

***Health Status and Outcomes in
Victoria's Mental Health Services***

February 1999

**Aged, Community and Mental Health
Department of Human Services**

Acknowledgments

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Introduction

The Mental Health Outcomes Project

Mental health services in Victoria have undergone significant change over recent years resulting in a redeveloped service system with a clearly articulated structure and a strong focus on community-based services. Service provision is supported by new management arrangements and a consistent case management framework.

Mental health services are increasingly turning their attention towards developing systems that drive and ensure higher quality services and better outcomes for consumers and carers.

The aim of the Mental Health Outcomes Project is to develop a suite of outcome measures for clients of public mental health services. This discussion paper specifically addresses the mental health services for adults (aged 16–64). Separate discussion papers will be developed for other age groups.

From the start, the development of outcome measures has occurred in consultation with consumers and carers and in collaboration with the field. A reference group was convened in September 1997, with its membership drawn from a range of stakeholders (Appendix 1).

This Discussion Paper has been developed in partnership with the reference group and aims to provide a basis for wider consultation with consumers, carers and other interested parties on the suite of measures which is proposed for adult mental health services. An overview of the proposed 'suite' can be found in Appendix 2; the measures are described in detail in the paper itself.

Feedback on this Discussion Paper is sought prior to finalising the Outcome Measurement Implementation Strategy. It would be appreciated if you could consider this Discussion Paper and provide any feedback by ***Friday 26 March 1999***.

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A Commitment to Quality

The impetus for measuring outcomes in public mental health services comes from a number of sources. It is underpinned by the Victorian State Government's principles for service delivery as follows:

- To put people first, rather than institutions or systems
- To ensure a fairer distribution of limited resources
- To obtain value for taxpayers' funds
- To provide a better health status and outcome for all Victorians.

The focus upon consumers and the commitment to quality are the dual imperatives underpinning these principles. This has a number of implications for outcome measurement. Putting people first means ensuring that their needs are met and also involving them in making that assessment. Consumers of mental health services need to have the opportunity to be actively involved in the design, planning, delivery and evaluation of services. The principles also imply that, if consumers are entitled to expect the best from their service provider, it is essential that consumers and their carers (and the Department of Human Services as the purchaser of services on their behalf) are well-informed about their services' clinical practice.

Measuring outcomes can only realistically be done by comparing consumers' health status over time. Collecting additional information about individual consumers is crucial for the purposes of developing a quality service but may give rise to concerns about confidentiality. These concerns will be addressed through stringent information management protocols.

It is important that routine outcome measurement is implemented in mental health services in a spirit of partnership with all stakeholders. This paper describes the ways in which outcome measurement will be of benefit to consumers, carers, clinicians, managers and planners. The Department is keen for the proposed uses of outcome measurement to be critically tested during (and beyond) the period of public consultation. The Department will continue to seek input from consumers and carers. The dialogue with clinicians will continue, to ensure that outcome measurement is seen as a core component of their work, which can enrich rather than intrude on clinical practice. Liaison with service providers will occur in order to develop an implementation strategy which addresses local needs in the areas of education, training, data entry and analysis.

These are some of the challenges which need to be met in order to implement successful outcome measurement and it is important to acknowledge that its implementation will be a developmental process, with continuing improvement over time.

Some Key Concepts Defined

A range of measures of various levels of sophistication have been developed over time in order to meet the needs of clinicians, managers, and administrators for monitoring and evaluation of mental health care.

Inputs

are the resources provided such as numbers of staff, buildings, numbers of beds. While easy to measure, there is a poor relationship between inputs and service activity, quality of care or health outcomes. Comparison between services based on inputs will provide little information about the quality of the service provided.

Outputs

are the products or services produced such as numbers of admissions or community contacts, numbers of occupied bed days, length of stay. These activity measures reflect met demand, but give little indication of need, quality of service provided or health outcomes. For example, growth in inpatient admissions may be due to greater numbers of readmissions, growth in the local catchment population, or less than optimal functioning of community-based services.

Outcomes

are 'results or visible effects'. Outcomes are measures of change over time. These may be categorised more specifically as *consumer* outcomes or *service* outcomes.

Consumer Outcomes

are the effects on a consumer's health status that are attributable to an intervention. Various scales have been developed to measure these changes. These scales may be consumer-rated or clinician-rated. Consumer outcome measures in the absence of information about service outcomes and outputs may give misleading information about the service provided.

