A review of crisis assessment and treatment (CAT) services and functions

A Victorian Government initiative

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A review of crisis assessment and treatment (CAT) services and functions

Published by the Victorian Government
Department of Human Services, Melbourne, Victoria, Australia.

This document may also be downloaded from the Department of Human Services website at www.health.vic.gov.au/mentalhealth/

Authorised by the State Government of Victoria, 50 Lonsdale Street, Melbourne.

Printed by Impact Digital, 69-79 Fallon St, Brunswick VIC 3056.

July 2007

(RCC_070614)

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Part 1: Introduction

Context for the review

Victoria has a well-developed mental health service system, which it continues to review and develop. The service delivery system was described in the frameworks documents (5, 6).

Mental health services have been subject to considerable attention nationally, in particular through the 2006 Council of Australian Governments (COAG) process, and two wide-ranging inquiries that preceded mental health being considered on the COAG agenda. Both the 'Not for service' report (18) and the Senate Select Inquiry (21) highlighted access to mental health services as needing substantial reform and improvement. As part of its input to COAG, the Victorian Government commissioned a report from the Boston Consulting Group (24), which likewise focussed on the need to improve access, including to those who at present are not receiving needed treatment for mental illness.

Victoria's state-funded mental health system comprises a range of bed-based and community services. Each component is to some extent interdependent on other components. For the system to operate efficiently and effectively, there must be sufficient capacity in each, but also an understanding of the roles and limitations of component parts. Consideration of the role, expectations and limitations of the crisis assessment and treatment component is the subject of this report.

Preceding and then running in parallel to the COAG process during 2006, has been the deliberations of the Victorian Ministerial Advisory Committee (MAC, Mental Health). The MAC uses subcommittees to analyse broad service delivery issues and to advise the Minister. Associated work is undertaken within the Department of Human Services, which may also pursue directions developed in the MAC forum. One of the MAC subcommittees undertook work concerned with the 'front end' of the mental health services system. The front-end subcommittee commenced by examining the strengths and weaknesses of the relationships between three key front end mental health services, that is, triage, crisis assessment and treatment (CAT) and enhanced crisis assessment and treatment (ECAT).

Triage is primarily a telephone screening and advice service while CAT is a community-based outreach service for assessing and treating people in the acute phase of their mental illness. ECAT is an emergency department–based psychiatric assessment and treatment service. It should be noted that, as originally described, CAT services comprised both short-term treatment in the community and a gatekeeping function for access to inpatient services. CAT services were not intended to be an emergency response to mental health crises, although expectations by the public have often lead to confusion regarding this role.

The front-end subcommittee primarily focussed on CAT, as this service had not been the subject of recent policy development. The CAT service was examined in the context of its place in the broader service system and in terms of its responsiveness to clients, carers and other services. In the absence of up-to-date, objective information about CAT services, a limited appraisal of CAT services was undertaken. It included a literature review, a policy audit of front-end services, an analysis of quantitative statewide data and

a survey of CAT managers, consumer and carer representatives, mental health staff and other stakeholders. The intent was to assess:

- whether the 1994 guidelines still apply to CAT activity
- evidence for the effectiveness of CAT services
- whether there had been a change in the nature or emphasis of CAT work over time
- areas for improvement for service delivery, particularly in terms of service timeliness and quality.

CAT services and functions

Mental health clinicians who staff CAT services have backgrounds in medicine, nursing, social work and psychology. The most common service model in the 13 metropolitan mental health services is that of CAT functions being provided by a dedicated CAT team, while the eight rural services predominantly provide CAT functions through integrated mental health service teams.

While CAT services vary in size according to the geographic area they cover, the smaller services are approximately 12–14 EFT and the larger ones are approximately 20–22 EFT. This staff complement allows for extended hours' coverage for the entire week as well as overnight call-out.

The CAT clinicians operate as part of a community mental health service. They work closely with triage and ECAT services. In 2005–06, CAT services saw nearly 40,000 people and approximately 40 per cent of these were assisted by the CAT service more than once in a 12-month period.

When CAT services have more than one request for urgent assessment at the same time, they prioritise on the basis of clinical need. While many factors will influence such a decision, level of risk to the individuals, their family and the broader community is a major factor in these assessments. This CAT function is one of several expected of CAT clinicians. The full complement of expected CAT functions, as outlined in the 1994 guidelines, is as follows:

- assessing people in the acute phase for whom inpatient admission is a likely outcome
- short-term intensive treatment in the community for clients of the service
- crisis intervention to identify problems, alleviate risks, plan and, where appropriate, implement crisis management plan
- supplementary out-of-hours treatment and support for other mental health services (such as community care, mobile support and treatment, and homeless)
- supplementary out-of-hours treatment and support for clients of child and adolescent mental health services and aged persons mental health services
- arranging admission to an acute mental health unit
- liaising with clients, inpatient staff and other ambulatory area mental health service staff
- facilitating timely discharge from an acute mental health unit.

Part 2: Literature review

Two key dimensions of 'responsiveness' are: quality of customer service and timeliness of service provision. Customer service encompasses a range of aspects including whether CAT fulfils it functions, and satisfaction by clients, carers and other stakeholders. Timeliness of service provision refers to the promptness with which service is provided in accordance with the level of acuity and risk involved for the consumer and others in the situation.

There is little research on either customer service or service timeliness issues in the context of CAT services. Similarly the literature does not differentiate the comparative effectiveness or merit of CAT services' community assessment and treatment functions. The research tended to compare intensive community intervention with inpatient care of people requiring acute mental health treatment.

In Victoria, the public specialist mental health service system has moved beyond this debate having supported the growth of community-based mental health services. This includes intensive community treatment services for people experiencing an acute episode. It is still useful to consider the findings in the literature to inform current thinking, despite the different service systems that underlie the reported research.

The literature review covers the research on crisis interventions and teams from both experimental and from 'expert opinion on systemic matters' viewpoints. The latter usually take the form of government reviews that canvass the judgement and experiences of clinicians, consumers, carers and other key stakeholders. Customer service and quality issues tend to be covered in government reviews that use qualitative information. Where articles were found on front-end issues beyond crisis assessment, these are also reported.

The literature considered mainly focuses on the role of acute community-based treatment, rather than response to mental health emergencies.

Crisis intervention: meta analysis

An updated Cochrane Review (13) assessed the effects of the crisis intervention model compared with standard care for people with serious mental illness experiencing an acute episode. 'Crisis intervention' was defined as immediate assessment, identification of the mental health problem followed by time-limited input of care during a crisis period. 'Standard care' meant mental health inpatient care.

Studies were selected for Cochrane analysis if they used randomised control trials. Out of a total of 21 studies, five met the strict criteria for inclusion. In each of the five studies, crisis intervention was not investigated on its own. All studies also had a broader home-based package that followed crisis intervention in the community. The statistical meta analysis for many variables was inconclusive. The significant results included

Table 1: Summary of the Cochrane review's findings

Variable	Community-based	Hospital-based
Overall death rate	No difference (very small numbers)	No difference (very small numbers)
Global state	No difference	No difference
Disruption of routines and social life	Less	More
Cost	Less expensive	More expensive
Repeat admissions	Possibly less	Possibly more

Of those allocated to home care on presentation, 44.8 per cent were admitted to hospital at least once within a 12-month period. Overall the data suggested the home care group had less repeat admissions after 12 months than standard care. However for this variable, one study 'pulled up' the results of two others. The authors' conclusion was that crisis treatment at home coupled with a home care package is a viable and acceptable way of treating people with a serious mental illness, however more evaluation studies were needed.

Crisis intervention: later studies using a quasi-experimental design and a randomised control trial

A study (9) in Cleveland Ohio evaluated the impact of a community-based crisis assessment program compared with a matched group using a hospital-based crisis assessment program. There were 1,100 subjects in each. The community-based crisis service reduced hospitalisation by a modest but statistically significant 8 per cent and it was found that consumers using a hospital-based intervention were 51 per cent more likely to be hospitalised 30 days after the crisis than consumers using the community-based service. Therefore treating people in the community rather than hospitalising them did not risk subsequent hospitalisation in a 30-day period.

A South Australian study (11) compared rates of inpatient admission between community-based psychiatric emergency services and hospital-based psychiatric emergency services. All involuntary hospital admissions were excluded from the sample, which left 298 contacts with the mobile service and 163 contacts with the hospital-based service. The study found that hospital-based services were three times more likely to admit patients than the community-based service regardless of the clients clinical characteristics: the admission rate for hospital based services was 43 per cent while for the community-based team it was 13 per cent. Therefore the community-based team was more likely to reduce the need for admission.

Table 2: Summary of Ohio and South Australian studies' results

	Community-based assessment	Hospital-based assessment
Cleveland, Ohio		
Hospitalisation	8% less	
Hospitalisation within 30 days		51% more
South Australia (psychiatric emergency)		
Admission to hospital regardless of client clinical characteristics	13%	43%

The Ohio and the South Australian studies both suggest that the availability of both community- and hospital-based emergency assessments is important.

A recent, more definitive randomised control trial was conducted in North Islington, London (12) comparing a crisis resolution team with standard care from inpatient services and community mental health teams. The crisis resolution team was expected to assess people for whom acute admissions were being considered and, where feasible, to provide intensive home treatment instead of admission. The community-treated patients were less likely to be admitted to hospital in the eight weeks after the crisis and this effect persisted for six months. In the 12 months before the introduction of the crisis resolution teams, there were 340 admissions and in the 12 months after the trial, when randomisation had ended and the crisis resolution teams were involved in all decisions to admit, there were 237 admissions. The crisis resolution teams reduced hospital admissions in mental health crises and the results suggested that this method also increased patient satisfaction.

Overall the meta analyses and the experimental design studies indicate that assessment and intensive treatment in the community is a viable and effective alternative to inpatient care for many acutely unwell patients.

