for the Victorian Government, but there are some significant failings in DHHS's approach to monitoring outcomes in CYMHS.

In a March 2019 publication about the Victorian Government's commitment to 'outcomes-thinking', the Secretary of the Department of Premier and Cabinet stated that:

> The best way to deliver public value to the people of Victoria is to clearly define the outcomes we are trying to achieve, and measure progress along the way.

There is no evidence that DHHS has asked a CYMHS to explain its performance with regards to outcome measures—neither their collection nor the results.

DHHS's *Health and Wellbeing Outcomes Framework*

DHHS's *Health and Wellbeing Outcomes Framework*, published in 2016, includes as an outcome that 'Victorians have good mental health', but none of the targets monitor the wellbeing of children and young people who have mental health problems nor the effectiveness of government programs to assist them. The selected outcomes measures take a prevention and population health approach to mental health, which is important, but does not allow for any outcome monitoring for people with more severe mental health problems that are using CYMHS.

The outcomes framework is not an effective mechanism for monitoring outcomes of CYMHS or the children and young people with mental health problems who CYMHS supports.

The one target against the outcomes is a 20 per cent increase in resilience of adolescents by 2025, which comes from the government's education policy, 'Education State'. Three of the measures defined against this outcome relate to children and young people, which are:

- the proportion of adolescents who experience psychological distress
- the proportion of adolescents with a high level of resilience
- the proportion of children living in families with unhealthy family functioning.

The suicide rate is also a measure, but it is not broken down by age to measure the rate for children and young people specifically.

10-year Mental Health Plan outcomes framework

DHHS's 10-year plan defines 16 outcomes and DHHS has developed indicators and measures for 10 of these. It reports progress against the indicators in its annual report to the Minister for Mental Health and publishes the report on its website.

Four of the 34 indicators relate to children and young people with severe mental health problems, as shown in Figure 3L. A further 18 of the indicators would provide useful information about CYMHS and its clients; however, they are only reported for adults or for the whole system, so children and young people cannot be separately monitored.

Figure 3L
Indicators in the 10-year mental health plan that relate to children and young people with severe mental health problems

Indicator	Reference year	Two years prior	One year prior	Most current data
Proportion of Victorian young people with positive psychological development	2016	70.1%	n/a	68.8%
Proportion of children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing	2017	4.6%	4.8%	4.9%
Proportion of Victorian Aboriginal children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing	2017	14.2%	15.6%	14.4%
Proportion of registered clients experiencing stable or improved clinical outcomes (children and adolescents)	2017–18	90.6%	91.3%	90.6%

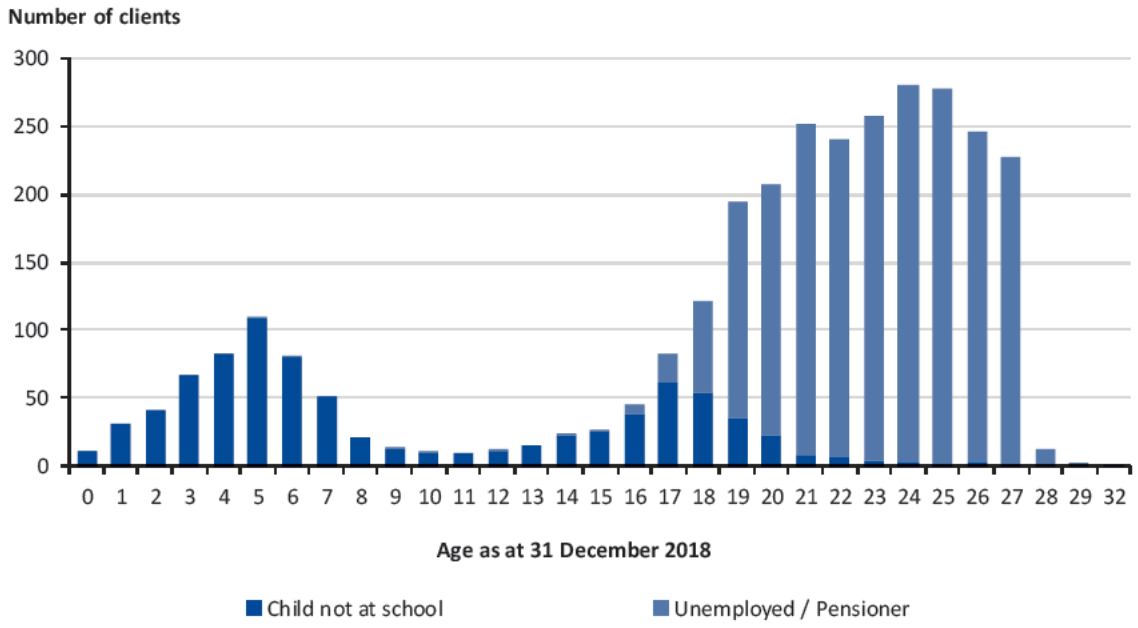
Source: DHHS *Mental Health Services Annual Report 2017–18.*

DHHS has not developed indicators or measures to monitor four other outcomes in its framework that relate to the wellbeing of children and young people with severe mental health problems. These outcomes are that Victorians with mental illness:

- participate in learning and education
- participate in and contribute to the economy
- have financial security
- are socially engaged and live in inclusive communities.

DHHS advises that it has developed an indicator for CYMHS clients' participation in learning and education, but this was not being used at the time of the audit and DHHS could not provide any evidence of this work. Our analysis of data from the five audited CYMHS shows that education and economic indicators are a significant issue for CYMHS clients, as seen in Figure 3M. We found 65 CYMHS clients of school age who had never attended school, while 19 per cent of clients over the age of 15 years were not employed or in any education program.

Figure 3M
Number of clients with 'education status' recorded as 'not at school' or 'unemployed/pensioner'



Note: Analysis is limited to the 12 848 CYMHS clients over three years to 31 December 2018 who had their education status recorded in the clinical database.
Source: VAGO analysis of information from five audited health services.

Our 2019 audit *Access to Mental Health Services* also found significant failings in the outcomes selected for the 10-year plan, with the following finding:

> There are few measures in the outcomes framework for the 10-year plan that directly capture performance against providing access to services or increasing service reach—this despite the acknowledged performance problems in this area—which shows a lack of focus on the most pressing issue the system faces.

Nationally agreed outcomes collection

A **self-rating measure** is a survey that asks clients, or their parents, or both, to rate various aspects of their health and wellbeing. The surveys are used as a part of therapeutic care and the results can also be used to inform research and service development.

The most commonly used self-rating measure in Australian clinical mental health services is the SDQ, which has three different versions: one for parents of children, one for parents of youth and a youth self-report version.

Under the *Second National Mental Health Plan*, endorsed in 1998, all Australian states and territories committed to routine collection of outcomes data in public mental health services. The National Outcomes and Casemix Collection (NOCC) was first specified in August 2002. It outlines the agreed national minimum requirements and includes a set of protocols about the times and points in service delivery when each outcome should be collected. The outcomes include a mix of self-rated and clinician-rated assessment tools.

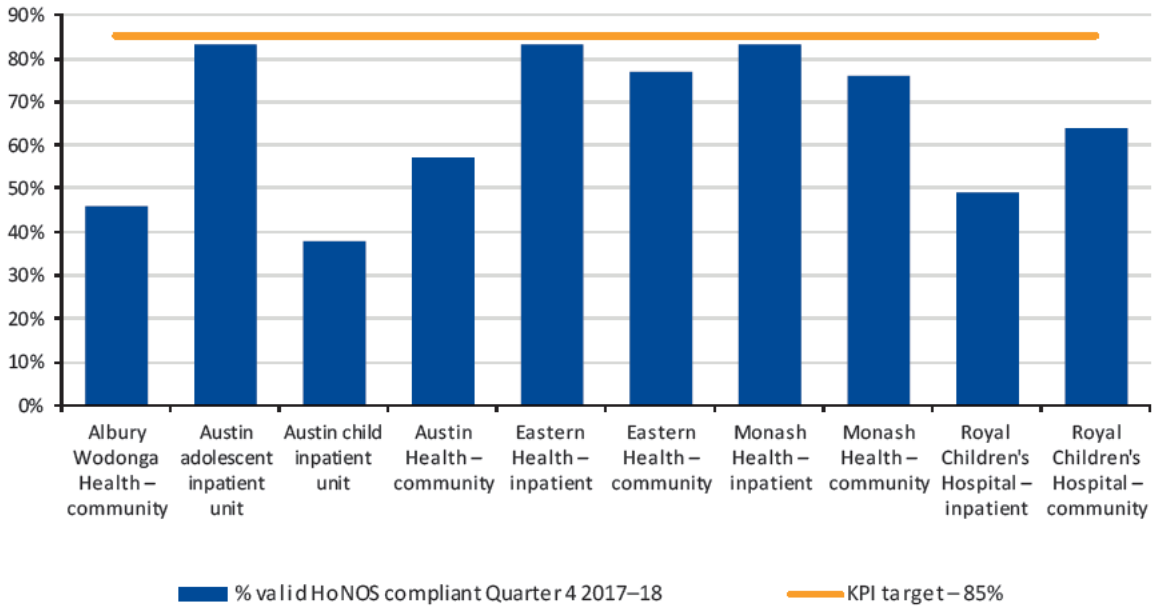
The NOCC protocols require CYMHS to collect seven different outcomes for all clients and they specify whether they need to be collected at admission, review, discharge, or all three points, which varies between inpatient, community residential or ambulatory settings.

DHHS monitors compliance with three elements of the NOCC protocols, by having KPIs for health services:

- completing the HoNOSCA outcome tool
- offering a self-rating outcome measure to inpatients only
- completing a self-rating measure.

CYMHS's performance against these KPIs shows that their completion of outcome measures varies between different settings and between services, as shown in Figure 3N.

Figure 3N
Completion of the HoNOSCA outcome measures in April to June 2018 by health service



Source: VAGO from DHHS website quarterly CAMHS KPIs.

DHHS's guidance to health services, *Outcome measurement in clinical mental health services*, published on its website, has not been reviewed since 2009 and contains errors. It states that the NOCC outcomes for 'community residential' are not applicable in Victoria for children and adolescents, despite such facilities now existing. Elsewhere on the DHHS website there is guidance on implementing the NOCC protocols that differs from this publication in stating whether measures should be collected at intake or admission.

International Declaration on Youth Mental Health

The United Kingdom's Association for Child and Adolescent Mental Health together with the International Association for Youth Mental Health published a declaration on youth mental health in 2011 and updated it in 2013. The declaration sets eleven 10-year targets for service provision for young people aged 12–25 years.

Benchmarking performance against other organisations or consensus targets like the international declaration is an important and effective strategy to identify opportunities for improvements in systems and processes. DHHS has never benchmarked Victorian CYMHS against these international targets and it does not collect the relevant data or other information to allow it to monitor them. For some of the targets, DHHS does not collect data in the right format, such as breaking down suicide rate by age. For other targets, DHHS has data that would allow some monitoring, but it has never done so, such as using CMI data to monitor accessibility, as discussed in Section 3.5, or the user-experience survey data, which it collects but has never analysed or used.

If DHHS proceeds with its commitment to develop strategic directions under its *Clinical Mental Health Services Improvement Implementation Plan,* which this audit recommends, it should consider benchmarking against the international targets. It should share the results of the benchmarking with CYMHS leaders and involve them in developing strategies to address any discrepancies identified between Victorian CYMHS's performance and the international targets. DHHS should also rectify the issues described in Figure 3O in regards to its capacity to monitor the important issues covered by the international targets.

