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SUMMARY REPORT

EVALUATIONS OF ADULT MENTAL HEALTH SERVICES' RESPONSIVENESS TO THE NEEDS OF STATUTORY CLIENTS, CHILDREN WHO MAY BE AT RISK AND THEIR PARENTS/ CARERS

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EXECUTIVE SUMMARY

Introduction

The Mental Health Branch of the Department of Human Services commissioned an evaluation of Child and Adolescent and Adult Mental Health Services' responsiveness to the needs of statutory clients, children who may be at risk and their parents/ carers. This activity is part of the Mental Health Branch's Quality Incentive Strategy operating within its Service Monitoring and Review Program.

Thomas and Associates were appointed by the Mental Health Branch to devise the evaluation protocols and to conduct two rounds of the evaluation in 1998/1999 and 1999/2000. This document describes the outcomes of the 1999/2000 round of the evaluation for Adult Mental Health Services, the second year of the evaluation.

Project Methodology

The evaluation process for this project during both evaluation periods involved two main activities.

The first activity was the preparation of a submission by each mental health service for consideration by an independent expert panel. The panel's role was to validate and if necessary amend the services' submission ratings. The evaluation studied performance in each of five areas.

- Systems Collaboration and Service Partnership
- Service Planning
- Service Access
- Service Delivery/ Case Management
- Quality Assurance and Research

Each of the five areas or sub-scales within the evaluation was comprised of items relating to those areas. Each item was scored using the same five point scale in order to permit inter-item comparisons and simple addition of items without weighting. During the 1999/2000 evaluation period, a series of regional consultations was conducted with representatives from Child and Adolescent Mental Health Services and Adult Mental Health Services to assist the services in their self-evaluation.

The second activity was the conduct of a telephone survey of Juvenile Justice and Child Protection Units concerning their collaboration with each of the Mental Health Services in both the Adult and Child and Adolescent mental health service sectors. These results did not contribute to the Quality Incentive Strategy.

Outcomes of the validated self evaluation of Adult Mental Health Services' responsiveness to the needs of statutory clients, children who may be at risk and their parents/ carers

In their evaluation submissions, Mental Health Services described a wide range of initiatives targeted at meeting the needs of statutory clients, children who may be at risk and their parents/ carers. The initiatives varied in status from well established to being in their formative stages. During the 1999/2000 evaluation round there was substantial activity surrounding the formation of working groups and committees in response to the Working Together Strategy.

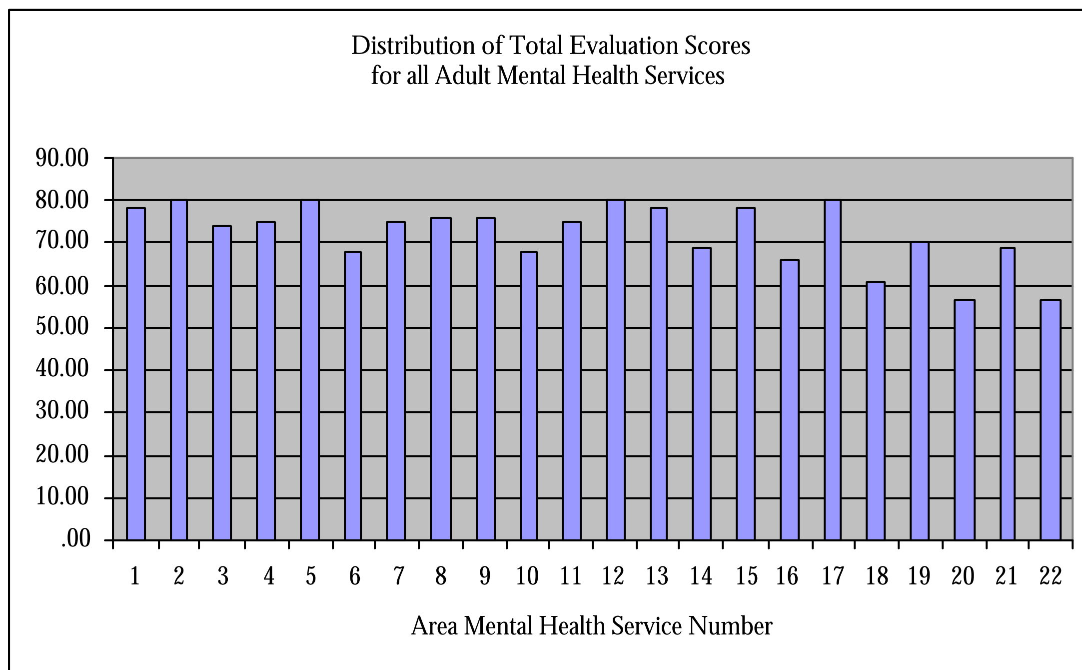
The quantitative rating component of the Mental Health Service evaluation task resulted in generally strong performance profiles for Adult Mental Health Services. A summary of the descriptive statistics associated with each of the evaluation tools sub-scales follows for the 1999/2000 evaluation round and includes the 1998/1999 system-wide percentage of maximum scores possible for each sub-scale for comparison.

	1999/2000					1998/99
Evaluation sub-scale	System-wide mean	Minimum score Achieved	Maximum score achieved	Maximum possible score	System-wide % of maximum score possible	System-wide % of maximum score possible
Systems Collaboration and Service Partnership	28.1	23	30	30	94%	76%
Service Planning	13.5	10	15	15	90%	71%
Service Access	8.4	6	10	10	84%	62%

Service Delivery/ Case Management	13.9	11	15	15	93%	81%
Quality Assurance and Research	8.4	3	10	10	84%	58%
TOTAL	72.3	57	80	80	90%	73%

The evaluation scores were based on the AMHS self-rating submissions alone, not the Juvenile Justice and Child Protection survey results. The Child Protection and Juvenile Justice evaluation information was not taken into consideration for the Quality Incentive Strategy calculations.

The figure below shows the distribution of total evaluation scores across the 22 Adult Mental Health Services that participated in the study.



In relative terms, for the 1999/2000 evaluation, the systems collaboration and service partnership sub-scale was shown to have the strongest results, with the system-wide mean being 94 per cent of the maximum score possible for that sub-scale. The service delivery/ case management sub-scale followed closely behind with 93 per cent of the maximum score possible for that sub-scale. At the lower end of the results, the service access and quality assurance and research sub-scales were shown to have the least strong results, with their

system wide means being 84 per cent of the possible maximum score for the respective sub-scales.

In comparison with the 1998/1999 results, an overall absolute improvement of 17 per cent was found in the system-wide percentage of maximum total evaluation score possible for the 1999/2000 results. In terms of individual sub-scale improvements, the quality assurance and research sub-scale saw the greatest improvement over last year's evaluation results. The 1999/2000 system-wide percentage of the maximum score possible for this sub-scale rose by 26 per cent over the 1998/1999 percentage. All other 1999/2000 sub-scale percentages rose by a magnitude in the range of 12 to 22 per cent.

Several services achieved the maximum sub-scale score possible for individual sub-scales. Ten services achieved this for systems collaboration and services partnership, eight for service planning, five for service access, twelve for service delivery/case management and ten for quality assurance and research. Overall, four services achieved the maximum score possible for the 1999/2000 total evaluation.

A detailed analysis of the outcomes for each item within the various sub-scales as well as the outcomes for the sub-scales is provided within this report. The items with the best system wide outcomes were:

> Systems collaboration and service partnership – Item B
> "Key agencies who may have a role in responding to the needs of families when a parent has a mental illness are identified and a staff member has responsibility for coordinating liaison with these agencies."

Systems collaboration and service partnership – Item E
"Protocols/ guidelines have been developed to ensure action has been taken so that all clinical staff are aware of notification requirements of Child Protection Services, in accordance with mandatory reporting, in relation to children who may be at risk."

The items with the least satisfactory system wide performance were:

Service access – Item B
"The Mental Health Service has data available about referrals made from Juvenile Justice/ Child Protection in relation to:

- -Parents with a mental illness with children who may be at risk
- -Parents of Statutory clients
- -Older Statutory Clients (17-21 years)."

Quality assurance/ research – Item B
"Research/needs analyses/service utilisation studies on the needs of parents with mental illness with children who may be statutory clients or may be at risk is being undertaken."

Outcomes of Survey of Juvenile Justice and Child Protection Units

In considering the survey feedback from Juvenile Justice and Child Protection units concerning their relationships with Adult Mental Health Services it is necessary to note that the extent of feedback for individual Adult services was less than for CAMHS services. This probably reflects a somewhat lower level of engagement between Adult services and the Juvenile Justice and Child Protection sectors.

The following is a summary of the comments received from the Juvenile Justice and Child Protection respondents.

The Juvenile Justice and Child Protection respondents were asked a series of questions concerning their relationship with Adult Mental Health Services. The questions asked were:

Do you have any comments on the **collaboration** (e.g. joint meetings, involvement in training, shared development of Individual Service Plans) you have had with Adult Mental Health Services in relation to statutory clients?

Do you have any comments on **service access** for statutory clients for Adult Mental Health Services (e.g. processing of referrals, documentation of acceptance criteria, secondary consultation)?

Do you have any comments on **service delivery and case management** for statutory clients in Adult Mental Health Services (e.g. case conferences, appropriate service delivery methods)?

What are the **best things** about the response of Adult Mental Health Services to the needs of statutory clients, children who may be at risk and their carers?

What are the **worst things** about the response of Adult Mental Health Services to the needs of statutory clients, children who may be at risk and their carers?

What would **strengthen your working relationship** with Mental Health Services?

