

# **National Demonstration Projects in Integrated Mental Health Care**

## **National Evaluation Framework**

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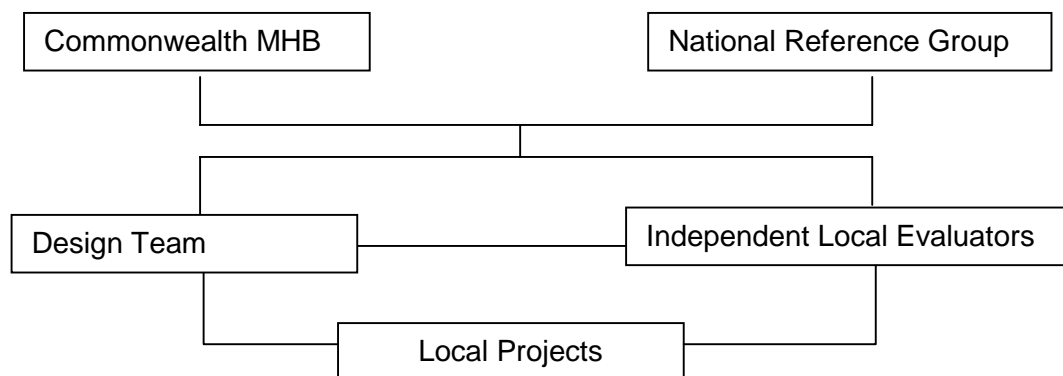
## National Demonstration Projects in Integrated Mental Health Care

### National Evaluation Framework

The National Demonstration Projects in Integrated Mental Health Care are designed to have two levels of evaluation, national and local. They will have structures to support a consistent approach at both levels, with support through the Mental Health Branch, the National Reference Group and the National Design Team. Discussion paper number 6 (Evaluation Guidelines) gives some detail on the approach to evaluation within the projects.

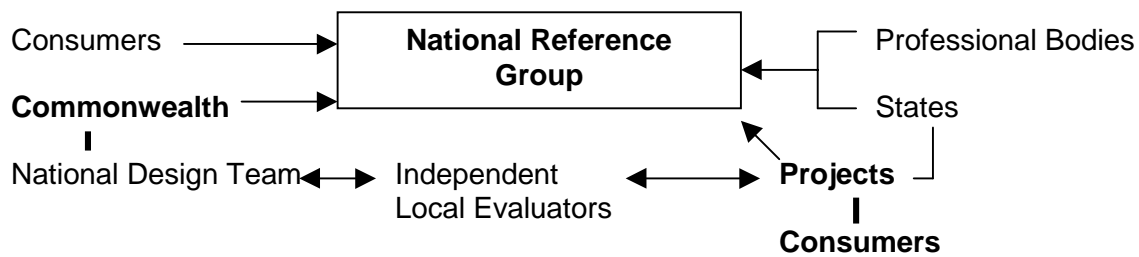
This paper describes the evaluation roles and the relationships between the different levels of activities involved in the Integrated Mental Health Care Demonstration Projects. The national level Reference Group provides commentary and advice to the Commonwealth and the National Design Team. Local projects and their evaluators feed their information through the National Design Team and the Commonwealth to the Reference Group. All activities are expected to be carried out in a manner consistent with the national evaluation framework.

**Figure 1: Support and Reporting Arrangements for the National Evaluation Framework**



The National Reference Group will assist by providing advice on the local project proposals and commenting on the way that the projects inform the national framework, including issues about:

- local demonstration project feasibility and scope;
- the scope of the set of demonstration projects, including the involvement of private psychiatrists, general practitioners, non-government organisations, consumers and local mental health associations;
- comment on arrangements for governance and ensuring that checks and balances are in place;
- comment on privacy issues for providers, both public and private;
- comment on ethics and the implications for consumers;
- comment on how the projects make an impact on State concerns;
- comment on the impact of government policy on the projects;
- comment on options for the pooling or cost tracking of public sector mental health funding including the Medical Benefits Schedule and the Pharmaceutical Benefits Scheme; and
- the design features of the national evaluation, including the collection of routine consumer outcomes, consumer feedback and other evaluation data.