Figure 3O
Relevant[(a)] targets in the *International Declaration on Youth Mental Health* and DHHS's ability to monitor each

Target	Available data or system to monitor?
1. Suicide rates for young people aged 12–25 years will have reduced by a minimum of 50 per cent over the next 10 years.	The Victorian population's suicide rate is not measured or reported by age.
5. All young people and their families or carers will be able to access specialist mental health assessment and intervention in youth-friendly locations.	Location of services is not monitored.
6. Specialist assessment and intervention will be immediately accessible to every young person who urgently needs them.	Accessibility or time lines of access is not monitored, as discussed in Section 3.5.
7. All young people aged 12–25 years who require specialist intervention will experience continuity of care as they move through the phases of adolescence and emerging adulthood. Transitions from one service to another will always involve a formal face-to-face transfer of care meeting involving the young person, his or her family/carers and each service involved in his or her care.	The KPI for follow-up applies only to inpatients and does not monitor the type of transition service provided.
8. Two years after accessing specialist mental health support, 90 per cent of young people will report being engaged in meaningful educational, vocational or social activity.	Not monitored, though the CMI database does collect information which shows poor outcomes, with 19 per cent not engaged.
9. Every newly developed specialist youth mental health service will demonstrate evidence of youth participation in the process of planning and developing those services.	Youth participation in CYMHS is not monitored.
10. A minimum of 80 per cent of young people will report satisfaction with their experience of mental health service provision.	DHHS's Your Experience of Service (YES) survey is completed by people aged over 16 years using mental health services. In the three months March to May 2018, 1 051 people aged 16–25 years completed the survey. The survey is not mandatory and health services administer it at widely differing rates. There is no evidence that DHHS analyses the results for under 25-year-olds CYMHS clients nor uses them to monitor performance.
11. A minimum of 80% of families will report satisfaction that they felt respected and included as partners in care.	The YES survey asks the young person's perception of their family's experience. Families themselves are not surveyed.

(a) Three of the targets relate to prevention and workforce issues that were out of scope for this audit.
Source: VAGO analysis of information provided by DHHS and the '10-year targets' in the *International Declaration on Youth Mental Health* published by the International Association for Youth Mental Health, October 2013.

Audited health services' outcomes monitoring

In addition to the outcome measures mandated by DHHS and NOCC, RCH has begun to use 10 tools to measure and monitor clinical outcomes. The selected tools are freely available and are commonly used in research, allowing RCH to benchmark outcomes for their clients nationally and internationally. The tools are rating scales and questionnaires developed for specific disorders, such as anxiety, obsessive compulsive disorder and suicidality, and are all tailored to children and young people.

DHHS was not aware of this work, possibly because it had not convened its six-monthly program meeting with RCH for nine months at the time of the audit and the work had occurred during that period. This represents a missed opportunity for DHHS to share RCH's work with other health services.

3.9 Data collection and reporting to DHHS

The Mental Health Branch requires CYMHS to report all client contacts and information through a computer application called CMI, which delivers data into a central database managed by DHHS called the operational data score (ODS).

DHHS has a manual that provides guidance on how to report activity into CMI. The manual is not publicly available, and DHHS advises that the manual is out of date and being updated, but could not provide evidence of the process or the expected completion date.

DHHS also communicates some reporting requirements to health services in a series of bulletins published on its website. Each relates to a specific matter, such as 'recording admissions' or 'deceased clients'—there is no single source of information on CMI and its reporting requirements except for seeking advice from the DHHS staff who are responsible for maintaining the database. CYMHS independently convene a network of their health information managers to provide support and upskilling to these specialised staff.

Our analysis of some CMI/ODS data (see the scope and methodology in Appendix D) identified some significant gaps in the information that can be entered into the database and the usefulness of other information that is entered, due to there not being any current guidance on terminology and definitions of fields.

We found the following specific issues with the CMI database:

- The 'legal status' information that can be recorded on DHHS's printed client registration forms does not have a corresponding field and cannot be entered into the CMI/ODS database.
- The 'sex' field on the client registration form and in the CMI database only include the options 'male' and 'female', which is not consistent with the Victorian Government's guidance on inclusive language. DHHS advises that it is working to improve mental health services' collection of sex/gender information in line with the 'Rainbow Tick' national accreditation program for organisations that are committed to safe and inclusive service delivery for lesbian, gay, bisexual, transgender and intersex people. There is no evidence yet of implementation in CYMHS.
- 'Living arrangements' has 20 response options that are not mutually exclusive or defined with business rules.
- 'Living status' response options include 'acute hospital' and 'psychiatric hospital', but there are no business rules to explain the distinction or why these would be an individual's place of residence.
- The 'carer relationship' field has 24 response options that are not defined or clearly described.
- The 'carer' field is used by health services to record the client's medical professional's details, which should be a separate and different field.

- Health services recorded 15 CYMHS clients born in Adelie Land, a French-claimed territory in Antarctica. This is likely to be a data entry mistake, as Adelie Land is the first option for country of birth in the alphabetic list on CMI and no respondent in the 2016 census was born there. During the audit, DHHS advised that it had introduced validations to identify this and ensure corrections are made.
- Health services can create their own response options for many fields in the database, which creates inconsistent data that is difficult to analyse at the sector or statewide level.

DHHS owns the CMI database and is responsible for managing and maintaining it. The Mental Health Branch uses this data to generate the KPI reports it uses to monitor CYMHS performance. It advised us that making changes to the database is difficult because it is managed by a different area within DHHS whose resources are stretched. DHHS's *Digitising health* strategy, published in 2016, notes 'Mental health modernisation' as a priority. DHHS advises that significant work is underway, including the appointment of a provider to transition the CMI/ODS database to a new platform. However, DHHS could not provide evidence of progress, methodology or timelines for this activity.

DHHS does not review whether CMI is collecting the appropriate and necessary information and was not aware of the failures of the CMI system that we identified through our analysis.

As a result of these database issues, DHHS cannot understand many important components of CYMHS, such as whether they are providing services to vulnerable populations, or the complexity and vulnerability of the clients who do access CYMHS. Without an accurate way to collect this information, DHHS cannot appropriately monitor the performance of CYMHS. The problems with collecting this information will also impede DHHS's ability to describe performance issues to government and advocate for additional resources where they might be needed.

4

Access and service responses for vulnerable populations

Mental health problems increase exponentially when there are other indicators of vulnerability, such as unstable housing and poverty, neglect and abuse, intergenerational trauma or developmental disabilities.

Both individuals and the society they live in substantially benefit from timely wrap-around care that coordinates the many services that can be involved for these most vulnerable children and young people.

4.1 Conclusion

Under-resourcing combined with a lack of DHHS service coordination and oversight mean that many vulnerable Victorians cannot access CYMHS for the support they need. Those who do get access often need multiple providers that are unable to coordinate around their shared clients' needs. This lack of coordination places pressures on CYMHS, which have become the last resort for 'housing' young people who disability and child protection services have not been able to support. DHHS's patchy and often reactive approach to system oversight has impacted its ability to identify systemic failures that are causing harm to vulnerable children and young people.

4.2 Prioritising access to vulnerable groups

DHHS has not identified priority populations for CYMHS nor enabled health services to prioritise access at the local level. DHHS advises that it is not its role to identify priority populations for CYMHS, but that individual health services in Victoria's devolved health system are responsible for managing access and any priority populations at the local level.

DHHS advises that its Policy and Funding Guidelines 2019–20 will include a new statement about prioritising access for vulnerable populations, though there is no evidence that DHHS has taken any action to enable this nor has any plans to monitor it. The statement to be included is:

> Vulnerable children and young people, particularly those involved with statutory services such as child protection, are prioritised.

Our analysis of three years of clients at the five audited health services shows that the rates of vulnerable client groups accessing CYMHS is low compared to less vulnerable groups.

People from culturally and linguistically diverse backgrounds are less likely to seek help for mental health problems, but no less likely to experience problems. Figure 4A shows that the majority of CYMHS clients are born in Australia and access CYMHS at a rate proportionate to their share of the total Victorian population aged under 25 years. People who were born in Southern Europe, Asia and on the Indian Subcontinent are underrepresented as CYMHS clients. The percentage of CYMHS clients from these three regions is less than half of what we would expect if they were accessing CYMHS at a rate proportional to their share of the Victorian population. Young people from these regions are at risk of not accessing the mental health services they need.

Refugees are more likely to have experienced trauma than the general population and are at greater risk of mental health problems as a result. Our data analysis shows that young people born in Sub-Saharan Africa, who are frequently refugees who have experienced trauma, are accessing CYMHS at a higher rate than their population share, but there is no evidence to show whether this rate is commensurate with the mental health needs of the population given its experience of trauma.

DHHS funds a torture and trauma counselling service, which is accessible to children and young people, but it has not evaluated it and so was not able to provide any information on the reach or impact of this program in supporting young people. Other CYMHS therefore miss out on any learnings from this initiative.

Figure 4A
Country of birth for CYMHS clients compared to country of birth for the total Victorian population aged 0–25 years

Region of birth	Percentage of Victorian population aged 0–25	Percentage of CYMHS clients	Percentage of expected numbers in CYMHS
Australia	79.87	79.21	99
Other Asia	6.07	2.18	36
Indian Subcontinent	3.02	1.47	49
English speaking countries in Northern Europe and North America	1.47	1.12	76
New Zealand and South Pacific	1.41	1.28	91
Middle East and North Africa	1.06	0.72	68
Sub-Saharan Africa	0.88	1.08	123
Western Europe	0.28	0.19	68
Eastern Europe	0.24	0.22	92
Southern Europe	0.21	0.09	43
Latin America	0.17	0.18	106
At sea	0.00	0.01	0
Not stated/inadequately described/no data	5.30	12.18	230

Note: Countries of birth were assigned to a region based on the categories used in either the DHHS report *Racism in Victoria and what it means for the Health of Victorians* or the ABS's geographical categorisations.
Source: VAGO, based on ABS Census 2016 population figures.

Use of an adult triage process

Mental health triage is the initial process to determine whether a person needs further assessment by a mental health service, and the type and urgency of the response required from mental health or other services.

DHHS introduced a *Statewide Mental Health Triage Scale* and guidelines in 2010 and has not reviewed it in the nine years since. The scale is still used by all audited CYMHS. It focuses on clinical urgency, specifically risk of physical harm to self or others. It does not give any focus to developmental or cumulative risks that are critical for children and young people, does not capture the severity or longevity of mental health problems, and does not enable prioritising access for high-risk and vulnerable groups of children or young people.

A quality triage process requires a clinical tool to assess urgency, but the tool itself does not and cannot take into consideration other important factors that must influence the triage process, such as severity, complexity, quality of care, workload and staffing. DHHS does not provide any current guidance to CYMHS on triage processes or assessing any of these matters.

The triage approach is the same across all age groups, despite the 2010 guidelines identifying the following six challenges particular to triaging mental health issues in children and adolescents, namely:

- not recognising lower-order autism spectrum disorders
- confusing post-traumatic stress disorder symptoms with psychosis
- failing to identify depression, especially when it is masked by aggression or other forms of acting out
- dismissing some symptoms—for example, self-harming behaviour in girls, rage attacks in prepubescent boys—as personality or behaviour issues not requiring mental health services
- underestimating the risks involved when self-harming behaviour is new, as opposed to longstanding
- not acknowledging that obsessive eating behaviours may be early signs of eating disorders.

While the triage tool does not cater to the needs of children and young people, if it is used by clinicians experienced in working with children and young people some of the risks could be minimised. However, our data analysis from the five audited health services showed that 118 children aged 18 years and under were triaged through either an adult or aged-care system response. A further 115 were admitted to an adult Crisis Assessment Team, who provide a 24-hour urgent assessment and brief, intensive treatment service. The audited CYMHS advise that their triage systems only operate during business hours and week days, and outside of these times, clients calling or attending emergency departments will be diverted to an adult triage service. This creates the risk that a clinician without CYMHS experience may underestimate the risk factors specific to young people and may triage the young person incorrectly.

DHHS has not taken any action to develop a triage approach that recognises the developmental risks for children and adolescents, or that would enable health services to prioritise access for particular population groups.

Aboriginal and Torres Strait Islander young people

There is no data available about the mental health of Aboriginal and/or Torres Strait Islander (Aboriginal) young people in Victoria, specifically. However, Aboriginal young people experience significantly worse mental health outcomes nationally, with four times the rate of suicide, for example.

DHHS's *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027* does not make any specific commitments about young people because its focus areas are mostly at the community level. The framework describes relevant new investments, which include some young people-focused initiatives—a youth mentoring program and support for Aboriginal children in out-of-home care and youth justice. DHHS advises that a project targeting families at risk of children needing out-of-home care is underway with positive results and an evaluation planned, but was unable to provide evidence of the progress of any other initiatives targeting children and young people or progress against the strategy itself.