Crisis intervention: New Zealand government report

A qualitative review of crisis mental health services in New Zealand (16) was completed in 2001 and covered community-based as well as hospital-based crisis services. It recorded many common services and challenges with Victoria. The review consulted widely with clinicians, other mental health practitioners, clients, consumers and other relevant stakeholders. The recommendations for improving the system covered many issues and the ones of most relevance to the front-end services are summarised here:

- Quality of service can be improved by ensuring minimum crisis staffing requirements, a mix of staff, a system for staff supervision and development, clear standards for assessment and intervention planning. The implementation, reporting and monitoring systems should also allow for routine audits of service performance.
- Communication with the public and other services was another area targeted for change. The eligibility criteria for crisis intervention within and without the New Zealand Mental Health Act needed to be made explicit, as were common ways to access crisis

services. Crisis and other mental health as well as related services must know their respective roles and responsibilities with respect to a person in crisis.

- Equally important was the development of clear links between crisis activities and the remainder of the community mental health services to ensure coordinated responses to the range of urgent and non-urgent calls for assistance. These links need to be made explicit through agreements, and can assist the transition of individuals through the range of required services. The agreements should define the threshold for transfer as well as transfer information.

The report made reference to the need for better management of people who are intoxicated, by closer cooperative arrangements between mental health, police and drug and alcohol services.

As a follow-on from the review, in 2003 the Health Research Council of New Zealand commissioned a literature search to find an evidenced-based model for providing mental health crisis services (10). The authors found 150 relevant articles, but the vast majority of the articles were descriptions of 'model' services with few analytical studies. There seemed to be no evidence that one model of service provision is better than another and it was clear that the service and policy context for models in other countries reduced their applicability to New Zealand. From the available material the emergent themes can be summarised as follows:

- Consumer satisfaction: Consumers like 24-hour seven day a week services that have a well-publicised accessible phone number. They want longer follow-up from the same person who saw them initially.
- Carer/family satisfaction and family burden: This has not been studied in detail. Carers appreciate a prompt, easily accessible response.
- Clinical outcomes and service utilisation: Some studies suggest crisis services reduce hospital admissions and the use of police services.
- Specialist populations: There is no evidence on the effectiveness of crisis services comparing rural with urban settings or in specific cultural groups. There appeared to be very little on child and adolescent services.
- Skills and competencies required by staff: The literature suggests that the presence of a psychiatrist in the crisis team increases the treatment and medico-legal options available.

Mental health presentations to ED: New South Wales and Victorian Auditor General and government reports

In 2000, the NSW Auditor General (2) released a report into the performance of emergency mental health services. The driving issue was considered to be the lack of timely access to emergency mental health services. The report examined the system from triage to assessment and then access to acute beds. Similarly, among the objectives of the 2002 Victorian Auditor General's report (3) was the intention to determine whether area mental health services were providing timely and appropriate services to adults in or at risk of psychiatric crisis.

Both reports concluded that system improvement could be achieved by services becoming more aware of the quality of their performance through the implementation of a variety of standards and measurements. This would enable monitoring and reporting of performance against response times in mental health service settings. One of the Victorian report's recommendations was that a review be conducted of the respective roles and responsibilities of emergency department (ED) clinical and mental health staff. This and more have since been undertaken. There were also a number of recommendations in the NSW report that Victoria has either implemented or is moving to adopt, such as enhancing specialist support in EDs and developing local protocols with police and ambulance services for the transport of mental health patients.

A report prepared for the Victorian Department of Human Services (7) examined mental health presentations in five metropolitan EDs. It revealed that approximately a third of people presenting for mental health issues are already being actively managed by mental health services, approximately a quarter had been admitted in the prior year and close to a half had prior contact with the mental health service system. Very few people needed immediate emergency treatment (Australasian Triage Scale category 1) and just under 50 per cent of the people presenting with mental health issues were in category 4 (semi-urgent) and category 5 (non-urgent). The triage scores suggest that there may be other ways of providing assistance to these people rather than attending ED. Other possible conclusions from these findings involve the availability of the continuum of mental health care services in the community, including after hours, and relapse prevention and early-intervention planning.

Mental health presentations to ED: study using a quasi-experimental design

The external influences on admissions to hospital-based emergency services were systematically studied in Berkeley California (4). Over an 18-month period, the researchers tracked the effects on weekly admissions to psychiatric emergency in ED in three sets of circumstances: reduction in outpatient services, greater efforts to identify and treat people with acute mental illnesses and enhanced emergency services with post-release case management provided by a dual diagnosis unit. The researchers controlled for effects that impact on emergency service usage: employment trends, extreme weather and holidays. Significant results were reported for the changed circumstances and were most evident for men seeking assistance in psychiatric emergency services.

Table 3: Significant factors affecting hospital-based emergency service usage

Factor	Impact on hospital emergency service
Increased unemployment	Increase in admissions
Extreme weather	Reduction in voluntary admissions
Holidays	Reduction in involuntary admissions
Closure of outpatient clinic	Increase in voluntary admissions (males)
Proactive identification and treatment of people with acute mental illness (such as homeless people)	Increase in involuntary admissions (males)
Enhancing emergency treatment for dual diagnosis	Persistent reduction in admissions (males)

In a recent Australian study (17), the researchers applied regression analyses to the 'Australian National Study of Low Prevalence (Psychoses) Disorder' data set to determine the relative impact of variables, such as symptom profile and risk-taking behaviour, on hospitalisation. The results of interest to front-end issues are that weeks in rehabilitation, increased contacts with GPs and contacts with case managers were significantly associated with reduced hospitalisation. Case management was understood to be more than an administrative interface between services, but rather comprised of assertive, responsive interventions.

The Berkeley study showed there are factors that clearly affect demand on ED, especially changes in other parts of the mental health service system. For instance, the closure of outpatient services and proactive seeking of people in the community with a mental illness both increase demand. Enhancing emergency treatment for dual diagnosis with follow-up interventions reduced the use of ED. This study adds substance to the observation made by Kalucy et al (14) who mapped the rise of mental health presentations to a South Australian hospital. The authors of these studies stated or implied that the rise in ED demand is at least in part attributable to insufficient community-based mental health services.

The American Psychiatric Association Taskforce (1) also asserted that emergency services cannot be thought of in isolation from other parts of the mental health service system. It was their view that a well-developed case management system may be able to manage many of its patients' crises. This seems to be borne out by the Australian National Study, which indicated that case management seemed to prevent avoidable hospitalisation and therefore additional pressure on the front end.

Mental health presentations and the police

A mobile crisis program, staffed by psychiatric nurses and police, was developed in Georgia US (20) to handle police psychiatric emergencies. The goals of the program were to provide community-based services to stabilise people experiencing psychiatric emergencies, to decrease arrests of mentally ill people in a crisis and to reduce police officers' time handling situations. The program showed that 55 per cent of the emergencies were handled by the mobile crisis program without hospitalisation,

compared with 28 per cent handled by regular police interventions. The majority of clients and police were satisfied with the program.

An article by Steadman et al (23) described three police–mental health arrangements in Pennsylvania, Tennessee and Oregon for the detention of people with a suspected mental illness. It reported on police frustration and poor management of people transported to ED who do not meet the criteria for involuntary treatment and yet refused voluntary treatment. The success of the arrangements in the three US states was attributed to a number of factors, including the specialised crisis response sites where police could bring people with a suspected mental disorder and be assured of their acceptance. Staff at the response sites not only assessed clients but also linked them with mental health and other community services.

The contrast in intervention between the two articles is interesting, in that the mobile crisis team with police and mental health staff is committed to managing and treating people in the least restrictive environment, that is the community, if possible. On the other hand, the arrangements in the three US states relies on police being the initial contact with the person who has the suspected mental illness, then taking them to a specialised crisis response site (a psychiatric hospital, secure facility or triage centre) with clinical services.

In the Tennessee arrangement (the Memphis Model), police have been trained to de-escalate crises and bring people to the appropriate specialised crisis response site for assessment and possible treatment. There was a high degree of consumer and carer satisfaction with the Memphis Model and consumer as well as police injuries have decreased dramatically since its introduction (22, 26, 28). However it is unknown whether bringing potential mental health clients to a specialised crisis response site means more consumers are admitted than if they were assessed in the community.

The 2003 New Zealand literature review identified problems with the applicability of other countries' models for emergency crisis services, and so too the wholesale transfer of mental health–police models need to be treated with caution. Also worth noting is the success of the Memphis Model is supported by what is estimated to be three times the availability of acute mental health beds per head of population compared with Victoria.

Crisis intervention: children, adolescents and aged mental health clients

As mentioned in the 2003 Health Research Council of New Zealand literature review on models for mental health crisis services, very little appeared to be written on child and adolescent emergency services. The same seems to be the case for aged psychiatric emergency services.

Gilling (8) described a system of management for adolescents in a rural Ohio ED. Forty-eight consecutive adolescent emergency hospital evaluations were studied to determine whether a significant proportion of the adolescents could be successfully treated in the community, closer to their homes. Social workers in the ED applied a standardised protocol including semi-structured interviews, suicide, homicide, global assessment of functioning and crisis triage rating scales. These staff had senior clinician telephone back-up, including a psychiatrist.

It was shown that using evidence-based tools aided decision-making for the psychiatrist who found that 90 per cent of the presenting adolescents could be successfully managed in the community. The possible lesson for CAT to be drawn from this article seems to be that some knowledge of non-adult psychiatric issues with strict protocols for assessment appears to ensure good decision-making for the non-adult assessment of a psychiatric presenting problem.

Thienhaus and Piasecki (27), from Nevada US, noted that given their proportions in the general population, geriatric patients are under-represented in psychiatric emergencies. The authors identified 10 key issues that should be covered in the psychiatric assessment with an older person's presentation given other confounding medical and social issues that may co-exist. The intent of the article is to enhance the quality and accuracy of assessment for older patients with an acute mental illness.

