Department of Human Services

Mental Health and Drugs Division

Submission Brief: Child and Youth Mental Health Service Redesign Demonstration Projects

Submission Due Date:	**Friday 17 October 2008 [4:30pm]**
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State Government Victoria Department of Human Services

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A Background and overview

This document has been prepared to assist interested service providers to prepare and lodge a submission to undertake one of two Child and Youth Mental Health Service Redesign Demonstration Projects ('the Demonstration Projects'). These four-year demonstration projects focus on improving outcomes for children and young people aged 0-25 years through the reform, expansion and better integration of mental health services funded through the three tiers of government.

The demonstration projects are to commence in 2008-09. The Department of Human Services (DHS) is seeking suitably qualified and experienced service providers to engage in a rigorous process of local planning and service redesign in order to deliver the services and reform agenda described in this brief. The project focus outlined in this submission brief draws on the mental health reform strategy green paper *Because Mental Health Matters*. Successful consortia will develop plans in the context of the mental health reform strategy statement which is due for release late 2008.

This is not an open public tender process — only consortia including at least Victorian public mental health services (both clinical and psychiatric disability rehabilitation and support services) and a primary health organisation (see section 2.7) are eligible to lodge a submission for these demonstration projects.

Because Mental Health Matters is available on the Mental Health and Drugs Division website at http://www.health.vic.gov.au/mentalhealth

Key project dates are indicated below.

Call for submissions advertised	22 August 2008
Information/briefing session for interested service providers	4 September 2008
Closing date and time for submissions	17 October 2008, (4:30pm AEST)
Shortlisting to be completed by	24 October 2008
Interviews to be conducted by	31 October 2008
All service providers to be advised of outcome by	7 November 2008
Project activities commence by	5 December 2008

Part D of this document provides a template for submissions.

1. Background

1.1 Organisational context

DHS is responsible for funding a wide range of services to diverse client groups across Victoria. The Department's principal function is to ensure the delivery of a range of health, housing and community services. Our mission statement is:

> To enhance and protect the health and well being of all Victorians, emphasising vulnerable groups and those most in need.

It is State Government policy that the funding of non-government agencies for the provision of services to the community be undertaken in a context of partnership between the Government and the service sector. To this end, DHS signed a partnership agreement with funded agencies in the health, housing and community services sectors in October 2002. The agreement is supported by regular partnership forums.

The projects described in this brief will be managed by the Mental Health and Drugs Division of DHS, a new division comprised of the former Mental Health and Drugs Policy Branches. Its functions encompass public sector policy, program, and service and workforce development in relation to mental health and drug matters.

1.2 Demonstration projects

The Victorian government has made available funding to seed mental health reform aimed at improving the way mental health care is provided for children and young people aged 0-25 years. As part of the whole-of-government Mental Health Reform Strategy, two demonstration projects will be funded to showcase reform by demonstrating how a coalition of providers can plan and deliver an earlier, better integrated and more comprehensive service response to children and young people within this age group who experience a mental health problem.

Existing services are operating under significant demand pressure. Current models of service are typically limited to responding to the needs of those with severe and complex problems — often at time of crisis. There is little capacity for early intervention and limited systematic attention to more commonly occurring and less severe mental health problems.

Services are now being invited to take up an opportunity to lead reform in the way that mental health care is provided to children and young people within their area. Existing resources will be bolstered by new funding to enable service redesign and system reform that will deliver a better system of mental health care for children and young people in two demonstration areas — one metropolitan and one rural.

These four-year projects will address the issues raised in the mental health reform consultation paper *Because mental health matters*. The focus is on both improving mental health service provision more broadly and strengthening prevention and early intervention capacity in universal (e.g. Maternity, Maternal and Child Health Nursing Services, GPs, kindergartens, schools and vocational services) and secondary level services (paediatricians, private psychiatrists and psychologists, allied health and others). Barriers to service access and continuity

of care within mental health services and between mental health and other services are to be addressed. The projects will draw upon evidence-based responses targeted at the specific and changing needs of children and young people.

The lead mental health service and fund holder designated in each of the two projects specified in this brief will be responsible for the timely delivery of the project outputs, activities and services described herein.

The projects will be supported by an independent evaluation process to be funded by the Mental Health and Drugs Division that will work closely with the consortia (see p.16). Workforce development initiatives to assist in meeting the needs of staff in pursuing government's mental health reform directions will also be provided and will be available to both demonstration project staff and mental health services across the state (see p.14).

In addition, in 2008-09 one-off service development grants will be provided for up to six applicant consortia that were not awarded a demonstration project but whose submission constituted a strong case for further planning and developmental work targeted at reform.

2. Objectives and scope of the demonstration projects

2.1 Purpose of the demonstration projects

The demonstration projects will aim to reduce the prevalence of untreated mental health problems and disorders across the 0-25 age group within a designated geographical area. This will be achieved through earlier recognition and timely responses to a larger number of children and young people with a broader range of mental health problems and disorders.

Achieving this will require substantial reform to the way that services are currently provided. Key parameters to be re-examined include who should receive services and from whom, the timing of service engagement and support, the type of interventions delivered, the way that services are organised and the location of service outlets.