The 2016 census showed that 1.4 per cent of 0–24 year-olds residing in Victoria identified as Aboriginal, although a considerably higher proportion of CYMHS clients, 2.4 per cent in the five audited health services, identified as Aboriginal. Without comparable Victorian population data on mental health problems in Aboriginal young people, we cannot determine whether 2.4 per cent is an appropriate proportion of Aboriginal clients to be accessing CYMHS. However, as Aboriginal children are 12 times more likely to be in out-of-home care than non-Aboriginal children, and Aboriginal people are nearly three times as likely to experience high or very high level of psychological distress, DHHS should monitor the rate that Aboriginal young people access CYMHS to ensure that they are getting the mental health support they need.

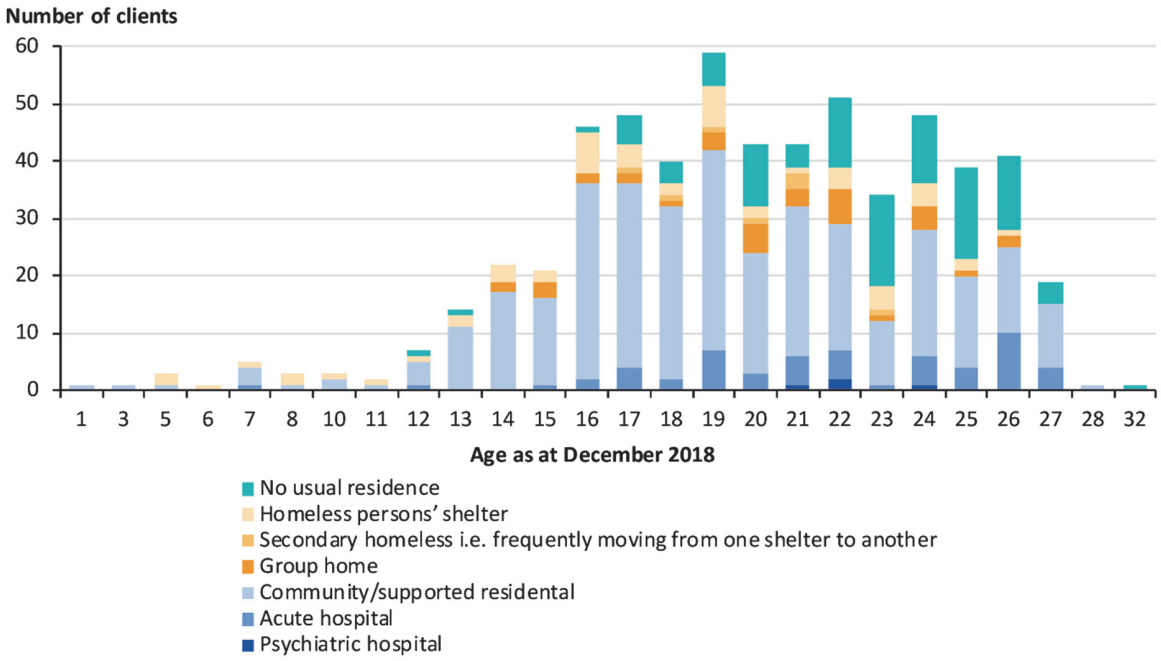
Homelessness and supported accommodation

In our analysis of five health services over three years, 596 CYMHS clients, or 3 per cent, lived in supported or unstable types of accommodation. The majority of these (56 per cent) were in community or supported residential accommodation. A further 10 per cent had their residence recorded as an acute or psychiatric hospital though, as discussed in Section 3.9, there are no business rules around recording this data so it is not clear what this represents.

Homelessness was recorded for 0.3 per cent of CYMHS clients at the five audited health services, while the 2016 census showed that a higher proportion, 0.5 per cent of Victorians aged 0–24 years, were homeless or living in unstable housing. The prevalence of mental health problems in young people who are homeless is not known, but DHHS data collected from 13 617 rough sleepers found that mental health problems had contributed to 27.5 per cent of those surveyed becoming homeless. We would expect that young people who were homeless or in unstable housing would have a higher rate of mental health problems and be a larger group of CYMHS clients.

DHHS does not publicly report on the number of young people living in supported accommodation, so we cannot confirm whether these young people are accessing CYMHS at the expected rate. DHHS could use their internal data to explore this question further and should do so.

Figure 4B
CYMHS clients in five audited health services 2016–18 by age and housing



Note: Business rules are not defined for CMI housing fields. It is unclear under what circumstances a young person would be registered as living in an acute hospital or a psychiatric hospital.
Source: VAGO analysis of CMI data provided by five audited health services. See Appendix D for data analysis scope and methodology.

Children in out-of-home care

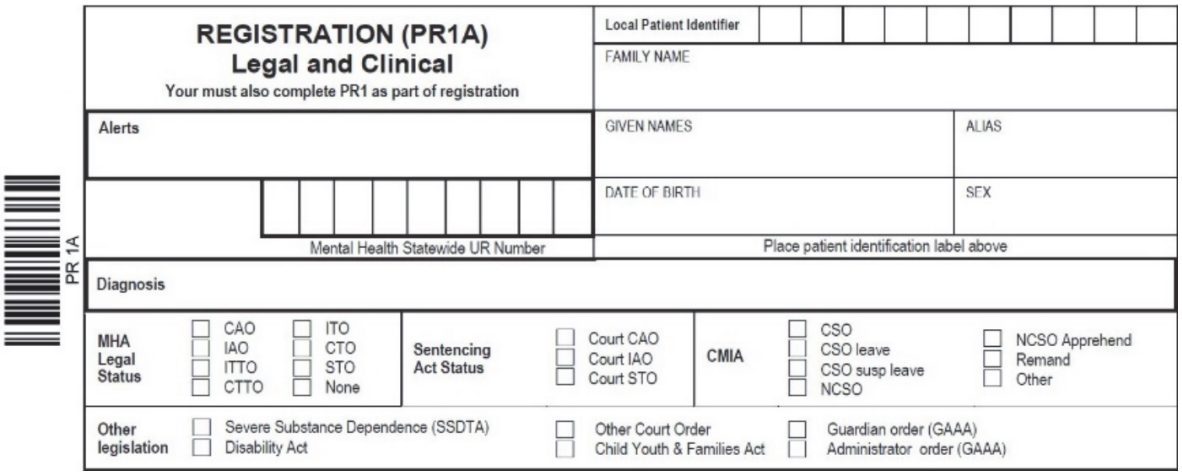
The OCP developed a guideline for health services on prioritising access for young people in out-of-home care in 2011 but has not reviewed it despite the guidelines having been scheduled for review in 2013, and the Act changing significantly in 2014. One audited health service was not aware that the guideline existed. DHHS advises that it is available on its website, but it is not on the Chief Psychiatrist's website page where other guidelines are listed. It can be found online as part of the DHHS *Child Protection Manual*.

Only one of the five audited health services had a documented procedure for prioritising access to children in out-of-home care. Two other services had statements about prioritising access to children in out-of-home care, one of which extended to also include Aboriginal and Torres Strait Islander children with psychosis, eating disorders and school refusal, but neither had a documented process for how this occurs. The remaining two services had no policy or procedure on prioritising access.

The child specialist program, which was newly funded in 2016–17, has a deliverable that services develop protocols between CYMHS and child protection, but there is no evidence of any progress with this nor any evidence that DHHS is attempting to monitor progress.

DHHS's reporting system does not collect any information about whether a child is in out-of-home care or if there are any other legal orders around their guardianship, disability or other health or welfare problems. The registration forms health services must complete for every mental health client include a place to record that a client has legal orders under the *Children, Youth and Families Act 2005*, but it is on the second, non-mandatory, page of the form and is one of several options under the heading 'other legislation', as shown in Figure 4C.

Figure 4C
Excerpt of mental health service registration form PR1A, which health services complete for all mental health clients



Source: Excerpt of DHHS's client registration forms provided by Austin Health.

Even if this field is ticked on the hard copy form, there is no place in the electronic database to input the information. Subsequently, DHHS has no way to monitor whether children in out-of-home care are accessing CYMHS or any information about this priority population group at all. Most health services operate parallel client management databases where this additional information can be recorded and is accessible to clinicians.

When this issue was identified, we attempted to determine the extent to which children in out-of-home care had been able to access CYMHS through other means. There are database fields which could potentially provide this information, but they fail to provide a reliable source of information, as follows:

- 'Referral source' is an optional field and was only populated for 9.7 per cent of the 18 460 clients whose data we analysed, which was insufficient to undertake any meaningful analysis.
- 'Housing' does not contain a response option for 'out-of-home care' or any similar term.

- 'Carer relationship' is predominantly used to record a client's general practitioner, although 95 clients were identified here as having either a 'case manager', 'appointed guardian' or 'appointed administrator', but there are no definitions for each field so their use cannot be relied on to inform accurate data.

4.3 Clinically unnecessary inpatient stays

Young people frequently stay in inpatient mental health facilities for longer than they need to be because their guardianship and/or housing arrangements change during, or as a result of, their hospital admission. One senior staff member advised us, 'you can't discharge children to homelessness'.

DHHS has not recognised the extent to which this occurs and the significant negative impacts on the young people and families involved as well as the very significant resource and workforce implications the issues present to health services.

DHHS does not strategically monitor extended stays (stays beyond clinical necessity), or any other matters relating to young people with multiple and complex needs, despite being advised of it repeatedly over many years by health services. While some of the drivers of these problems are complex social and family issues, DHHS has not taken any strategic action to address the system issues around service coordination for these people, which they do have the ability to improve.

DHHS does not have long-term housing or care options for young people with multiple and complex needs. In 2015–17, a young person was a CYMHS inpatient for two years because no agency could find a suitable housing service to meet their needs. DHHS had to find and modify a house for this patient to be discharged to. In other similar cases, DHHS waits for the young person to turn 18 so they can be discharged to adult accommodation.

How often this happens cannot be determined through the current systems of data collection and monitoring, but during our audit we worked closely with senior CYMHS clinicians and an independent subject matter expert to design an approach that would allow us to explore the extent of clinically unnecessary inpatient stays.

Health services advised that there are too many occurrences where a portion of a consumer's time in the hospital is clinically unnecessary for the service to document every case during the time of the audit. Instead, a selection of examples from recent years was provided to the audit team by senior clinicians who were involved in providing and coordinating care to the relevant clients and who also had the skills and authority to determine at what point in the person's inpatient stay it became clinically unnecessary.

Case studies of clinically unnecessary inpatient stays

The five audited health services provided us with 29 detailed examples of young people whose recent inpatient stay included a period that was clinically unnecessary. These inpatient stays ranged from two to 254 days, making a cumulative total of 1 054 days, or almost three years. Time periods for the case studies varied, but all were within the past 12 months and one service presented eight such cases within a six-month period.

Figure 4D
Summary of case studies of clients with wholly or partly clinically unnecessary extended inpatient stays

Age group	Presence of intellectual or developmental disabilities	Total length of stay	Length of stay clinically unnecessary
12–15 years	Yes	approx. 268 days + ongoing	approx. 254 days + ongoing
18–25 years	No	212 days + ongoing	212 days + ongoing
16–18 years	Yes	267 days	189 days
18–25 years	No	125 days	70 days
18–25 years	No	169 days	60 days
16–18 years	No	42 days	34 days
18–25 years	No	52 days + ongoing	30 days + ongoing
13–15 years	Yes	53 days	30 days
13–15 years	No	71 days	30 days
16–18 years	Yes	approx. 55 days + ongoing	at least 21 days + ongoing
16–18 years	No	43 days	16 days
16–18 years	Yes	Ongoing (58 days)	14 days
13–15 years	Yes	12 days	12 days
13–15 years	Yes	13 days	10 days
16–18 years	No	11 days	9 days
16–18 years	Suspected	12 days	9 days
0–12 years	No	approx. 35 days	approx. 7 days
0–12 years	Yes	10 days	7 days
13–15 years	No	13 days	6 days
16–18 years	No	12 days	6 days
16–18 years	No	13 days	5 days
0–12 years	Yes	6 days	5 days
16–18 years	No	5 days	4 days
16–18 years	No	3 days	3 days
13–15 years	No	5 days	3 days
13–15 years	Yes	2 days	2 days
16–18 years	No	3 days	2 days
13–15 years	Yes	2 days	2 days
16–18 years	Yes	2 days	2 days

Note: We conducted fieldwork in the last two weeks of January 2019. 'Ongoing' refers to consumers who were inpatients at that time with no fixed discharge date.
Source: VAGO, based on clinician interviews.