Summary of the literature review

A limitation of all the literature reviewed is that CAT functions cannot be separated from the overall mental health service system. Accepting this limitation, the emerging themes in literature indicate that CAT assessment and intensive treatment in the community is a viable and effective service for many acutely unwell patients. There is also evident consumer and carer satisfaction with this model. The role of assessment is important in so far as it is the prelude to treatment, but there does not seem to be conclusive evidence that the place of assessment, whether it be centre- or hospital-based or in the place of residence, determines the subsequent place of treatment for consumers. At a systemic level, there does not seem to be an evidence-based model for a preferred configuration.

The government reports that concentrate on improving the quality of crisis psychiatric services suggest the following issues be addressed:

- staffing composition and supervision
- better service performance standards and feedback to services
- communicating eligibility criteria to the public
- agreed links between services when the consumer requires engagement with other parts of the service system
- better interventions for people with comorbid mental health and drug and alcohol issues.

These are areas that also deserve closer attention in Victoria.

On the specific matter of CAT staff working with police, the timing and method of inclusion of the assessment and treatment skills of CAT or related staff in police situations is the subject of continuing endeavour.

There appears to be Australian and US evidence that reduced community-based mental health services can increase demand on ED, acute mental health units and, by implication, on other front-end services.

In the next section there is a discussion of issues that arise from the described roles of Victoria's current mental health front-end services and their potential impact on CAT services.

Part 3: Issues in front-end services and their implication for CAT services

Victorian services have changed considerably since CAT services were first established. In the original 1994 frameworks documents, triage was not funded or described as a separate function. Mental health services in EDs were minimal at best. The time at which these components were developed needs to be taken into consideration when considering the overarching service delivery model. Prior to 1995 there were no statewide CAT services. Since then CAT services have struggled to meet expectations and perceived need. The question needs to be asked whether CAT services can ever realistically fulfil the expectation for immediate urgent response to all requests, or whether the mental health service system needs to better integrate its urgent response with mainstream health services such as EDs and ambulance.

In an environment of increasing demand, triage is an important first point of contact for people inquiring about eligibility for mental health services and advice about mental health issues. A desire for immediate access to CAT service from groups as diverse as consumers and carers, police, GPs and other teams in the mental health system has led to the perception that the demand for urgent community assessment has overwhelmed the capacity of CAT to perform short-term community-based intensive treatment. In a number of emergency departments, there are increasing presentations by people with actual or suspected mental illness.

To aid in understanding the expectations of CAT and its immediate service context, table 4 describes the roles of the three front-end services using the Mental Health Branch (MHB) guidelines. The flow chart in appendix 1 shows the place of CAT services in relation to other mental health services and maps the possible relationship between front-end and other services. It is recognised that there will be variations in individual area mental health services (AMHS). Appendix 2 summarises recent MHB initiatives in front-end services, providing both a policy and funding context for the front-end services.

The issues that arise from these front-end services roles in relation to CAT services are outlined in Table 4.

Table 4: Roles in the front end – summary of roles of triage, CAT and ECAT services

Triage (from 2005 Triage program management circular) (19)	CAT (from 1994 guidelines) (6)	ECAT (from 2005 guidelines) (15)
The MHB specifies that telephone contact for triage be a single phone number operating 24-7 (this does not necessarily require a centralised triage service): • At the point of contact with the mental health service system, the triage clinician conducts a preliminary assessment as t o whether a person is likely to have a mental illness or disorder and the nature and urgency of the response required. • Triage can also be used for assessment of current and former consumers who make unplanned contact with the mental health service. • Triage clinicians should be available to provide advice and consultation to primary care providers to assist them in treating and supporting consumers with MH issues. • Where it is considered that AMHS are not the most appropriate response option, the person may be referred to another organisation or given other advice. • Where the triage assessment indicates that specialist MH services are required (or possibly required) a more comprehensive assessment is provided through the intake assessment with the relevant community MH team. The outcome may be referral to another organisation and/or the person being treated by the AMHS.	**CAT is described as a 24-7 community service with the essential roles being** • Assessment and screening of people in the acute phase of their mental illness or mental disorder: gate-keeping to acute mental health services, whether this be acute inpatient care or acute community-based care. • If admission into an inpatient unit is the optimal treatment for the person, then CAT facilitates the admissions process. • CAT liaise with clients, inpatient staff and other ambulatory AMHS staff on matters of the person's inpatient treatment and community support and also facilitate timely discharge from inpatient beds. • CAT provide short-term intensive treatment and support to people in the community during the acute phase of their mental illness: acute care in the community. • Crisis intervention is framed in terms of specialist psychiatric telephone counselling to identify problems, alleviate immediate risks and agree on a plan of action. This may also occur in an outreach capacity. • CAT also provide supplementary out-of-hours support to other non-acute ambulatory mental health services including aged and child and adolescent services. *The CAT guidelines also specify that CAT staff develop individual service plans for clients and transfer plans for clients receiving continuing treatment.*	**ECAT is described as a 24-7 psychiatric assessment and treatment service in ED:** • The mental health presence in ED responds to people with a broader range of mental health problems than that of other specialist mental health services and provides a consultation and liaison function in ED. • A mental health practitioner will be available to the ED in the AMHS catchment and on-call after-hours. There is a special focus on suicidal behaviour. • All persons referred to and presenting for admission to hospital are assessed, thus preventing unnecessary hospitalisation where services can be provided adequately in the community. Hospital admissions will involve the CAT service. • A client's LOS in acute facilities is minimised through expediting the earliest possible discharge with CAT or other referral or follow-up. • All referred clients are to be linked to appropriate follow-up care. If necessary short-term management of the client should be provided until appropriate follow-up can be organised. • Provision of primary, secondary and tertiary consultation to other community service providers in relation to psychiatric crisis management and treatment. • Ongoing education and training of ED staff is provided in identifying, assessing and managing persons who are suicidal or are experiencing a mental illness.

Triage

The mental health telephone triage function provides an initial assessment of people seeking assistance from public mental health services. It is expected to be a 24–7 service. Typically adult mental health services also conduct after-hours triage for child and adolescent mental health services (CAMHS) and aged persons mental health services (APMHS).

Triage is a specialised screening, advisory and support role that is still evolving in a number of mental health services. The most basic task of the triage clinician is to decide whether or not a person needs specialist mental health services and the urgency of the response required. If the person is considered to require further assessment or treatment from the mental health service, the triage clinician decides where to direct the person in the mental health service system: to CAT, mobile support and treatment or community care services or to ECAT in the ED, if need be.

In a well-developed triage service, triage staff can also spend time assisting people who do not need an immediate service response but who would benefit from advice about how to manage their problems until they are seen by a mental health professional. Alternatively, for those people who do not require treatment from specialist public mental health services, triage can provide advice about the most appropriate service for their needs, and facilitate a referral to alternative services.

Crisis assessment and treatment

The 1994 CAT guidelines do not describe CAT as an emergency service offering an immediate response. Nevertheless there is often an expectation by the public and other services that CAT provide an urgent response to requests for assessment in the community. When there are a number of concurrent requests for assessment, these are prioritised and accommodated with their other responsibilities.

At the same time, the complementary aspect of CAT service, namely intensive community-based treatment for acutely unwell people, is rarely criticised and its provision is consistent with the principle of treating people with a mental illness in the least restrictive environment. The 1994 CAT guidelines describe intensive treatment and support as ‘the primary role of the CAT service’. This statement is at odds with the public focus on emergency assessment. Demand pressures can lead to a tension between urgent assessment in the community and short-term intensive treatment in the community. Without the provision of this short-term psychiatric treatment and support, many people with an acute mental illness would be hospitalised or their ongoing treatment in the community would be compromised.

Assessment in the community is the most public component of the CAT role and the most likely to draw criticism when it is not delivered according to the expectations of the person making the request. Expectations cover a range of matters from the timing of service, the manner in which decisions are communicated, especially decisions that a CAT service is not required, through to family-sensitive practice.

Although CAT services are described as a 24–7 service in the guidelines, most operate during extended business hours with an infrequently used call-out capacity. Occupational health and safety issues have restricted overnight call-outs for CAT-only staff to potentially unsafe community locations, such as remotely located private residences.

Instead people requiring overnight psychiatric assistance generally need to attend their local ED, sometimes transported by ambulance or by police under section 10.

Emergency services, primarily ambulance and police, are often the first point of contact for people experiencing, or perceived to be experiencing, an acute mental health episode. To facilitate access to appropriate treatment and care, CAT, mental health triage, and hospital emergency departments often support the emergency services response. Further work needs to occur to co-ordinate a well-developed and integrated emergency response involving ambulance, police, EDs and mental health services. This would include local protocols to guide clinical and other staff in managing occupational safety.

The 1994 guidelines present two possible ambiguities for CAT services in light of the recent further development of triage. CAT staff are required to assess people in the acute phase of their mental illness, implying that non-acute requests have been screened and directed to more appropriate services within or outside the clinical mental health service. It is suspected that the possible consequence of underdeveloped mental health triage, is that CAT staff conduct non-acute assessments, which erode their capacity to fulfil their core functions.

Similarly the provision of what is described in the guidelines as 'specialist psychiatric telephone crisis counselling' by CAT could be seen as an overlap with triage. In fact this is more likely to be crisis advice and support. Triage should be able to offer advice and support in a wide range of situations, where immediate or acute intervention is not required. Where a situation demands immediate or acute intervention, referral to CAT or ECAT is essential.

Enhanced crisis assessment and treatment

Generally, clients who are seen by ECAT have been either referred by mental health triage or assessed by the ED triage as being likely to need a further mental health assessment and intervention. ECAT has some elements of mental health triage in that people can be referred to the relevant parts of mental health or other service system. ECAT staff are expected to provide a 'holding strategy' if the client needs a specialist mental health service until the client is assured of being taken by the relevant team. Similarly ECAT has a CAT-like gatekeeping function to the acute mental health service. In fact CAT and ECAT services often share staff.

ECAT provides extended (up to 24-hour) psychiatric crisis assessment and treatment. In a number of EDs there is on-call overnight coverage. People presenting to ECAT are prioritised for assessment in a similar way to people waiting in the community. As for other health conditions, EDs are important areas for people to seek emergency or urgent care. Through the mental health presence in ED, busy EDs provide specialist mental health practitioners to assist with the assessment and treatment of those presenting with mental health problems. This is a broader group than those who require specialist mental health service and often includes people with physical or drug and alcohol comorbidities as well as those in situational crises.