**Figure 2: Representation on the National Reference Group**

The Commonwealth expects the national level evaluation will deliver a synthesis of the local level findings, rather than a parallel evaluation process with its own separate hypotheses and objectives. For this reason the relationship between the Commonwealth, its advisers and the independent local evaluation teams will be important.

Table 1 sets out the expected roles and relationships under the National Evaluation Plan. It shows the different levels of involvement in the evaluation of the Projects, the tasks expected to be necessary at each level and the various methods that might be used.

**Table 1: Roles and Relationships in the National Evaluation Plan**

<i>Partners/Who</i>	<i>Tasks/What</i>	<i>Methods/How</i>
Consumers	Promote consumer interests Monitor and feedback on all aspects of projects	Representation on central reference group and local governance structures Communication strategy
Project management committee Local stakeholders/partners	Ensure scientific and organisational governance	Accountability and governance structures (see discussion papers #s 5&7) Representation on project structures
Colleges and professions	Monitor and feedback Communication with the professional bodies	Representation on central reference group and local governance structures Communication strategy
States	Communication with public sector mental health services Monitor funds pool calculations and spending	Representation on central reference group and local governance structures Risk assessment
National Design Team Independent local evaluators	Synthesise local evaluation reports Draw out lessons for the wider system	Develop evaluation guidelines (see discussion paper #6) Analysis and feedback of similarities and differences between projects
Independent local evaluators Project team	Monitoring and reporting on local projects	Develop evaluation plans Synthesis of local data Regular reports
National Design Team Project management and independent local evaluators	Synthesis of client data Synthesis of cost data	Care management software Regular reports Monitoring pool spending
National design team Mental Health Branch (MHB)	Assist in design and support of projects. Reference group communication	Planning workshops Discussion papers for projects Agree local evaluators Website publications
National design team MHB/HIC Commonwealth MHB	Funds pool calculations and monitor spending Organise national approach  Develop National MH Strategy to support projects	Data from HIC, analysed at MHRI and CHSD (see discussion paper #3). Negotiate representation on National Reference Group Seek EOIs in all States/Territories Secure resources to develop support tools, communication, information, trouble shooting

At the national level, the design team and the Commonwealth, with advice from the Reference Group, will jointly sign off on the evaluability of local projects. This includes the use of consistent tools for measurement and agreed criteria for the selection of local evaluators and implies a strong partnership approach being developed between the local evaluators and the local projects.

The national level of evaluation is not expected to produce a single overall set of conclusions independent of the local evaluation findings, nor is it expected to arbitrate between the local projects and their evaluators. This implies that any disputes at local level are mediated at that level such that a consolidated position is then put forward to the national level.

## The National Evaluation Questions

The purpose of the demonstration projects is to create a more flexible integrated framework within which mental health services can be delivered (a process goal), with the aim being to improve outcomes within available resources for the consumers of those services (an outcome goal).

In Discussion Paper Number 6 this is represented as a central hypothesis or key evaluation question for the demonstration projects:

*The integration of public mental health services and private psychiatrist services will lead to measurably better outcomes for consumers and providers without any detriment to local services<sup>a</sup>.*

This question logically splits into three hypotheses, about consumer outcomes, provider outcomes and the wider system, with important implications for data collection:

### 1. The need to measure consumer outcomes.

The 'mental health' outcomes for much of the public sector are measured in part by the absence of negative outcomes (eg, death, physical co-morbidities, relapse). The MH-CASC Project demonstrated that for the majority of consumers treated, the clinical profile at the commencement of the study was little different from the end of the study. Therefore consumer measurement need not be frequent – the Information Plan<sup>1</sup> details the recommended data collection cycle and this is reproduced as Appendix 2. Also, outcomes other than mental health status need to be considered, and projects need to ensure that outcome measurement is relevant to both the traditional consumers of the public sector and those of the private sector.