Service Outcomes

are the range of effects and the global impact of service provision on stakeholders including the consumer, the service system, or the broader community. Service outcome measures may include quantitative aspects of service provision as well as broader, qualitative aspects such as service timeliness, responsiveness, consumer satisfaction or a given population's health.

Recent Initiatives in Health Status Measurement

A number of recent developments have informed the outcome measurement project.

Commonwealth Outcome Measurement Trials

One of the key objectives of the first *National Mental Health Strategy* was to undertake regular reviews of outcomes of mental health services. To assist with this process, the *National Mental Health Plan* implemented a two-stage research program. Stage 1 identified six potentially useful outcome measures (Andrews, Peters & Teeson, 1994). These included three measures of self-reporting (BASIS, MHI and SF36) and three clinician rating measures (HoNOS, RFS and LSP). The authors argue that measurement of outcome should cover symptoms and disability. Andrews et al reviewed uni-dimensional measures (symptoms, quality of life, functioning, burden) as well as multi-dimensional measures and concluded that a measure which can be used across all groups of consumers (that is, a generic measure) for comparison may be the most appropriate for routine measurement on a large scale (nationwide or statewide) rather than a measure which addresses only the particular facets of a single condition.

Stage 2 was centred around the field trialing of the recommended measures. The Commonwealth trials have shown that the issue of outcome measurement is broader than the choice of a rating tool, and that the issues of utility and acceptability to both consumers and clinicians need to be explored further. In the interim, the Mental Health Inventory has been recommended by the Commonwealth for consideration as a self-rating measure 'in appropriate situations' and the HoNOS as a measure for rating by clinicians.

Under the *Second National Mental Health Plan*, the Commonwealth is undertaking to support:

- Further refinement and introduction of population-based outcome measures to assess the mental health and well-being of the Australian community.
- Further refinement and introduction of outcome measures to monitor service performance.
- Further development of individual clinical outcome measures including quality of life and measures to assess consumer and carer satisfaction with services.

The Victorian 1996 HoNOS Trial

Background

In 1996 the Victorian Department of Human Services conducted a clinical outcome measurement trial in a number of mental health services. The objective of the trial was to examine the utility of consumer outcome measures in the Victorian context.

Choice of Instrument

The instrument selected for the trial was HoNOS (Health of the Nation Outcome Scales), which was developed by the Royal College of Psychiatrists in London. HoNOS comprises a set of 12 items. These include both clinical problems such as depressed mood, hallucinations and delusions, as well as social aspects of clients' functioning such as living conditions and relationships. By comparing HoNOS ratings over time, outcomes can be measured, informing the consumer, clinical practice and statewide planning. HoNOS was chosen because of its perceived brevity, clarity, comprehensiveness, sensitivity to change and because it does not rely on a diagnosis.

Scope and Timelines

The sample population for the trial consisted of persons who were being treated by public mental health services. The trial commenced in April 1996 and involved five area mental health services (three metropolitan and two rural). These agencies were:

- The Royal Melbourne Hospital
- The Alfred Health Care Group
- Central East/PANCH
- Geelong Mental Health Service
- Lakeside Hospital.

The agencies assessed clients from the range of service elements (from crisis to continuing care) and included both community-based and inpatient services. More than 3,500 ratings were collected during the three-month trial. The data collection process was followed by statistical analysis and an exploration of the utility of HoNOS as a clinical outcome measurement tool.

Training

HoNOS training for the Victorian trial was based on the guidelines and other resource materials supplied by the UK HoNOS Project. A working party developed a Victorian 'Train the Trainer' course, which was delivered to clinical staff from the participating agencies. The trainees from each participating agency in turn provided training to all prospective raters within their agency. Approximately 300 raters were trained in the use of HoNOS prior to the start of the trial. Training working party members continued to provide local support for rating queries during the trial.

Inter-Rater Reliability

HoNOS ratings were made by staff from a variety of professional backgrounds. Just over half of all the ratings were performed by nurses, with others completed by psychiatrists, medical officers, clinical psychologists, social workers and occupational therapists. Some ratings were completed by a multi-disciplinary team. 152 ratings of 46 clients were made specifically for the examination of inter-

rater agreement. The analysis of the trial data established that the total HoNOS score has very good inter-rater reliability.