To protect these young people's privacy, the audit will not report the case studies collected and analysed, but instead focus on the system issues that our analysis of the case studies revealed.

System failures identified

We found four main types of system failure through analysis of the case studies, namely:

- the family's (or out-of-home carer's) inability to cope at home with the young person's challenging behaviours
- the family's inability to participate in therapeutic care at hospital
- failure of disability services, including failure to repair damaged disability accommodation and failure to receive NDIS supports
- failures relating to child protection, including failure to engage or organise placements in a timely manner, including when abuse is disclosed during an inpatient stay.

If health services' local relationships fail to resolve system issues for complex clients, there are no mechanisms to escalate them. The Chief Psychiatrist's support and advice is frequently sought, though not routinely, and there is no established mechanism that can be applied to resolve barriers to discharging children who are 'stuck' in inpatient units.

Health services described examples where they had failed to gain a timely response from local disability and child protection workers. In several cases, senior clinicians attributed the delay to a lack of understanding of the serious negative impacts on a child or young person from being in a mental health facility beyond clinical necessity. This included a perception from other services that the child was in a safe place. This view contrasts with the opinion of mental health practitioners that the young person's health and wellbeing was deteriorating because of the inpatient stay.

The resource implications of clinically unnecessary inpatient stays are also significant. The 1 054 bed days in the past 12 months that we found through our case studies equates to $750 448 of direct funding, given the DHHS bed price for child and adolescents is $712 per day. Given that the actual cost of inpatient mental health beds exceeds the funding provided, as discussed in Section 2.3, and that higher staffing ratios and use of facilities—such as multiple beds for one complex client—are common place, as discussed in Section 4.5, the actual cost will far exceed this amount.

Failure to get NDIS supports in place for young people with dual disability

There were several examples of the NDIS contributing to a young person's inpatient stay extending beyond clinical necessity. In at least two cases, an NDIS plan did not exist yet or did not include a high enough level of support for the child to be discharged from hospital, and CYMHS staff were writing applications or appeals to the National Disability Insurance Authority while the young person remained an inpatient. In another example, an extensive NDIS plan had been approved and funded, but the family had not engaged the services, preventing discharge.

During the audit, DHHS undertook a 'data snapshot' with responses from nine health services. It identified 11 consumers, in an unknown timeframe, who had clinically unnecessary inpatient stays totalling 336 days, and a further 15 consumers with a total of 966 days of clinically unnecessary stays in bed-based rehabilitation settings. DHHS did not report if any of these consumers were children or young people, and noted the low response from health services means the data is likely a significant under-estimate of the problem.

DHHS is referring to this issue as 'social admissions', with the following definition:

> Social admissions involve participants being relinquished by their carers or NDIS providers at Emergency Departments and subsequently admitted into inpatient care, without a clinical need to be admitted or remain in hospital. This cohort often presents with complex support needs, primarily in relation to acute behaviours of concern associated with multiple disabilities which in many cases is not associated with a mental health presentation.

This data snapshot is part of a detailed analysis of ‘social admissions’, which is an emerging issue for clinical mental health services. The snapshot considers drivers and impacts, as well as service gaps that contribute to the problem. The analysis notes that DHHS is putting other interim data collections in place to calculate clinical hours dedicated to NDIS-related activity and the numbers of 'social admissions', with plans to amend the ongoing data collection to include these issues.

DHHS's actions to understand and address this issue have been insufficient and slow. During the audit, in 2019, DHHS was identifying funding requirements resulting from the impact of the transition to the NDIS on clinical mental health services and its clients. In February 2019, DHHS launched a website to increase the clinical mental health workforce’s 'literacy on the NDIS'. These actions are occurring three years after the full NDIS rollout commenced 1 July 2016 and six years after the trial sites began in 2013. Our audit found examples of CYMHS clients having clinically unnecessary stays as a result of problems with access to NDIS funding for accommodation dating back to 2016 and that DHHS was aware of the issue at this time.

There is activity underway to improve client information sharing and other collaboration between clinical mental health services and the National Disability Insurance Agency. This is being progressed through a series of inter-jurisdictional committees.

The focus of DHHS's work around mental health and the NDIS is people with psychosocial disability, which is a term used to describe a disability that may arise from a mental health issue. Most young people with 'dual disability', which CYMHS support and this audit examined, do not meet the criteria for having a psychosocial disability. Instead, they have intellectual or developmental disabilities that are complicated by serious mental health problems. There is no evidence that DHHS's work to improve the interface between clinical mental health services and NDIS includes this group of clients nor has any focus on CYMHS's particular issues or needs, which can be different from the adult mental health system

DHHS needs to expand the work that it is now commencing to improve the interface between clinical mental health services and the NDIS to specifically include the needs of CYMHS and young people with dual disability as soon as possible.

Long stays in CYMHS inpatient facilities

Long stays in inpatient facilities can be both a partial indicator of clinically unnecessary stays and a system failure in their own right that should be monitored.

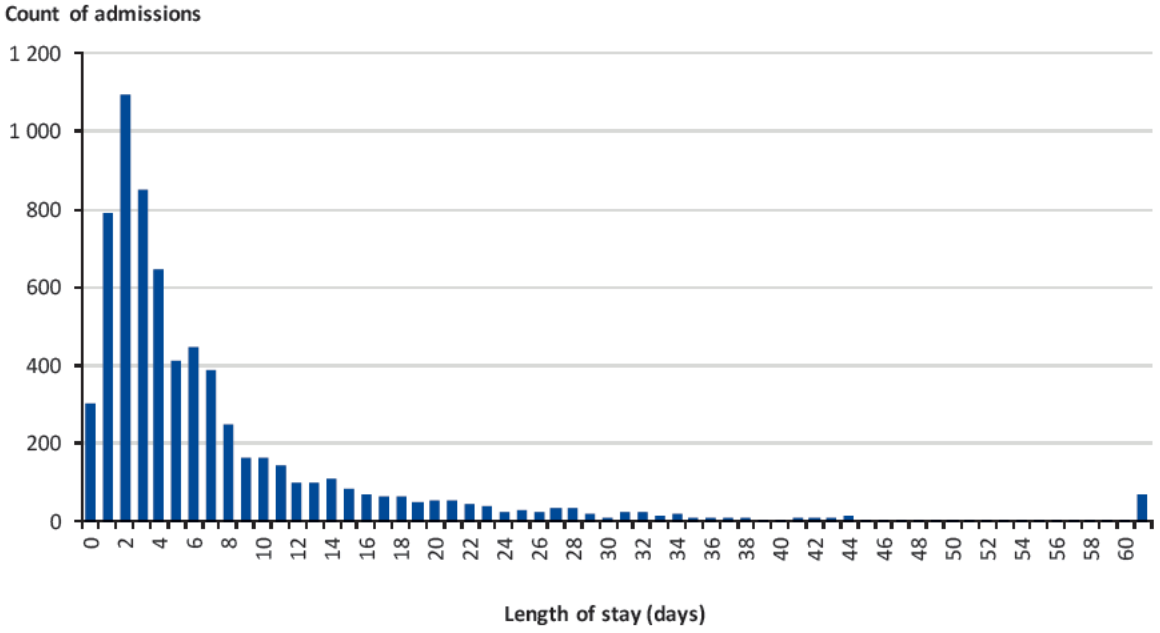
Children and young people's mental health and wellbeing can deteriorate when their inpatient stay are long, and even more so when they are clinically unnecessary. They commonly experience escalations in their frustration, which can lead to aggressive behaviours. This can have the following consequences:

- Staff may need to use restrictive interventions (such as seclusion, sedation or restraint) to manage a child or young person's behaviour, which can be traumatising for them.
- Children and young people may be violent and abusive to staff in the inpatient unit.
- Children and young people who have escalated, especially those who are not staying in a high-dependency area and are free to move about the unit at will, may frighten other children and young people. These other young people may not only be traumatised by aggressive behaviour they have witnessed in the unit, but may not have received adequate treatment and as a result may be more likely to present in crisis at a later date.
- Agitated children and young people may damage facilities, leading to expenses for the health service and further bed closures while the unit is repaired.

Monitoring long stays is quite achievable with the current data collection systems, and is done for the adult mental health system, but DHHS does not monitor long stays for CYMHS. DHHS could not provide any rationale for this.

Our data analysis showed that over three years there had been 228 inpatient stays greater than 35 days (a long stay) for clients aged 0–25 years in the four health services we looked at. Figure 4E shows that long stays are only 3 per cent of the total number of inpatient stays, which may explain them being missed by DHHS. However, they represent a significant resource burden that should be monitored and better understood.

Figure 4E
Number of admissions by length of stay for four audited health services 2016–18



Note: Admissions recorded as zero days are generally part of a planned discharge or recovery program where the young person is admitted to the inpatient facility for a day and returns home before evening.
Source: VAGO analysis of information from audited health services, January 2019.

The long stays are distributed across the four audited health services that we analysed despite their different models of care, as shown in Figure 4F below.

Figure 4F
Number of long inpatient admissions (35 days or more) for 0–25 year-olds during 2016–18, by audited health service

	Number of long admissions			
Health service	0–17 year-olds	18–25 year-olds	Age unknown [(a)]	Total
AWH	4	24		**28**
Austin Health	49	45		**94**
Eastern Health	18	48	4	**70**
RCH	36	0		**36**
Total	**107**	**117**	**4**	**228**

(a) Age at admission unknown but these clients were identified as 0–25 years during 2016–18 through other service contacts.
Note: Monash Health was excluded because our data analysis could not separate the long inpatient stays from community residential stays in their Y-PARC or PARCs.
Source: VAGO analysis of information from audited health services.

Our analysis did not allow for separating Monash Health's Y-PARC data from its inpatient unit admissions, so we cannot report a count of long stays at Monash Health that is comparable to the other audited services. DHHS could undertake further analysis of the CMI data that it collects to determine the extent of long stays at Monash.

There are also significant impacts on the workforce from long and/or clinically unnecessary inpatient stays, which audited health services describe as including:

- personal wellbeing burden on staff experiencing sustained aggression from clients with challenging behaviours
- increased supervision for staff involved in care to debrief difficult shifts and develop skills in working with challenging behaviours
- increased sick leave rates and therefore increased costs for backfill
- challenging staff morale.

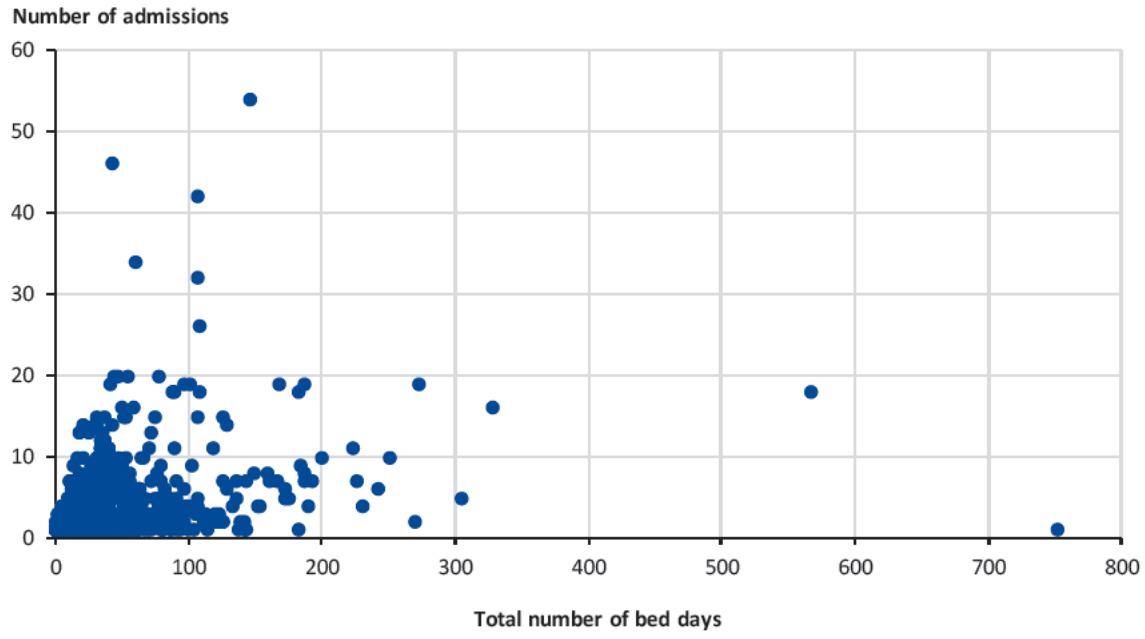
These are clearly clients with complex needs, as our data analysis showed that they accounted for a total of 652 admissions and 25 per cent of the total bed days that we reviewed. Of the clients with a long admission of 35 days or more, 64 per cent had other admissions during the three-year period we analysed.