### 2. The need to measure the impact of the projects on local services.

Evaluation will need to address whether the projects did in fact implement integrated services. That is, if the projects did not do as was intended, then outcomes cannot be attributed (positive or negative) to 'integration'. This implies an agreed, operationalised definition (and this becomes a measure) that can be applied at the beginning, the middle and end of the project. The National Standards<sup>3</sup> have described criteria regarding 'integration' and these should be addressed in each project as a starting point, with additional criteria added as required to improve the measurement of this dimension over time. Projects will also be asked to examine questions of long term sustainability. The challenge is to determine what aspects of the projects' impact we want to measure; to test a number of possible sub-hypotheses; and to

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<sup>a</sup> The impact on local services can be assessed through looking at consumers, service providers, funding changes, and outcomes.

determine whether there can be a uniform yet independent approach to evaluation for all projects.

Under the overall national evaluation framework, projects may include a number of more refined sub-hypotheses. The detailed specification of these would need to be negotiated with the local evaluation teams. If there is consistency across projects in terms of this approach, then there are a number of questions that might be answerable by a synthesis of the local evaluation findings:

- What works best, and for whom?
- What can we learn from comparing the results of different models of service integration?
- What can we learn from comparisons at different times within local settings?
- What can we learn from comparisons across local settings?

### ***Evaluation hierarchy***

Given the potential scope of the evaluation, it is important to set evaluation priorities. In Discussion Paper Number 6 three levels for the evaluation were identified, with Level One being the starting point and the first priority for the evaluation.

#### ***Level 1 Impact on consumers***

Discussion Paper Number 5 on clinical issues described 5 consumer cohorts and identified the priority as being consumers in Cohorts 3 and 4 - those consumers currently being seen in either the private or public sectors whose outcomes would be improved by access to the other sector. Evaluating the impact on these consumers is the core evaluation task.

#### ***Level 2 Impact on providers***

Level 2 is to evaluate the impact of the project on providers seeing those consumers in Cohorts 3 and 4.

#### ***Level 3 Impact on the system***

The final level of the evaluation is to evaluate the impact on the system as a whole. This has several components:

- What is the impact on consumers in Cohorts 1 and 2 (ie, those consumers currently being seen in the private sector or the public sector who are “being treated by the right provider/s, in the right place and at the right time”)?
- What is the impact on Cohort 5 ? That is, what is the impact on those people in the local community who would benefit by the provision of mental health services but who are not currently being seen by either sector.
- What is the impact on providers not directly participating in the MHI Project?
- What system-wide changes have occurred as a result of MHIP?
- What is the impact of these system-wide changes?
- Are impacts reproducible in other settings?
- Are impacts sustainable?

## Principles, Methods and Tools for Evaluation

The Mental Health Branch has promoted a set of principles that have already been agreed through the National Strategy, and that means that where State or local level issues arise there is already a reference point where some clear direction is given.

The first principle in Discussion Paper Number 6 recognises that these are demonstration projects, **not clinical trials**, nor the testing of a particular centrally determined organisational or funding model. The major requirement is that the evaluation encourages the **transparency of processes around integration** by looking at outcomes for clients and for providers. This is so that those working through the national evaluation framework can understand how effective and how generalisable a project's interventions might be. In other words, can its gains be described, are they sustainable and can they be reproduced elsewhere?

The second general principle promotes an approach that seeks to ensure minimal or no duplication of data entry, and not adding to the reporting burdens of local providers. While the projects will attempt a minimalist approach, experience suggests that establishing a culture of consistent and good quality consumer-level data collection, is quite demanding.

This suggests that there should be incentives and feedback built into projects to encourage consumer level collections. An alternative, 'minimalist' strategy might be to sample consumer outcomes. This could either be through a 'census approach', a survey or random and in-depth follow-up of selected cases. The independent local evaluators will need to carefully consider what is most likely to yield the most useful information.

Overall, the expectation is that the projects will **add lasting value to local services** by basing the evaluation design and data requirements on feasible improvements to the mainstream organisational and information systems in line with the national objectives (see Appendix 1).