Changing these parameters will require building capacity to respond more systematically to varying levels of mental health need across a range of services over time, beginning within specialist mental health services, drug and alcohol services, primary health services and developing more effective alliances and partnerships with early childhood and youth services, schools, vocational services, housing and social supports. While the focus will be sub-regional, the success of the work being undertaken will be measured through formative and summative evaluation and will inform mental health reform across the State.

Initially the demonstration projects will develop approaches primarily aimed at 'providing earlier age-appropriate treatment and support to children and young people with emerging or existing mental illness and their families'. This will address 'Focus Area 2.2' of the mental health reform consultation paper *Because mental health matters*. Over time, the consortia will develop broader alliances capable of 'strengthening capacity for early identification and intervention through universal services, including early childhood services and schools', thereby addressing 'Focus Area 2.1'.

The demonstration projects will provide a structural framework to support and share learning and to inform the statewide reform agenda. While the focus will be on trialing new ways of improving service access and responsiveness, it is not intended that the demonstration projects will pre-empt changes to governance of mental health services. The findings of the demonstration projects will, however, inform future directions in this area.

2.2 Scope of reform

The demonstration projects will require redesign of the way that services are currently provided, including the timing of responses, the type of interventions employed, the partnerships required and the service settings and locations.

Consortium partners and others services will be expected to make a concerted early effort to define the medium to longer term reform vision for the project area consistent with the intention of the directions being proposed for the Mental Health Reform Strategy, which will provide the statewide context for local action. A reform action plan to be developed by the consortia (see section 2.8) will describe the staging of initiatives and innovations.

While the development of a reform action plan will be informed by and aligned with local needs, responses to a number of key questions about 0-25 reforms will be sought through project activities irrespective of the catchment area. These include:

- How can barriers to seamless, effective mental health care for those with severe illness and complex problems across this age range be removed within specialist mental health services and between specialist services and other service sectors?

- How can clinical and PDRSS responses for young people with serious mental illness become better integrated, more age-appropriate and recovery focused?

- How can new early intervention services for children (0-12) and young people (12-25) best operate in partnership with primary care networks that increase the number of children and young people with a broader range of problems and disorders being assessed and treated earlier and more effectively?

- How can partnerships best work to promote an integrated response between mental health services, early childhood services, child & family services, schools, support, housing and educational/vocational services?

- How can program partners take better account of the particular needs of vulnerable young people involved with child protection and youth justice in service provision?

In responding to these questions, service redesign and reform endeavours must take into account the particular and changing mental health needs across the developmental spectrum within the 0-25 year old cohort. Consortia will consider and develop service responses for infants and pre-school children, primary-school-aged children, young adolescents of secondary school age, older adolescents and young adults.

2.3 Reform outcomes

The *Because mental health matters* green paper discusses key changes required in order to achieve better outcomes for children, young people and their families. Some reforms will be system-wide, such as the goal of strengthening the capacity for early identification and intervention through universal services, and the goal of providing earlier and age-appropriate treatment and support to children and young people with emerging or existing mental health problems and their families. Other goals aim to deliver appropriate mental health support for particular groups of vulnerable young people, such as those who are homeless or on statutory orders. In addition, service responses need to be strengthened for clients who present with complex presentations, such as eating disorders or dual diagnosis. The green paper proposes a new service configuration (*Because mental health matters,* p. 62) for delivering, and sustaining, this broad reform agenda.

These projects will therefore aim to deliver substantive and measurable change in the interrelated areas of client outcomes and service system capacity. In particular, the projects are expected to deliver:

Outcomes for children, young people and their families:

- Earlier and appropriate interventions that minimize the impact of problems on learning and development.
- A welcoming culture within services that are easier to access and use.
- Earlier access to help through community based services and more rapid responses where problems are severe and complex, and require intensive community and acute hospital care.
- A broader range of evidence-based age appropriate treatment options.
- More flexible services in familiar local settings such as schools, community health settings, and General Practice (GP) clinics.
- Continuity of care across different service types and programs.
- Recovery-focused care, where clinical and non-clinical support services work together to address whole-of-life circumstances to maintain or re-establish engagement in age-appropriate and meaningful social activities as part of recovery.

Outcomes for the service system:

The redesign of services and reforms pursued in these projects will result in:

1. More effective and efficient service provision resulting in increased numbers of children and young people with a broader range of mental health problems accessing services, being assessed and, where appropriate, treated earlier.
2. Service delivery based on cross-sector regional planning and the development of functional partnerships that draw upon the broad range of services able to impact upon mental health, and improve access to age-appropriate mental health care within communities.

Activities will include:

- Collecting and sharing data about local areas of need and disadvantage
- Mapping local service responses and developing co-ordination and care pathways in response to community need
- Providing a broader range of evidence-based treatment options, tailored to age, severity and the stage of problem or illness.
- Establishing a broader range of acute care options such as day programs and intensive community responses.
- Better integrating and coordinating flexible service responses across sectors including coordinated mental health and drug and alcohol service provision.
- Improving continuity of care across service settings, particularly at critical transition points within services (for example between CAMHS and Adult Mental Health Services).
- New service and care models to engage vulnerable 'at risk' children, young people and their families who are falling between the gaps of specialist mental health and other services in conjunction with statewide initiatives including those involved with Child Protection and Youth Justice services.
- New early intervention services built into or linked to local networks such as Primary Care Partnerships, BestStart and headspace sites utilizing State, Commonwealth and Local Government investments and optimising access to MBS rebateable services.
- Expanding shared care arrangements delivered locally between specialist mental health services, GPs and other private mental health care providers.