Findings

- The HoNOS has very good inter-rater reliability.
- The instrument is sensitive to change in consumers' mental health.
- The HoNOS rating reflects clinical assessment.
- The HoNOS can be used as an indicator of severity of mental illness.
- There was a strong correlation between the total HoNOS score and the service setting with higher scores (greater severity) found in inpatient, homeless, CAT, secure/extended care and MST services, and much lower scores in non-acute service settings. The mean total HoNOS score ranged from 9.9 in continuing care services (n=926) to 17.3 in acute inpatient services (n=176).
- The HoNOS is convenient and easy to use. By the end of the trials it took 39 per cent of raters less than five minutes and a further 44 per cent of raters five to ten minutes to complete a HoNOS rating.
- Adequate training needs to be provided to all potential raters.
- It is essential that consumers and service providers have access to data in a timely and confidential manner.

Routine Use of HoNOS in Clinical Practice

The Health of the Nation Outcome Scales (HoNOS) are receiving increased acceptance in mental health services across Australia. In Victoria a recent audit found that, of more than 60 mental health services canvassed, more than half were routinely using outcome measures. Two of the measures proposed for use in the outcome measurement suite, namely the HoNOS and the Life Skills Profile (LSP), were among the instruments most commonly used.

For example, following the Victorian HoNOS trial, Geelong Hospital continued their use of HoNOS through participation in the Mental Health Classification and Service Costs (MH-CASC) study, and outcome measurement has now become a routine component of clinical practice. It was noted that 'there was considerable clinical value in ensuring that each clinician thought about the full range of issues canvassed by HoNOS each time a client was assessed, reviewed or discharged from the service'.

Traditionally, all State-managed mental health services have been required to use the Psychiatric Records Information System Manager (PRISM). The Redevelopment of Acute and Psychiatric Information Directions (RAPID) will provide a more integrated approach to information management needs and support the introduction of routine outcome measurement. Health status ratings made by consumers or clinicians and other outcome data will be entered at agency level, enabling local aggregation and analysis.

Service Monitoring

It is essential that the Mental Health Outcomes Project be seen in the context of the broader quality and effectiveness strategy for mental health services in Victoria. Public mental health services are already expected to comply with a range of performance monitoring requirements. These initiatives, which are briefly outlined below, provide a context for the development of the Mental Health Outcomes Project. The project will add to the range and depth of information available concerning the quality and effectiveness of mental health services provided. This will also result in a progressive reorientation of the existing reporting mechanisms from input/output-focused to outcome-focused.

Service Specifications

Service specifications for registered funded agencies providing mental health services are largely drawn from the policy document *Victoria's Mental Health Service—The Framework for Service Delivery (March 1994)*. For example, Crisis Assessment and Treatment (CAT) services are required to be available 24 hours per day seven days a week. Services are monitored on a routine basis to ensure their compliance with the relevant specifications.

Output and Activity Indicators

As part of the service contract, providers commit themselves to deliver a specified service at an agreed price. Performance indicators have been established and are undergoing further development.

Examples of performance indicators include measures of inpatient activity (such as readmission rate, length of stay) and community-based services activity (such as community treatment rates or contacts per client per month).

Performance indicators provide feedback to the area mental health services to enable them to compare performance over time, against targets and with peers, and to examine the possible causes for variations in performance.

Performance indicators at this time are largely measures of service activity and throughput.

Clinical Reviews

The Chief Psychiatrist is responsible for the medical care and the treatment of mentally ill people pursuant to the *Mental Health Act 1986*. In exercise of this responsibility, Clinical Reviews are undertaken by the Office of the Chief Psychiatrist to ensure that treatment and care of people with a mental illness is consistent with the objectives and principles set out in the Act and with established clinical best practice.

Clinical Reviews are undertaken to ensure continuous improvement in the quality of mental health services. They are an effective means of examining and improving the quality of treatment and care, and enabling service providers to critically evaluate the ways in which they fulfil their clinical responsibilities.

Each area mental health service is reviewed by a small team of senior mental health practitioners with extensive experience and expertise in service provision in Victoria. A three-year rotating program of Clinical Reviews has been established.

Clinical Reviews are undertaken in the context of a quality improvement framework, with reports provided to the Chief Executive Officer of the agency for action.