### ***How will local data collection be undertaken?***

Data requirements, timing of reports and evaluation resources will be considered by both the projects and their evaluators from the local perspective, and then the level of resources required to achieve the aims of the evaluation will be determined with the Commonwealth. This agreement will then take the form of a contract between the independent local evaluators and the Commonwealth as the funder of the evaluation.

The expectation of local projects is that a core minimum data collection system will be managed in a way that enables the production of timely and relevant reports. These reports will be based on fulfilling the core evaluation requirements, which are for **five reports to be produced over two years**, starting in June 2000, and ending in September 2003.

Specific outcome measures will be based on the use of evaluation tools that are consistent with the objectives for the demonstration projects (see the references to principles, standards and tools below and in Discussion Paper #6 and the associated references).

Data elements that are required are specified in Table 2. Additional local data requirements will be specified in the local evaluation plan and form part of the proposed contract with the Commonwealth.

## **What will be the evaluation process and timeline?**

The evaluation takes place in three stages, which began with planning in the first group of projects May 1999 and will end in September 2003. Individual projects will have start dates agreed in consultation with the State, local agencies and service providers, and signed off with the Mental Health Branch and National Design Team according to the broad specifications laid out in Table 2.

### **Pre-project.** 6 months .

Including: establishment of baseline data for comparative purposes (from existing reviews, standards/indicators, current consumer data and any other local mental health data collections); description of planned interventions; and thorough descriptions of the context within the local areas for the projects, including indicators of sustainability.

### **During project.** Two years

Including: evaluation of consumer opinion of service provision; quality review mechanisms within and between services; recording of any changes in the interventions; and measurement of objective criteria such as mental health outcome measures and health status of clients, time taken to provide a service, costs of service provision, and rates of institutionalisation and hospitalisation.

### **Post-project.** 6 months – to finish in September 2003.

Including: a description of the wind-down or re-development phase; measures of sustainability, follow-up of clients and services at the end point of the formal evaluation period; implications for future funding and service delivery systems.

The National Design Team will be involved in the selection of the local evaluators for the demonstration projects and the establishment of the detailed criteria for data collection. Table 2 below shows more detail of the expected tasks and timeframes for the local evaluation which is designed to encourage a uniform approach.

The evaluation of the mental health demonstration projects will be coordinated with the results from related projects (such as the Commonwealth's aged care-based coordinated care trials).

## **Overview of the National Evaluation Framework**

The National Mental Health Strategy has supported the development of a number of practical resources that are available to the projects in the form of guidelines, planning documents and measurement tools:

- an agreed national mental health information strategy including an agreed set of consumer outcome measures<sup>1</sup> and a data collection cycle, the relevant aspects of which are summarised in Appendix 2 below.
- guidelines for developing local information systems.<sup>2</sup>
- a national framework of quality standards<sup>3</sup>. Standard 8 on Integration is reproduced as Appendix 3 below.
- version 1 of a mental health casemix classification system.<sup>4</sup>

These points of reference for the projects will be helpful in dealing with negotiations on local measurement issues and ensuring some consistency of the data collected across the various national demonstration projects. The rationale for the data collection requirements, in terms of the aims of the national strategy, is included in the attached Appendix 1: 'Relationship to National Policy and Planning Objectives'.

Table 2 below is in three parts corresponding to the expected evaluation reports on the projects. The table describes the work involved in local evaluation and how it fits into the national evaluation plan. It gives direction and a set of explicit expectations of the key questions to ask and the data collection requirements for the independent local evaluators.

In the table, 'Inputs' means the resources (human, financial, capital and intellectual) which are used in implementing a planned intervention. '

Activity" is what is done with those inputs, i.e. the actual intervention, or the recipe for change.

'Outcomes' is the immediate effects of the planned intervention on individuals, families or specific client groups, which can be measured.

'Impacts' refers to the wider community or systems effects, and might be assessed through interviews with key stakeholders and consumer research. I

n other words, outcomes are related to changes to services and individuals that are attributable to the interventions, and impacts are basically seen as systemic changes with the focus being on indicators of integration and sustainability.