An understanding of development and the changing needs of children and young people will underpin the proposed reforms across the 0-25 year old age range. The projects will need to attend to strengthening intensive treatment and support for those experiencing severe mental illness, as well as aiding early recognition and providing assessment and treatment to a broader range of problems that are less severe and not currently responded to by specialist mental health services.

The projects will focus on social, emotional and behavioural problems in early childhood to the more common problems and high prevalence disorders of childhood and early adolescence and the emergence of substance use problems, to complex conditions and serious illness characteristic of low prevalence disorders more characteristic of later adolescence and young adulthood.

In the first instance, consortia will be required to focus on two priority areas in planning demonstration activity to ensure general system readiness to respond early:

1. Expanding assessment of and responsiveness to pre-school and primary school aged children who display early signs of social, emotional and behavioural problems.

2. Developing strategies to better engage adolescents and young adults 12-25 years with a broader range of moderate to severe mental health problems, including co-occurring drug and alcohol problems.

2.4 Service reform principles

The work of consortia towards service reform will be underpinned and guided by seven key principles:

1. **Outcome focus**: the goal of measurable improved client outcomes will be a priority in project planning, implementation, monitoring and evaluation.
2. **Reform agenda**: critical review of existing services in the light of the full spectrum of need and readiness for innovation are key starting points for building substantive change and a coherent expanded service system; projects must do more than fill gaps.
3. **Shared responsibility**: recognition that building a broader response to mental health requires the development and maintenance of effective partnerships across service sectors.
4. **Early intervention**: responding early in life, early in the course of a disorder, and early in an episode of illness to reduce the risk and impact of mental health problems on individuals, their families and carers, and the wider community.
5. **Recovery orientation**: providing coordinated support and treatment options that promote optimal functioning and participation in the community, self determination and hope
6. **Consumer-centred approach**: services are planned in response to the contemporary needs and circumstances of children, adolescents, young adults and their families.
7. **Evidence-based planning and practice**: developing responses based on identified needs and the best available evidence to achieve desired outcomes.

2.5 Target groups

The demonstration projects will focus on reforming the provision of services to children, young people and their families 0-25 years at high risk of or experiencing social, emotional and behavioural problems and mental illness.

2.6 Catchment area

Projects will reform service provision across an area that is subregional and the size of one or more Primary Care Partnership or Area Mental Health Service catchments. It is therefore envisaged that the age specific target population for metropolitan projects would be 100,000 to 200,000 and for rural 50,000 to 100,000. Ideally, areas will align with other key health catchments or planning areas to enable optimal data analysis.

The final catchment size will be agreed with the successful consortia.

2.7 Eligible applicants

Submissions for the Demonstration Projects will only be considered from applicants who constitute a core consortium comprising at least:

- a Child and Adolescent Mental Health Service (CAMHS),
- an Adult Area Mental Health Service (AMHS),
- an entity related to the primary health sector (for example, a Primary Care Partnership, or a group representative of GPs); and
- a regional Psychiatric Disability Rehabilitation and Support Service (PDRSS).

In addition to specialist clinical and PDRS services, primary health representation is seen as critical, given that these services are an important gateway to, and partner for, mental health services. This is seen as a minimum number of partners to facilitate early action planning. Submissions from more broadly based consortia will be welcome.

It is expected that a range of other service types and stakeholders will be partners to the consortia in the demonstration project areas and actively involved in the reforms.

These will include:

- consumers and carer representatives or organisations,
- drug and alcohol services,
- acute health services (including maternity services, emergency departments),
- early years services and networks (maternal and child health, early childhood intervention services, kindergartens),
- paediatricians,
- private practitioners (psychologists, allied health and MBS providers),
- CHILD FIRST — child and family support service,
- Take Two
- Disability services
- Child Protection and out of home care agencies
- schools and post compulsory/ tertiary education services,
- vocational services,
- headspace,
- local government (child, family and youth services),
- police,
- Youth Justice and correctional services,
- other primary health providers,
- Indigenous services; and
- services for Culturally and Linguistically Diverse (CALD) communities.

It is expected that these partners will be represented on the Regional Advisory Group or that mechanisms will be put in place by consortia to ensure their involvement.

2.8 Project outputs

The demonstration projects have three interdependent deliverables:

2.8.1 A work plan

This document will describe the activities, processes and timelines that will be employed by the consortia to deliver the reform action plan (see below). It is expected that the development of the work plan will be completed by the end of 2008.