The responses to these questions have been subjected to a thematic analysis in order to provide a comprehensive overview of the responses of the respondents. Comments about individual services are presented in the individual service reports. The themes discovered by the thematic analysis were the following:

Collaboration:
- AMHS' collaboration in developmental stages

Service Access:
- CP & JJ's limited need for access to adult mental health services
- Difficulty in access to AMHS for 17-20 year olds

Service Delivery and Case Management:
- Need for more collaboration from AMHS in joint case work
- CP & JJ's limited but positive experience with the adult services

Best Things:
- AMHS' willingness to work collaboratively
- AMHS' knowledge of mental health

Worst Things:
- Difficulty of access to AMHS for high-risk and 17-20 year olds
- AMHS' lack of flexibility in treatment model
- Lack of resources (staff)
- Different perspective of who the client is (AMHS – parent; CP & JJ – child)
- AMHS not understanding issues of children at risk
- AMHS unwilling to share information

Things that would Strengthen the Relationship:

- More collaboration/ relationship building/ joint training
- Co-location of workers
- Common protocols/ policies/ structures
- Regular meetings
- Communication
- Recognition of 17-20 year olds

Conclusions

The evaluation outcomes for AMHS services provided by the Independent Review Panel activities and the survey responses from Juvenile Justice and Child Protection services, both provide important insights into service responsiveness of AMHS services.

The evaluation has shown major improvements within the mental health service sector in meeting the needs of statutory clients, children who may be at risk and their parents and carers. The 1999/2000 quantitative validated evaluation scores have shown large improvements from the 1998/1999 levels. This is also reflected in the more positive tenor of the comments made by the Child Protection and Juvenile Justice staff in reflecting upon the responsiveness of the Mental Health Services in meeting the needs of the target client group and their families.

The Mental Health Services provided details of an impressive set of service improvement activities, some centred on the Working Together initiative and others in partnership with other programs and agencies. There is no doubt that the responsiveness of Mental Health Services has strongly improved during the period of the 1999/2000 evaluation.

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SECTION 1

INTRODUCTION AND BACKGROUND

BACKGROUND

The Mental Health Branch of the Department of Human Services has commissioned an evaluation of Child and Adolescent and Adult Mental Health Services' responsiveness to the needs of statutory clients, children who may be at risk and their parents/ carers. This activity was part of the Mental Health Branch's Quality Incentive Strategy operating within its Service Monitoring and Review Program.

Thomas and Associates were appointed by the Mental Health Branch to devise the evaluation protocols and to conduct two rounds of the evaluation in 1998/1999 and 1999/2000. This document describes the outcomes of the 1999/2000 round of the evaluation for Adult Mental Health Services, the second year of the evaluation.

In conducting the project information about mental health service responsiveness was sought from two sources. The primary source of this information was that of the Adult and Child and Adolescent Mental Health Services themselves. The services completed a detailed evaluation submission[1] in which they provided evidence of their activities in response to a set of criteria/ items. A second important source of evaluation information was that provided by Juvenile Justice and Child Protection Services. These services completed an evaluation questionnaire to provide their information[2].

DEVELOPMENT OF THE EVALUATION TOOLS AND METHODS

Prior to the conduct of the 1998/1999 evaluation round, it was necessary to develop the evaluation tools and methods to be employed within the evaluation. This development process involved detailed consultations with all Child and Adolescent and Adult Mental Health Services as well as Juvenile Justice and Child Protection services.

The first step in the development of evaluation tools and protocols involved a comprehensive analysis of the evaluation literature and other service responsiveness tools. A set of detailed consultations was held with the Project Advisory Group with the purpose of formulating discussion materials to be used in consultations with the participating services.

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[1] This questionnaire appears as an attachment to this report

[2] This questionnaire also appears as an attachment to this report.

In November 1998 a letter was forwarded by the consultants to all services outlining the project consultations and how the tools and methods were to be developed. In December 1998 a series of regional consultations was conducted by the consultants with all services. These consultations were attended by 75 participants. The purpose of the consultations was to discuss the draft evaluation criteria and protocols.

The outcomes of the consultations were used to inform redrafting of the discussion materials. The redrafted documents included more specific discussion of the in-scope consumer groups targeted within the evaluation and various refinements to specific items. These materials were circulated to services in December for further comment and then finalised.

On 29 January, 1999 the Mental Health Branch hosted a Quality Incentive Program Forum involving all Mental Health Services. The meeting was attended by 110 representatives. At that meeting the finalised evaluation tools and methods for this project were presented to services in order to enable them to prepare for the evaluation. The process observed in the evaluation is described in the next section of this report.

MENTAL HEALTH SERVICE EVALUATION TOOL CONTENT

The evaluation criteria used in this project and the associated evaluation tools were developed following analysis of previous service responsiveness tools, published research and consultations with service providers and other key informants.

The evaluation criteria fell under the following headings:

Systems Collaboration and Service Partnership Subscale
This sub-scale was concerned with the collaboration and partnerships between the mental health agencies and Juvenile Justice and Child Protection sectors to ensure responsive service to statutory clients and children who may be at risk and their carers.

Service Planning Subscale
This sub-scale included items that related to the planning of services for statutory clients, children who may be at risk and their carers.

Service Access Subscale
This sub-scale includes items that related to the access for statutory clients, children who may be at risk and their carers to mental health services.

Service Delivery/ Case Management Subscale
This area focused on the delivery of services specific to statutory clients, children who may be at risk and their carers.

Quality Assurance and Research Subscale

This area focused on the collection of data, quality assurance information and conduct of research pertinent to the needs of statutory clients, children who may be at risk and their carers.

Each criterion was addressed by multiple items. The evaluation items were grouped under each of the above headings in the evaluation questionnaire.

The same rating scale was used for each evaluation item. The scale points and scores were:

1. No action taken and no documented plan for addressing the criterion
2. Documented plan in place for addressing the criterion but no action taken
3. Criterion met by piecemeal or one off activities
4. Systematic action taken to address the criterion but limited scope
5. Action taken to meet the criterion which is comprehensive and involves the service as a whole

The above numerical rating system was used to derive summed scores for each of the evaluation criterion sub-scales and the total evaluation score. The same survey tool as used in the 1998/1999 was used in 1999/2000.

JUVENILE JUSTICE AND CHILD PROTECTION SERVICE EVALUATION TOOL CONTENT

The evaluation criteria and associated survey tool[3] used by Juvenile Justice and Child Protection services were developed following a detailed analysis of previous service responsiveness tools, published research and consultations with service providers and other key informants, prior to the 1998/1999 evaluation period.

The evaluation criteria fell under the following headings:

- Collaboration
- Service Access
- Service Delivery and Case Management

The same survey tool as used in 1998/1999 was used in 1999/2000 with the exception that the wording of some questions was tightened and the referral estimate questions were dropped as they had not provided data of satisfactory validity.

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[3] The tools appear as attachments to this report

THE EVALUATION PROCESS

The following evaluation process was followed for the 1999/2000 evaluation round:

Mental Health Services

- Thomas and Associates contacted the management of each AMHS & CAMHS to arrange briefings about the evaluation process by letter and telephone.
- The evaluation questionnaire and project methods were forwarded to CAMHS & AMHS management for distribution to their nominated responsible officer(s) for the evaluation.
- Meetings were held between the CAMHS and AMHS liaison officer(s) and consultants to clarify any aspects of the evaluation process and documentation requirements and MHS responses to the process
- The meetings were supplemented by telephone support from the consultants to assist services in the development of their evaluation submissions.
- CAMHS & AMHS delivered their submissions to Thomas and Associates by close of business March 1, 2000.
- The submissions were considered by an Independent Expert Panel to validate the submissions. The Expert Panel consisted of eminent mental health and evaluation professionals with no conflicts of interest[4].
- Comments on the interim ratings were returned to the Independent Expert Panel for their consideration and the ratings were finalised.

This process followed was exactly the same as the one followed during the 1998/1999 evaluation round and was similar to the one followed for the evaluations of service responsiveness to the needs of women and to the needs of people from NESB in 1997/98, but with improvements to procedures designed to streamline the evaluation process. The improvements included tighter guidelines governing the content of submissions and constraints upon the volume of materials to be provided by services in their submissions. These constraints were requested by services in the consultations concerning the evaluation design and were welcomed by services.

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[4] The Independent Expert Panel for this evaluation consisted of Professor Lerma Ung, School of Nursing, Deakin University, Professor Alun Jackson, Head of the School of Social Work, University of Melbourne and Dr. Susan Paxton, School of Psychology, University of Melbourne.

Juvenile Justice and Child Protection Services

- Telephone contact was made with the managers of each of the Juvenile Justice and Child Protection Units across the nine regions, to advise them of the 1999/2000 round of evaluations. The survey tool was administered by the consultants during a phone interview with each of the managers or acting managers.
- The responses were due by April 1, 2000.
- The Independent Expert Panel did not view the Juvenile Justice and Child protection responses and the consultants did not process the responses until the Panel's deliberations had been completed. This procedure was observed to ensure that the ratings validations were not biased by these considerations.

The process followed for the 1999/2000 evaluation round differed from the 1998/1999 round in that surveys were completed via a telephone interview rather than a mailed out questionnaire. This aspect of the research methodology was changed to ensure a more complete collection of data occurred.

THE MENTAL HEALTH SERVICES' EVALUATION SUBMISSIONS

From the perspective of the Adult Mental Health Services the preparation of the evaluation submission involved the completion of a questionnaire about service activities. The questionnaire used in the 1999/2000 evaluation round was exactly the same as that used in the 1998/1999 round. The questionnaire included ratings of the extent to which certain activities have been pursued by the service. In this sense it was a self-rating exercise. The evaluation questionnaire required the provision of some supporting detail (to a strict maximum of 200 words for each item) and some supporting documentation if relevant. The completed questionnaire and the supporting documentation formed the evaluation submission.

The evaluation submissions prepared by services were validated by an Independent Expert Panel. The Panel considerations involved a validation of the answers provided by the services to the questions posed in their submission documentation. This was not meant to "catch out" services but to provide credibility to the process to ensure that professional and community expectations were met concerning the propriety and independence of the evaluation procedures. In 34 out of the 35 services, the Independent Expert Panel ratified the ratings provided by services in the submissions. This procedure ensured a communality of approach in the answering of the evaluation questions across services.