Government has substantially increased mental health resources in ED, including additional mental health clinicians, and has updated ECAT guidelines. This is in response to growth in mental health ED presentations, which mirrors the trend in overall growth in ED presentations.

Summary of front-end issues that can impact on CAT

- Triage services are still developing in a number of AMHS. The possible consequence of underdeveloped mental health triage is that CAT staff spend considerable time conducting non-acute triage assessments, which erodes their capacity to fulfil their core functions.
- The 1994 CAT guidelines describe intensive treatment and support as 'the primary role of the CAT service', while the public perception of the CAT service is that it should provide an immediate response to urgent requests for service.
- The recent growth in ECAT funding to support their development in EDs has the potential to enable CAT to better perform their community-based functions.
- CAT are not funded or staffed to provide an emergency response. Community expectations and the role of non-mental health emergency services need further clarification.
- The interdependence of the front-end services is well understood. As the component services of the front end are interdependent, so is the front end with other parts of the public mental health service system, such as continuing care teams, adult acute inpatient units, and the primary care sector.

Part 4: Analysis of statewide data

The purpose of the statewide data analysis is to assess whether the focus and nature of CAT activities have changed over time, particularly in relation to their work with actual and potential clients as well as other stakeholders.

- The primary sources of data are the Victorian Health Information Reporting System (VHIRS) and the Client Management Information/Operational Data Store (CMI/ODS).
- It should be noted that the data considered in the report is the 'best available' in that it relies on AMHS accuracy for input and coding. For example at the time of data analysis, there were two AMHS that were yet to submit complete 2005–06 CAT data.
- CAT activity was identified through program-type descriptions and funding source codes. CAT contacts with adult, child and adolescent mental health as well as aged persons mental health services are included in the data.
- Where there is a trend analysis conducted, a five-year timeframe from 2001–02 until 2005–06 is used. Only significant trends are reported.
- The backdrop to the consideration of this data is that over the five-year timeframe. There have been significant increases to mental health services but limited growth in funding to CAT services.

Comparative data about CAT activity is provided for:

- the percentage of CAT clients by gender
- recipients of CAT service
- location of CAT service and medium of CAT service
- CAT assessments
- provision of support to child and adolescent mental health services (CAMHS), aged persons mental health services (APMHS) and other community mental health services
- diagnoses of CAT clients
- outcome of CAT short-term, intensive intervention.

Registered CAT clients

Taken as an average over the five-year period 2001–02 until 2005-06, males form 51 per cent and females 49 per cent of the unique registered CAT clients.

Changes in service recipients of CAT service

Table 5: CAT contacts by service recipient by year

Service recipient	Contacts 2001–02	Contacts 2005–06	Percentage difference between 2001–02 and 2005–06
Acute health	12,821	25,755	101
Aged care assessment services	238	340	43
Ambulance	1,229	1,826	49
Client group	825	1,096	33
Family and others	485	422	-13
Police	6,442	8,141	26

Data source: VHIRS

There have been shifts in the amounts of contact with a number of service recipients.

- There have been significant increases in CAT contacts with aged care assessment services, ambulance services, client group, and the police.
- 'Client group' means that the CAT clinician had contact with a group of clients.
- There has been a significant decrease in 'family and other' contacts where CAT clinicians contact the family without the client being present.
- There have been very significant increases in CAT contacts with acute health, which matches the significant rise in referrals from that source.
- The term 'acute health' refers to any place in the acute hospital other than ED. However some CAT services use 'acute health' and 'ED' codes interchangeably.

Changes to CAT service location and service medium

Table 6: CAT contacts by service location by service medium by year

Service location	Service medium	Contacts 2001–02	Contacts 2005–06	Perentage difference between 2001–02 and 2005–06
Emergency department	Direct	15,708	32,264	105
Emergency department	Telephone	8,054	22,779	183
General hospital	All	5,524	6,808	23
Other	Other	196	376	92
Private psychiatric service or PDSS	Other	2	10	400

Data source: VHIRS

- Substantial proportions of CAT contacts are centre-based or in the person's home. These contact numbers have remained largely stable over the five-year period.
- There have been significant increases in CAT contacts in general hospitals taking into account all CAT service mediums.
- There have been significant increases in CAT contacts in 'other' locations using 'other' CAT service mediums. 'Other' locations refer to locations not mentioned in the data set (such as supported residential services). The definition of 'other' service medium is recorded with non-replicable contacts, such as answering machine, SMS, voicemail.
- There have been significant increases in CAT contacts in private psychiatric services/ PDSS using 'other' CAT mediums.
- There has been a very significant rise in CAT contacts in ED locations with both direct and telephone service.

Changes to percentage CAT clients by diagnostic groups

The main contributions came from the CAT contacts with clients in the following diagnostic groups:

- a highly significant decrease in the number of clients with 'behaviour and emotional disorders – onset usually in childhood and adolescence'
- a moderately significant decrease in the number of clients with 'dementia'
- a significant increase in the number of clients with 'mood affective disorder'
- a significant increase in the number of clients with 'diagnosis not recorded'
- a significant decrease in the number of clients with 'other non chapter V mental and behaviour diagnosis code'.

Note: A client who has contact with a CAT service may also be a client of another mental health team.

Changes in CAT assessment and short-term intensive treatment in the community activity

It is not possible to differentiate CAT assessment activity from short-term intensive treatment activity in the existing data. This is a matter that will be taken up by the Mental Health Branch. However by strictly defining the parameters of a data search, an indication can be gained of assessment activity. Where clients have received more than one CAT contact in a year, this may or may not have involved an assessment, but alternatively could reflect support to other community mental health team's clients or CAT intensive treatment in the community or some other CAT function. For the purposes of the exercise, it is assumed that registered clients who have had only one direct contact in a financial year have had an assessment. The data gathered with this restriction represents an underestimate of the number of assessments conducted by CAT.

Table 7: Clients receiving only one direct CAT contact during the financial year

Contact type	Case status	2001–02	2002–03	2003–04	2004–05	2005–06	Percentage difference between 2001–02 and 2005–06
Registered client contact	No case	5,144	5,320	5,294	5,833	6,088	18

Data source: VHIRS

Using the described parameters for the data-search, it appears that there has been a significant increase in the number of assessments in the five-year period.

Changes in the provision of CAT support to CAMHS, APMHS and other community mental health services

- Typically this support occurs in urgent situations out-of-business hours.
- It is noteworthy that nearly all sites have recorded CAT out-of-hours support to non-adult age groups, that is, CAMHS and APMHS clients. The exceptions are at sub-acute sub-centres, which mainly have elderly clients, and at a youth sub-centre.
- There is variation in the numbers of non-adult clients seen by CAT at different sites, with one rural site providing support to a considerable number of CAMHS clients.

Outcome of CAT short-term, intensive treatment in the community

CAT short-term, intensive treatment of people with an acute mental illness in the community is subject to outcome data collection. The outcome measure under consideration in this report is the Health of the Nation Outcome Scales (HoNOS), taken on entry and discharge from CAT service. It should be noted that outcome measurement in Victorian mental health services is at an early stage of development.

The four sub-scales measured by HoNOS are:

Behavioural problems

- Aggression
- Self-harm
- Substance abuse

Symptomatic problems

- Hallucinations and delusions
- Depression
- Other symptoms

Impairment

- Cognitive dysfunction
- Physical disability

Social problems

- Personal relationships
- Overall functioning
- Residential problems
- Occupational problems

Each item can be scored between 0–4 and the total score can be between 0–48.

Unfortunately data quality on the HoNOS (and other outcome measures) is variable due to sometimes incomplete recording by clinicians. This may partly have its basis in differing instructions for outcome measure collection by the State and the Commonwealth. Nevertheless, the collection of outcome measures is improving and there is sufficient data to report on CAT activity in the 2005–06 financial year.

Only those AMHS where CAT services are reliably collecting HoNOS data and the data can be differentiated from integrated team activity, are included.

Metropolitan AMHS

Eight from a possible total of 13 metropolitan AMHS, including one with two CAT sub-centres

Rural AMHS

Three from a possible total of eight rural AMHS, including one with three CAT sub-centres and two with two CAT sub-centres

Table 8: Comparison of 2005–06 average metropolitan and rural HoNOS scores for Victorian acute mental health units and acute treatment in the community

		Average acute unit HoNOS score	Average acute treatment in community HoNOS score
Metro	Entry	14.9	13
	Discharge	7.8	8
Rural	Entry	16.6	13
	Discharge	7.4	7

Data source: CMI/ODS

Note: The mental health inpatient data is an average of all metropolitan and rural sub-centres, while that for the CAT treatment in the community is an average of the metropolitan and rural sub-centres mentioned above.

- Short-term intensive treatment of acutely unwell people in the community by CAT services appears to achieve significant improvements as measured by the HoNOS score.
- These improvements are largely comparable to those found in acute mental health inpatient units.
- In CAT services where matched pairs (entry and exit scores for the same client) can be compared, the spread of entry scores is fairly uniform across the percentile ranges, though with more scores being above the average of 13. The average reduction after CAT intervention is approximately 5–6 for each percentile band in most services. This suggests that the average acute treatment scores in community (CAT) HoNOS scores in the above table reflect consistent improvement in CAT clients.

Summary of statewide data

- While there may be variations at individual AMHS, from the available data, a number of statewide trends seem apparent about the focus and nature of CAT activities.
- Many ECAT and CAT services share staff and ECAT largely report through the CAT data set. CAT and ECAT both report on activity in ED.
- The CAT service has significantly increased their response to acute health, police, ambulance services and ED.
- This is very likely to be in response not only to demand in EDs but also to the increase in funding to ECAT.
- It appears that the number of assessments conducted by CAT have grown substantially.
- The diagnostic profile of clients who receive CAT contacts suggests that the service is now seeing fewer clients diagnosed with ‘behaviour and emotional disorders – onset usually in childhood and adolescence’ that is, usually younger people and fewer with ‘dementia’, typically older people. Clients with ‘mood affective disorder’ (for example,

depression, bi-polar and delusions), particularly those with the high-prevalence condition of depression, may be more likely to attend ED. This may account for the significant increase in these clients seen by CAT services.