2.8.2 A child and youth mental health reform action plan

The reform action plan will identify the extent of the reforms to be undertaken and how services will be delivered differently to improve access, address gaps and expand the reach of mental health care in accord with the service reform principles and other requirements outlined in this brief. Planning will take into account the particular and changing mental health needs across the developmental spectrum within the 0-25 year old cohort. The plan will incorporate:

- a detailed needs analysis of the proposed project catchment area,
- a mapping of current mental health service provision for those 0-25,
- a review of current service arrangements and practice, service strengths and gaps
- reform areas and actions to be taken to respond better to social, emotional and behavioural problems and mental disorders in infants, toddlers and preschool children; primary aged children; secondary school aged adolescents and older adolescents and young adults,
- the evidence that underpins the services and models of care being proposed,
- service outcomes, targets and key performance indicators, how these will be monitored and reported on as well as project driven evaluation and review mechanisms,
- the partnerships that will be strengthened or established within and across service sectors to deliver the proposed reforms,
- mechanisms for ongoing consultation between consumers, carers and consortia partners in planning and service evaluation; and
- staging and timelines for key activities.

The reform action plan will be endorsed by all consortium members and the Department of Human Services Regional Director on behalf of the Regional Partnership Group (see section 2.12). Once endorsed by the Mental Health and Drugs Division, the reform action plan will become the formal agreement between the Division and the consortium regarding project activities. The plan will also be the basis for determining the level of project funding.

It is anticipated that the development of the reform action plan will take four to five months.

2.8.3 Implementation of the reform action plan

Implementation of the reform action plan will commence by July 2009.

2.9 Project management

The Area Mental Health Service within the consortium will receive and acquit project funds and accept accountability for delivery of the project outcomes on behalf of the consortium.

The department will contract with the relevant Health Service delivering the Area Mental Health Service program as the legal entity accountable for the delivery of the project. The Health Service will be subject to the policy and service standards and guidelines that comprise the contractual requirements with the department regarding mental health services.

The Mental Health and Drugs Division will update consortia with information regarding new developments such as the release of new policies, initiatives, strategic documents and training opportunities, in a timely manner. This will enable work in the projects to remain currently and relevant to broader statewide developments associated with the Mental Health Reform Strategy.

DHS will undertake to address any issues requiring clarification or discussion at the earliest opportunity in order to reach resolution.

2.10 Funding

Project funding will be provided across four years for both of the projects commencing in 2008-09 in accord with the schedule below. Some establishment funding will be available in 2008-09. In addition, a limited number of non-recurrent service development grants to the parties will be funded in 2008-09 only (see 2.11).

The annual funding across the four years (from 2008-09 to 2011-12 inclusive) for the metropolitan demonstration project will be up to $1.9 million per annum pro rata and the rural project up to $900,000 per annum pro rata.

In the fourth year, a plan for ongoing funded service provision that sustains the reforms will be negotiated with services involved. It is expected that some project funding will have been used for one-off establishment activities. The extent and nature of continuing service provision will draw on the evaluation findings and be consistent with the broader statewide mental health policy and directions at the time.

As the reform delivered through the demonstration projects will include existing services, it is expected that project funding will be combined with existing funding and resources to deliver the project outputs.

DHS will undertake to action funding in a timely manner.

Staged funding

The amount of funding provided to each project will be negotiated with the successful consortia and will take into account the size of the project area, the population 0-25 yrs to be served, and the scope of the proposed reforms.

Project funding will be allocated in a two-stage process:

Stage 1 — Project development funding ($150,000 one-off) to employ a project coordinator will be provided on announcement of the two successful consortia. The coordinator will act as the consortium's primary point of contact with the Mental Health and Drugs Division for the duration of the project. This position will be required to develop a work plan and assist the consortium to undertake the tasks required to develop the Child and Youth Reform Action Plan within agreed timelines (see section 3).

Stage 2 — Implementation funding (recurrent project funding) will be provided once the reform action plan is agreed by the Regional Partnership Group and the Mental Health and Drugs Division in the second quarter of 2008-09. Development of the reform action plan will be the mechanism by which the level of recurrent project funding will be agreed. Implementation of reforms will then commence.

While it is expected that most of the new funding will be combined with existing resources to expand activities involving mental health services directly, allocation of some funding to other services to enable a consortium to better deliver their reform action plan will be at the discretion of the consortium.

Any proposal for funding non-State services will need to be discussed in advance with the Mental Health and Drugs Division. For example, funding could be provided to strengthen supports to GPs or to purchase capacity through headspace with the aim of assisting better partnerships with schools. Funding could be allocated to coordinate an innovative service team, bringing together staff from a range of programs including mental health, drug and alcohol and child and family support staff to provide 'wrap-around' services for young people living in supported accommodation settings.

Some establishment funding will be made available to the consortia in 2008-09.

2.11 Service development grants

To capture broader interest at this early stage of reform, promising consortia that submit unsuccessful proposals may be offered limited one–off funding to progress local service reform planning and activities.

Although the number of consortia that will receive service development funding, and the quantum of this funding, will be dependent upon the number and quality of submissions received, it is expected that up to six one-off grants of between $50,000 and $150,000 will be provided.

In their submission, all consortia should indicate the reform area(s) that they would focus on with a service development grant.

2.12 Project governance and support

The Mental Health and Drugs Division will manage the projects within government and will put in place activities to assist the consortia to successfully deliver the projects.