Quality Incentive Strategy

In 1996–97, the Mental Health Branch introduced a Quality Incentive Strategy to provide financial incentives for the provision of high quality mental health services. The incentives consisted of additional payments for each of the adult mental health services dependent upon satisfactory performance on the three measures identified. In 1996–97 these included measures of consumer and carer satisfaction, service responsiveness to people of a non-English-speaking background and data timeliness. In the 1997–98 Quality Incentive Project, adult mental health services were assessed against the above measures as well as an additional measure concerning the responsiveness of services to meeting the needs of women. The focus in 1998–99 and 1999–2000 will be upon service responsiveness to the needs of children/young persons who may be at risk and statutory clients of Child Protection or Juvenile Justice services and their families and carers.

The Quality Incentive Strategy complements the work being undertaken on performance indicator development and consumer outcome measurement and adds significantly to the range of data available to enhance service delivery and to inform policy and service development.

Consumer and Carer Satisfaction

Consumer and Carer Satisfaction Surveys are routinely undertaken as part of the Quality Incentive Strategy. Gauging customer (that is, consumer and carer) satisfaction with public mental health services is an important part of service evaluation as satisfaction with services is strongly related to a client's willingness to be involved in treatment.

The survey process seeks consumer and carer opinion on key areas of service delivery such as service availability, information provision, the quality of treatment and assistance, staff attitudes, opportunities for consumer participation and issues specific to hospital-based services.

An individual report detailing survey outcomes is prepared for each service and is available to regions. Aggregated statewide data providing insights into the consumer and carer experience of public mental health services is also prepared.

Standards and Accreditation

In the *National Mental Health Policy and Plan* (1992), Commonwealth, State and Territory Health Ministers endorsed the development of national outcome standards for mental health services and of quality assurance programs for mental health services. They also expressed support for an independent system of assessing whether services are meeting standards.

It was felt that specific standards were required for mental health services in order to address the specific service requirements associated with mental health treatment.

The national standards project was undertaken jointly by three organisations with experience in developing and assessing health care standards, namely the Australian Council on Healthcare Standards (ACHS), the Community Health Accreditation and Standards Program (CHASP) and the Area Integrated Mental Health Service Standards (AIMHS) and produced a set of mental health service standards which can be applied to all mental health services across Australia.

Accreditation is an important component of the development of a quality system. It can provide an independent measure of a quality organisation and is typically intended to convey that the organisation meets specified standards of care. Hospitals undertake accreditation within this context. Following their mainstreaming, Victoria's mental health services now participate in accreditation. With the National Standards finalised, work in Victoria will now focus on incorporating the National Standards into the accreditation process.

Conclusion

Performance monitoring—whether by consumers, carers, service providers, hospitals, networks or the Department of Human Services—serves a number of important purposes, including the measurement of service effectiveness and performance outcomes and contract monitoring.

Health Status and Outcomes in Mental Health

The overarching aims of the Victorian Outcome Measurement Project are to:

1. Ensure that the mental health sector undertakes continuous quality improvement.
2. Enable consumer health status to be monitored by consumers and clinicians.
3. Enable the comparison of services.
4. Foster an ethos of routine outcome measurement.
5. Provide the basis for the ongoing development of health status and outcome measurement.

Criteria for a Suite of Measures

The development of the suite of outcome measures proposed for adult clinical services has been informed by consultation with the reference group, analysis of the relevant literature and Commonwealth studies. The preferred approach is a multi-dimensional one where combinations of inputs, outputs and outcomes are considered to create a picture of service performance.

Measures need to meet the following criteria:

Acceptability—acceptable to consumers and carers, being culturally-appropriate, non-intrusive, non-stigmatising and confidential.

Compatibility—compatible with the relevant legislation, the National Mental Health Standards and Victorian policy.

Economy—as few measures as possible, each measure included in the suite has a clearly defined purpose and overlap is avoided or minimised.

Feasibility—compatible with routine clinical practice without imposing an unnecessary burden upon consumers, carers, clinicians or managers.

Adequate coverage—covers both community-based and inpatient services and is not restricted on the basis of diagnosis.

Continuity—able to inform practice and review and to provide an opportunity for the comparison of outcomes over time.

Integration—the inter-relationship with current data collection and monitoring mechanisms is clearly defined and duplication is avoided or minimised.