**Table 2: Independent Local Evaluation Framework**

**Baseline Report (Report No. 1)**

Context		Inputs		Activities		Outcomes	Impacts
<b>Broad Local System</b>	Description and short history of local care system as it relates to Mental Health Services	<b>Consumers</b>	What are the existing mechanisms of mainstream participation for all consumers and carers?	<b>System</b>	How is consumer and carer data captured? Describe pre-trial information systems.	Recommended ways to strengthen MH consumer input into higher level participation mechanisms	Do MH issues feature in mainstream consumer information?
		<b>NGOs, other Depts, GPs</b>	Describe the pattern and structure of relationships between NGOs, other sectors and Mental Health Services.		Describe Governance, Organisation and Management systems.		Any existing data on other service providers' views of mental health services.
			Describe local Divisions of General Practice, involvement of GPs with mental health. Previous projects and/or experience of integrated care activities.		Extent of existing system integration (Standard 8)		
<b>Mental Health System</b>	Broad description and short summary of Mental Health Services from health perspective	<b>Consumers</b>	What are the existing mechanisms for MH consumer and carer participation?	<b>Service</b>	Proposed changes in activities due to the project.	Recommended ways to strengthen MH consumer and carer participation	Chose measures for consumer impact
		<b>Staff</b>	Summarise existing staff and skill mix.		Assessment of governance and management systems.		Any existing data on private psychiatry sector views of mental health services.
			<b>Design &amp; Planning</b>	Describe existing service design linking with Integration Standard 8.	Describe existing public and private consumer mix.		Any existing data on mental health services' views of private psychiatry sector.
		Describe design and rationale of new MHIP interventions.		Include accreditation and national standards.	Any existing consumer views of existing service taking into account national standards		
		Set out summary of MHIP plan.		Describe existing services provided to consumers.			
		<b>Finance Capital</b>	Pre trial analysis of sources and use of funds: Commonwealth, State, Individual, Insurance.	Describe existing use of clinical and functional measures as set out in National Mental Health Info. Strategy.			
			Describe availability and use of Capital items including buildings, IT system etc.	Describe existing consumer forums, consumer involvement, complaints mechanisms, etc.			
			Also intellectual capital and/or significant local investments in new systems.				

**Table 2 continued : Intermediate Reports (Reports No. 2, 3, & 4)**

Context		Inputs		Activities		Outcomes	Impacts	
<b>Broad Local System</b>	Unanticipated contextual changes	<b>Consumers</b>	Describe consumer and carer input to wider health system	<b>System</b>	Describe mainstream consumer and carer involvement strategies	Are MH consumer and carer issues visible?	Has anything changed further up the line?	
		<b>NGOs, other Depts GPs</b>	Level and pattern of involvement.		Development of IT/ information systems.	Changes in use of IT and other systems in wider health system.	Wider system perception of project.	
			Level and type of involvement. New projects and/or structures for integrated care activities.		Maintenance of project governance and management .	Changes in patterns of project governance and management .	Changes in other services' views of mental health services.	
<b>Mental Health System</b>	Unanticipated system changes	<b>Staff</b>	Changes to staff mix and skill mix and how they are used.	<b>Service</b>	Extent of changes to system integration (Standard 8).	Changes in availability and use of specialist psychiatric beds, access to other facilities/beds/services. Changes on indicators of integration.	Changes in consumer views of existing service taking into account national standards.	
			<b>Design &amp; Planning Finance</b>		Describe any new service designs linking with Integration Standard 8.			Changes in activities due to the project, both actual and planned.
		Describe development of the MHIP interventions.			Changes to service systems, both actual and planned.			
		Current , patterns of expenditure and commitments.			Changes to IT and other systems.			
		<b>Capital</b>	Use of physical resources, new resources available.		Describe new patterns of funding and management and their sustainability.	<b>Consumer</b>		Use of clinical and functional measures as set in NMHI Strategy.
			Use of non-health capital resources.	Strategies to change public and private consumer mix.	Changes to public and private consumer mix.			
				Development of consumer-based outcome measures.	Changes in routine use of consumer-based outcome measures.			