Regional Partnership Group

The DHS Regional Director will be asked to convene a Regional Partnership Group. The Regional Partnership Group will comprise managers and service leaders of state and local government programs to advise on and support demonstration activity. Representatives will be sought from early years programs, schools — student wellbeing and support services, drug and alcohol services, child and family support services (CHILDFIRST), youth services, Child Protection, Out of Home Care and Youth Justice. Representation from schools and early childhood services will be sought through the Regional Director of the Department of Education and Early Childhood in the two project areas. Representation of early childhood, child and family support and youth services provided through local government will also be sought.

The Partnership Group will act as a planning partner for the consortium, sharing information about the role that a broader range of services can play in mental health care and providing opportunities to link or build networks and joint endeavours that can better support mental health reform across health, education and support sectors.

Statewide Advisory Group

A Statewide Reform Advisory Group will be convened by the Mental Health and Drugs Division. The membership of this group will consist of key leaders and stakeholders in child and youth mental health service provision including consumers and carers. The purpose of this group will be to advise on project directions, evaluation and monitoring, workforce development and the applicability of demonstration project work to broader system reform. The Advisory Group will also provide a forum for ongoing discussion and planning on how the projects align with and the support the broader statewide reform program.

Workforce development program

A workforce development program will be established to support services undertaking projects. The Statewide Advisory Group will also assist in determining the scope of activities and training priorities.

The Mental Health and Drugs Division will contribute funding to a workforce development program that will provide education and training focused on service leadership and reform, change management and the knowledge and skills required to deliver new service models and approaches. A priority will be to identify the skills required to deliver a reformed evidence-based system (for example, partnership development, phase specific care, single-session assessments, brief evidence-based interventions, family therapy, education and support, day program group skills, consultancy skills and shared care, care pathways and partnerships).

As a first priority, workforce development activities will address the needs of staff involved in the demonstration projects. They will, however, also be made available and promoted to mental health services more broadly across the state.

The development of the program will draw upon the expertise, experience and advice of those organisations already involved in education and training in these areas.

3. Timelines for project commencement

Action	Purpose	Timelines
Submission brief distributed.	Describe the project aims and objectives, service reform principles and outcomes, and the service requirements.	August 2008.
Briefing session.	Provide detailed information and respond to consortium members and other parties interested in submission.	September 2008.
Submission closing date.	Two month timeline for submission preparation.	17 October 2008.
Selection process for demonstration projects and evaluation provider complete.	Whole-of-Government panel will have reviewed submissions and agreed the two sites for the demonstration projects. Stage 1 funding flows. Sites to receive one-off project development funding selected and funding flows.	November 2008.
Evaluation contractor appointed.	Evaluation design in place early to assist consortia with outcome and performance monitoring.	November 2008
First meeting of the Statewide Advisory Group.	This group will oversight the development of the projects and will provide advice on evaluation and workforce developments.	November 2008.
Regional Partnership Group established in the two project areas.	Promote opportunity for a broader range of service engagement in a Whole-of-Government reform agenda.	December 2008.
Stage 1 Project development – Work plan development	Appointment of project co-ordinators. Development of work plan. Early needs analysis and mapping work commences.	End December 2008.
First draft Reform Action Plan framework developed	Ensure that the consortium's Reform Action Plan is consistent with Mental Health Reform Strategy directions and supported by local services. Funding levels agreed in principle. Plan reviewed by Statewide Advisory Group.	End first quarter 2009.
Reform Action Plan finalised and implementation commences.	Plan signed-off by consortia and DHS Regional Director on behalf of Regional Partnership Group and submitted to Mental Health and Drugs Division for endorsement. Second stage funding for the project flows.	Second quarter 2009.

4. Performance monitoring and project evaluation

Consistent with the intent for collaboration between the department and the successful consortia in the development of the demonstration projects, the Mental Health and Drugs Division will contract an independent evaluation early in the project timelines that will assist planning in outcome measurement and project monitoring. A framework for both formative and summative evaluation will also be established early that will assist consortia in project design. The formative evaluation will provide regular feedback and enable project monitoring and realignment as implementation progresses.

An evaluation framework, including a minimum data set and key performance indicators, will be developed in collaboration with the successful consortia and the Statewide Advisory Group and will be important in monitoring the scope and effectiveness of reforms.

The framework will wherever possible draw upon existing data collection processes (for example, RAPID, ADIS, VAED, VEMD) to minimise the data collection burden. Measures will take into account overall levels of service output, service effectiveness and system change.

The reform action plan will require population of a range of measures across a number of domains:

- Service outputs: age cohorts served, direct care, consultation and education and training activities, service throughput and quality, (for example, increased numbers of clients assessed and treated, relapse/readmission rates, diversity of problems seen; and levels of impairment) .

- Types of intervention, for example, individual or group therapy; family education and support.

- Service effectiveness: individual outcomes, client and family satisfaction.

- System development: service location (numbers of clients assessed and treated in non-clinical settings including primary care settings, schools, supported housing, refuges), patterns of demand and referral, joint or shared care arrangements, breadth of consultation and supports provided, uptake of mental health MBS items.