Aggregation—supports the aggregation of data and the comparison of service effectiveness at various levels—individual, service provider, statewide.

Overview of Proposed Measures

Based on the above criteria a suite of measures proposed for Adult Mental Health Services has been developed. The measures relate to both consumer and service outcomes.

The table below shows the type and focus of the proposed measures. A detailed description of each measure follows in the next section.

Type of measure	Domain	Focus	Data collection instrument/mechanism
Adult MH consumer outcomes	Health outcome	Health status, severity and change over time	12-item HoNOS scale with total score.
		Health status, change over time and consumer participation	Self-rating tool—for example Mental Health Inventory or BASIS-32
	Psycho-social functioning	Level of disability of client population	16-item version of Life Skills Profile (LSP)
	Aim of treatment	Aim of treatment intervention	Focus of Care rating
Adult MH service outcomes	Client attributes	De-identified clinical and socio-demographic data	Existing PRISM/RAPID data
	Service activity	Quantitative measures documenting key parameters of service delivery (for example utilisation, throughput)	Key Performance Indicators (KPIs) derived from existing Minimum Data Set and other indicators under development.
	Evidence of service responsiveness	Responsiveness to client need	Indicators under development
	Evidence of integrated service	Service components work in unison, facilitating continuity of care	Indicators under development; may include: <ul style="list-style-type: none"> • Time between referral and initial appointment. • Time between discharge from inpatient service and first appointment at community-based service
	Satisfaction	Consumer satisfaction	Annual survey
		Carer satisfaction	Annual survey

Health Outcome Measure (Clinician-Rated)

Health of the Nation Outcome Scales (HoNOS)—version 4 (1996) was developed by the Royal College of Psychiatrists in London. HoNOS comprises a set of 12 clinician-rated items, each assessing an important issue commonly encountered by clients. These include both clinical problems such as depressed mood, hallucinations and delusions, as well as social aspects of clients' functioning such as living conditions and relationships.

Rationale

HoNOS was chosen because of its brevity, sensitivity to change and because it does not rely on a diagnosis. The instrument was designed for use with persons with a mental illness, and it covers a range of domains (behaviour, impairment, symptoms and social problems). Its psychometric properties are satisfactory and HoNOS can be supported by information systems.

Health Outcome Measure (Rated by Self or Carer)

Two instruments will be trialed. These are the Mental Health Inventory (MHI) and the Behaviour and Symptom Identification Scale (BASIS-32).

Rationale

The advantages of self-rating by consumers include:

- Consumers are an expert regarding their own mental health.
- Active involvement in health monitoring.
- Consumer rating may reveal information of which the clinician was not aware.
- A dual perspective in tracking 'change over time'.

Psycho-Social Functioning

The original *Life Skills Profile* (Rosen et al, 1989; Parker et al, 1991) is a 39-item scale measuring psycho-social functioning and can serve to indicate the level of client disability. The focus of the instrument is upon the client's general functioning over the three months prior to the rating. An abbreviated version of the Life Skills Profile (LSP-16) comprising 16 items was developed as part of the MH-CASC project. It is proposed that this abbreviated scale be used in Victoria.

Rationale

In order to interpret the extent of clinical change in a client population it is important to understand the overall level of disability of the population concerned. This will be probed by gauging the psycho-social functioning of clients. Because of its focus upon general functioning (and because it excludes crises) the LSP complements the HoNOS (where raters are asked to rate the most serious problem encountered in the rating period). The tools further complement each other as the LSP excels in long term non-acute settings whereas the HoNOS more readily shows change in acute settings.

Aim of Treatment

Focus of Care: Clinicians are asked to identify which of four types of focus best described the care provided to the patient over the period rated. The four types of focus, and their definitions, are as follows:

Focus of Care Rating	Description
Acute	Short term reduction in severity of symptoms and/or personal distress associated with recent onset or exacerbation of psychiatric disorder.
Functional gain	Improve personal, social or occupational functioning or promote psychosocial adaptation in a patient with impairment arising from a psychiatric disorder.
Intensive extended	Prevent or minimise further deterioration and reduce risk of harm in a patient who has a stable pattern of severe symptoms/frequent relapses/severe inability to function independently, and is judged to require care over an indefinite period.
Maintenance	Maintain level of functioning, minimise deterioration or prevent relapse where the patient has stabilised and functions relatively independently.