The consultants were not involved in the evaluation of the service submissions. This meant that the consultants could act as resource and support people to the services to assist with the production of their submissions. It is important to understand that the relationship

between the consultants and the services was one in which the consultants had the objective of assisting, not judging, services.

The following sources of information were used to support service submissions.

- policies and procedures
- information brochures/ pamphlets
- clinical guidelines
- program planning documentation
- program evaluation documentation
- quality assurance initiative documentation
- research/ evaluation proposals and reports
- staff position descriptions
- community development documentation
- agency liaison documentation/ records
- training initiatives/ plans
- educational tools/ professional and development activities
- organisational charts
- annual reports
- referral records
- Minutes of meetings etc.

THE JUVENILE JUSTICE AND CHILD PROTECTION EVALUATION SUBMISSIONS

From the perspective of Juvenile Justice and Child Protection Services, the preparation of their submissions consisted of the completion of the evaluation questionnaire via a telephone interview. The questionnaire did not seek supporting documentation as it was designed to elicit opinions about current service delivery arrangements. The survey responses were not viewed by the Independent Expert panel whose sole task was to validate the CAMHS and AMHS submissions.

OPERATION OF THE INDEPENDENT EXPERT PANEL

The Independent Expert Panel members for the 1999/2000 evaluation round were identical to the 1998/1999 round. The panel consisted of Professor Lerma Ung, School of Nursing, Deakin University, Professor Alun Jackson, Head of the School of Social Work, University of Melbourne and Dr. Susan Paxton, School of Psychology, University of Melbourne.

Professor Lerma Ung is Professor Nursing at Deakin University. Professor Ung has extensive international experience in the delivery of clinical services across the health and human services sector and in the evaluation of service quality.

Professor Alun Jackson is Head of the School of Social Work at the University of Melbourne and is an experienced evaluator of health and human service programs and agencies. Professor Jackson has an extensive publication record in this area and his book in the management of health and human service agencies, now entering its second edition, is a standard text internationally.

Dr. Susan Paxton is an international authority in eating disorders and the mental health of young women. She is a psychologist and Senior Lecturer in the School of Psychology at the University of Melbourne. Dr. Paxton has published extensively in this field and has also practised as a clinical psychologist.

The panel members separately and independently rated service submissions. In the event of disagreement discussions were held to arrive at a common rating. In all but one case, the Panel validated the submissions from the agencies. This was a major improvement on 1998/1999 agency ratings.

SECTION 2

ANALYSIS OF ADULT MENTAL HEALTH SERVICES' RESPONSIVENESS TO STATUTORY CLIENTS, CHILDREN WHO MAY BE AT RISK AND THEIR PARENTS/CARERS RESULTS ON ALL SUB-SCALES AND TOTALS FOR ALL SERVICES FOR 1999/2000

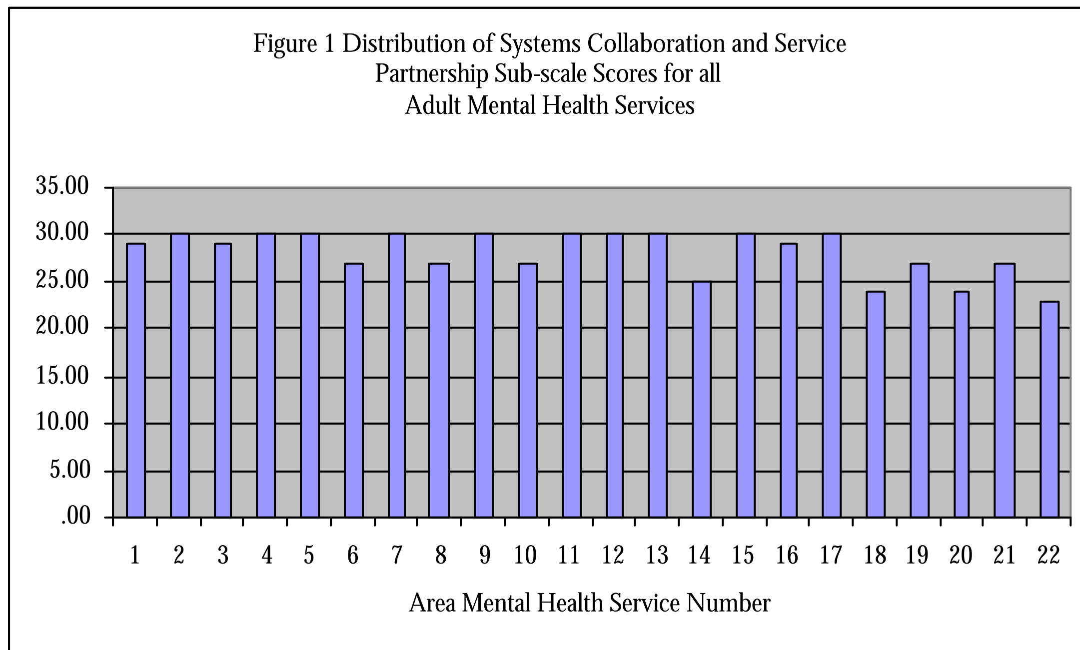
We now turn to a presentation of the results for the panel validated self evaluation task completed by Mental Health Services during the 1999/2000 evaluation round.

Discussion of the analyses of the outcomes of each sub-scale and the AMHS services' responsiveness scale follows. As a courtesy to the reader, the text of the items of the sub-scales are included in each section. The actual format of the assessment tool can be found in the copy of the tool attached to this report.

Systems Collaboration and Service Partnership Sub-scale

Figure 1 shows the frequency distribution of systems collaboration and service partnership sub-scale scores for all services.

Ten services obtained the maximum score possible on this sub-scale of 30 points, suggesting that almost half of the AMHS services had taken comprehensive action towards working collaboratively with other services. Two services also scored highly with 29 points. The lowest scores obtained were 23 points and 24 points.



The mean sub-scale score for all services was 28.1 out of a possible total of 30 with a standard deviation of 2.3.

Collaboration and Partnership Sub-Scale Items Frequency Distributions

Below is the frequency distribution table for the collaboration and partnership sub-scale, indicating the number of services that scored each of the scale ratings (1-5), and including the item mean ratings for both 1999/2000 and 1999/1998 for comparison.

	1999/2000 Number of services to score each rating					1999/ 2000	1998/ 1999
Evaluation Items	No action taken (1)	Docu-mented plan (2)	Piece-meal (3)	System-atic (4)	Compre-hensive (5)	Mean rating	Mean rating
A. Joint service planning meetings are conducted between MHS and Juvenile Justice/ Child Protection agencies concerning provision of services for statutory clients and children who may be at risk and their carers.	0	0	1	5	16	4.68	3.68
B. Key agencies who may have a role in responding to the needs of families when a parent has a mental illness are identified and a staff member has responsibility for coordinating liaison with these agencies.	0	0	0	3	19	4.86	4.14

C. There are local guidelines/ agreements/ protocols which specify collaborative arrangements, management of complaints/ disagreements and information exchange between MHS and Juvenile Justice/ Child Protection Services.	0	0	1	8	13	4.55	3.23
D. Action has been taken to ensure that MHS staff are aware of and understand Child Protection and Juvenile Justice organisational structures and processes.	0	0	1	9	12	4.50	3.41
E. Protocols/ guidelines have been developed to ensure action has been taken so that all clinical staff are aware of notification requirements of Child Protection Services, in accordance with mandatory reporting, in relation to children who may be at risk.	0	0	1	2	19	4.82	4.23
F. The preparation of staff training and development plans has included consideration of working with families when the parent has a mental illness, and the assessment of risk to children.	0	0	2	3	17	4.68	4.05

As shown in the above table, in comparison to the 1998/1999 results, there was an increase in all item mean ratings for the 1999/2000 evaluation period, indicating that most services had applied either systematic or comprehensive action to address the criterion of this sub-scale.

The items with the least satisfactory levels of performance were Items C (protocols which specify collaborative arrangements/information exchange between MHS & JJ/CP) and D (understanding of JJ & CP organisational structures). Items C and D were also the items that scored the lowest means for the 1998/1999 evaluation.

The items within this sub-scale upon which services performed best overall were Items B (key agencies identified) and E (clinical staff aware of notification requirements). Item B was the highest scoring item and Item E was the second highest scoring item in the whole evaluation for the 1999/2000 period. Item E was also the best performing item in the 1998/1998 evaluation.

Thus, while protocols have been developed in most instances to document notification requirements of Child Protection services, there is still a need for guidelines which outline the arrangements and information exchange between MHS and Juvenile Justice/ Child

Protection as well as an overall awareness by MHS of the way Juvenile Justice/ Child Protection is organised and the processes they follow.

Service planning sub-scale

Figure 2 shows the frequency distribution of service planning sub-scale scores for all services.

For this sub-scale, eight services achieved the maximum score possible of 15 points. Four services followed closely behind on a score of 14 points. On the lower end of the score spectrum were scores of 10 and 11 points. However, these lower scores were still approximately two thirds of the maximum score possible.

Figure 2 Distribution of Service Planning Sub-scale Scores
for all Adult Mental Health Services

16.00
14.00
12.00
10.00
8.00
6.00
4.00
2.00
.00

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22

Area Mental Health Service Number

The mean service planning sub-scale score for all services was 13.5 out of a possible total of 15 with a standard deviation of 1.5.

Service Planning Item Sub-Scale Items Frequency Distributions

Below is the frequency distribution table for the service planning sub-scale, indicating the number of services that scored each of the scale ratings (1-5), and including the item mean ratings for both 1999/2000 and 1999/1998 for comparison.