Part B: Specifications and evaluation

5. Project and service specifications

All consortia must address the following points in their submission:

Specification 1: The consortium

The successful consortium must have a background relevant to, and experience in, the proposed activities and be able to demonstrate the provision of quality services as well as high quality cross sector project management and service reform.

- Composition of consortium

  This is not a public tender process. Only consortia comprising clinical public mental health services in Victoria as core partners are eligible to lodge a submission for a demonstration project. The consortium must comprise at least:

  - a Child and Adolescent Mental Health Service (CAMHS)
  - an Adult Area Mental Health Service (AMHS)
  - a regional Psychiatric Disability Rehabilitation and Support Service (PDRSS); and
  - an entity related to the primary health sector (for example, a Primary Care Partnership, or a group representative of GPs).

- Relevant experience

  The submission must describe the consortium's experience in the provision of projects of similar complexity, change management and high quality services to children, young people and families. Where appropriate, suitable references may be provided.

- Governance

  The submission must show evidence of a suitable governance structure to be able to plan and deliver the proposed reforms to the 0-25 year old age group.

Specification 2: Project deliverables

The information requirements of consortia submitting a proposal are provided in this submission template Part 2 (page 29).

In the first instance, and at a minimum, information about the first round of reform activities will be required. That is :

- An expanded assessment of pre-school and primary school children who display early signs of social, emotional and behavioural problems; and
- Improved engagement of adolescents and young adults 12-25 years with a broader range of moderate to severe mental health problems, including co-occurring drug and alcohol problems.

All service activities will require compliance with relevant service or other quality-based service standards.

Specification 3: Budget

The submission should indicate how the project will be managed financially within the health service as lead agency and fund holder for the consortium. The extent of any health service corporate overheads to be deducted from the project funding should be identified in the submission. Transparent accounting processes for the expenditure of project funding will be required for both consortia members and the Mental Health and Drug Division and should be described in the submission.

Where it is proposed to fund or purchase services from other organisations, processes should be described. It is expected that project funding distributed by the health service will not attract health service corporate overheads.

6. Evaluation of submissions

6.1 Selection criteria

The following criteria will be used to evaluate submissions and to determine the two successful consortia. The submission process itself is described in Part C of this document.

Criterion 1: Understanding of mental health reform: The submission reflects a clear understanding of mental health reform directions for children and young people (aged 0-25) in Victoria and offers an early vision and viable approach as to how this would be achieved in the proposed catchment area.

Applicants demonstrate a sound understanding of issues in mental health reform and a willingness, shared across the consortium, to develop or strengthen partnerships and to progress the mental health reform agenda generally. The consortium demonstrates an understanding of the drivers and the goals of service reform that will underpin service redesign in these projects particularly in relation to Focus Area 2.1 and 2.2 in the consultation paper *Because Mental Health Matters*. Throughout the submission, the consortium demonstrates application of the seven service reform principles (see section 2.3) as applied to this age group in presenting a viable approach that outlines how reform might be achieved in the area.

The submission also outlines how broader alliances involving universal and secondary services will be developed over time.

Criterion 2: Needs and outcome targets: The submission demonstrates the need for the project in the proposed area, describes the catchment and provides initial estimates in relation to improved and expanded services and improved client outcomes.

The submission provides an initial analysis of the area's demographic profile indicating areas of high need and population vulnerability, access issues and concerns, suggest priority areas for reforms and indicative outcomes and targets for expanded and reformed services (see sections 2.2 and 4).

Criterion 3: Capacity: The submission demonstrates that the consortium membership comprises the necessary leadership, experience and expertise to

manage complex service development projects and to plan, deliver and sustain over time system-wide service reforms in accordance with these specifications.

The submission demonstrates that consortium membership is configured in accordance with these specifications. It describes the existing resources, services and infrastructure that will be brought to the project and which would provide a sound platform on which to build the reforms. Consortia show evidence of collaborative leadership, partnerships, workforce knowledge and skills, service structures and suitable governance arrangements.

A brief description of current services provided to the cohort by consortium members and demonstration of relevant experience and expertise in the delivery of high quality services as well as project management is provided. The submission lists the key people across the participating organisations who will work together to deliver the projects.

Criterion 4: Readiness - The submission provides evidence of existing innovation and collaboration in the area of child and youth mental health including partnerships between and beyond consortia members that would support the commencement of the project within the timelines specified and designated budgets.

The submission demonstrates the readiness of the consortia to engage in and deliver the project at this time and within the required timelines.

Evidence provided includes existing networks, cross sector collaboration, planning and projects related to service innovation or any reforms for children and young people 0-25 years and families on which further work can be built. Effective consumer and carer consultation and participation models that could be strengthened to focus better on children and youth are highlighted.

Criterion 5: Financial and technical: The submission includes sufficient supporting documentation to demonstrate satisfactory financial, technical, planning and other resource capability and viability to deliver the projects.

The submission indicates how the project will be managed financially within the Health Service as lead agency and fund holder for the consortium. Corporate overheads to be deducted by the fund holder are identified in the submission. Transparent accounting processes for the expenditure of project funding are in place for both consortia members and the Mental Health and Drug Division and are described in the submission. Where it is proposed to fund or purchase services from other organisations, processes are described.