Rationale

The Focus of Care is intended for use in community-based services only. It classifies the consumer's primary need for treatment and will be recorded at each contact, enabling a month-by-month comparison of community episodes according to their focus of care.

Utility

Consumer and Carer Involvement

The benefits of outcome measurement to the consumer are significant. Routine outcome measurement ratings can assist in the following areas:

- **Assessment is holistic**
completing the HoNOS rating requires the clinician to take into account issues such as the consumer's relationships and accommodation.
- **The Individual Service Plan is realistic**
increasing severity of symptoms or deterioration in 'life skills' may signal need for review.
- **Review occurs regularly**
a missing HoNOS rating can be picked up on the Client Management Interface (CMI) and may signal that a review has not occurred.

Individual HoNOS scores will only be accessible by anyone who currently has access to the client file—that is, only those professionals who need to access the information for the purposes of treatment. The Department will only receive *de-identified* data downloaded from the agency's CMI.

Consumers may choose to complete a self-rating instrument such as the Mental Health Inventory (MHI), which can be compared with the clinician's score. This introduces another opportunity for consumers to participate in case planning and review.

In addition to the opportunity to be actively involved in the health status ratings, consumers will retain the capacity to provide comment upon the various aspects of the mental health service provided by completing the Consumer Satisfaction Questionnaire. The questionnaire information constitutes the second strand of consumer outcome information collected. Effective service provision implies that consumers are engaged effectively by the service and are satisfied with the service provided (at a number of levels including access, information, responsiveness and so on). These various components of user satisfaction are covered by the questionnaire and will be fed back to Mental Health Branch in aggregated form, where the service can be identified but not the consumer.

An '*Outcome Measurement Helpline*' will be established to support the early implementation of outcome measurement by responding to queries from consumers, carers, raters and other stakeholders in relation to the implementation of the consumer outcome measures.

The Clinician's Perspective

The use of non diagnosis-specific tools means that an instrument's appeal to clinicians will be derived from its brevity and convenience.

If outcome measurement is to be integrated into routine clinical practice, it is imperative that ratings are made at moments which make sense from a clinical and consumer perspective. Natural points of transition during episodes of care are

community service:	(re)entry to the service, review and closure
inpatient service:	(re)admission to the service, review and discharge
day program:	(re)admission to the program, review and discharge

It is proposed to add value to the health status assessment in two ways. In the first place the HoNOS rating will be enriched by the inclusion in the suite of other data types, ranging from the consumer's self-rating to service activity data. Secondly the introduction of RAPID's CMI will mean that all outcome measurement data generated by the service will be available for aggregation and analysis locally as soon as they are entered.

This will provide clinicians with instant access to outcome measurement data. Some strategies for using outcome measurement data in the clinical context are:

- **Histograms**

HoNOS ratings on the client file or CMI provide a readily accessible summary of case severity as well as an overview of change over time.

- **Second Opinion**

The clinician's assessment can be compared to the consumer's self-assessment or to ratings made by peers.

- **Plan Caseload**

Team leaders can use aggregated HoNOS and LSP scores to compare severity, dependence levels or outcomes by team member, diagnostic group, and other parameters. Used in this way, the HoNOS/LSP combination may play a role in both caseload management and in the review of individual clinical performance.

- **Flag Cases for Review**

Very high or very low scores on HoNOS items or groups of items can be used to 'flag' cases for monitoring or review (for example, in terms of safety, urgency, treatment options or discharge).

- **Case Review**

HoNOS, LSP and consumer ratings can be used to inform case review. For example, the various consumer outcome measures can be used in conjunction with the Focus of Care rating in order to review clinical decision making.

- **Monitor Impact of Transitions**

The HoNOS rating undertaken following referral to a different service or service element provides a way of monitoring and quantifying the impact of such transitions.

- **Identify Training Needs**

Clinicians may use aggregated HoNOS scores of their clients to analyse their clinical effectiveness from a number of perspectives (for example, outcomes by client group) and to identify training needs.

The Service Provider Perspective

The Mental Health Branch will continue to work with service providers to minimise the need for additional data entry and to avoid all duplication. To this end, the Mental Health Outcomes Project is working in close collaboration with RAPID.

At the service level, clinical data, including outcome measurement data, will be entered into the CMI. This system is available for area mental health service providers to use as a local clinical management system while also providing an interface to other RAPID components.