	1999/2000 Number of services to score each rating					1999/ 2000	1998/ 1999
Evaluation Items	No action	Docu-mented	Piece-meal	System-atic	Compre -	Mean	Mean

	taken (1)	plan (2)	(3)	(4)	hensive (5)	rating	rating
A MHS has a service plan or strategy developed that includes plans for improving collaboration with Child Protection/ Juvenile Justice services to meet the needs of statutory clients and children who may be at risk and their carers.	0	0	2	8	12	4.45	3.05
B Service data illustrating the profile of current clients who are parents of dependent children and highlighting the key characteristics of this client group is available and can be collated at regular intervals for service planning.	0	0	0	12	10	4.45	3.45
C. Specific initiatives targeted to the needs of parents with a mental illness and children who may be at risk have been planned/ introduced	0	0	3	2	17	4.64	4.18

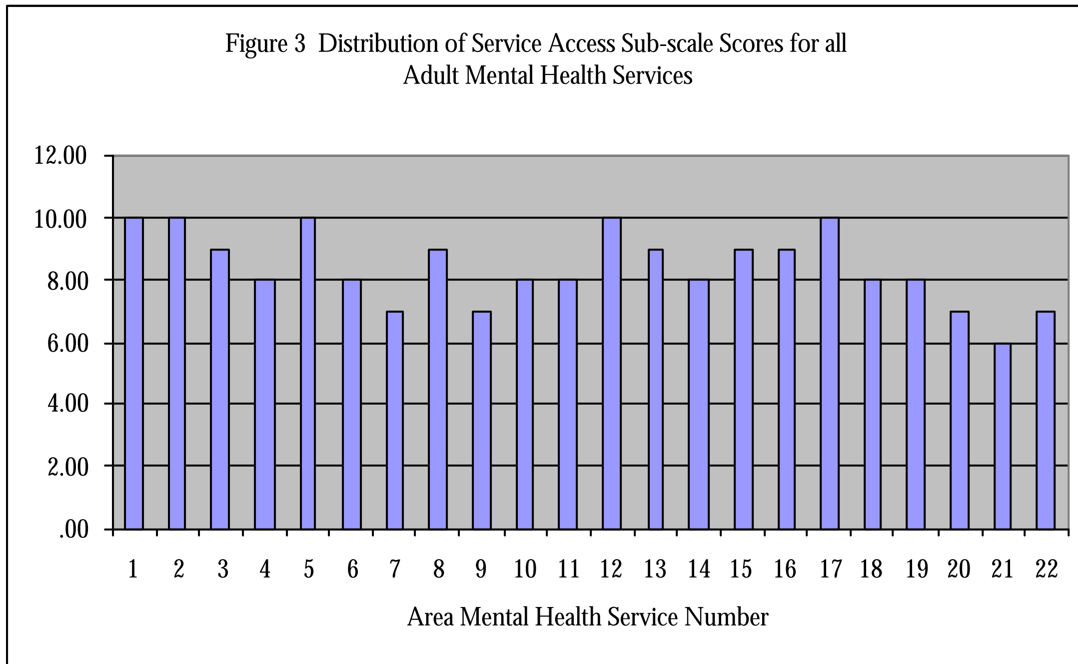
As shown in the table above, compared to the 1998/1999 year's evaluation results, each item mean rating had increased for the 1999/2000 period. Items A and B had increased by more than one point over last year's results, indicating that there has been a shift from piecemeal/systematic action, to systematic/comprehensive action for each of these items.

The item that performed best on this sub-scale for the 1999/2000 evaluation was Item C (initiatives targeted to needs of parents with a mental illness and children at risk). This was reflected in the multitude of initiatives that AMHS had introduced during the 1999/2000 period which were aimed at improving responsiveness to the specific needs of parents with a mental illness and the recognition of the needs of the dependent children of those parents.

Service access sub-scale

Figure 3 shows the frequency distribution of service access sub-scale scores for all services.

Five services scored the maximum score possible for this sub-scale of 10 points. Five services also scored highly with a score of nine points. The lowest score obtained by a service on this sub-scale was six points, followed closely by three services with scores of seven points each.



The mean value for the service access sub-scale was 8.4 out of a possible total of 10 with a standard deviation of 1.2.

Service Access Sub-Scale Items Frequency Distributions

Below is the frequency distribution table for the service access sub-scale, indicating the number of services that scored each of the scale ratings (1-5), and including the item mean ratings for both 1999/2000 and 1999/1998 for comparison.

	1999/2000 Number of services to score each rating					1999/ 2000	1998/ 1999
Evaluation Items	No action taken (1)	Docu-mented plan (2)	Piece-meal (3)	System-atic (4)	Compre-hensive (5)	Mean rating	Mean rating
A. The Mental Health Service has disseminated information to local Child Protection and Juvenile Justice Services about how to make referrals to them in relation to: • Parents with a mental illness with children who may be at risk • Parents of Statutory clients • Older Statutory Clients (17-21 years)	0	0	2	8	12	4.45	3.27
B. The Mental Health Service has data available about referrals made							

from Juvenile Justice/ Child Protection in relation to: • Parents with a mental illness with children who may be at risk • Parents of Statutory clients • Older Statutory Clients (17-21 years)	1	0	5	9	7	3.95	3.00

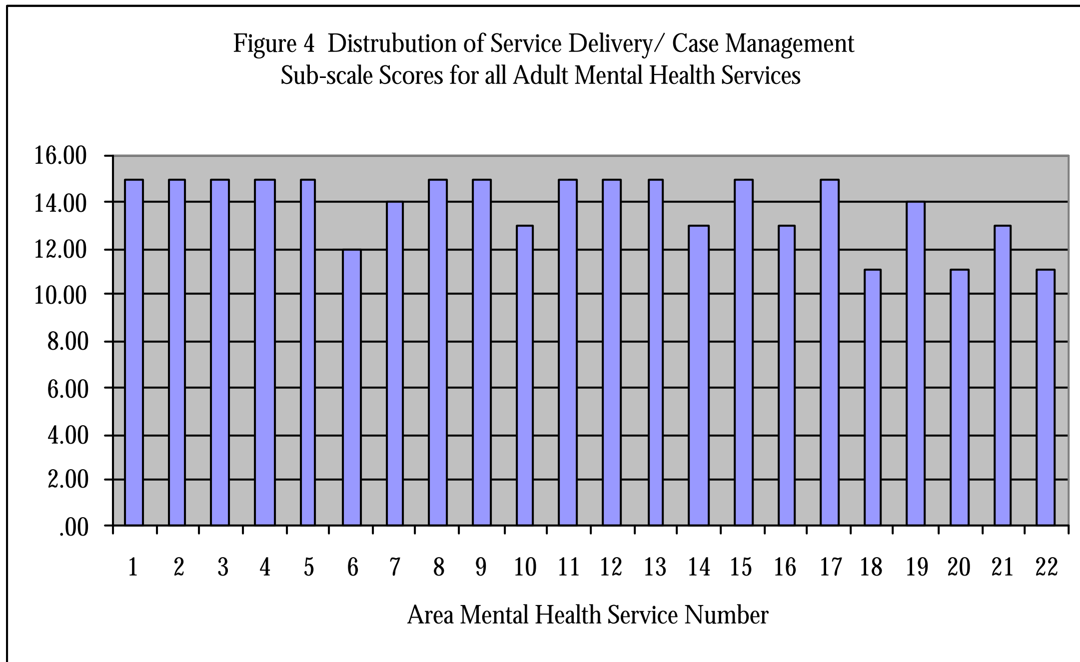
Overall the performance of services on the two items of the service access sub-scale was not strong relative to the item ratings across the whole evaluation. As with the other sub-scales, however, there had been an increase in the item mean ratings over the 1998/1999 evaluation results.

Item B (referral data available) was the lowest scoring item of the entire 1999/2000 evaluation. Five out of the 22 services had only addressed the criteria of Item B with piecemeal or one-off activities, and one service had taken no action at all, thus suggesting the need for improved data collection and reporting of referrals.

Service Delivery/ Case Management Sub-scale

Figure 4 shows the frequency distribution of service delivery/ case management sub-scale scores for all services.

In general services scored well on this sub-scale. A total of 12 services obtained the maximum score possible for this sub-scale of 15 points. In addition, two services scored a total of 14 points. The lowest score obtained was 11 points by three services.



The mean score for the service delivery/case management sub-scale was 13.9 out of a possible total of 15 with a standard deviation of 1.5.

Service Delivery Case Management Sub-Scale Items Frequency Distributions

Below is the frequency distribution table for the service delivery/ case management sub-scale, indicating the number of services that scored each of the scale ratings (1-5), and including the item mean ratings for both 1999/2000 and 1999/1998 for comparison.

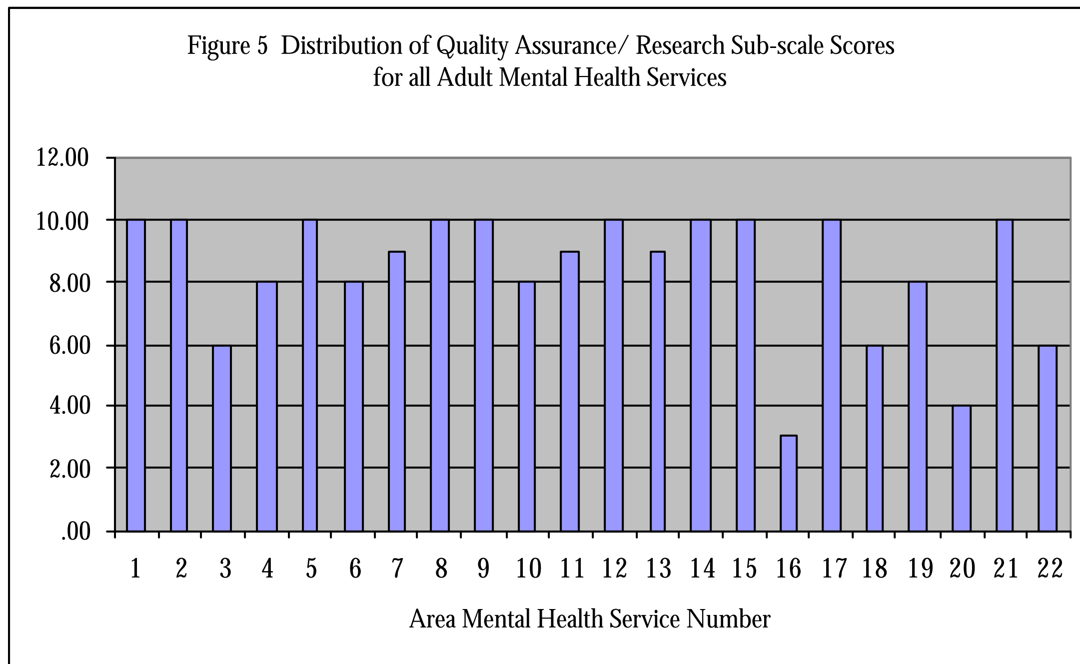
	1999/2000 Number of services to score each rating					1999/ 2000	1998/ 1999
Evaluation Items	No action taken (1)	Docu-mented plan (2)	Piece-meal (3)	System-atic (4)	Compre-hensive (5)	Mean rating	Mean rating
A. MHS staff routinely participate in inter-agency case conferences around the needs of: • Protective services clients whose parent/carer is a client of the Mental Health Service • Juvenile Justice clients who are also clients of the Mental Health Service	0	0	1	7	14	4.59	4.18
B. MHS case managers notify and consult with Juvenile Justice/ Child Protection services/workers according to a documented protocol when case closure is to occur for clients who are parents of statutory clients or children who may be at risk.	0	0	1	7	14	4.59	3.86
C. The Mental Health Service has identified and implemented intervention strategies/ innovative programs to meet the needs of parents with a mental illness and with children who are statutory clients or may be at risk.	0	0	2	3	17	4.68	4.18