**Table 2 continued : Final Report (Report No. 5)**

Context		Inputs		Activities		Outcomes	Impacts	
<b>Broad Local System</b>	Summary and interpretation of health care system changes.	<b>Consumers</b>	Describe consumer and carer input to wider health system	<b>System</b>	<b>Summary of mainstream consumer and carer issues</b>	Describe MH consumer and carer issues on mainstream agenda	What has changed?	
		<b>NGOs, other Depts</b>	Changes in the mix and use of inputs.		Use of IT/ information systems.	Assessment of usefulness of IT and other systems in wider health system.	Final take-up rate of IT and other systems in wider health system.	
		<b>GPs</b>	Level and pattern of involvement throughout the project.		Changes in project governance and management .	Assessment of project governance and management systems, including sustainability.	Appraisal of generalisability of project structures.	
			Changes in practices and the sustainability of such changes.		Changes to system integration (Standard 8).	Changes to availability and use of specialist psychiatric beds, access to other facilities/beds/services.	Appraisal against baseline.	
<b>Mental Health System</b>	Summary and interpretation of changes to the local mental health care system	<b>Staff</b>	Changes to staff mix and skill mix and an account of the process by which such changes were achieved and resources required.	<b>Service</b>	Changes in activities due to the project's interventions.	Summary of changes in mental health services and private psychiatry.	Appraisal against baseline.	
			<b>Design &amp; Expertise</b>		Changes in services and use of expertise due to the project.		Changes to service systems.	Changes on indicators of integration
		Summarise the implementation of the MHIP interventions.			Changes to IT and other systems.	Assessment of use and usefulness of IT and other systems in MHSs and private psychiatry.	Final take-up rate of IT and other systems in MHS public & private.	
		<b>Finances</b>	Use of funds within the project, extent of integration of funds, changes in patterns of what is funded.	<b>Consumer</b>	New patterns of management and their sustainability.	Summary of changes on clinical or functional measures.	Appraisal against baseline.	
			<b>Capital</b>		Use of capital resources in the project.	Use of clinical and functional measures as set in NMH Strategy.	Summary of changes to public and private consumer mix.	Appraisal against baseline
					Development use and ownership of project's intellectual capital.	Use of strategies to change public and private consumer mix.	Summary of changes in consumer-based outcomes, or intermediate outcomes.	Appraisal against baseline.

## References

1. Commonwealth Department of Health and Family Services, Canberra (1999) *Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998 – 2003*. Commonwealth Department of Health and Family Services, Canberra.
2. Morris-Yates, A and Andrews G. (1997) *Local Level Information Systems for Mental Health Services: General Principles and Guidelines. Developing Outcome-Oriented Information Systems for Mental Health Services*. Discussion Paper No.1. Canberra, Commonwealth Department of Health and Family Services.
3. National Mental Health Working Group (1997). *National Standards for Mental Health Services*.
4. Buckingham, W, Burgess, P, Solomon, S, Pirkis, J and Eagar, K (1998). *Developing a Casemix Classification for Mental Health Services*. Vols. 1 & 2. Commonwealth Department of Health and Family Services, Canberra.

## Appendix 1: Relationship to National Policy and Planning Objectives

Under the Commonwealth Department of Health and Family Services' planning framework for Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998 – 2003, six information development 'modules' are included in the set of priorities and strategies that have been agreed to by all States and Territories.

The first three of these modules are particularly relevant to the MHIP initiative and others may be informed by the findings from the projects at a later time. The six modules are:

- 1) An Implementation Strategy for Introducing Routine Consumer Outcome Measurement in Mental Health Services
- 2) Development and Implementation of National Service Quality Indicators for Mental Health Services
- 3) Further Development and Implementation of a National Mental Health Casemix Classification System based on the findings of the Mental Health Classification and Service Costs Project
- 4) Understanding Population Mental Health Needs
- 5) Further Development of the National Minimum Data Set for Mental Health Services
- 6) Annual Monitoring and Reporting of Progress Under the Australian Health Care Agreements and the Second National Mental Health Plan

Measurement instruments for use in specialised Child and Adolescent mental health services are expected to be finalised in the second year of operation of the Second National Mental Health Plan, so these may be able to be used in some projects.