For most data collected as part of the proposed suite, no additional 'measurement' effort is required. Instead, clinical data entered into the CMI as part of routine service provision will be analysed from the perspective of outcome measurement. There are some exceptions to this, namely the consumer outcome measures (which will require repeated ratings over time) and the measures which rely for data collection on the existing Quality Incentive and Satisfaction Questionnaire processes.

Data entry arrangements will be piloted in the first stage of implementation to ensure that the practical feasibility of introducing outcome measurement is addressed at the same time as its relevance from other perspectives. The training needs of data entry staff in relation to outcome measurement will be addressed as part of RAPID implementation training.

Possible use of outcome measurement data for service provider purposes includes:

Service Outcome Data

will allow an agency to review its own performance primarily in terms of throughput, outputs and linkages and to compare itself to other providers in terms of efficiency and responsiveness. The agency will have access to its own data and RAPID development is likely to include provision for access to statewide data for comparison.

Consumer Outcome Data

will allow an agency to review its own performance in terms of user satisfaction and service effectiveness. For example, agencies can use aggregated HoNOS and LSP scores to compare severity, dependence levels or outcomes by program, subcentre, campus, service type or other parameters (for example, length of stay).

Service responsiveness to the needs of client groups with special needs can be gauged to some extent through the responses to the satisfaction questionnaires and through quantitative data documenting utilisation levels.

Framework for the Analysis of Outcome Measurement Data

It is acknowledged that not all service providers may have access to sufficient expertise in statistical analysis to make optimal use of the complex array of data collected as part of routine outcome measurement. In order to assist agencies with the analysis of local outcome measurement data, consultants will develop a framework for combining and interrogating subsets of outcome measurement data. The focus will be upon developing practical products such as sample standard reports or query tools which will allow agencies to integrate outcome measurement data into routine clinical practice.

The Planning Perspective

Once outcome measurement is implemented, de-identified client data will be forwarded on a monthly basis from each provider's CMI to the statewide Health Data Warehouse. The Mental Health Branch will have access to outcome measurement data forwarded to the warehouse and will have the capacity to perform further analysis upon these data.

The Next Steps

Implementation

Implementation of the outcome measures described in this paper is currently being developed and will take into account comments received through the consultation process.

It is anticipated that statewide implementation of routine outcome measurement will be incremental over 1999.

The Implementation Strategy is likely to comprise the following core components:

Information Dissemination

Information will be developed to inform consumers, carers and the sector of requirements in relation to outcome measurement. This Discussion Paper is the first step in this process, which will also include briefing sessions, public forums and regular updates.

Training

A Training Strategy will be developed to support the statewide implementation of the suite of measures. Appropriate skills-based training sessions will be developed and delivered to raters (both clinicians and consumers) and data entry staff, and a training manual will be developed to support local training initiatives. Agencies will eventually be expected to incorporate outcome measurement training into induction programs delivered to new staff. Additional training programs will be developed to meet the need of other stakeholders (for example, consumers, DHS regional staff, and so on).

Information Systems

An Information Systems Strategy will be developed to ensure that the statewide implementation of outcome measurement is consistent with Information Systems developments.

Developmental Approach

Data collected during the first phase of implementation will be analysed to inform service providers of any changes to the suite and rating or data collection arrangements.

The proposed measures and the processes for recording and analysing data will continue to be monitored and refined in order to ensure that mental health services in Victoria move on from 'routine' to 'best practice' outcome measurement.

A formal evaluation of the viability and utility of the outcome measurement suite will be conducted following implementation.