As shown in the above table, compared to the 1998/1999 evaluation results, the 1999/2000 results showed an increase of approximately half a point for each item indicating that there had been a small improvement since last year's evaluation.

Item C (intervention strategies/innovative programs identified & implemented) was the highest scoring item mean for this sub-scale. This item was also the equal third highest scoring item for the entire 1999/2000 evaluation (along with Item F from the collaboration and partnership sub-scale) and had been the equal second highest item rating in the evaluation overall for 1998/1999, indicating a relatively high level of performance in these activities.

Quality Assurance/ Research Sub-scale

Figure 5 shows the frequency distribution of quality assurance/ research sub-scale scores for all services. While ten services achieved the maximum possible of 10 points on this sub-scale, the other services were widely distributed. Next, three services scored 9 points, four services scored 8 points, and three services scored 6 points. The lowest scores obtained for this sub-scale were 3 and 4 points.



The mean score for the quality assurance/research sub-scale ratings was 8.4 out of a possible total of 10 with a standard deviation of 2.1.

Quality Assurance/ Research Sub-Scale Items Frequency Distributions

Below is the frequency distribution table for the quality assurance/research sub-scale, indicating the number of services that scored each of the scale ratings (1-5), and including the item mean ratings for both 1999/2000 and 1999/1998 for comparison.

	1999/2000 Number of services to score each rating					1999/ 2000	1998/ 1999
Evaluation Items	No action taken (1)	Docu-mented plan (2)	Piece-meal (3)	System-atic (4)	Compre-hensive (5)	Mean rating	Mean rating
A. There is evidence that the needs of parents with a mental illness with children who may be	0	2	2	5	13	4.32	3.05

statutory clients or may be at risk have been considered in QA activities.							
B. Research/needs analyses/service utilisation studies on the needs of parents with mental illness with children who may be statutory clients or may be at risk is being undertaken.	1	2	4	3	12	4.05	2.73

Although some services scored well on the quality assurance/research sub-scale, this sub-scale, along with the service access sub-scale, was the one on which AMHS performed the equal worst, with the system wide mean per cent of the possible total being 84 per cent. There was, however, a considerable increase for the item means of both items on this sub-scale from the 1998/1999 evaluation results.

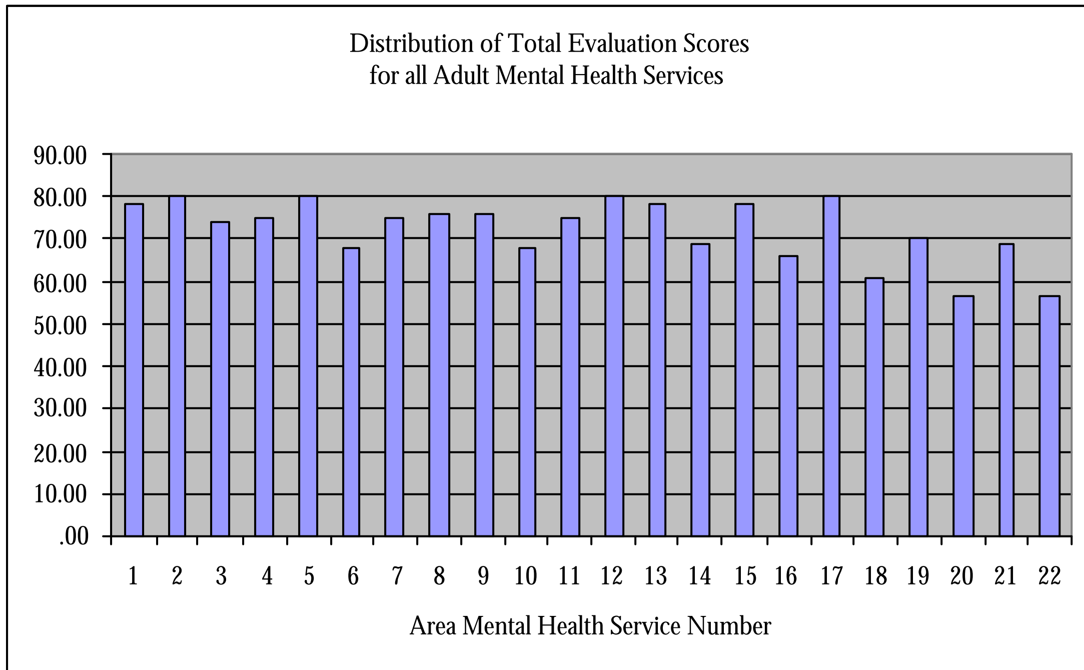
The item that scored the second lowest mean rating in the whole evaluation for 1999/2000 was Item B (research/ needs analysis of target group undertaken) of this sub-scale. This item was the lowest scoring item in the whole evaluation for the previous year's results.

Therefore, quality assurance/ research is still an area upon which many Adult Mental Health Services will need to focus their attention.

Total Scores

The total scores comprise the summed scores on all items.

Figure 6 shows the frequency distribution of total evaluation scores for all services. Four services scored the maximum score possible for the entire evaluation of 80 points which was an excellent effort. Three services also scored highly with 78 points. The lowest scores obtained for the evaluation was 57 points by two services.



The mean score for the total evaluation score was 72.3 out of a possible total of 80 with a standard deviation of 7.2.

Summary of Quantitative Results

The quantitative rating component of the Mental Health Service evaluation task resulted in generally strong performance profiles for Adult Mental Health Services. A summary of the descriptive statistics associated with each of the evaluation tools sub-scales follows for the 1999/2000 evaluation round and includes the 1998/1999 system-wide percentage of maximum scores possible for each sub-scale for comparison.

	1999/2000					1998/99
Evaluation sub-scale	System-wide mean	Minimum score Achieved	Maximum score achieved	Maximum possible score	System-wide % of maximum score possible	System-wide % of maximum score possible
Systems Collaboration and Service Partnership	28.1	23	30	30	94%	76%
Service Planning	13.5	10	15	15	90%	71%
Service Access	8.4	6	10	10	84%	62%
Service Delivery/ Case Management	13.9	11	15	15	93%	81%
Quality Assurance and Research	8.4	3	10	10	84%	58%
TOTAL	72.3	57	80	80	90%	73%

In relative terms, for the 1999/2000 evaluation, the systems collaboration and service partnership sub-scale was shown to have the strongest results, with the system-wide mean being 94 per cent of the maximum score possible for that sub-scale. The service delivery/ case management sub-scale followed closely behind with 93 per cent of the maximum score possible for that sub-scale. At the lower end of the results, the service access and quality assurance and research sub-scales were shown to have the least strong results, with their

system wide means being 84 per cent of the possible maximum score for the respective sub-scales.

In comparison with the 1998/1999 results, an overall absolute improvement of 17 per cent was found in the system-wide percentage of maximum total evaluation score possible for the 1999/2000 results. In terms of individual sub-scale improvements, the quality assurance and research sub-scale saw the greatest improvement over last year's evaluation results. The 1999/2000 system-wide percentage of the maximum score possible for this sub-scale rose by 26 per cent over the 1998/1999 percentage. All other 1999/2000 sub-scale percentages rose by a magnitude in the range of 12 to 22 per cent.

Several services achieved the maximum sub-scale score possible for individual sub-scales. Ten services achieved this for systems collaboration and services partnership, eight for service planning, five for service access, twelve for service delivery/case management and ten for quality assurance and research. Overall, four services achieved the maximum score possible for the 1999/2000 total evaluation.

A detailed analysis of the outcomes for each item within the various sub-scales as well as the outcomes for the sub-scales is provided within this report. The items with the best system wide outcomes were:

> Systems collaboration and service partnership – Item B
> "Key agencies who may have a role in responding to the needs of families when a parent has a mental illness are identified and a staff member has responsibility for coordinating liaison with these agencies."
>
> Systems collaboration and service partnership – Item E
> "Protocols/ guidelines have been developed to ensure action has been taken so that all clinical staff are aware of notification requirements of Child Protection Services, in accordance with mandatory reporting, in relation to children who may be at risk."

The items with the least satisfactory system wide performance were:

> Service access – Item B
> "The Mental Health Service has data available about referrals made from Juvenile Justice/ Child Protection in relation to:
> - -Parents with a mental illness with children who may be at risk
> - -Parents of Statutory clients
> - -Older Statutory Clients (17-21 years)."
>
> Quality assurance/ research – Item B
> "Research/needs analyses/service utilisation studies on the needs of parents with mental illness with children who may be statutory clients or may be at risk is being undertaken."