Under module 2, National Service Quality Indicators for Mental Health Services were designed for use in assessing service quality and as a guide for continuous quality improvement in all mental health services across Australia. Implementing the National Service Standards is an agreed priority during the Second National Mental Health Plan. The Commonwealth, States and Territories have agreed to complement these by supporting the development of a national set of indicators for use in monitoring the quality of mental health services.

Examples of indicator coverage within the demonstration projects are provided in the table in the current draft of the evaluation guidelines (draft discussion paper no. 6). These present an ideal opportunity to test the use of various indicators in relatively controlled settings, with evaluation resources built in. With respect to integration in particular, projects should have an agreed, operationalised definition (to be used as a measure) that can be applied at the beginning, the middle and end of the project. The National Standards' criteria regarding 'integration' can then be assessed for their adequacy for evaluation purposes.

As the projects are developed and the evaluation findings are analysed, the feasibility of using different indicators will be tested. These could then be reported to the National Mental Health Information Strategy Committee (ISC), a subcommittee of the AHMAC National Mental Health Working Group. The ISC is expected to draw on input from service providers, professional bodies, consumers and carers in developing the indicators considered for national application.

The broader issues of the impact of the projects on local services will have their own developmental aspects. Assessing the relative efficiency and effectiveness of the services before, during and after the project implies measures for mental health services that are rudimentary at best and will be difficult to either assemble or implement within the time frame available. Proxy measurements from existing systems will likely be required, and these have the potential to be developed into better indicators over the life of the projects.

## Appendix 2: Proposed Data Collection Cycle

INPATIENT SETTINGS	DATA COLLECTED AT:
Age RUG-ADL (for over 65 years only – within 24 hours of admission) Episode Start Date Reason for Episode Start	At admission
HoNOS/HoNOSCA	At admission, based on preceding two weeks and At discharge, based on preceding 3 days.  If Episode continues beyond three months: <ul style="list-style-type: none"> <li>reassess at three months and</li> <li>repeat at 3 monthly intervals thereafter; and</li> <li>repeat at discharge.</li> </ul>
Principal Diagnosis Legal Status (1) Episode End Date Reason for Episode End	At discharge.  If Episode continues beyond three months: <ul style="list-style-type: none"> <li>collect at three months and</li> <li>repeat at 3 monthly intervals thereafter; and</li> <li>repeat at discharge.</li> </ul>
<b>COMMUNITY SETTINGS</b>	<b>DATA COLLECTED AT:</b>
Age Episode Start Date Reason for Episode Start	At registration
HoNOS/HoNOSCA Focus of Care (1) Children’s Global Assessment of Functioning Scale (2) ICD-10 Factors Influencing Health Status (2)	One week following registration, based on preceding two weeks and At discharge from care.  If Episode continues beyond 3 months: <ul style="list-style-type: none"> <li>reassess at 3 months; and</li> <li>repeat at 3 monthly intervals thereafter; and</li> <li>repeat at discharge from care.</li> </ul>
Principal Diagnosis (2) Legal Status (1) Life Skills Profile (1) Episode End Date Reason for Episode End	At 3 months following episode start or discharge from care if occurs sooner.  If Episode continues beyond 3 months: <ul style="list-style-type: none"> <li>reassess at 3 months; and</li> <li>repeat at 3 monthly intervals thereafter; and</li> <li>repeat at discharge from care.</li> </ul>

### Notes

1. Required for adult consumers only.
2. Required for child/adolescent consumers only.

Source: Based on the collection cycle recommended in the MH-CASC Report, modified to incorporate use of data both for casemix classification and outcome measurement purposes. Detailed data protocols will be developed to guide agencies in collecting data under a range of circumstances.