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Appendices

Appendix 1: Reference Group Membership

Chairperson	Ms Joanna Birdseye, Manager, Monitoring and Review Unit, Mental Health Branch, Department of Human Services
Members	Mr Paul Bolt, Manager Continuing Care, Peninsula Health Care Network
	Ms Lyn Chaplin, Consumer Consultant, Koonung
	Dr Peter Doherty, Director of Psychiatry, The Alfred Hospital
	Ms Roma Drummond, Carer
	Ms Nina Dunstone, Consumer Consultant, Maroondah Hospital
	Ms Margaret Goding, Senior Project Officer, Northern Metropolitan Region, Department of Human Services
	Ms Joyce Goh, Manager, Planning & Quality, Mental Health Program, Western Health Care Network
	Professor Helen Herrman, Professor and Director of Psychiatry, St. Vincent's Hospital and Community Psychiatric Services
	Ms Anne Jeffs, Staff-Consumer Consultant, North East Area Mental Health Service
	Dr John Little, Director of Psychiatry, Grampians Psychiatric Service
	Ms Helen Rizzoli, Health Information Manager, Psychiatric Services, St. Vincent's Hospital
	Ms Jenny Smith, Area Manager, Inner West Area Mental Health Service, The Royal Melbourne Hospital Mental Health Program
	Mr Phil Barelli, Project Manager, Mental Health Branch, Department of Human Services
	Mr Kevin Carter, Project Manager, Mental Health Branch, Department of Human Services
	Mr Gavin Jackson, Project Manager, Monitoring and Review Unit, Mental Health Branch

Mr Gilbert Van Hoeydonck, Senior Project Officer, Mental Health
Branch, Department of Human Services

Appendix 2: List of Abbreviations

ACHS	Australian Council on Healthcare Standards
AIMHS	Area Integrated Mental Health Service Standards
AMHS	Area Mental Health Service
BASIS-32	Behaviour and Symptom Identification Scale
CAT	Crisis Assessment Team
CCU	Community Care Unit
CHASP	Community Health Accreditation and Standards Program
CMI	Client Management Interface (a component of RAPID)
CTO	Community Treatment Order
DHS	Department of Human Services
DRG	Diagnosis-Related Groups
EFT	Equivalent Full-Time (position)
EQUIP	Evaluation and Quality Improvement Program
FOC	Focus of Care
GP	General Practitioner
HoNOS	Health of the Nation Outcome Scales
HoNOS-SR	Health of the Nation Outcome Scales (Self-Rating Version)
IRSED	Index of Relative Socio-Economic Disadvantage
ISP	Individual Service Plan
KPI	Key Performance Indicator
LSP	Life Skills Profile
LSP-16	Abbreviated version of the Life Skills Profile
MHB	Mental Health Branch
MH-CASC	Mental Health Classification and Service Costs Project
MHI	Mental Health Inventory
MST	Mobile Support Team
NESB	Non-English-Speaking Background
PDSS	Psychiatric Disability and Support Services
PRISM	Psychiatric Records Information System Manager
RAPID	Redevelopment of Acute and Psychiatric Information Directions
RCTO	Restricted Community Treatment Order

Appendix 3: Detailed Overview of Measures and Data Collection

Type of measure	Domain	Focus	Data collection instrument/mechanism	Data level	Rated or collected by	Frequency
Adult MH consumer outcomes	Health outcome	Health status, severity and change over time	12-item HoNOS scale with total score	Consumer	Clinician	Ratings at admission, case review, case closure/discharge
		Health status, change over time and consumer participation	Self-rating tool—for example Mental Health Inventory or BASIS-32 (to be decided)	Consumer	Consumer and /or Carer	As appropriate. Recommended: same rating points as for clinician rating
	Psycho-social functioning	Level of disability of client population	16-item version of Life Skills Profile (LSP)—only in non-emergency/non-acute services	Consumer	Clinician	Admission and case review
	Treatment Aim	Aim of treatment intervention	Focus of Care rating (pick 1 of 4 options)	Consumer	Clinician	Admission
	Client Attributes	De-identified clinical and socio-demographic data	Existing PRISM/RAPID data	Consumer	Clinician	Admission
Adult MH service outcomes	Service activity	Quantitative measures documenting key parameters of service delivery (for example, utilisation, throughput)	Key Performance Indicators derived from existing Minimum Dataset and other indicators under development	Aggregated	Service	Quarterly
	Evidence of service responsiveness	Responsiveness to client need	Indicators under development	Service	Service	Quarterly (KPIs)
	Evidence of integrated service	Service components work in unison, facilitating continuity of care	Indicators under development; may include: <ul style="list-style-type: none"> • Time between referral and initial appointment. • Time b/w discharge from inpatient service and first appointment at community-based service 	Aggregated	Service	Quarterly
	Satisfaction	Consumer satisfaction	Annual survey as part of Quality Incentive Strategy	Service	Consumers	Annual
		Carer satisfaction	Annual survey (QI Strategy)	Service	Carers	Annual