Criterion 6: Staffing and employment: The consortium has satisfactory staffing policies and practices and demonstrates commitment to equal employment opportunity and maintenance of occupational health and safety. The submission describes satisfactory minimum competencies of staff and policies to maintain competency over the period of service.

Submissions include written evidence of appropriate project management structure(s), which may include statement of roles, responsibilities and qualifications and competencies of key staff, staff training, reporting structures, supervision and infrastructure support policy and procedural documentation, articulated policies for managing critical incidents.

6.2 Selection process

The selection process will be managed by the Operations Branch of the Mental Health and Drugs Division.

It is envisaged that the Mental Health Inter-Departmental Committee overseeing the development of the Mental Health Reform Strategy within government may nominate representatives to participate on the selection panel.

Submissions will be evaluated against the indicated criteria. An initial evaluation may be used to short-list submissions.

Following short-listing, one or more consortia may be approached to meet with the evaluation panel to provide clarification or further information.

All consortia will be advised in writing of the final outcome of the submissions process, including the identity of the successful consortia.

6.3 Scoring

Submissions will be initially scored against the following scale:

Evaluation	Score
Exceeds all aspects of the selection criterion	4
Exceeds some aspects (and meets all other aspects) of the selection criterion	3
Meets the selection criterion	2
Fails some aspects of the selection criterion	1
Fails all aspects of the selection criterion.	0

6.4 Service development grants

Consortia that are unsuccessful in obtaining a demonstration project but are assessed as having significant potential for furthering the mental health reform agenda may be considered for a one-off Service Development Grant. In order to maximise equity across the sector, consortia whose submission for a demonstration project was successful, will be deemed ineligible for a Service Development Grant.

Services interested in also submitting for a service development grant should indicate this interest in their submission. Consortia awarded a service development grant will be asked to develop and submit a work plan to the Operations Branch of the Mental Health and Drugs Division in due course as the basis for funding and contracting.

Timelines for service development grants are as for demonstration project submissions.

Part C: Conditions applying to this submissions process

7. General conditions

Format of Submission

A pro-forma submission format is at Part D of this document. Consortia must address their submission to the specifications and their application will be assessed against the evaluation criteria set out in these specifications. The pro-forma submission format has been structured to reflect the information requirements of this submission process.

This template for submissions is available in electronic format (in Word for Windows format) and can be downloaded from the website of the Mental Health and Drugs Division at:

http://www.health.vic.gov.au/mentalhealth/

To be considered, a demonstration project submission will need to be submitted on the electronic template and endorsed and submitted by authorised officers of the consortium comprising at least a CAMHS, an adult mental health service, an entity related to primary health (for example, a Primary Care Partnership or a group representative of GPs) and a regional psychiatric disability rehabilitation and support service.

Legal entity

Service providers must provide proof of their legal status. A legal agreement can only be entered into by DHS with a service provider or individual with legal status established under:

- Associations Incorporation Act
- Co-operatives Act
- Corporations Law
- Health Services Act
- An Individual Act of Parliament
- Natural Person (a person at least 18 years of age, with a mental capacity to understand the agreement, not under any order or bankrupt)
- Trustee Act.

DHS prefers to deal with service providers which have an Australian Business Number (ABN).

Consortia

The specialist mental health service auspice will be lead agency and fund holder for the project. Consortium members specified in this brief operate under differing auspice and governance arrangements and it is not expected that these arrangements will change for the purposes of these projects. The consortium will be voluntary in nature with no separate legal status, except where this is already in existence between members.

The Department expects that partnership arrangements will form within the service sector to aid the delivery of service reforms and to better meet the needs of the community.

The submission must however indicate the role of consortium members and how consortia organisations will relate to each other in planning and delivering the projects and implementing reforms.

Form and application of agreement

Since the fund holder for the two successful consortia needs to be one of the participating clinical public mental health services, there will already be an existing Service Agreement between the auspicing health service and the DHS. Formal confirmation of funding and expectations for the demonstration project will therefore be by means of a variation to the existing service agreement.

Payments

Service providers must have the capacity to accept electronic funds transfer as a facility for payments. A payment schedule will be negotiated with the successful service provider. DHS will make payments according to the satisfactory delivery of outputs and achievement of key stages.

The successful service providers may be required to authorise the Department to issue a Recipient Created Tax Invoice (RCTI) in respect of any part of the services provided.

Statement of departures

Service providers must state in their submissions that they have not proposed any changes ("departures") from the specification (Part B) of this document and the conditions of the standard DHS service agreement (Attachment I) or, where they are proposing departures from these sections, they should submit details with their submission.

By making a submission in response to this document, service providers are deemed to have accepted these conditions.

8. Lodgement of submissions

The submission must be enclosed in a sealed envelope and clearly addressed as follows:

CONFIDENTIAL
Submission: Child and Youth Mental Health Service Redesign Demonstration Projects
Mr Paul Smith
Director
Operations Branch
Mental Health and Drugs Division
Department of Human Services
Level 17, 50 Lonsdale Street
MELBOURNE VIC 3000

Closing Date and Time: 4:30pm (AEST) on 17 October 2008

and must arrive at the above address by 4:30pm (AEST) on 17 October 2008.