We reviewed the diagnostic codes that health services had recorded against these clients to understand the types of mental health problems and complexity that this group experienced. Their diagnoses include the following:

- acute psychiatric, for example schizophrenia—70 per cent
- anxiety disorder—38 per cent
- problems with the social or home environment—45 per cent
- additional medical diagnosis requiring hospital treatment—63 per cent
- depressive mood disorder—29 per cent
- eating disorder—28 per cent
- self-harm—19 per cent
- developmental disability—18 per cent
- maltreatment syndromes, assault or adverse childhood—17 per cent
- suicide ideation—14 per cent
- autism—11 per cent
- homelessness—6 per cent.

Our data showed that multiple stays, which add up to long periods of time as inpatients, are also common in child and youth mental health. When we added clients' multiple stays together, we found 394 young people over three years who had each been inpatients for a total of 35 or more days. Of these, 72 young people (2 per cent) had been inpatients for more than 100 days out of the three years.

Figure 4G
Number of admissions by total bed days for four audited health services, 2016–18



Source: VAGO analysis of information from audited health services, January 2019.

Referral practices as a system blockage

Disputes around referral practices and discharge processes in one region create delays in discharging all young people from inpatient care while their follow-up care is arranged because it is provided by a different CYMHS.

Several interrelated system issues contribute, which include disagreement between the two CYMHS over the information that needs to be provided and received as well as the processes for receiving referrals and communicating with clients, including the role of case managers. Significant demand pressures on both CYMHS across both their inpatient beds and outpatient case managers exacerbates the issues.

Inpatient stays are being extended beyond their clinical necessity while the referral and discharge processes are negotiated.

DHHS advises that it has resolved this issue as follows:

> Clinical Directors have been advised to establish structured monthly liaison meetings and escalate any matters that cannot be resolved to the Chief Psychiatrist.

Health services advise that this is an ongoing issue that DHHS needs to monitor.

DHHS intervention in long or clinically unnecessary stays

DHHS has not taken strategic action in response to health services' advice about the challenges of managing 'dual disability' clients who have extended stays in inpatient units aside from the RCH project and the Alfred Health MHIDI pilot project, both of which are outlined in Section 4.5.

There is no evidence of systematic or reliable notifications of extended stays in CYMHS, and there is no mechanism for the Chief Psychiatrist to monitor and intervene in such cases in a timely manner. As an example, the Chief Psychiatrist only became aware of one of these examples more than two months into the period deemed to have been clinically unnecessary, and not via communication of the extended stay, but when reviewing another issue.

Health services have no mechanisms to effectively and efficiently escalate and resolve cases where clients no longer require mental health treatment, but cannot be re-engaged with services to support their other complex needs, such as disability supports. Where direct attempts to engage the necessary services fail, health services sometimes contact the OCP or rely on personal and professional relationships to escalate issues to more senior people in child protection or disability services within DHHS.

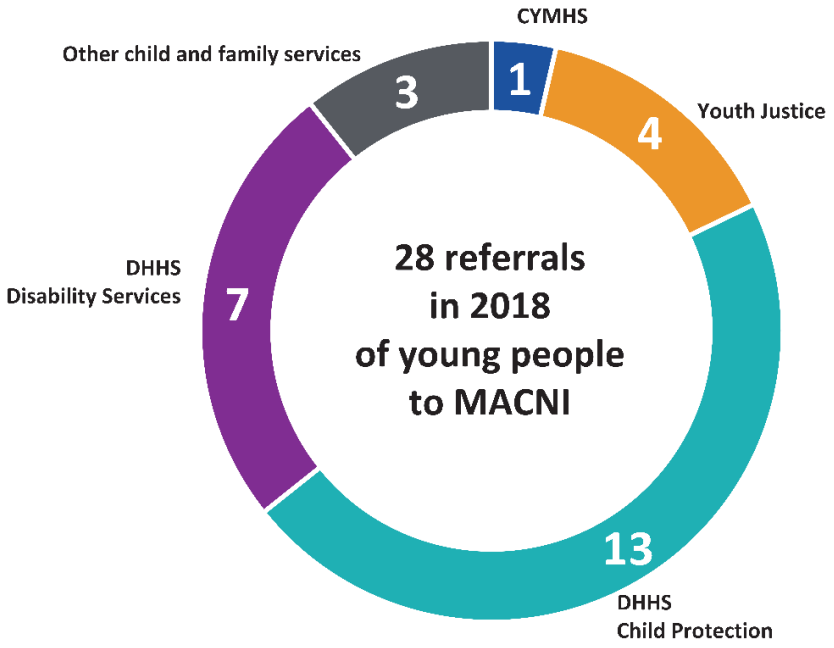
Each of DHHS's 17 'management areas' operates a Complex Client Panel, with membership from across DHHS program areas, local service providers, Victoria Police, hospitals, and other government departments such as DJCS. DHHS advises that the panels discuss 'a range of complex clients' and the panel members 'assist in service access, referral and support'. There is no evidence that these panels have been used to address service coordination or access issues that are causing clinically unnecessary inpatient stays in CYMHS, or that CYMHS have ever participated in these panels.

Not all complex clients 'stuck' in in-patient services will have their service needs met through local or area-based coordination. One audited health service suggested the need for a statewide version of the high-risk youth panels that some CYMHS convene to assist with service access and case planning for the most complex clients.

Multiple and Complex Needs Initiative

Currently, 14 young people aged 17–25 years with a diagnosed mental illness are receiving case management support through the MACNI program managed by DHHS, with funding contributed by DJCS. Only one of 28 referrals for young people under 25 years to the MACNI program in 2018 was from CYMHS. Figure 4H shows the referral source for younger MACNI clients.

Figure 4H
Referral sources for MACNI clients aged under 25 years in 2018



Source: VAGO analysis of information provided by DHHS.

MACNI provides up to three years of case management for people aged 16 years and over with complex needs, which include two or more of the following:

- mental illness
- substance-use issue
- intellectual impairment
- acquired brain injury.

To qualify for MACNI, people must also have exhibited dangerous behaviour, or behaviour that is likely to put themselves or another person at risk of serious harm.

Possible cases are referred to the DHHS MACNI coordinator in the client's region, and a panel of senior staff from DHHS programs and local service providers will first consider whether the person is eligible and then develop a care plan to respond to the person's needs and negotiate the services that their agency will contribute.

DHHS advised in November 2018 that it does not 'market' MACNI because despite a recent funding increase, MACNI is almost at capacity. In April 2019, DHHS advised that MACNI does have capacity to take on new clients in all areas. There is no evidence that DHHS has ever 'marketed' to or communicated with CYMHS about the MACNI service. DHHS should advise CYMHS leaders of the process for referring a client to MACNI, the criteria for clients that are eligible and update this guidance regularly, as well as directing MACNI coordinators in each area to ensure they engage with their local CYMHS.

Audited health services report that they do not engage MACNI to support care coordination for the complex clients they have 'stuck' in inpatient facilities for several reasons:

- Clients are not eligible if they are under 16 years.
- Strict eligibility criteria around mental health diagnosis can often not be met for complex young people, so they are ineligible for MACNI.
- It takes too long to be useful because its process involves 12 weeks to establish a care plan and monthly meetings of regional MACNI panels.

One audited health service reported that a young person remained an inpatient beyond clinical necessity when their forthcoming 16th birthday would make them eligible for a MACNI referral. If MACNI or a similar support with a more flexible age eligibility was available, the young person could have potentially been discharged earlier.

In the Western region, DHHS has recognised that there are young people below MACNI's eligibility age of 16 who do require a similar service, and it was trialling a High-risk Youth Panel for 12–16 year-olds during the audit that was based on the principles of MACNI. There is no evidence that the pilot will be continued, nor are there any plans for how its evaluation findings and lessons will be shared.

4.4 Service coordination around multiple and complex needs

Despite clear evidence that CYMHS clients frequently have multiple and complex service needs, and international evidence that coordination of care and systems is crucial for improving outcomes, DHHS has taken no action to direct, facilitate or enable CYMHS to participate in any form of service or care coordination with other service agencies.

DHHS data linkage work has shown that in 2014–15 the following proportions of each service's clients were also registered mental health clients:

- 42 per cent of youth justice admissions
- 19 per cent of out-of-home care clients
- 31 per cent of Child FIRST family services clients.

These findings resulted from an exploratory piece of analysis by the then-new data linkage group within DHHS, and further analysis of this data that was planned has not been completed.

The most promising evidence for improving outcomes for children and adolescents as well as adults with complex needs and serious mental health problems appears when a 'systems of care' or ‘wraparound’ approach is used to improve the quality and consistency of service delivery. These approaches centre on integration or coordination of the multiple services involved in these complex young people's care. The approach has been shown to reduce the severity of mental health problems and decrease functional impairment that results from mental health problems.

This 'systems of care' approach is not a discrete program or project that can be trialled on a small scale—it requires substantial system reform. For example, in one large-scale initiative in the United States with positive outcomes, single centralised authorities with responsibility for the mental health service system were established in each local area and these authorities were mandated responsibility to develop and coordinate the wide range of services in the public sector including housing, income support, job training, psychosocial rehabilitation, advocacy and general health services, alongside specialist mental health services.

Key features of the 'systems of care' models that have been implemented and evaluated with positive outcomes are:

- a family focus and involvement in care and service planning
- cultural competency for staff
- interagency involvement and partnership across multiple sectors including welfare, health, justice, education and mental health
- coordination and collaboration between professionals to avoid duplication and eliminate gaps in care
- community-based service provision within close geographic proximity to the targeted community
- accessibility in terms of physical location, scheduling and financial constraints
- care individualised to the specific needs and strengths of the child

- use of the least restrictive setting possible.

Evaluation research conducted around the development of 'systems of care' approaches for both adults and children with complex mental health problems has consistently demonstrated that government-supported strategies can effectively enhance integration of services at a system level and consequently improve outcomes for children and young people.

Local care coordination

Each health service invests significant time and resources into developing and maintaining relationships with service providers who they need to engage in service coordination, most frequently child protection, but when local relationships fail to resolve matters there is no mechanism for CYMHS to escalate matters other than alerting the Chief Psychiatrist.

All audited health services actively participate in monthly or bimonthly meetings with their local child protection services in which high-risk children are discussed and CYMHS clinicians provide advice about management of mental health problems. The purpose of these forums is both case management of high-risk clients and upskilling the child protection workforce in working with mental health problems and behavioural disorders. One health service reported it has a similar arrangement with its local disability service provider, although the others reported that engagement with disability services had ceased since DHHS-funded services had been withdrawn with the transition to the NDIS.

Two health services described a 'high-risk youth' or 'complex care' panel that they convene internally to coordinate the most complex clients and escalate to involve senior staff in the most high-risk or complex cases. One of these panels involves senior staff from external agencies such as child protection and disability to participate as relevant.

Service coordination practice in Victoria

DHHS's 2016 *Mental Health Workforce Strategy* identifies that skill development in care coordination and service coordination is required. This acknowledgement came 16 years after DHHS began a strong policy and program focus on service coordination for DHHS's many other program areas, as described in Figure 4I.

Figure 4I
Service coordination in Victoria

Since 2000, DHHS and its predecessors have had a strong policy and program of funded initiatives to enable service coordination between the many different types of services available across Victoria's health and human services system.

The Victorian service coordination framework helps health service providers work together to align practices, processes and systems so:

- people access the health services they need, no matter what service they go to first
- providers exchange the right information so consumers receive good care from the right providers at the right time
- people have their health and social needs identified early, preventing deterioration in health.

Service coordination places consumers at the centre of service delivery. The idea is to maximise consumers' likelihood of accessing the services that they need.

Service coordination also enables organisations to remain independent of each other, while cooperating to give consumers a seamless and integrated response.