- When CAT services engage in short-term, intensive treatment in the community, it seems that the people who are able to utilise this service, fare as well as those in acute units. This is consistent with the positive findings in the research for treatment of acute mental illness in the community.

The next section examines the response to a survey concerning CAT functions by various stakeholders.

Part 5: Analysis of CAT survey data

A survey was developed to scope the extent of change in CAT practice against the benchmark of the 1994 guidelines and to learn how CAT services:

- prioritise their functions
- assess their performance on these functions
- work with police
- identify their clinical and customer-service training needs.

The survey was adapted for varying audiences, with core questions remaining consistent so comparisons could be made between different groups. Those aspects of the surveys that are relevant to CAT service delivery are reported here. (See appendix 3 for the CAT managers survey.)

The surveys were piloted at two AMHS during August 2006 and the content was modified in response to pilot site feedback and FEMAC members' feedback. Surveys were distributed to all AMHS' CAT managers, AMHS managers, clinical directors, program managers as well as AMHS consumer and carer consultants. Copies were also emailed to the executive committee of the Carers' Network, the Victorian Mental Illness Action Council (VMIAC) and the GPDV Mental Health Reference Group.

A total of 63 people participated in the survey. There are 21 AMHS and at least one respondent from 17 AMHS replied.

Respondent category	Response rate
Metro CAT managers	9
Rural Community Team/CAT managers	5
Consumers	7 (no responses from VMIAC)
Carers	9 (1 response from the Carers' Network)
Senior AMHS clinicians/managers	30
GPDV Mental Health Reference Group	3

While the numbers in each group do not permit strong conclusions to be drawn about the groups' views, especially for consumers and carers, indicative conclusions can be made. The GPs responses were reported with those from AMHS.

The tables containing the quantitative and qualitative responses are in appendix 4, organised by topic as found in the survey, while a summary of the survey findings is provided here.

Summary of survey data

There are a number of important findings in the survey data:

- CAT services appear to be fulfilling all the functions outlined in the 1994 guidelines.
- There appears to be significant ongoing involvement with police, often at the instigation of CAT.
- Operational arrangements seem to ensure 24–7 CAT availability, though there is variability in clinician numbers in a given shift.
- There is a high level of agreement as to the priority areas for CAT activity between CAT managers, consumers and carers: assessment, crisis interventions and short-term intensive treatment in that order. AMHS respondents also rated these highly but there was more variability in their scores.
- Although the amount of time being spent on the various functions seems congruent with the top three priority areas compared with the rating and time allocation to other areas, most time appears to be spent on assessment and crisis interventions. A number of respondents commented that there are insufficient resources to adequately provide short-term intensive treatment.
- Some rural services were having difficulties providing CAT functions due to a shortage of staff, including experienced staff, and inadequate arrangements to support them.
- The need to educate the public about the CAT role was mentioned by a number of different respondents in relation to curtailing the perception that CAT is an emergency service. Just as essential is the need to clarify expectations of the CAT service within AMHS given the diversity of views about priority functions in CAT work by AMHS respondents compared with those of CAT managers.
- Consumers and carers did not underscore 'responsiveness' in terms of prompt services as a significant issue. They were generally more focussed on receiving assessment and crisis intervention rather than commenting on the immediacy of the response.
- 'Responsiveness' in terms of customer service was more of a concern.
- CAT managers commented that more assessments and support of ED has eroded the ability to perform other functions, particularly intensive treatment in the community. This activity often has to be re-scheduled in the face of other demand. Insufficient availability of intensive treatment in the community was also an issue for consumers and carers.
- Not unexpectedly consumers and carers do not rate CAT performance as highly as the CAT managers. However the gap between their perceptions of service performance is not great. CAT managers acknowledged that they needed more training in assisting APMHS and CAMHS clients.
- Consumers, carers and AMHS respondents tended to be more concerned with poor communication by clinicians. Consumers and carers also wanted more education and support with managing acute mental illness in the community.

- It was hypothesised that multidisciplinary CAT teams may be in a better position to provide family-centred practice. Many of the surveyed CAT services, especially metropolitan ones, do have multidisciplinary staff. Although no firm conclusions can be made on the basis of the survey results, it seems that more has to be done to achieve consumer- and family-centred practice than engaging staff from a variety of professional backgrounds. Relevant resources, such as a recently published clinical resource (25) that addresses cultural diversity, gender, dual diagnosis and related issues for CAT clinicians, are available.
- There was agreement among the survey groups that risk assessment and critical incident debriefing needed more attention. It is encouraging to see that CAT managers agree with consumers and carers that more work has to be done on issues such as family-centred practice and assessing client and family satisfaction.
- In fact it is a recurring theme with consumers, carers and AMHS respondents that the quality of communication needs to improve with CAT. For consumers and carers, it was not only that their views should be taken into account during and after a crisis, but also that they be seen as partners.

Part 6: Discussion and possible future directions

Evidence of CAT service responsiveness and effectiveness: the literature and quantitative data

There is limited literature about the 'customer service' aspect of a responsive CAT service or about service timeliness. However, the literature review suggests that CAT assessment and intensive treatment in the community is a viable and effective service for many acutely unwell patients. There is also evidence of consumer and carer satisfaction with this model. The role of assessment is important in so far as it is the prelude to treatment, but there does not seem to be conclusive evidence that the place of assessment, whether it be centre- or hospital-based or in the place of residence, determines the subsequent place of treatment for consumers. At a systemic level, there does not seem to be an evidence-based model for a preferred configuration of front-end services.

The 1994 CAT guidelines describe intensive treatment and support as 'the primary role of the CAT service'. This statement is contrary to the public perception that the CAT service should provide an immediate response to urgent requests for service, typically assessment and crisis intervention. There is undoubtedly a tension in CAT functions between urgent assessment in the community and short-term intensive treatment in the community. However it was speculated earlier in the report that the recent strengthening of ECAT services in ED would enable CAT to perform more community-based work.

An analysis of Victorian statewide data trends over that past five years and the survey results indicate that the demand for immediate access to assessment and crisis intervention services has redirected CAT activity. In turn this has reduced CAT service's capacity to perform short-term community-based intensive treatment. It appears that the number of assessments conducted by CAT has grown substantially.

The requirement to maintain access to assessment and crisis intervention services is unquestioned. What is of concern is that CAT services' ability to provide acute treatment in the community seems to be compromised. This was implied in the data, and many survey respondents commented that there are insufficient resources to adequately provide short-term intensive treatment.

The statewide outcome data suggest that although CAT clients receiving intensive treatment in the community may not be quite as unwell as those in acute units, both groups appear to undergo the same level of improvement by the end of the course of treatment. This is consistent with the positive findings in the research for treatment of acute mental illness in the community. The effective community treatment of people in the acute phase of their mental illness can therefore be considered a critical 'deliverable' in the mental health system.

Evidence of CAT service performance and responsiveness: qualitative data

The survey results were mainly used to check the fidelity of CAT practice with the 1994 CAT guidelines and to identify the possible scope for improvement in CAT practice. The overall tone of the survey responses from all groups demonstrated a regard for CAT staff and their work despite the perceived need for performance improvement in some aspects.

It was found that CAT services appear to be fulfilling all the functions outlined in the 1994 guidelines and there appears to be significant ongoing involvement with police, often at the instigation of CAT. Operational arrangements seem to ensure 24–7 CAT availability, though there is variability in clinician numbers in a given shift. As stated earlier there is a high level of agreement as to the priority areas for CAT activity between CAT managers, consumers and carers: assessment, crisis interventions and short-term intensive treatment in that order. Most time appears to be spent on assessment and crisis interventions. Consequently, the amount of activity in other CAT functions may be adversely affected. Among the key areas identified by the survey for improvement in service quality were CAT services' work with APMHS and CAMHS clients. There was agreement among the survey groups that risk assessment and critical incident debriefing needed more attention.

Not unexpectedly, consumers, carers and AMHS respondents did not rate CAT performance as highly as the CAT managers. However the gap between their perceptions of service performance is not great. CAT managers acknowledged that they needed more training in assisting APMHS and CAMHS clients. A recurring theme with consumers and carers was that the quality of communication needed to improve with CAT clinicians. It was not only that their views should be taken into account during and after a crisis, but also that they be seen as partners. At the same time, consumers and carers wanted more education and support with managing acute mental illness in the community. Such issues could be raised and dealt with through more systematic consumer and carer feedback mechanisms. These aspects of customer service are the responsibility of AMHS and should form part of their quality improvement processes.

Possible future directions for front-end services

CAT services have been in existence since the mid 1990s. They are an important part of 'front-end' services, which in addition to CAT, include triage and ECAT. ECAT services and their role have recently been strengthened both with additional funding and policy development, while 24-hour telephone triage services are continuing to be developed. Appendix 2 provides a more detailed summary of recent initiatives in front-end services from both a policy and funding perspective.

Enhancing triage

There is a need to change the balance of CAT activity to enable more intensive treatment in the community while maintaining timely assessment and crisis intervention. Not only can intensive community treatment be effective but also it is also consistent with the principle of treating people with a mental illness in the least restrictive environment. One way of achieving this is to ensure that CAT services are able to concentrate on their key functions. Telephone triage services are still evolving in a number of AMHS. An enhancement of the existing triage service could see triage clinicians more readily provide advice to people with psycho-social crises, and give guidance in situations involving mental illness. This is crucial in situations where early intervention and good management can achieve benefits for the ill person, delay the need for mental health intervention or result in appropriate referral to alternative service provision.