A summary of all sub-scale scores broken down by service appears on the following page.

AMHS SUB-SCALE TOTALS 2000 SUMMARY TABLE

ID code	AMHS	Systems Collaboration and Service Partnership Sub-scale Total	Service Planning Sub-scale Total	Service Access Sub-scale Total	Service Delivery/ Case Management Sub-scale Total	Quality Assurance and Research Sub-scale Total	Total Score
1	Service 1	29	14	10	15	10	78
2	Service 2	30	15	10	15	10	80
3	Service 3	29	15	9	15	6	74
4	Service 4	30	14	8	15	8	75
5	Service 5	30	15	10	15	10	80
6	Service 6	27	13	8	12	8	68
7	Service 7	30	15	7	14	9	75
8	Service 8	27	15	9	15	10	76
9	Service 9	30	14	7	15	10	76
10	Service 10	27	12	8	13	8	68
11	Service 11	30	13	8	15	9	75
12	Service 12	30	15	10	15	10	80
13	Service 13	30	15	9	15	9	78
14	Service 14	25	13	8	13	10	69
15	Service 15	30	14	9	15	10	78
16	Service 16	29	12	9	13	3	66
17	Service 17	30	15	10	15	10	80
18	Service 18	24	12	8	11	6	61
19	Service 19	27	13	8	14	8	70
20	Service 20	24	11	7	11	4	57
21	Service 21	27	13	6	13	10	69

22	Service 22	23	10	7	11	6	57

Initiatives and Strategies

In their evaluation submissions, Mental Health Services described a wide range of initiatives targeted at meeting the needs of statutory clients, children who may be at risk and their parents/ carers. The initiatives varied in status from well established to being in their formative stages.

During the 1999/2000 evaluation round there was substantial activity surrounding the formation of working groups and committees in response to the Working Together Strategy. Across each of the Child and Adolescent Services as well as the Adult Mental Health Services, there appeared to be a strong emphasis on building collaborative links with Child Protection and Juvenile Justice as well as other agencies and community groups.

Another focus for many AMHS was the recognition that although their primary clients were adults with a mental illness, consideration of the needs of the dependent children of their clients was also important. This recognition was reflected in the incorporation of dependents' information within individual service plans and on client data bases, as well as staff training courses and programs run on this topic.

Some of the individual service responses to meeting the needs of the target group included the following:

- The appointment of additional staff such as a Quality Improvement Coordinator and Referral Data Project Officer.
- Implementation of a new documentation system (ACE) which aids the thorough collection and documentation of relevant information to cases
- Introduction of a parenting education sessions and suicide information programs
- The compilation and distribution of Juvenile Justice and Child Protection information kits throughout a region.

SECTION 3

RESPONSES TO SURVEY QUESTIONNAIRES

All Regional Juvenile Justice and Child Protection Regional managers were interviewed by telephone using the questionnaire that appears as an appendix to this document.

Juvenile Justice (JJ) and Child Protection (CP) were asked to provide input concerning their relationships with the Mental Health Services. Because the units are regionally based this means that their interactions are with one or perhaps two Mental Health Services in both the Adult and Child and Adolescent Area. Separate evaluation information was obtained for each mental health service.

As with the 1998/1999 evaluation round, the 1999/2000 JJ & CP evaluation information was not included in the evaluation scores for Mental Health Services, nor was it taken into consideration for the Quality Incentive Strategy calculations. However, this information provides valuable feedback to services as part of their quality improvement plans and activities. Where this information was available for specific services it has been provided in the individual service reports.

The majority of the input from the JJ & CP services was qualitative in nature. However, they were asked to provide ratings of overall collaboration in relation to statutory clients with each mental health service. These ratings were provided on a four point rating scale with 1= poor, 2= fair, 3=good, 4=excellent. For the entire CAMHS system the rating of collaboration by JJ and CP units was a mean of 2.76 on the four point scale. This compares with a collaboration rating mean by JJ and CP units for the entire AMHS system of 2.30 on the four point scale. Thus both CAMHS and AMHS services were seen on average as falling between fair to good.

In general, and as was the case last year, there was a relatively low level of engagement between AMHS and the JJ and CP Units, and this was reflected in the relatively small number of comments provided about specific mental health services. These service specific comments can be found in the individual service reports for each of the adult mental health services.

The comments that have been included in this section of the Summary Report are the general comments that the Child Protection and Juvenile Justice Managers provided about AMHS overall during the 1999/2000 evaluation round.

The Juvenile Justice and Child Protection respondents were asked a series of questions concerning their relationship with Adult Mental Health Services. The questions asked were:

Do you have any comments on the **collaboration** (e.g. joint meetings, involvement in training, shared development of Individual Service Plans) you have had with Adult Mental Health Services in relation to statutory clients?

Do you have any comments on **service access** for statutory clients for Adult Mental Health Services (e.g. processing of referrals, documentation of acceptance criteria, secondary consultation)?

Do you have any comments on **service delivery and case management** for statutory clients in Adult Mental Health Services (e.g. case conferences, appropriate service delivery methods)?

What are the **best things** about the response of Adult Mental Health Services to the needs of statutory clients, children who may be at risk and their carers?

What are the **worst things** about the response of Adult Mental Health Services to the needs of statutory clients, children who may be at risk and their carers?

What would **strengthen your working relationship** with Mental Health Services?

The responses to these questions have been subjected to a thematic analysis in order to provide a comprehensive overview of the responses of the respondents. Comments about individual services are presented in the individual service reports. The themes discovered by the thematic analysis were the following:

Collaboration:
- AMHS' collaboration in developmental stages

Service Access:
- CP & JJ's limited need for access to adult mental health services
- Difficulty in access to AMHS for 17-20 year olds

Service Delivery and Case Management:
- Need for more collaboration from AMHS in joint case work
- CP & JJ's limited but positive experience with the adult services

Best Things:
- AMHS' willingness to work collaboratively
- AMHS' knowledge of mental health

Worst Things:
- Difficulty of access to AMHS for high-risk and 17-20 year olds
- AMHS' lack of flexibility in treatment model
- Lack of resources (staff)
- Different perspective of who the client is (AMHS – parent; CP & JJ – child)

- AMHS not understanding issues of children at risk
- AMHS unwilling to share information

Things that would Strengthen the Relationship:

- More collaboration/ relationship building/ joint training
- Co-location of workers
- Common protocols/ policies/ structures
- Regular meetings
- Communication
- Recognition of 17-20 year olds

These themes are now discussed in detail.

Collaboration

Collaboration in developmental stages

The overall sense of the comments that Child Protection and Juvenile Justice Managers made in relation to the collaboration of AMHS with their services was that this was an area that still required attention and that collaborative links were only in their formative stage.

> "Collaboration is developing. More of a focus on CAMHS but we are broadening it out to AMHS now. Developed a protocol with CAMHS, and now the AMHS are keen to adopt this. Protocol in terms of roles, responsibilities, service parameters, contacts, etc."
>
> "Developing relationships – gaining momentum in doing this."
>
> "The collaboration is not as prominent as with the CAMHS services, albeit AMHS are involved with us and there are some inter working groups including a sponsored forum for the Infant Unit. Recently had more contact from AMHS in relation to setting up more regular meetings especially to do with Infants Unit."
>
> "Probably at a developmental stage. Overall improvement. Client needs have changed. Older clients have increased. Will need to collaborate more as this group is increasing. Good examples of good work done with difficult clients with complex issues."
>
> "Overall patchy."

Service Access

Limited need for access to adult services

A couple of services reported their limited need for the Adult services:

> "Limited in our need for their service. The Protocol document describes how to access services but we haven't needed services really."
>
> "Been fairly limited number of referrals to them."

Difficulty in access for 17-20 year olds

Once again, the issue that was raised during last year's evaluation round, that of the difficulty of placing adolescents in the 17-20 year range, was raised again during the 1999/2000 evaluation round.

> "One issue – they have more restricted criteria for access for older aged clients (ie., those 17 years of age and up)."

> "Gatekeeping is very tight – difficult to get clients especially 17-20 year olds into the service. Acceptance criteria is tight. Response poor for clients at risk of suicide, unless they have other mental health issues. Confusion around substance abuse and assessment and access of dual diagnosis clients. Poor access for clients with personality disorders."

> "Specific difficulty for clients moving into the adult services. There is no smooth transition for chronic clients."

Service Delivery & Case Management

Need for collaboration

The overall flavour of the comments provided by the Child Protection and Juvenile Justice Managers with reference to service delivery and case management was that collaboration between the services needed to improve.

> "There is room for improvement – joint work, exercises at the worker level rather than management level."

> "Not enough consultation or collaborative work that occurs. Few cases have worked well."

> "Limited networking and collaboration with case workers leads to poor responses for most clients."

> "Can be reluctant in some cases to share information which is helpful for managing clients."

Limited but positive experience with the adult services

Whilst many of the comments related to the need for further collaboration for effective service delivery and case management to occur, some Child Protection and Juvenile Managers were unable to comment as they have limited experience with joint service provision with the adult services.

> "Very limited experience with the adult service."

Their limited experience sometimes appeared to be positive none-the-less.

> "Limited referrals, but on those, meetings have been attended, and workers allocated to a case and communication lines kept open."

> "Haven't heard any complaints."

> "Not aware of any particular difficulties."

Best Things

Willingness to work collaboratively

In general, the best thing about AMHS from the perspective of the Child Protection and Juvenile Justice Managers was the willingness of AMHS to work collaboratively and responsively alongside their services in order meet the clients' needs.

> "Willingness to engage."

> "Their willingness to work with statutory clients and their willingness to work collaboratively with us."

> "Community based services – prompt response, shared information, strong awareness of linkages and importance of collaboration."

> "When collaborative practice works, it is very good."

> "In a couple of cases where collaboration has been strong, there have been positive outcomes."

> "That they are there for our clients. They are willing to go out with us to see clients. This has helped a lot to manage and contain potentially disruptive visits when mental issue are involved, reducing the need to call in the police. Much more calm way of doing things."