Resources to support service coordination practice in Victoria include:

- the *Practice Manual and Good practice guide*
- the continuous improvement framework
- individual tools and templates found online, including consent forms in over 50 languages
- ICT specifications for software vendors
- sector-specific training guides.

Source: VAGO, from DHHS materials.

Over the past two decades, funding and programs to develop capability for service coordination throughout Victoria has been largely managed through Primary Care Partnerships (PCP). These are alliances of many different health and human services that work together to improve population-based planning and coordination of care for consumers. The work of PCPs has included negotiation and documentation of shared principles, protocols, governance arrangements, service agreement templates and other resources that provide guidance to service providers seeking to enhance interagency collaboration.

When last reviewed in 2010, less than 50 per cent of Victoria's 31 PCPs had engaged any of their local mental health services in their service coordination work. There is no evidence that DHHS has provided guidance or direction to mental health services to engage with PCPs or their service coordination initiatives, nor facilitated or enabled such engagement.

The Chief Psychiatrist's intervention

Under the Act, the Chief Psychiatrist has the responsibility 'to promote cooperation and coordination between mental health service providers and providers of other health, disability and community support services'. The Secretary of DHHS has the same responsibility under the Act, and there has never been any planning about how that responsibility would be coordinated or jointly implemented or monitored between the two.

The Chief Psychiatrist does not directly engage with the Secretary nor have any process to escalate complex matters that require a coordinated response from different program areas across DHHS. The Chief Psychiatrist role is positioned in the organisational structure four reporting lines below the Secretary. A review of the Chief Psychiatrist's role in 2016 made a recommendation on this matter which DHHS has not responded to:

> That the Chief Psychiatrist meets formally with the Secretary twice a year to provide feedback on issues concerning the quality and safety of care in clinical mental health services. This briefing should occur independently of the director of Mental Health and the Deputy Secretary of Health Service Performance and Programs (HSPP). The Chief Psychiatrist should also have the opportunity to meet at least twice a year with the HSPP Deputy Secretary.

The Chief Psychiatrist meets regularly with the Public Advocate and has asked them to escalate issues to the Secretary on their behalf. There is a formal arrangement that the Public Advocate meets regularly with the Secretary.

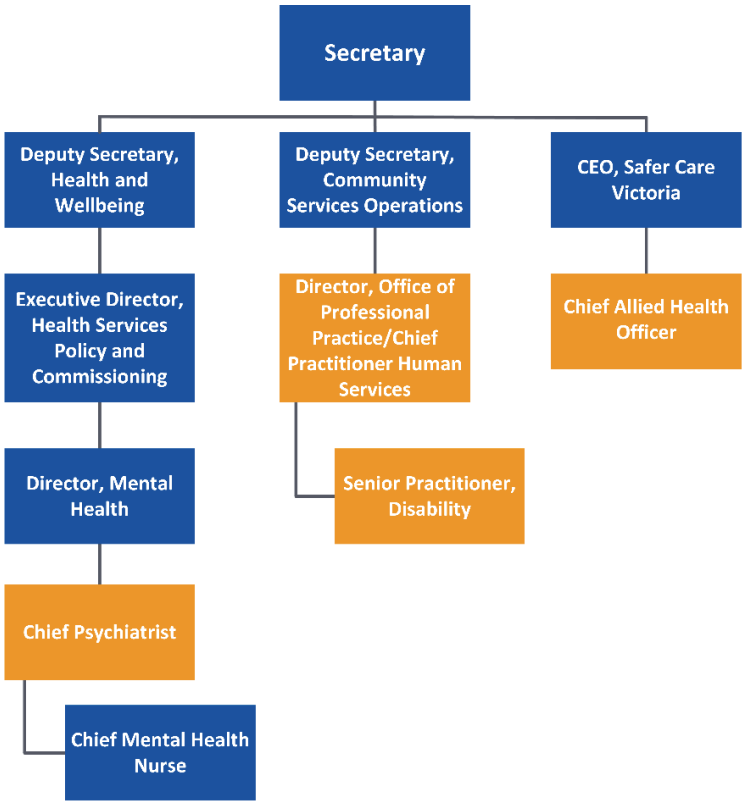
Around one complex case with a young person 'stuck' in a CYMHS inpatient unit, the Chief Psychiatrist led a process that involved fortnightly meetings with other program areas in DHHS over a period of 18 months. There were no formal mechanisms that could be enacted to enable this process, and finding the right people to participate with sufficient authority caused significant delays in resolving the complex needs of this young person.

The Chief Psychiatrist meets regularly with their equivalent legislated positions in the disability services and child protection areas, but there is no evidence of outcomes achieved and no evidence of shared identification of priority issues across their sectors or for shared clients. The positions are located in separate divisions of DHHS, as shown in Figure 4J, which may be impeding their capacity to collaborate.

The **Public Advocate** is appointed by the Governor of Victoria. Their roles and powers are outlined in the *Guardianship and Administration Act 1986,* which involve promoting and safeguarding the rights and interests of people with disability.

The Public Advocate's 'community visitors' program involves volunteers who make scheduled but unannounced regular visits to all inpatient mental health services and draw up reports of their observations. The right to make these visits and how they will be conducted are described in the *Mental Health Act 2014*.

Figure 4J
Position of the Chief Psychiatrist and Chief Practitioners for child protection, disability services, and allied health in the DHHS organisational structure



Source: VAGO analysis of DHHS organisational structures.

There are no structures or mechanisms to guide cross-sector collaboration within DHHS, nor are there governance arrangements over complex clients who require service coordination that cannot be resolved through area-level Complex Client Panels or the small cohort that qualify for the MACNI program, both of which have limitations for CYMHS clients that were described in Section 4.3. DHHS should consider establishing a mechanism that allows CYMHS to escalate complex clients who are deteriorating due to clinically unnecessary stays to a cross-sector group of senior officials who can mobilise rapidly and make decisions about service gaps and service coordination barriers for the most complex and vulnerable clients.

4.5 Managing dual disability in CYMHS

Caring for young people with complex needs where mental health problems coexist with intellectual disabilities and/or autism and challenging behaviours creates significant challenges for CYMHS. These challenges include the use of restrictive interventions, impacts on a workforce who may lack the skills and training to work with the clinical issues these clients bring, as well as the issue of extended stays, which have previously been discussed.

RCH described this challenge for CYMHS in their response to DHHS's 10-year plan, as follows:

> Difficulties such as severe challenging behaviours in adolescents with Autism Spectrum Disorder pose a major practical, physical and emotional difficulty for carers as well as lead to substantial burden on the residential care system. Across the state, clinical services through regular CAMHS/CYMHS and private practitioners is difficult or impossible to obtain. These young people represent a 'blind spot' or service gap, with high morbidity and cost.

Some young people with dual disabilities also present challenges in terms of the type of inpatient accommodation they require. The case studies that we examined included examples of young people who damaged property, had significant personal hygiene challenges, and who needed to be separated from other patients for safety reasons. In some instances, these patients had to be allocated two rooms to enable staff to clean and maintain their accommodation to a safe standard.

RCH accommodates patients with dual disability who bring very challenging behaviours in a 'pod' that would usually accommodate four patients. At the time of the audit, this pod had been almost continually occupied by just one patient at a time—four different ones—for 18 months. DHHS is aware of this issue and the impact it has on the availability of mental health inpatient services to young people who need them; however, it has not taken any meaningful action to understand or rectify the issue.

Frequency of dual disability in CYMHS

Our data analysis identified 303 CYMHS clients who had intellectual disability of different severity levels, recorded as:

- 246 (81 per cent) mild
- 50 (17 per cent) moderate
- 6 (2 per cent) severe
- 1 (0.3 per cent) profound.

Our analysis also showed that many of these clients had multiple conditions or risk factors, as follows:

- autism (41 per cent)
- anxiety disorder (33 per cent)
- congenital developmental disability (30 per cent)
- problems with social/home environment (29 per cent)
- acute psychiatric, for example schizophrenia, (29 per cent)
- other medical diagnoses requiring hospital treatment (28 per cent)
- depressive mood disorder (17 per cent)
- maltreatment syndromes including assault and adverse childhood (15 per cent)
- alcohol and other drug issues (12 per cent)
- conduct disorder (12 per cent)
- eating disorder (11 per cent)
- suicidal ideation (11 per cent)
- self-harm (8 per cent)
- homelessness (1 per cent).

This analysis excluded 25 per cent of clients where the health service had not recorded any diagnostic codes for that client in their database. The majority of clients whose diagnoses are unknown are outpatient or community clients because 96 per cent of inpatients had diagnostic codes recorded.

Although mental health diagnoses are not recorded for all clients, we have assumed that access to CYMHS indicates the presence of a moderate to severe mental health problem.

In order to protect their privacy, we cannot report the age breakdown for these clients, but our data analysis shows a significant peak in numbers at the five audited health services at age 16. Of 302 clients, 12 per cent were aged 16 years at 31 December 2018. Given our data shows the age at that time for clients who have accessed CYMHS at any point in the three years prior, these clients may have been aged between 14 and 16 years at the time of accessing CYMHS.

This peak at age 16 is consistent across Monash Health, RCH and Eastern Health's data, but was not seen in Austin Health or AWH's data. The number of clients with intellectual disability recorded as a diagnosis was also significantly lower at Austin Health than the other audited services, which may reflect different data entry or diagnostic processes. Further investigation is required to understand the different service responses and access arrangements for young people with dual disability.

MHIDI initiative at Alfred Health

DHHS sought expressions of interest from all CYMHS in 2016 and awarded $5.5 million over four years to Alfred Health to develop and deliver MHIDI. The project included $250 000 of establishment funds to develop resources, protocols and policies.

Other CYMHS have expressed strong interest in learning what they might be able to adapt to their own service from Alfred Health's initiative. However, DHHS has not taken action to disseminate the resources developed, outcomes or lessons learned. While the project has not been independently evaluated, an extensive report which outlines achievements and challenges, lessons learned and strategies trialled was provided by Alfred Health to DHHS in April 2018.

Alfred Health made four recommendations to DHHS about system issues for young people with dual disability, which were:

1. critical need for step-up, step-down residential options such as a PARC service that can specifically cater to young people with a dual disability aged 12–18 years
2. an urgent need for access to special beds/pods for 13–18 year-olds in current inpatient settings for a longer length of stay in order to conduct effective psychiatric reviews with specialised treating teams competent in dual disability
3. more overnight respite options for families
4. improving placement options for children who are not able to stay in the family home and better systems to support families during a process of relinquishing care, including clarifying the options where the state-funded disability services that used to be central to these cases no longer exist with the transition to NDIS.

DHHS has not responded to the recommendations or acted on them. While these recommendations involve complex system issues that will not be resolved quickly or easily, DHHS needs to act to better understand and address the needs of young people with dual disability.

RCH Dual Disability Service

RCH established a 'Dual Disability Service' in 2016, in which doctors from their developmental medicine area work together with CYMHS to assess and plan treatments for children and young people who have neurodevelopmental disorders and mental health problems, such as adolescents with autism who have severely challenging behaviours.

In their response to the 10-year plan, which DHHS became aware of during the audit, RCH advised DHHS of the high demand for this service and noted that they had collected data through its pilot phase that could assist with 'scaling up and expansion' of the model.

Our data analysis showed that RCH had 114 CYMHS clients with intellectual disability, the largest of any of the audited health services. It is possible that the existence of a dedicated service increases the recording of diagnoses, which contributes to the higher number of clients that we identified in the data analysis at RCH.

DHHS was not aware of the RCH Dual Disability Service and does not provide funding or support for it. Other CYMHS that reported challenges managing these complex clients with dual disability were also not aware of the RCH service or any lessons from it.

Since DHHS ceased to convene its quarterly 'CYMHS leaders' meetings in 2016, there have not been formal opportunities to circulate information among CYMHS, which is a missed opportunity to improve CYMHS service delivery. DHHS needs to re-establish and facilitate a network where operational and clinical leaders of CYMHS can share lessons and challenges to address CYMHS system issues.

Appendix A *Audit Act 1994* section 16—submissions and comments

We have consulted with DHHS, AWH, Austin Health, Eastern Health, Monash Health and RCH, and we considered their views when reaching our audit conclusions. As required by section 16(3) of the *Audit Act 1994*, we gave a draft copy of this report, or relevant extracts, to those agencies and asked for their submissions and comments. We also provided a copy of this report to the Department of Premier and Cabinet.