Enhanced triage could manage a proportion of clients that would otherwise be seen by the CAT service, by either providing appropriate telephone advice or connecting the person with other services in the mental health system. It is anticipated that with enhanced triage, those services where CAT clinicians are currently engaging in non-urgent assessments, CAT could turn their attention more to assessment and treatment of acute mental illness in the community. One consequence of enhanced triage may also be a possible reduction in ED presentations. Enhanced triage would not preclude the CAT service attending as soon as practicable (given the priorities at the time), but the consumer or carer could receive telephone triage support as needed until the arrival of the CAT clinicians. There are limits to the improvements that can be achieved in triage without the direction of additional resources to the area.

Diversifying the locations for CAT service delivery

At present, mental health assessments can occur in ED at any time, in the community mainly during extended business hours and to a more limited extent in community mental health centres during business hours. An alternative or additional way of maximising the amount of CAT service time could be to make selective but greater use of mental health centres as a daytime site for urgent assessments. This would use CAT clinician time more efficiently by negating the need for travel time and the routine presence of two clinicians. Not only could assessments occur in a more timely way, but also the more economical use of resources may permit a greater capacity to perform short-term intensive treatment.

This possibility needs further consultation with consumers, carers and clinicians as well as consideration of infrastructure requirements at some community mental health services. Experience has already lead AMHS to this direction and it should be noted that this idea builds on existing practice. The suggestion does not preclude outreach by CAT for assessment and crisis intervention, however it would facilitate CAT providing a spectrum of services, including assessment and acute community treatment.

Clarifying the roles of emergency and CAT services

In order to improve the existing emergency mental health response system needs to focus on enhancing the interface between mental health triage, CAT, emergency services and EDs, both locally and system-wide. More discussion with the police and ambulance emergency services is required regarding how to respond to crises, so that the pathways to treatment and care for consumers and carers are clear and appropriate. It would be preferable for existing emergency services to be strengthened to fulfil their emergency response role, recognising that the expertise of CAT services is to assess and treat acutely unwell people. An increased capacity for CAT services to deliver intensive community treatment may rely on additional targeted resources for that function.

There were several calls from most of the surveyed groups for better, more consistent practice and to widely communicate the non-emergency status of the CAT service. Through the review process, a number of stakeholders have suggested that the name ‘CAT’ be changed as it places undue emphasis on the crisis assessment aspect of the CAT role while underplaying the intensive community treatment aspect. Further, it may

advisable to clarify the role of CAT in relation to other front-end services. This also suggests that if policy or guidelines are to be developed, this should occur for front-end services rather than revising CAT guidelines alone. Policy development and a clear communication strategy could be supported by a working party and consultations with stakeholders.

Supporting CAT service quality

The survey responses contained a number of suggestions for enhancing CAT service quality. Improvement to service through more or better education and training should be part of local AMHS quality improvement activity, however the Mental Health Branch could support a process to identify the workforce capacity requirements of CAT clinicians. A clearer understanding of the knowledge, skills and attitudes required by CAT clinicians would inform professional development needs.

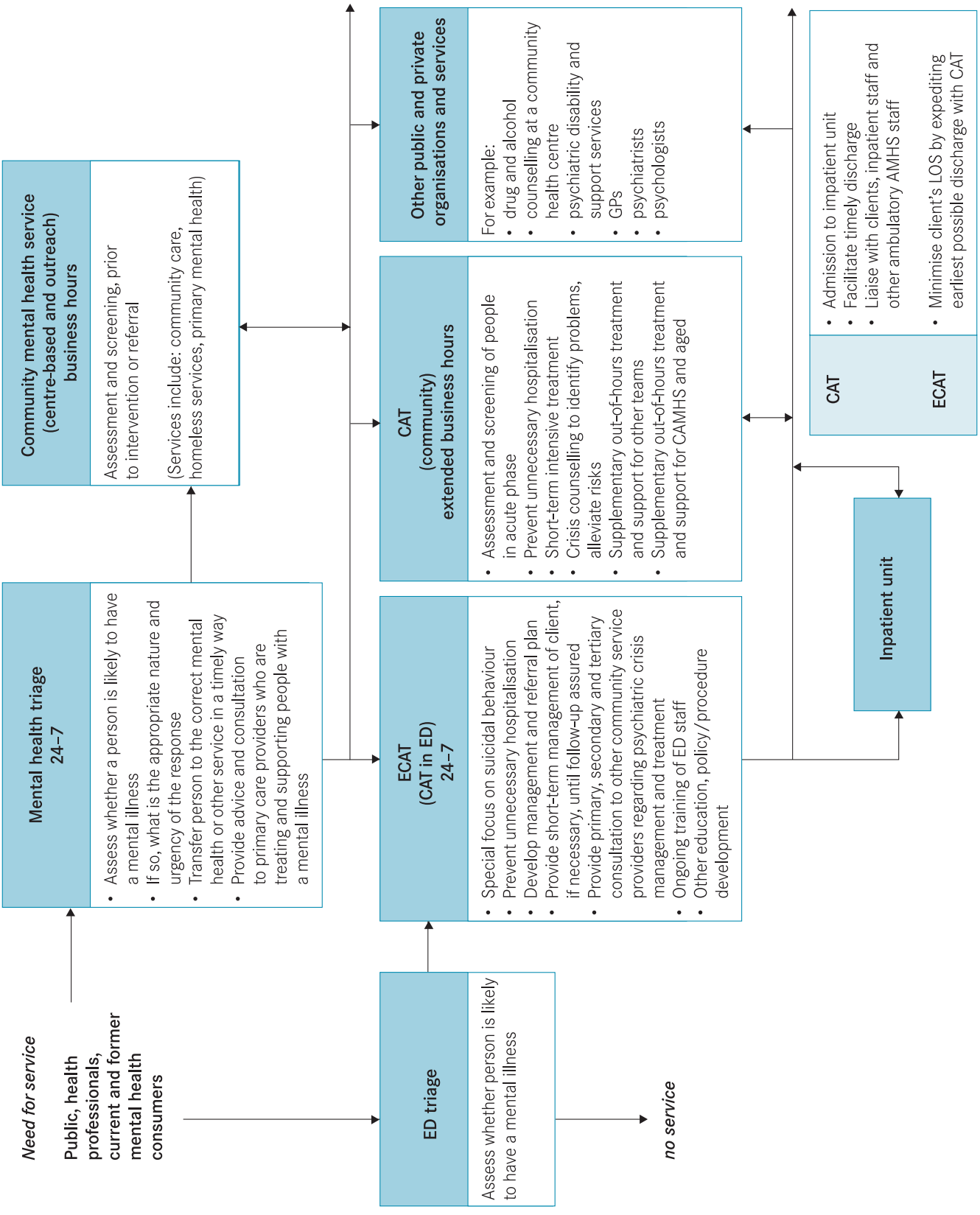
Strengthening the ability of telephone triage to appropriately respond to requests for advice and guidance as well strengthening the ability of CAT services to deliver their urgent assessment, intervention and intensive community treatment functions has the potential to use existing or additional resources in a way that re-balances the front end. Taken together this will enable CAT services to better perform their functions and will further improve responsiveness to requests for mental health service.

Conclusion

CAT and other front-end services are located within the broader service system that includes emergency services, mental health and primary care services. While the review focussed on CAT services, a larger question needs to be asked about the optimal interventions with and service pathways for people with a mental illness who undergo an acute episode. In particular for people who experience relapses, the relationship between front-end services and other parts of the mental health service system are instrumental in supporting efforts in illness prevention, relapse and recovery management. The developments occurring in primary care, particularly the improved access by GPs to counselling services, are worth noting. These changes are important for people who have mental health issues, but do not require specialist mental health services. Just as importantly, there are increasing opportunities for partnerships between area mental health services and primary care providers to work with people who have a serious mental illness, whose treatment and care can be shared or managed in the longer term by the primary care sector.

Appendices

Appendix 1: Pathways to service through the front end



Appendix 2: Recent and current developments in the Mental Health Branch (2003–07) that support front-end activity

Front-end service	Initiative (year)	Description	Anticipated impact on front end/patient flow
Triage	Triage Redevelopment Project (2004–05)	• Five projects funded covering 11 AMHS, were funded at a total cost of $550,000 to improve the local responsiveness of triage functioning • Each of the project reports has recommendations for improving practice in the context of their local issues • The project reports are being synthesised into triage training packages covering such matters as staff triage guidelines, change management and service quality improvement. The training packages will be available soon	• Improved customer service experienced by potential and current mental health clients: timely service, accurate referral to appropriate service
	Triage program management circular (2005)	• Prompt and professional response to inquiry • Central telephone number for each AMHS • 24–7 coverage • Assess information: eligibility and priority for specialist mental health service • Offer advice on suitable alternative services if ineligible for AMHS • Ensure continuity of care by having access to MH client information and protocols/MOUs/agreements with other parts of the MH and community service systems	• Client or prospective client directed to the correct part of the mental health service system or an alternative service in a timely way • Better customer service
	Triage improvement funding (2005–06)	• Funds distributed to each AMHS ($37,500 each) for triage infrastructure, such as IT and telephony	• Improved responsiveness to clients as a result of better infrastructure
	Evaluation of the Southern Health Psychiatric Triage Service (in progress: 2006)	• Assess the impact of a centralised single point of entry for triage on client satisfaction, timeliness of client reaching the appropriate service and demand on various parts of the mental health service system before and after the introduction of the new triage process • Identify best practice standards that may be applied to other services	• Improved quality of service experienced by potential and current mental health clients: timely service, accurate referral to appropriate service
	Triage Outcome Classification Project (in progress: 2006)	• Develop a standardised system for prioritising triage contacts	• Statewide consistency in triage response • Greater clarity regarding expected responses to different presentations
Triage in ED (prior to ECAT)	Emergency Care Practice Project (2004–05)	• Strengthen the Australasian Triage Scale by introducing mental health specific descriptors • Improved decision-making by ED triage staff whether or not a person needs assessment by ECAT • Prioritising people who need an ECAT assessment • Referring other presentations to appropriate alternative services • The tool is currently being implemented in EDs across the State	• Reduce the wait in ED by people presenting with a potential mental health • More people assessed within a four-hour timeframe • Improved cooperation between ED staff and ECAT