Mental health knowledge

There were also a couple of comments pertaining to the strength of AMHS being their knowledge of mental health issues and now being more flexible to also consider the needs of the dependent children of parents with a mental illness.

> "Clear understanding of the mental health and psychiatric needs of clients."

> "They're probably beginning to take the issue of the children of parents with mental health issues more seriously."

Other comments

There were a few other brief comments about what was good about AMHS.

> "Communication."

> "New staff position for 14 - 22 year olds."

> "Involvement of some CATs in regional forums for high risk clients."

Worst Things

In spite of the clear improvements that have been made and the many positive comments made about AMHS services, the comments by the Juvenile Justice and Child Protection Managers indicated some areas that still require attention.

Access issues

A key area that was identified as needing improvement within AMHS was the difficulty of gaining access to mental health services across a variety of particular circumstances:

> "Kids on the cusp (~17 years) and access issues are not dealt with appropriately."

> "Ability to access residential services for high risk clients when required."

> "Crisis Access Team (CAT) access. Access criteria regarding what a mental health crisis is. Sometimes an assessment has to wait until the next day. This can have implications for our decisions as to whether to remove the child or not."

Lack of flexibility

Another key area that was identified as needing improvement within AMHS was their lack of flexibility. In particular definitional issues relating to what exactly constitutes a mental health disorder and how to handle at-risk clients.

> "Psychiatrists- restricted psychiatric position and model. Not always willing to be flexible and adopt creative options appropriate to high risk adolescents at risk to themselves and others."
>
> "Some staff come from adult, clinical model which is not appropriate or flexible."
>
> "Narrow definition of mental health."
>
> "Before the Enhanced Client Outcome (ECO), they weren't really willing to come out to visit cases, but this has changed."

The next four themes under the "worst things" had only a few comments under each but were valid points none-the-less.

Lack of Resources

> "Not having enough resourcing, high case loads which impact on quality of response."
>
> "Lack of resources."

Different perspective of who the client is

> "Conflict in terms of philosophy – different perspective about who the client is and the effects our service is having on their clients (parents) and vice versa."

Not understanding children at risk

> "Inability to consider the needs of and risks to the child (from parent)."

"Lack of understanding of risks to children."

Lack of shared information

"Poor communication. Lack of reciprocation – particularly regarding client information sharing. JJ not viewed as a partner."

"Lack of shared information for difficult clients with complex needs."

Things that would Strengthen the Relationship

More collaboration/ joint training/ relationship building

When asked "What would strengthen your working relationship with Mental Health Services?" a large number of the Child Protection and Juvenile Justice Managers' responded with calls for further collaboration, joint training and commitments to relationship building between the services.

"Heaps of money! Used to strengthen relationships and support the initiatives of the Working Together Strategy groups – education, joint training, development of protocols/guidelines, forums on particular issues, involvement in on the ground staff, etc."

"We are working on a lot of things at the moment (training, relationship building), so more of what we are doing at the moment would be good."

"Joint training with all case workers – not right across the board at the moment."

"Develop a more coordinated approach."

"More frequent contact & joint training. Increased collaboration."

"More joint training. Continuing commitment to resolve problems as they become apparent."

Co-location of workers

Another common response was the enthusiasm for a model of shared service provision which incorporates co-located workers. This model allows for increased communication and understanding of each others services and has proven very effective in the regions where this has been implemented.

> "Co-location model works extremely well."
>
> "Co-location would allow everyone to see what everyone does."
>
> "A shared initiative is a proposal to employ a coordinator to organise all of these working together activities but this requires money."
>
> "Co-location of workers."
>
> "We have a regular CAMHS worker who works in at the CP office and this has proven to be an effective method of bringing that service into ours. This type of arrangement could be continued and expanded upon."

Common protocols/ policies/ structures

Another key area that could add strength to the relationship between Mental Health Services and Child Protection and Juvenile Justice is the development of common protocols, policies and even structures across all of the services.

> "A common policy about sharing information. A common mission statement about duty of care."
>
> "There are still structural issues to be resolved – MHS and CP operate from very different structural bases. We are still separate entities but we have made some attempts at building bridges between our services and some headway has been made. We need to keep working on this."
>
> "Collaboration & agreement to a common assessment reference means we are then able to look at complementary interventions and case management plan for clients at risk."
>
> "At the moment we have a very good working relationship with the co-located CAMHS worker, but if she were to leave, I'm not sure how well things would go as there are no formal structures in place. We need to build co-location into the protocol and service structures."

Regular meetings

> "More regular meetings, not just when we are meeting about cases."
>
> "More meetings together – more contact – more ability to talk."
>
> "Continued manager meetings."
>
> "Regular meetings and debriefings between MHS and us."

Communication

> "WTS has been captured by management, but there needs to be some mechanisms for communication and flow of information up and down the hierarchy to those working on the ground. Eg. Community based clinicians had not seen feedback of surveys."
>
> "Improved communication with CAMHS."
>
> "Implementing structural communication systems."

Recognition of 17-20 year olds

> "Developing recognition within AMHS that the 17-20 age group is not fitting the current adult model."
>
> "MHS are good at working with children but not with adolescents. They need to develop their system surrounding youth. Work out their procedures and then communicate them to us."

CONCLUSIONS DRAWN FROM THE SURVEY RESULTS

The comments made by the Child Protection and Juvenile Justice Managers have provided valuable insights into the working relationships and provision of services of the Adult Mental Health Services. In particular, AMHS have been commended for willingness to work collaboratively and their knowledge of the mental health area.

While there is recognition by Child Protection and Juvenile Justice Managers of many positive aspects of service provision by Adult Mental Health Services, there are still some major concerns held by these workers. Similar to last year's evaluation results, there is a desire for AMHS to work even more collaboratively and for the transition of clients from CAMHS to AMHS to be more streamlined. Access for clients aged 17-20 still appears to be problematic. Increased flexibility, resources and the sharing of information would improve this situation from the perspective of the Child Protection and Juvenile Justice Managers.

Many of the Managers' suggestions for the strengthening of relationships between Child Protection and Juvenile Justice follow the underlying principles of the Working Together Strategy. There has been a call for joint relationship building, joint training, the co-location of workers and common protocols to be put in place between all services.

Thus, the survey results provide a useful adjunct to the evaluation outcomes provided by the assessments of service responsiveness reported in Section 2 of this document.

SECTION 4 CONCLUSIONS

This section of the report reflects upon the evaluation with a review of the methodology and final outcomes for 1999/2000.

REFLECTIONS UPON THE EVALUATION

In providing a commentary on the outcomes of and trends within the evaluation outcomes, it is necessary to reflect upon the roles of the various participants within the evaluation process. The Independent Review Panel's role was to review all of the documentary information provided by the Mental Health Services and to arrive at a set of ratings that accurately reflected the relationship between the information provided and the available ratings. Essentially their role was summative[5]. The role of the consultants was to liaise with all services to assist them with the preparation of their documentation. Each service met with the consultants on at least one occasion and some met on several occasions. Although the consultants did not vote in the rating processes, we observed them at close hand. It is, therefore, possible and appropriate for the consultants to provide qualitative information of their detailed observations of trends within the services. This information can be used in a formative fashion. Thus the following observations stem from the consultants' close proximity to the evaluation processes and site visits. They are not observations made on behalf of the Independent Review Panel but are intended to complement the Panel's activities.

REVIEW OF THE EVALUATION METHODOLOGY

The evaluation methodology has functioned very well. The validated self evaluation methodology was very well understood by the participants with there being very little call for amendment of service ratings by the Independent Expert Panel in the second round of the evaluation, and only modest amendments in the first round. The support provided by the consultants to the agencies was well received and used by the participating services in the preparation of their submissions.

The evaluation process has tracked and possibly assisted with the impetus for major improvements in the delivery of services to and responsiveness to the needs of statutory clients, children who may be at risk and their parents/carers. This is particularly pleasing.

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[5] In evaluation, summative assessment is designed to accurately assess the level of the thing being measured on the attribute under assessment. Formative assessment is designed to provide information about how the scores on that attribute might be improved.

REVIEW OF THE EVALUATION OUTCOMES

The 1999/2000 evaluation outcomes for AMHS services validated by the Independent Review Panel activities and the survey responses from Juvenile Justice and Child Protection services both provide important insights into service responsiveness of AMHS services.

In their evaluation submissions, Adult Mental Health Services described a wide range of initiatives targeted at meeting the needs of statutory clients, children who may be at risk and their parents/ carers. The initiatives varied in status from well established to being in their formative stages. During the 1999/2000 evaluation round there was substantial activity surrounding the formation of working groups and committees in response to the Working Together Strategy.

The quantitative rating component of the Mental Health Service evaluation task resulted in generally strong performance profiles for Adult Mental Health Services. In relative terms, for the 1999/2000 evaluation, the systems collaboration and service partnership sub-scale was shown to have the strongest results, with the system-wide mean being 94 per cent of the maximum score possible for that sub-scale. The service delivery/ case management sub-scale followed closely behind with 93 per cent of the maximum score possible for that sub-scale. At the lower end of the results, the service access and quality assurance and research sub-scales were shown to have the least strong results, with their system wide means being 84 per cent of the possible maximum score for the respective sub-scales.

In comparison with the 1998/1999 results, an overall absolute improvement of 17 per cent was found in the system-wide percentage of maximum total evaluation score possible for the 1999/2000 results. In terms of individual sub-scale improvements, the quality assurance and research sub-scale saw the greatest improvement over last year's evaluation results. The 1999/2000 system-wide percentage of the maximum score possible for this sub-scale rose by 26 per cent over the 1998/1999 percentage. All other 1999/2000 sub-scale percentages rose by a magnitude in the range of 12 to 22 per cent.

Thus, the 1999/2000 quantitative validated evaluation scores have shown large improvements from the 1998/1999 levels. This is also reflected in the more positive tenor of the comments made by the Child Protection and Juvenile Justice staff in reflecting upon the responsiveness of the Mental Health Services in meeting the needs of the target client group and their families. In particular, the Juvenile Justice and Child Protection Managers commended AMHS for their willingness to work collaboratively and their knowledge of the mental health area.