Responsibility for the accuracy, fairness and balance of those comments rests solely with the agency head.

Responses were received as follows:

RESPONSE provided by the Secretary, DHHS

Secretary

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Andrew Greaves
Auditor-General
Victorian Auditor-General's Office
Level 31, 35 Collins Street
MELBOURNE VIC 3000

Dear Mr Andrew Greaves

Thank you for the opportunity to comment on the Proposed Performance Audit Report on child and youth mental health services in accordance with *section 16 (3) of the Audit Act 1994.*

The department acknowledges the value of this audit in determining if child and youth mental health services are effectively preventing, supporting and treating child and youth mental illness.

The department accepts all the recommendations in the report. I note that work is currently underway to address a number of recommendations, including the development of a mental health Performance and Accountability Framework.

I also note that implementation of the report's recommendations will be informed by the outcomes of the Royal Commission into Victoria's Mental Health System, particularly recommendations relating to system design. I will continue to keep you updated on the Royal Commission and any impact it may have on the implementation of the recommendations outlined in the child and youth mental health services report.

I would like to thank you and your staff for your work with the department in facilitating his report.

Yours sincerely

Kym Peake
Secretary

27 / 5 / 2019

VICTORIA State Government

RESPONSE provided by the Secretary, DHHS—continued

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Department of Health and Human Services action plan to address recommendations from Child and Youth Mental Health

No	VAGO recommendation	Action	Completion date
1	In conjunction with child, adolescent and youth mental health services and consumers, develop strategic directions for child, adolescent and youth mental health services that include objectives, outcome measures with targets, and an implementation plan that is supported by evidence-based strategies at both the system and health service levels (see Section 2.2)	**The department accepts this recommendation**	December 2021
2	When implementing the six recommendations from the VAGO audit *Access to mental health services*, ensure that the needs of children, adolescents and young people as well as child, adolescent and youth mental health services are considered and applied, wherever appropriate (see Section 1.4)	**The department accepts this recommendation**	December 2021
3	Establish and implement a consistent service response for 0–25 year-olds in regional Victoria that need crisis or specialised support beyond what their local child, adolescent and youth mental health services' community programs can provide, including reviewing the extent to which the six funded regional beds are able to provide an evidence-based child and adolescent service (see Sections 2.4 and 3.2)	**The department accepts this recommendation**	December 2021
4	Establish and implement a transition plan towards achieving a consistent service response for 19–25 year-olds with moderate and severe mental health problems (see Section 2.5)	**The department accepts this recommendation**	December 2021
5	Develop and implement a child, adolescent and youth mental health workforce plan that includes understanding the specific capability needs of the sector and specifically increasing capabilities in the area of dual disability, ie. intellectual or developmental disabilities complicated by mental health problems (see Section 2.7)	**The department accepts this recommendation**	December 2020

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RESPONSE provided by the Secretary, DHHS—continued

6	Refine, document and disseminate the performance monitoring approach for child and youth mental health services so it consolidates current disparate reporting requirements and includes: a. measures that allow monitoring of long inpatient stays, priority client groups, clinical outcomes and accessibility of CYMHS b. introducing quality and safety measures of CYMHS community programs in the Victorian Health Services Performance Monitoring Framework c. the role of the Chief Psychiatrist in performance monitoring, and how the information it receives from mandatory reporting informs DHHS's performance monitoring d. documenting in one place all reporting requirements for CYMHS from all areas of DHHS, including administrative offices Safer Care Victoria and the Victorian Agency for Health Information e. how DHHS will respond to performance issues (see Sections 3.2 and 3.6)	**The department accepts this recommendation**	December 2020
7	Ensure that six-monthly mental health program meetings occur and information received is consolidated to identify systemic and persistent issues (see Section 3.4)	**The department accepts this recommendation**	October 2019
8	Initiate negotiations with the Department of Treasury and Finance during the state budget process to ensure that Budget Paper 3 performance measures from approved additions include monitoring of child, adolescent and youth mental health services (see Section 3.6)	**The department accepts this recommendation**	July 2019
9.	Disseminate evaluations and reviews of child, adolescent and youth mental health service projects and services to all child, adolescent and youth mental health service leaders (see Section 3.7)	**The department accepts this recommendation**	July 2019

RESPONSE provided by the Secretary, DHHS—continued

OFFICIAL: Sensitive

10	Formally respond to all recommendations made in the 2016 review of the role of the Chief Psychiatrist and advise the Minister on intended actions (see Section 3.7)	**The department accepts this recommendation**	December 2019
11	In consultation with health services, ensure that the Chief Psychiatrist's guidelines and directions are effectively communicated to those responsible for their implementation in child, adolescent and youth mental health services and that their implementation is supported and monitored (see Section 3.7)	**The department accepts this recommendation**	July 2020
12	Benchmark the performance of child, adolescent and youth mental health services in Victoria at the system level against other jurisdictions, and national and international targets, and report the findings and opportunities for improvement subsequently identified in the Mental Health Annual Report (see Section 3.8)	**The department accepts this recommendation**	July 2021
13	Ensure that the data which DHHS and/or health services need to collect about CYMHS for their reporting and monitoring obligations, including the outcome measures and targets developed through Recommendation 1, is consistent with what is collected and recorded in the Client Management Interface (CMI) database and develop a single and comprehensive source of guidance and business rules about data reporting requirements (section 3.9)	**The department accepts this recommendation**	December 2021
14	Update the triage scale and process so it is developmentally-appropriate for children, adolescents and young people, and considers how triage can be provided at peak periods of demand such as evenings and weekends (see Section 4.2)	**The department accepts this recommendation**	July 2020
15			

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RESPONSE provided by the Secretary, DHHS—continued

OFFICIAL: Sensitive

	Ensure the registration forms that DHHS issues to health services can record a child, adolescent or young person's legal status with regards to guardianship, out-of-home care, and restrictive interventions or compulsory treatment under the *Disability Act 2006*, that the information can be entered into central databases, that business rules exist for doing so and data entry is monitored to ensure it is occurring (see Section 4.2)	**The department accepts this recommendation**	July 2020
16	Provide written guidance to CYMHS leaders about both the DHHS Complex Care Panels and the Multiple and Complex Needs Initiative which includes how to refer clients to each, how to contact the necessary staff in each DHHS geographic area for information and advice, which clients are eligible for each, and is updated at least annually (see Section 4.3)	**The department accepts this recommendation**	December 2019
17	Consider establishing a High-Risk Complex Care Child and Youth Panel, with executive representation from out-of-home care, disability services, and mental health areas of DHHS, with remit to include: • health services can rapidly escalate cases to the panel when a local service response is not meeting a young person's needs, to prevent a clinically unnecessary inpatient stay that may cause deterioration of the young person's health and wellbeing • identify and address service gaps and service coordination challenges that are contributing to clinically unnecessary inpatient stays • liaison with the National Disability Insurance Agency, as required (see Section 4.4).	**The department accepts this recommendation**	December 2020
18	Create a channel for the Chief Psychiatrist to independently brief the Minister or the Secretary, if they deem it necessary (see Section 4.4).	**The department accepts this recommendation**	December 2019

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RESPONSE provided by the Secretary, DHHS—continued

19	Establish and implement a consistent service response for 0–25 year-olds who have intellectual or developmental disabilities and moderate to severe mental health problems (see Section 4.5)	**The department accepts this recommendation**	December 2021
20	Establish a mechanism for operational and clinical leaders of all child, adolescent and youth mental health services to collaborate with each other and with DHHS to improve service response consistency, and strengthen pathways between services for clients and families, including reviewing catchment boundaries and access to specialised state-wide programs (see Section 4.5).	**The department accepts this recommendation**	December 2021

RESPONSE provided by the Chief Executive Officer, AWH

Albury Wodonga Health

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"The Best of Health"

May 24th 2019

Mr. Andrew Greaves
Victorian Auditor General's Office
Level 31
35 Collins Street
Melbourne, Victoria 3000

Dear Mr. Greaves

Thank you for providing a copy of the proposed report on Child and Youth Mental Health Services in Victoria and for acquitting our comments pertaining to an earlier draft.

Albury Wodonga Health has no further comment to be made in relation to this report and would like to thank you for the opportunity to participate in this audit.

Yours sincerely,

Leigh McJames
Chief Executive Officer

ABN 31 569 743 618

RESPONSE provided by the Acting Chief Executive Officer, Austin Health

22 May 2019

Mr Andrew Greaves
Auditor-General
Victorian Auditor-General's Office
Level 31, 35 Collins Street
MELBOURNE VIC 3000

Dear Mr Greaves

Proposed Performance Audit Report Child and Youth Mental Health

Thank you for your letter dated 10 May 2019, regarding the proposed performance audit report *Child and Youth Mental Health* and the invitation to provide a formal response. Austin Health appreciates the opportunity extended by the Victorian Auditor-General's Office to participate in this much needed audit to confirm that public-hospital child and youth mental health service delivery is accountable to the community.

Austin Health is acutely aware of the need to ensure that mental health services meet the needs of some of the most vulnerable children, young people and their families across Victoria, and to enable a system that is responsive to demographic changes. Senior organisational leaders have reviewed the report and we confirm that it captures the significant issues and barriers in the service system currently – the report is fair and balanced in its approach, despite it having highlighted a broad range of systemic and long-term deficits. We welcome the audit recommendations and, particularly, the recommendations that DHHS:

- In conjunction with child, adolescent and youth mental health services and consumers, develop strategic directions for mental health services that include objectives, outcome measures with targets, and an implementation plan that is supported by evidence-based strategies
- Develop and implement a child, adolescent and youth mental health workforce plan that includes understanding the specific needs of the sector
- Refine, document and disseminate the performance monitoring approach for child and youth mental health services such that it consolidates current disparate reporting requirements and,
- Establish and implement a consistent service response for 0-25 year olds who have intellectual or developmental disability and moderate to severe mental health difficulties.

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RESPONSE provided by the Acting Chief Executive Officer, Austin Health—continued

Austin Health is pleased to note the recommendation regarding the need for negotiation with the Department of Treasury and Finance. This is particularly important in the context of recommended improvements, but in recognising also that infrastructure limitations have for many years played a significant role in the lack of appropriate service system response – for example, the absence of dedicated 18-25 youth inpatient capacity across all child and youth mental health services, leading to admission to what are considered adult inpatient beds.

Austin Health is committed to ensuring delivery of high quality mental health services to children, young people and their families. We appreciate the opportunity to have been involved in this important audit and look forward to working collaboratively with DHHS, the Office of the Chief Psychiatrist and Chief Mental Health Nurse, and other service providers to implement and deliver upon recommendations as outlined within the report.

Finally, we would like to thank the VAGO auditing team for their work and the professional manner in which the audit was conducted.

Yours sincerely

Shelley Castree-Croad
Acting Chief Executive Officer

RESPONSE provided by the Chair, Eastern Health

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24 May 2019

Mr Andrew Greaves
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Dear Mr Greaves

Re Proposed Performance Report Child and Youth Mental Health

Thank you for the opportunity to comment on the proposed Performance Audit Report for Child and Youth Mental Health. Eastern Health welcomes the VAGO review of Child and Youth Mental Health Services (CYMHS). The focus on child and youth mental health services is extremely important, acknowledging the significance of mental health problems in people under the age of 25 years and that intervention early in life, and early in mental illness, can reduce its duration and impact.

Eastern Health CYMHS provides high-quality services to children and young people and their families. Eastern Health is the lead agency for the treatment of severe and complex mental health illness in the Eastern Region of Melbourne. Taking an early intervention, developmentally informed, family-based and recovery-oriented perspective, the service provides specialist mental health assessment and interventions for infants, children and young people and their families. CYMHS offers a full range of community-based services and acute psychiatric inpatient care as well as support to partner agencies that work to prevent, treat or facilitate recovery from the broader spectrum of mental disorders, or otherwise promote healthy social and psychological development in children and young people. We aim to improve the lives of young people, strengthen diverse communities and reduce morbidity in future generations. The service also has a prime role in training the child and youth mental health workforce of the future, actively contributing each year to the Developmental Psychiatric Course run by

RESPONSE provided by the Chair, Eastern Health—continued

Mindful, and providing a range of educational and professional development opportunities to psychiatry, mental health nursing and allied health students and clinicians.