Front-end service	Initiative (year)	Description	Anticipated impact on front end/patient flow
ECAT (started 1998–99)	Expansion ECAT service (2004–05, 2005–06, 2006–07)	• Assessment and intervention for people presenting to EDs with mental problems • Management and referral plan, including for people who are not eligible for MH services • Short-term management of people with a mental illness until follow up is assured • An additional $3.9 million over three successive financial years has been committed to increase the number of EDs with 24–7 or extended hours access to ECAT (approx 34 EFT)	• More timely access to assessment, intervention and 'holding strategy' services for people with a suspected mental illness in previously under-resourced ECATs • Improved continuity of care for people between assessment and transfer to appropriate services in the mental health or other service systems in previously under-resourced ECATs
CAT	Expansion of CAT service (2003–04)	• Assessment and screening of people in acute phase • Prevention of unnecessary hospitalisation • Short-term intensive treatment • Admission and timely discharge from acute unit • Supplementary out-of-hours treatment and support • An additional $1 million over three successive financial years has been committed to increase the numbers of CAT staff in a number of services, especially South West AMHS	• More timely access to assessment, intervention and treatment services in the community for people with a suspected mental illness • Improved continuity of care for people between assessment and transfer to appropriate services in the mental health or other service systems
	Prevention and Recovery Care (PARC) service (2003–04, 2004–05, 2005–06, 2006–7)	• PARC is a new supported residential service for people experiencing a significant mental illness but who do not need or no longer require a hospital admission. In the continuum of care they sit between adult acute psychiatric units and a client's usual place of residence • PARC services assist in averting acute admissions and facilitate earlier discharge from acute units. PARC clients receive 24-hour residential coverage and psycho-social support from PDRSS staff plus twice daily 'in-reach' CAT staff • Average length of stay is approx 14 days with a maximum of 28 days • There are three operational 10-place PARC services and four other approved PARC services in the development phase • Funding is available for two additional PARC services (There is also an eight-bed rehabilitation/accommodation service in the metro area)	• Increased capacity in the acute end of service spectrum • The 'step up' early intervention capacity of PARC may avoid admissions for some mental health patients • The 'step down' aspect of PARC from the acute unit may result in better recovery for some mental health patients and therefore lower readmission rates • Similarly, timely discharge to a PARC service may enable more clients to be treated in the acute unit or for clients to be treated for appropriate lengths of time in the acute unit

Front-end service	Initiative (year)	Description	Anticipated impact on front end/patient flow

CAT continued	Police protocol (2004)	• The Victoria Police–Department of Human Services Mental Health Branch Protocol,
		  • aims to establish clear guidelines for police and mental health services staff in handling situations where both services are involved
		  • to promote an adequate standard of care to a person with a mental illness in such a situation
		  • to outline procedures for the management of psychiatric crises and high-risk situations, which involve people who have a suspected mental illness
		• The protocol clarifies the responsibilities of both services within available resources: how the police can support mental health workers in a crisis situation and vice versa
		• The respective Department of Human Services and Victoria Police legal units endorsed the content of the protocol. The Chief Commissioner Victoria Police and the Executive Director Metropolitan Health and Aged Care Service (Department of Human Services) signed it in 2004
			• Improve quality of interaction between the services and the person with a suspected mental illness in a situation
			• Optimise client flow from the community to the acute mental health or other settings

	Emergency Services Liaison Committee (ESLC – 2004)	• ESLC were set up in all 21 area mental health services in the late 1990s. They were mandated under the 2004 'Protocol between Victoria Police and Department of Human Services Mental Health Branch' connected with Victoria Police's local priority policing policy and include representatives from local mental health services, police and ambulance services. ESLC often resolve issues of mutual concern at the local level • The MHB has asked the ESLC in each AMHS, to operationalise those aspects of the police–departmental protocol related to timely response by Police, ambulance and mental health services to a crisis situation. • ESLC are expected to submit their documentation on this issue by 29 September 2006. Once the ESLC report back to the MHB, the documentation will be tabled at the IDLC for further consideration	• Local application of the above with agreements between Victoria Police and mental health services

Appendix 3: Survey for CAT managers

AMHS in which the CAT team operates_____

1. How do you rate the following CAT functions in order of priority? As far as possible number them 1–8 or 9, with 1 being the highest priority and 8 or 9 being the lowest.

Assessment of people in the acute phase for whom inpatient admission is likely outcome	
Short-term intensive treatment in the community for existing clients of the service	
Crisis intervention to identify problems, alleviate risks, plan and where appropriate implement crisis management plan	
Supplementary out-of-hours treatment and support for clients of other teams (including CCT, MST and homeless)	
Supplementary out-of-hours treatment and support for clients of CAMHS and aged psychiatry	
Admission to acute mental health unit	
Liaison with clients, inpatient staff and other ambulatory AMHS service staff	
Facilitation of timely discharge from acute unit	
Other, please specify	

(Functions taken from 1994 Psychiatric assessment and treatment services guidelines)

2. What is the rationale or driving force behind the priorities?

3. *For non-integrated CAT teams:* estimate the percentage time the CAT team spends on the following activities

For integrated teams: **of the time spent performing CAT functions**, estimate the percentage of this time the team spends on the following activities.

Assessment of people in the acute phase for whom inpatient admission is likely outcome	
Short-term intensive treatment in the community for existing clients of the service	
Crisis intervention to identify problems, alleviate risks, plan and where appropriate implement crisis management plan	
Supplementary out-of-hours treatment and support for clients of other teams (including CCT, MST and homeless)	
Supplementary out-of-hours treatment and support for clients of CAMHS and aged psychiatry	
Admission to acute mental health unit	
Liaison with clients, inpatient staff and other ambulatory AMHS service staff	
Facilitation of timely discharge from acute unit	
Other, please specify	
Total	100%

4. Do you feel this has changed over the past five years? If yes, give a brief indication in what way.

5. Please rate the team's performance on these functions.

1=very satisfactory, 2=satisfactory, 3=variable, 4=unsatisfactory, 5=unable to perform
Please give one or more reasons for ratings that are recorded in the 3–5 range such as time constraints, skills training and safety issues

	Rating	Reason if rating between 3–5
Assessment of people in the acute phase for whom inpatient admission is likely outcome		
Short-term intensive treatment in the community for existing clients of the service		
Crisis intervention to identify problems, alleviate risks, plan and where appropriate implement crisis management plan		
Supplementary out-of-hours treatment and support for other teams (including CCT, MST and homeless)		
Supplementary out-of-hours treatment and support for clients of CAMHS and aged psychiatry		
Admission to acute mental health unit		
Liaison with clients, inpatient staff and other ambulatory AMHS service staff		
Facilitation of timely discharge from acute unit		
Other, please specify		

6. How is demand for 'assessment and screening of people in the acute phase' prioritised? For example, by agreed criteria, standardised evidence-based tools, a combination of both or other?

7. If there are periods where demand for 'assessment and screening of people in the acute phase' prevents or seriously delays CAT staff from responding to other functions, how is this managed? How often does this happen?

Does the reverse occur, that is, treatment in the community prevents response to acute assessments? How often and how is this managed?

8. What percentage of CAT work is with police? How much is initiated by CAT staff and how much is initiated by police request? How do you manage the police requests for urgent response to which CAT staff are unable to immediately respond?

9. What hours of operation does your CAT service have? What hours is your CAT service available for overnight call-out? What are the arrangements with ECAT during overnight call-out?

Time of day	Hours	EFT	Professional disciplines and designations
AM			
Overlap shift			
PM			
Overnight arrangements			

10. Are CAT and ECAT managed in the same program?

11. How often and in what circumstances do CAT refer to ECAT and ECAT to CAT? Briefly describe the relationship between the CAT and the ECAT.

12. What are the current arrangements for clinical supervision and training/professional development for CAT staff? And what are the objectives for the training?

13. What areas of CAT clinical practice do you feel could be updated? For example, risk assessment, critical incident debriefing. Please provide reasons why updating is needed ands suggestions for improvement.

14. What other areas of CAT practice do you feel could be updated? For example, customer-focussed practice: assessing client/family satisfaction, family-centred practice, working with CALD communities, police–CAT interactions. Please provide reasons why updating is needed ands suggestions for improvement.

15. How do you collect and respond to information about client/carer and other key stakeholder satisfaction with CAT service?

16. Can you give any examples of best practice referrals from CAT to other parts of the AMHS and from CAT to primary care providers? Are these supported by MOUs/ protocols/agreements?

17. Any comments about how CAT and the mental health service system in general work with mental health clients and any improvements that could be made?

18. Any comments you wish to make that have not been covered by the survey?

Thank you!

Appendix 4: CAT service survey results

CAT functions by average rating of priority by survey respondents

(Ratings: 1 – 8)

CAT function	Metro CAT managers average rating of priority	Rural CAT managers average rating of priority	Consumers average rating of priority	Carers average rating of priority	Other MH service managers/ providers average rating of priority
Assessment of people in the acute phase	2	3	2	2	2
Short-term intensive treatment in the community	3	4	4	4	4
Crisis intervention to identify problems, alleviate risks	2	3	3	1	3
Supplementary out-of-hours treatment and support for clients of other teams	6	5	5	6	5
Supplementary out-of-hours treatment and support for clients of CAMHS and aged psychiatry	7	5	5	7	6
Admission to acute mental health unit	5	5	4	4	4
Liaison with clients, inpatient staff and other ambulatory AMHS service staff	7	7	7	6	6
Facilitation of timely discharge from acute unit	5	5	6	6	5
Other, such as client review, community education, consultation		5			

Comments: Metropolitan and rural CAT managers, consumers and carers agreed which were the top three CAT functions – (1) assessment of people in the acute phase, (2) crisis intervention to identify problems, alleviate risks and (3) short-term intensive treatment in the community, in that order. Consumers, carers and AMHS respondents also allocated equal third rating to the facilitation of timely discharge from acute units. However with the three groups, the average rating masked great variability in the individual scores, meaning that there is considerable disagreement within these groups as to the priority of this function.