There is no doubt that the responsiveness of Adult Mental Health Services has strongly improved during the period of the 1999/2000 evaluation.

We thank all the participants for their contributions to the evaluation.

Dr. Shane Thomas
Ms Jenny Anderson

15 June, 2000

APPENDIX 1

AMHS EVALUATION KIT

THOMAS & ASSOCIATES

1999/ 2000 EVALUATION OF

ADULT MENTAL HEALTHSERVICES' RESPONSIVENESS

TO THE NEEDS OF

STATUTORY CLIENTS, CHILDREN WHO MAY BE AT RISK AND

THEIR PARENTS/ CARERS

This questionnaire with its supporting documentation should be returned by close of business on **March 1, 2000** to:

Prof. Shane Thomas
Thomas & Associates
P.O. Box 584 or 34 Beaver Street
Moonee Ponds VIC 3039 Essendon Vic 3040

Please complete the following contact details:

This document is the response of the following Mental Health Service:

Mental Health Service Name:

If there are any queries about this submission the following person should be contacted:

Mental Health Service Representative Name:

Contact telephone:
Contact fax:

The interim ratings should be sent to the following person:

Name:
Contact telephone:
Contact fax:
Postal Address:

SERVICE OVERVIEW (Limit 500 words)

Please provide an overview of the plans, strategies and activities you have pursued in meeting the needs of statutory clients, children who may be at risk and their parents/ carers within your mental health service with particular emphasis upon those activities conducted within the last 12 months..

On the following pages please provide a self rating for each evaluation item, a short rationale for your rating and details of any documents you may have appended to support your rating. Please refer to the detailed definitions of the 5 point rating scale in the attached document to assist the accuracy of your ratings.

SYSTEMS COLLABORATION AND SERVICE PARTNERSHIP

Collaboration and Partnership Subscale Item A	Joint service planning meetings are conducted between MHS and Juvenile Justice/ Child Protection agencies concerning provision of services for statutory clients and children who may be at risk and their carers
Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

Collaboration and Partnership Subscale Item B	Key agencies who may have a role in responding to the needs of families when a parent has a mental illness are identified and a staff member has responsibility for coordinating liaison with these agencies
Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

Collaboration and Partnership Subscale Item C	There are local guidelines/ agreements/ protocols which specify collaborative arrangements, management of complaints/ disagreements and information exchange between MHS and Juvenile Justice/ Child Protection Services
Rating descriptor	**Your rating(please tick one box)**
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

Collaboration and Partnership Subscale Item D	Action has been taken to ensure that MHS staff are aware of and understand Child Protection and Juvenile Justice organisational structures and processes
Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

Collaboration and Partnership Subscale Item E	Protocols/ guidelines have been developed to ensure action has been taken so that all clinical staff are aware of notification requirements of Child Protection Services, in accordance with mandatory reporting, in relation to children who may be at risk
Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

Collaboration and Partnership Subscale Item F	The preparation of staff training and development plans has included consideration of working with families when the parent has a mental illness, and the assessment of risk to children.
Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

SERVICE PLANNING

Service Planning Subscale Item A	MHS has a service plan or strategy developed that includes plans for improving collaboration with Child Protection/ Juvenile Justice services to meet the needs of statutory clients and children who may be at risk and their carers
Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

Service Planning Subscale Item B	Service data illustrating the profile of current clients who are parents of dependent children and highlighting the key characteristics of this client group is available and can be collated at regular intervals for service planning
Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

Service Planning Subscale Item C	Specific initiatives targeted to the needs of parents with a mental illness and children who may be at risk have been planned/ introduced
Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

SERVICE ACCESS

Service Access Subscale Item A	The Mental Health Service has disseminated information to local Child Protection and Juvenile Justice Services about how to make referrals to them in relation to: -Parents with a mental illness with children who may be at risk -Parents of Statutory clients -Older Statutory Clients (17-21 years)
Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

Service Access Subscale Item B	The Mental Health Service has data available about referrals made from Juvenile Justice/ Child Protection in relation to: -Parents with a mental illness with children who may be at risk -Parents of Statutory clients -Older Statutory Clients (17-21 years)

Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

SERVICE DELIVERY/ CASE MANAGEMENT

Service Delivery/ Case Management Subscale Item A	MHS staff routinely participate in inter-agency case conferences around the needs of: -Protective services clients whose parent/carer is a client of the Mental Health Service -Juvenile Justice clients who are also clients of the Mental Health Service
Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

Service Delivery/ Case Management Subscale Item B	MHS case managers notify and consult with Juvenile Justice/ Child Protection services/workers according to a documented protocol when case closure is to occur for clients who are parents of statutory clients or children who may be at risk.

Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

Service Delivery/ Case Management Subscale Item C	The Mental Health Service has identified and implemented intervention strategies/ innovative programs to meet the needs of parents with a mental illness and with children who are statutory clients or may be at risk.
Rating descriptor	**Your rating(please tick one box)**
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

QUALITY ASSURANCE/ RESEARCH

Quality Assurance/ Research Subscale Item A	There is evidence that the needs of parents with a mental illness with children who may be statutory clients or may be at risk have been considered in QA activities.
Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

Quality Assurance/ Research Item B	Research/needs analyses/service utilisation studies on the needs of parents with mental illness with children who may be statutory clients or may be at risk is being undertaken.
Rating descriptor	Your rating(please tick one box)
1. No action taken and no documented plan for addressing the criterion	
2. Documented plan in place for addressing the criterion but no action taken	
3. Criterion met by piecemeal or one off activities	
4. Systematic action taken to address the criterion but limited in scope	
5. Action taken to meet the criterion which is comprehensive and involves the service as whole	
Details of documents attached	

SUPPORTING COMMENTS
(Limit 200 words)

REFLECTIONS UPON SERVICE STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS (Limit 500 words total for all three)

What do you consider to be the best things about your service in relation to the provision of services to statutory clients?

What do you consider to be the worst things about your service in relation to the provision of services to statutory clients?

What do you consider to be the best areas of opportunity for improvements in your provision of services to statutory clients?

APPENDIX 2

SURVEY FORM USED WITH JUVENILE JUSTICE AND CHILD PROTECTION UNITS

EVALUATION OF CHILD AND ADOLESCENT, AND ADULT MENTAL HEALTH SERVICES' RESPONSIVENESS TO THE NEEDS OF STATUTORY CLIENTS, CHILDREN WHO MAY BE AT RISK AND THEIR CARERS 1999/2000

SURVEY RESPONSE FORM FOR JUVENILE JUSTICE AND CHILD PROTECTION UNITS

Please confirm your regional details:

Region:	
Unit Type:	
Respondent's Name:	
Position:	
Address:	
Phone No:	
Fax No:	

Please confirm the names of the Child and Adolescent and Adult Mental Health Services in your area:

Name(s) of CAMHS		Name(s) of AMHS	
Service 1		Service 1	
Service 2		Service 2	
Service 3		Service 3	

Overall, how would you rate the **collaboration** (e.g. joint meetings, involvement in training, shared development of Individual Service Plans) you have had with each service in relation to statutory clients? (Please complete for each service).

CAMHS	Poor	Fair	Good	Excellent	Not Applicable
CAMHS Service 1	❐	❐	❐	❐	❐
CAMHS Service 2	❐	❐	❐	❐	❐
CAMHS Service 3	❐	❐	❐	❐	❐
AMHS					
AMHS Service 1	❐	❐	❐	❐	❐
AMHS Service 2	❐	❐	❐	❐	❐
AMHS Service 3	❐	❐	❐	❐	❐

COLLABORATION:

Do you have any comments on the **collaboration** (e.g. joint meetings, involvement in training, shared development of Individual Service Plans) you have had with **Child and Adolescent Mental Health Services** in relation to statutory clients?

Comments on Service 1	Comments on Service 2	Comments on Service 3
Overall comments		

Do you have any comments on the **collaboration** (e.g. joint meetings, involvement in training, shared development of Individual Service Plans) you have had with **Adult Mental Health Services** in relation to statutory clients?

Comments on Service 1	Comments on Service 2	Comments on Service 3
Overall comments		

SERVICE ACCESS:

Do you have any comments on **service access** for statutory clients for **Child and Adolescent Mental Health Services** (e.g. processing of referrals, documentation of acceptance criteria, secondary consultation)?

Comments on Service 1	Comments on Service 2	Comments on Service 3
Overall comments		

Do you have any comments on **service access** for statutory clients for **Adult Mental Health Services** (e.g. processing of referrals, documentation of acceptance criteria, secondary consultation)?

Comments on Service 1	Comments on Service 2	Comments on Service 3
Overall comments		

SERVICE DELIVERY & CASE MANAGEMENT:

Do you have any comments on **service delivery and case management** for statutory clients in **Child and Adolescent Mental Health Services** (e.g. case conferences, appropriate service delivery methods)?

Comments on Service 1	Comments on Service 2	Comments on Service 3
Overall comments		

Do you have any comments on **service delivery and case management** for statutory clients in **Adult Mental Health Services** (e.g. case conferences, appropriate service delivery methods)?

Comments on Service 1	Comments on Service 2	Comments on Service 3
Overall comments		

REFLECTIONS UPON SERVICE STRENGTHS, WEAKNESSES AND OPPORTUNITIES:

What are the **best things** about the response of **Child and Adolescent Mental Health Services** to the needs of statutory clients, children who may be at risk and their carers?

What are the **best things** about the response of **Adult Mental Health Services** to the needs of statutory clients, children who may be at risk and their carers?

What are the **worst things** about the response of **Child and Adolescent Mental Health Services** to the needs of statutory clients, children who may be at risk and their carers?

What are the **worst things** about the response of **Adult Mental Health Services** to the needs of statutory clients, children who may be at risk and their carers?

What would **strengthen your working relationship** with Mental Health Services?

THANK THE RESPONDENT FOR THEIR TIME.