Service demand is consistently high and unfortunately, the service cannot provide care to many of the referred children and young people each year. On average, the service receives over 10,000 calls to its dedicated telephone access service each year. Following a triaging process, in the past year, only the most complex and severe 1265 young people and their families received direct case management, intervention and care from Eastern Health, with the remainder being referred to alternative services. At any given time the service is working with around 750 families across four community outpatient sites, with the predominant diagnoses being anxiety (27%), mood disorders (28%), eating disorders (6.5%), personality disorders (6.5%) and first episode psychosis (4.5%).

Acute inpatient care is provided for children and adolescents under the age of 18 years within Eastern Health's Adolescent Inpatient Unit (AIPU), with a shorter average length of stay than peer services. The AIPU provides care that emphasises least restrictive care and accessible, evidence-based, community-based treatment.

Compared to the National Mental Health Outcomes Data for young people at entry to CYMHS services, Eastern Health CYMHS clients are substantially more severe in presentation. The average symptom intensity and impact for those commencing care with Eastern Health CYMHS is higher than 70% of those entering comparable peer organisations around Australia, consistent with our emphasis on assessing and treating those with the most severe problems and who cannot be treated in less intensive settings. A recent two-year sample of community-treated clients indicated improvement in symptom severity for approximately 72% between case start and finish.

Failure to attend (FTA) appointment is a common issue in child and youth mental health settings, with 15 - 36% of first appointments not attended[1]. The Eastern Health CYMHS FTA rate reduced from 18% to 3% following the introduction of a model of care in 2014 that emphasises greater efficiency in our triage service and active collaborative engagement with families.

Given that resources are limited, Eastern Health works to support the capability and capacity of our partner agencies in delivering optimal care for children and young people within the Eastern region. This includes providing primary and secondary consultations to other regional health, educational and welfare services, including two local Headspace centres. Eastern Health also delivers a monthly community education program to key stakeholders and partners.

The service continually strives to innovate, utilise resources efficiently and promote evidence-based practice that meets the needs of children and young people within the Eastern Region. Current initiatives to improve our service and capability include:

RESPONSE provided by the Chair, Eastern Health—continued

- Initiation of the Infancy Access Project using the 2017 Specialist Child Initiative funding, with the aim of supporting greater early intervention with 'at-risk' families, and in recognition of the comparative under-representation of children under four years of age within Eastern Health's service. Developed in collaboration with Maroondah Maternal Child Health Service (MCHS), the project provides mental health assessment and intervention with families referred by the MCHS, and is delivered alongside the MCHS nurse in the family home and/or MCHS centre. Early results indicate a 29% increase in engagement with CYMHS by this previously under-represented group and, resources permitting, the project will expand to all local government regions in the Eastern Region.
- The development of a cross-sector Youth Suicide Post Vention and Recovery Protocol. This protocol, led by Eastern Health CYMHS in partnership with 14 key stakeholders, including Victoria Police, Ambulance Victoria, local Headspace centres and local government, aims to provide support to the local community, especially to friends and other young people who can be especially vulnerable following a death by suicide. The plan aims to ensure that local services, including Headspace, schools, mental health services and councils, are rapidly activated to develop a coordinated plan to support the community after a young person's death, and ensure appropriate supports are in place for the young people affected.
- The Youth Engagement and Treatment Team Initiative (YETTI) is an innovative model of care developed by Eastern Health CYMHS following a submission to the Eastern Melbourne Primary Health Network tender in 2017. This delivers an early intervention service to primary health for young people aged 12-25 years at extreme risk of developing a serious mental illness. YETTI co-locates with external community agencies, such as Headspace centres, GP clinics and community health services, to provide capability and capacity building support to agency staff, as well as direct services to referred young people and their families. The Program has obtained consistently positive feedback and outcomes.
- Eastern Health CYMHS has developed a comprehensive eating disorder program and which includes an integrated mental health and paediatric assessment clinic. Consistent with the evidence, support and treatment is in the form of intensive community-based treatment, including multifamily therapy for Anorexia Nervosa and Family-Based Treatment, with admission to the Box Hill Hospital Paediatric Unit for medical stabilisation if required. Given the importance of early intervention for emerging eating disorders and the increasing referral of young people with eating disorders, Eastern Health would welcome additional resources to support the expansion of this service.
- In 2018-19 to-date, Eastern Health has provided three Youth Mental Health First Aid two-day training courses for a total of 60 participants and ten Community Education Seminars to 223 health, education and welfare staff across the Eastern Region.

Eastern Health CYMHS is keen to continue to work with the Department of Health and Human Services, the Office of the Chief Psychiatrist and other CYMHS to develop strategic directions for child, adolescent and youth mental health services to improve the outcomes for children and young people. In collaboration with the Primary Health

RESPONSE provided by the Chair, Eastern Heath—continued

Network for the Eastern Region, Eastern Health has commenced a strategic plan for child, adolescent and youth services which we believe will be a catalyst for further development of the service. Eastern Health also supports the Victorian Royal Commission into Mental Health Services as another means of focusing attention on this critical service to our community.

Yours sincerely

Dr Joanna Flynn AM
Chair, Eastern Health Board

References:

1. Marshall et al. 2016. *What IAPT services can learn from those that do not attend.* Journal of Mental Health, 25(5), 410 -415.

RESPONSE provided by the Chief Executive Officer, RCH

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The Royal Children's Hospital Melbourne

May 24, 2019

Mr Andrew Greaves
Auditor-General
Victorian Auditor General's Office
Level 31/35 Collins Street
MELBOURNE 3000

Dear Mr Greaves,

Thank you for your letter dated May 10, 2019 to The Hon Rob Knowles AO, Chairman of The Royal Children's Hospital (RCH) providing a final opportunity to comment on the provisional report and recommendations into Child and Youth Mental Health Services (CYMHS) in the health sector.

The RCH has reviewed the report and VAGO's recommendations. In particular we note the significant funding disparity across mental health service providers and welcome action in this regard. Notwithstanding the forthcoming Royal Commission into Victoria's Mental Health System, the RCH looks forward to action on VAGOs recommendations and the opportunity to work collaboratively with the Department of Health and Human Services (DHHS) and our peers to deliver improvement to mental health services for children, young people and their families.

Again, thank you for the opportunity to work with you on this important review.

Kind regards

John Stanway
Chief Executive Officer

Appendix B
DHHS funding for child and youth mental health 2018–19

Health Service	Inpatient funding ($)	Child and adolescent treatment services ($)	Other specialised programs ($)	Total CYMHS ($)
Monash Health	9 267 475	8 972 474	6 489 481	24 729 430
Austin Health	5 981 334	7 098 963	2 943 371	16 023 668
Royal Children's Hospital	4 160 928	10 856 000	2 471 153	17 488 081
Eastern Health	3 120 696	7 889 115	4 768 661	15 778 472
Melbourne Health	4 160 928	0	3 535 171	7 696 099
Alfred Health	0	4 621 759	3 346 207	7 967 966
Bendigo Health	2 193 367	3 213 003	2 092 409	7 498 779
Barwon Health	0	2 498 146	2 538 710	5 036 856
Latrobe Regional Hospital	520 116	2 527 136	1 963 522	5 010 774
Ballarat Health	520 116	2 124 821	1 698 458	4 343 395
Peninsula Health	2 193 367	0	1 621 403	3 814 770
Goulburn Valley Health	0	2 093 017	1 385 686	3 478 703
Albury Wodonga Health	0	2 013 665	1 048 713	3 062 378
Ramsay Healthcare	520 116	778 477	1 290 282	2 588 875
South West Healthcare	0	1 355 596	941 989	2 297 585
St Vincent's	0	0	712 836	712 836
Forensicare	0	0	144 770	144 770
Total	**32 638 443**	**56 042 172**	**38 992 882**	**127 673 437**

Source: VAGO, based on information from DHHS.

Appendix C DHHS program descriptions

Program name	Program description
Child and Adolescent Assessment Treatment	A range of services including crisis assessment, case management, individual or group therapy, family therapy, parent support and medication-based treatments for children and adolescents experiencing significant psychological distress or mental illness. Services support a timely response to referrals, including crises, delivered on an outreach basis, where appropriate.
Conduct Disorder Program	Services that provide prevention programs for children and young people at risk and clinical services for those with established conduct disorder.
Early Psychosis Program	Specialist treatment and improved continuity of care services for young people with an emerging disorder, particularly co-existing substance abuse problems.
Intensive Youth Support	Provision of mobile intensive mental health case management and support to adolescents who display substantial and prolonged psychological disturbance, have complex needs, which may include challenging, at-risk and suicidal behaviours, and who have been difficult to engage utilising less-intensive treatment approaches.
Community Specialist Statewide Services—Eating Disorders	A range of specialist clinical community mental health assessment, treatment or consultancy services that support eating disorder groups on a statewide, inter-regional or specific catchment area basis. The focus of these community services is on a clinical service provision to people with a mental illness.
Youth Suicide Prevention	Youth suicide prevention programs aim to reduce suicide among young people aged 10–25 years. Programs provide preventative support, activities and early intervention services to the young person, their family and friends and the broader community.
Acute Care—Child and Adolescent	Inpatient units provide short-term psychiatric assessment and treatment for children and adolescents with severe psychological disturbance who cannot be effectively assessed or treated in a less-restrictive community-based setting.

Source: DHHS Policy and Funding Guidelines 2018–19 Section 3.4, Chapter 3, page 226–229.

Appendix D
Clinical data analysis methodology

Our clinical data analysis in this audit involved the five audited health services, which provided to us all community contacts and admissions for all clients aged 0–25 years across three years from 1 January 2015 to 31 December 2018.

The data that we received and analysed from CMI/ODS was:

- 18 460 unique clients
- 10 demographic fields that were used in the analysis were populated for 92 per cent of clients, though this included some 'unknown' responses
- 28 191 program incidences (that is, admissions for inpatients or enrolment in a community program), which represented program-level information for 15 988 (87 per cent) clients
- ICD10 codes for diagnoses were available for 75 per cent of clients (93 per cent inpatients, 69 per cent community)
- outcome measures—at least one was available for 61 per cent of clients, 46 per cent of clients had a HoNOSCA and 31 per cent had at least one SDQ score.

The data analysis sought to explore:

- the current client group's demographics and clinical characteristics including levels of severity and complexity
- the number of clients seen by CYMHS as a whole and each specific service within CYMHS, including emergency department presentations
- the number, length and frequency of inpatient stays
- the age and clinical characteristics of clients with longer inpatient stays.

Auditor-General's reports tabled during 2018–19

Report title	Date tabled
Local Government Insurance Risks (2018–19:1)	July 2018
Managing the Municipal and Industrial Landfill Levy (2018–19:2)	July 2018
School Councils in Government Schools (2018–19:3)	July 2018
Managing Rehabilitation Services in Youth Detention (2018–19:4)	August 2018
Police Management of Property and Exhibits (2018–19:5)	September 2018
Crime Data (2018–19:6)	September 2018
Follow up of Oversight and Accountability of Committees of Management (2018–19:7)	September 2018
Delivering Local Government Services (2018–19:8)	September 2018
Security and Privacy of Surveillance Technologies in Public Places (2018–19:9)	September 2018
Managing the Environmental Impacts of Domestic Wastewater (2018–19:10)	September 2018
Contract Management Capability in DHHS: Service Agreements (2018–19:11)	September 2018
State Purchase Contracts (2018–19:12)	September 2018
Auditor-General's Report on the Annual Financial Report of the State of Victoria: 2017–18 (2018–19:13)	October 2018
Results of 2017–18 Audits: Local Government (2018–19:14)	December 2018
Professional Learning for School Teachers (2018–19:15)	February 2019
Access to Mental Health Services (2018–19:16)	March 2019
Outcomes of Investing in Regional Victoria (2018–19:17)	May 2019
Reporting on Local Government Performance (2018–19:18)	May 2019
Local Government Assets: Asset Management and Compliance (2018–19:19)	May 2019
Compliance with the Asset Management Accountability Framework (2018–19:20)	May 2019
Security of Government Buildings (2018–19:21)	May 2019
Security of Water Infrastructure Control Systems (2018–19:22)	May 2019

Security of Patients' Hospital Data (2018–19:23)	May 2019
Results of 2018 Audits: Universities (2018–19:24)	May 2019
Results of 2018 Audits: Technical and Further Education Institutes (2018–19:25)	May 2019

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