## Appendix 3: Extract from 'National Standards for Mental Health Services' - Standard 8 Integration

### Standard 8.1 - Service Integration

The MHS is integrated and coordinated to provide a balanced mix of services which ensure continuity of care for the consumer.

#### Criteria

- There is an integrated MHS available to serve each defined community.  
Notes and Examples: All of the separate programs such as inpatient care, crisis intervention, case management & rehabilitation, disability support, health promotion, developmental programs are functions of one mental health service. Separately funded programs work collaboratively to achieve a single integrated mental health care system for the defined community.
- The consumer's transition between components of the MHS is facilitated by a designated staff member and a single individual care plan known to all involved.  
Notes and Examples: Case manager maintains contact with consumer between inpatient and community setting and between acute and rehabilitation programs.
- There are regular meetings between staff of each of the MHS programs and sites in order to promote integration and continuity.  
Notes and Examples: Team leaders meetings, service wide meeting which includes inpatient and community staff.
- Opportunity exists for the rotation of staff between settings and programs within the MHS, and which maintains continuity of care for the consumer.
- The MHS has documented policies and procedures which are used to promote continuity of care across programs, sites, other services and lifespan.  
Notes and Examples: How a consumer might receive treatment from the one mental health service at several sites such as inpatient, living skills centre and home, how staff of different disciplines or programs might work together, arrangements for shared care with General Practitioners, private psychiatrists, non-government organisations and other relevant agencies. Links between child, adolescent, adult and elderly programs, service providers and settings.
- The MHS has specified procedures to facilitate and review internal and external referral processes within the programs of the MHS.  
Notes and Examples: Documented policy and procedures, regular meetings with other service providers.
- The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.  
Notes and Examples: The MHS continually monitors and reviews the individual care plan.  
Cross References: Cultural Awareness (7), Service Development (9), and Planning for Exit (11.5)

## Standard 8.2 - Integration within the Health System

**The MHS develops and maintains links with other health service providers at local, state and national levels to ensure specialised coordinated care and promote community integration for people with mental disorders and/or mental health problems.**

### Criteria

- The MHS is part of the general health care system and promotes comprehensive health care for consumers, including access to specialist medical resources.  
Notes and Examples: The MHS works collaboratively with General Practitioners, welfare services, disability support services, school counsellors and aged care assessment teams.
- Mental health staff know about the range of other health resources available to the consumer and can provide information on how to access other relevant services.  
Notes and Examples: Up-to-date resource folder, education by other health service providers including General Practitioners, private psychiatrists and other private therapists.
- The MHS supports the staff, consumers and carers in their involvement with other health service providers.  
Notes and Examples: Support might be in the form of referral, sharing of resources and/or sharing of expertise between the MHS and the Emergency Department.
- The MHS has formal processes to promote inter-agency collaboration.  
Notes and Examples: *Documented policies & procedures exist; links with other mental health services and other health service providers are developed, such as private psychiatrists, General Practitioners, non-government organisations and other agencies.*
- The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.  
Notes and Examples: The MHS continually monitors and reviews complaints regarding access to the MHS.

## Standard 8.3 - Integration with Other Sectors

**The MHS develops and maintains links with other sectors at local, state and national levels to ensure specialised coordinated care and promote community integration for people with mental disorders and/or mental health problems.**

### Criteria

- Mental health staff know about the range of other agencies available to the consumer and carers.  
Notes and Examples: Resource folder and education by other agencies.
- The MHS supports its staff, consumers and carers in their involvement with other agencies wherever possible and appropriate.  
Notes and Examples: Support might be in the form of referral, sharing of resources, sharing of expertise to agencies like Department of Housing, Disability Services, CES, Police Services, schools, Commonwealth Rehabilitation Services and Court Liaison Services.
- The MHS has formal processes to develop intersectoral links and collaboration.  
Notes and Examples: Documented policies and procedures, minuted meetings.
- The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.  
Notes and Examples: The MHS continually monitors and reviews the level and type of intersectoral activities participated in by the MHS.

Cross References: Service Development (9), Access (11.1), Entry (11.2), Inpatient Care (11.4.E), and Planning for Exit (11.5)