Several carers emphatically stated their priority, embedded in all CAT functions, was for CAT clinicians to provide information, education and support to carers during consumer's the acute phase, whether the consumer is being treated in the community or in the acute unit. It was noted that if this is done well in the community, there may be less need for admission.

The average ratings of priority by AMHS respondents masks great variability in the rating of most CAT functions. This may be a function of the greater number of respondents from AMHS, but it also suggests that there are widely differing expectations of the CAT service within AMHS.

Estimated average percentage time performing CAT functions (CAT managers only)

CAT function	Metro CAT managers estimated average percentage time	Rural CAT managers estimated average percentage time
Assessment of people in the acute phase	14	21
Short-term intensive treatment in the community	34*	23
Crisis intervention to identify problems, alleviate risks	18	17
Supplementary out-of-hours treatment and support for clients of other teams	7	9
Supplementary out-of-hours treatment and support for clients of CAMHS and aged psychiatry	4	5
Admission to acute mental health unit	8	12
Liaison with clients, inpatient staff and other ambulatory AMHS service staff	7	9
Facilitation of timely discharge from acute unit	7	11
Other, such as client review, community education consultation		7

**This figure has been enlarged by the response of one CAT service where there is no ED and therefore CAT staff are able to engage in a far more intensive community treatment.*

Comments: On average it is estimated that metro CAT services spend approximately 32 per cent of their time on assessment and crisis interventions and 34 per cent on short-term intensive treatment (probably an underestimate and overestimate respectively). On average rural CAT services spend approximately 38 per cent of their time on assessment and crisis interventions and 23 per cent on short-term intensive treatment. Taking metro and rural figures together, most time is spent on assessment and crisis interventions.

Average rating of CAT service performance on functions by survey respondents

(1=very satisfactory, 2=satisfactory, 3=variable, 4=unsatisfactory, 5=unable to perform)

CAT function	Metro CAT managers average rating of performance	Rural CAT managers average rating of performance	Consumers average rating of performance	Carers average rating of performance	Other MH managers/ service providers average rating of performance
Assessment of people in the acute phase	2	2	3	2	2
Short-term intensive treatment in the community	2	2	3	2	2
Crisis intervention to identify problems, alleviate risks	2	2	2	2	2
Supplementary out-of-hours treatment and support for clients of other teams	2	2	2	3	3
Supplementary out-of-hours treatment and support for clients of CAMHS and aged psychiatry	3	2	3	3	3
Admission to acute mental health unit	2	2	2	2	2
Liaison with clients, inpatient staff and other ambulatory AMHS service staff	2	2	3	2	2
Facilitation of timely discharge from acute unit	2	2	3	3	3

Comments: Metro and rural CAT managers tended to rate performance on most functions as satisfactory, with the metro services more inclined to rate out-of-hours support to CAHMS and aged psychiatry as variable.

Consumers were the most critical of CAT service with an average rating of 'variable' for five out of the eight functions. Two areas of variable performance were functions considered a priority, namely assessment of people in the acute phase and short-term intensive treatment in the community.

Carers and AMHS respondents were less critical of CAT service than consumers with an average rating of 'variable' on three out of the eight functions. Carers, consumers and AMHS respondents agree that facilitation of timely discharge from acute unit and out-of-hours treatment and support for clients of CAMHS and aged psychiatry were variable.

Changes over the past five years

Most metro and rural CAT managers observed that their staff were now conducting more assessments and crisis interventions. One service perceived that there was no change.

Metro CAT managers comment that support for ED and acute activity meant there was less time for ongoing care of clients and carers. There were more requests from police, GPs and ED.

Rural CAT managers comment that there is a reduced ability to provide short-term intensive treatment. Demand for acute beds can lead to more acutely unwell clients being managed for longer in the community.

CAT operational issues

Managing demand for 'assessment and screening of people in the acute phase'

As acute assessment takes priority, the metro CAT managers almost all re-schedule home treatment and other functions. Rural CAT managers also do this or use clinicians from other parts from the service.

In comparison, the majority of consumers suggested training and using staff from other areas and carers wanted more CAT teams and a priority system.

There were a wide variety of solutions offered by AMHS. The two most common suggestions were to introduce more CAT resources, especially in high population growth areas and during peak periods, and to concentrate on CAT core functions. There was disagreement on what constitutes CAT core functions.

Adequacy of current CAT hours in meeting client needs (AMHS only)

Approximately half of the respondents stated that the current CAT hours were sufficient. A minority commented that rural regions have insufficient resources for out-of-hours work and others wanted to further strengthen police, ambulance and ED for out-of-hours work.

CAT work with police (CAT managers only)

Almost all metro CAT managers estimated that approximately 10–20 per cent of their work involved police. CAT was more likely to initiate contact with police than vice versa. This is likely to be an example of safe practice in assessment. Most rural CAT did not provide an estimate of time involved with police.

Operation of CAT service (CAT managers only)

Both metro and rural CAT services operate extended business hours with arrangements for overnight coverage. Although there are variations in the business hours, typically they are 8.30 am until 10.30 pm. There are usually on-call overnight arrangements. There are also variations between services in the number of EFT allocated to a given shift. The minimum is two clinicians per shift.

It is hypothesised that multidisciplinary teams may tend to be more consumer and family focussed. The main professional group in CAT teams appears to be psychiatric

nurses. Seven out of eight metro teams have at least some representation from another profession, usually social work or psychology, while this is the case for two out of five rural teams.

Circumstances in which CAT refer to ECAT and ECAT to CAT (CAT managers only)

CAT and ECAT refer to each other on a daily or at least regular basis. Clients in ED may be referred to CAT for home treatment and clients may be seen in ED where there are safety concerns for CAT. One rural service commented that on weekends CAT refers to ECAT those clients who are receiving short-term intensive intervention but do not need admission. This is part of their crisis safety plan.

Need to update CAT clinical practice

(more than one response possible)

Clinical area	Metro and rural CAT	Consumers	Carers	Other MH managers/ service providers
Risk management	4	2	1	7
Critical incident debriefing	3	2	4	2
CAT manager 'other': training in drug and alcohol, child and adolescent issues, updates on the Mental Health Act, processes for identifying need, triage training	7			
Consumer and carer 'other': Need to regularly updating practice in relation to client needs, client/family liaison, include working with carers as partners, refer families to carer consultant, police liaison		1	4	
AMHS 'other': working with local teams, GP liaison, client/family liaison, better work with Axis 2 clients, overdose assessment, clinical documentation and handover, medications, drug and alcohol, early intervention and discharge				20
No response		3		4

Comment: There should be consistent criteria, tools, clinical documentation, data and response expectations for CAT across the state.

Need to update other areas of CAT practice

(more than one response possible)

Practice area	Metro and rural CAT	Consumers	Carers	Other MH managers/ service providers
Customer-focussed practice	4	2	2	7
Assessing client/family satisfaction	3	3	4	8
Family-centred practice	4	4	4	9
Working with CALD communities	3	2	2	8
Police–CAT interactions	4	2	3	7
CAT manager 'other': CBT in crisis settings, evidence-based practice, treatment plans, outcome measures, feedback from consumers, carers and other services, the importance of family history and single session/ solution-focussed therapy	6			
Consumer and carer 'other': Information to consumers and carers regarding how to cope, need access to step up–step down service, give families carer consultant contact details, better use of emergency plans and advance care directives		2	7	
AMHS 'other': working with residential care facilities, clients with behavioural disturbances, communication with other clinicians, management of dual diagnosis, non-pharmacological interventions and advanced nursing practice, assisting GPs and other referrers regarding acute care/referral, treating people with dignity/customer service				12
No response				6

Comments: Approximately half of the CAT managers, consumers and carers thought that more training was needed in risk management and critical incident debriefing. The latter was seen as particularly important by carers. AMHS noted the importance of providing realistic expectations of the CAT service. Some of the suggestions for practice improvement were also deemed applicable to the other mental health teams. Family/carer issues are often neglected due to volume of work.

Collectively, CAT managers, consumers, carers and AMHS respondents regarded one or more of the first five practice areas in table 13 as needing further attention. As one carer expressed it, 'not all clinicians need updating in all areas'. It is noteworthy that 'other' training possibilities by CAT were in the realm of professional skills. Consumers and carers were more interested in receiving support and information about how to cope.

Additional comments

Comments about how CAT and the mental health service system in general work with mental health clients:

There was a wide range of views expressed by CAT managers, consumers, carers and AMHS respondents. Here are some examples:

CAT managers:

- There is a need to focus on family and carers.
- Take the 'crisis' out of CAT as the name sets up a totally inappropriate expectation.
- The pressure generated from ED waiting times has shifted focus from community care provision to timely responses to the ED.
- There is a need to prevent burnout of CAT clinicians – provide opportunities to experience other CAT services or use expertise in other ways.
- Review the CAT model.

Consumers:

- More consideration and communication needed with consumers.
- More training for CAT regarding a professional, respectful approach in crisis, on the telephone and in other contacts.
- Rotate staff between various roles so they get fresh perspectives.
- Need to educate the public about what CAT can and cannot provide – it is not an emergency service.

Carers:

- More communication and involvement by carers.
- More resources including outreach and accommodation.
- More access to education and information.
- More prevention and early intervention.

AMHS respondents (includes the GP responses):

- There is a sense of rigidity about the CAT role and it is too focussed on the notion of crisis.
- Develop consistent KPIs for CAT.
- There is community misperception that CAT is an emergency service such as ambulance and police.
- A number of 'long-stayers' in the CAT service may be burnt out.

- Generally, clinicians do provide customer-focussed, family-sensitive and holistic services to clients and their families.
- CAT needs to concentrate on the original intention of the service.
- Better collaboration in treatment and care planning through the use of Advanced Care Directives.
- In some rural areas CAT work is sometimes carried out by staff with insufficient experience and inadequate support.
- Greater capacity to outreach/home visit by case managers is likely to relieve some demand on CAT.

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