Emailed submissions may be accepted at the discretion of the Department. Service providers wishing to lodge an electronic submission must contact Mr Bill MacDonald (telephone 03-9096 7971 or email Bill.MacDonald@dhs.vic.gov.au) at least two working days before the closing date. Late submissions may be accepted if the Department considers that genuine and reasonable extenuating circumstances exist. Service providers should contact the Department before the specified closing time in order for such circumstances to be considered. Incomplete submissions will be accepted at the Department's discretion.

Submissions forwarded through Australia Post should be posted (addressed as above) to ensure receipt no later than the closing time (registered post is recommended).

Submissions must be signed and dated by an authorised officer of the service provider.

An original and three copies of the entire submission must be submitted.

All submissions must be in English.

Submissions will be opened after the closing time for submissions and notification of receipt will be forwarded to each service provider.

9. Requests for Further Information

Clarification of Processes

Service providers may telephone Mr Bill MacDonald on 03-9096 7971 to clarify matters relating to the submissions process, or to clarify aspects of the specification. Verbal explanations or instructions given to service providers prior to the acceptance of any submission shall not bind DHS.

Information session

An information session will be held to brief parties interested in preparing a submission for the Child and Youth Mental Health Service Redesign Demonstration Projects. Details are:

Date: **Thursday 4 September 2008**

Time: **12:30-2:00pm**

Venue: **Room 1.02, level 1, DHS, 50 Lonsdale Street, Melbourne.**

Please contact Mr Mario Nicolosi by close of business on Friday 29 August 2008 to confirm your attendance at the information session. Mario can be contacted by ringing (03)-9096 7577 or emailing mario.nicolosi@dhs.vic.gov.au

Additional Information Required by DHS

- Should information additional to that contained in a submission be required while submissions are being considered by DHS, written information and/or interviews may be requested at no cost to DHS.

- The name and telephone number of an officer or employee of the service provider capable of clarifying technical and commercial aspects of the submission must be provided.

10. Reservations

Withdrawal from process

DHS may withdraw from the submissions process described in this document for any reason, prior to signing any agreement with any service provider for the delivery of the services described in this document.

Lowest cost submission

In the case of fixed price submissions, the lowest cost submission, or any submission, will not necessarily be accepted.

Negotiation

DHS may elect to negotiate with short-listed service providers after the nominated closing date for submissions.

Part offers

DHS may accept submissions in relation to part of the scope of activity described in this brief, or appoint one, more than one or no service provider on the basis of the submissions received.

11. Conflicts of interest

Declaration

Service providers must declare to DHS any matter or issue which is, or may be perceived to be, or may lead to a conflict of interest regarding their submission or participation in the provision of the services described. Where applicable, service providers must also describe a strategy designed to avoid any conflict of interest.

12. Confidentiality

Ownership of submissions

All submissions and any accompanying documents become the property of DHS.

Ownership of information

Ownership of all information, reports or data provided by DHS to service providers resides in the State of Victoria. The service provider shall not, without written approval of the Secretary to DHS, use the information or reports other than in the development of the submission or the performance of the assignment. This information, in whatever form provided by DHS or converted by the service provider, must be destroyed in a secure fashion following advice of the outcome of the submission process or at completion of the assignment.

13. Disclosure

Presumption to full disclosure

The Victorian Government has a strong presumption in favour of disclosing agreements and, in determining whether any clauses should be confidential, specific Freedom of Information (FOI) principles (including a public interest test) will apply. The Government cannot pre-empt the workings of the FOI Act or constrain the Auditor General's powers to secure and publish documents as appropriate.

Disclosure of submission and agreement details

Subject to this clause and the Conditions of Agreement, all documents provided by the service provider will be held in confidence so far as the law permits. Notwithstanding any copyright or other intellectual property right that may subsist in any documents, by making a submission the service provider licenses DHS to reproduce the whole or any portion of the submission documents for the purposes of evaluation

In making its submission, the service provider accepts the Department may publish (on the internet or otherwise) the name of the successful or recommended service provider(s) and the value of the successful agreement(s), together with the provisions of the agreement generally.

Non-disclosure of agreement provisions

Non-disclosure of agreement provisions must be justified under the principles for exemption within Section 34(1) of the *Freedom of Information Act 1982,* providing that information acquired by an agency or a Minister from a business, commercial or financial undertaking is exempt under the Act if the information relates to trade secrets or other matters of a business, commercial or financial nature and the disclosure would be likely to expose the undertaking unreasonably to disadvantage. The Department will consider these arguments in the evaluation and negotiations with service providers.

14. Lobbying

Service providers are reminded that they should not attempt to exert influence on the outcome of the assessment process by lobbying, directly or indirectly, DHS staff or Members of Parliament.

Part D: Template for submissions

Submission

for

Child and Youth Mental Health Service Redesign

Demonstration Projects

Note:

This template for submissions is available in electronic format (in Word for Windows format) and can be downloaded from the website of the Mental Health and Drugs Division at:

www.health.vic.gov.au/mentalhealth

If you experience difficulties downloading the electronic version, the template can also be sent to you by email or on disk on request from DHS at:

Mr Gilbert Van Hoeydonck
Child and Youth Mental Health Services
Operations Branch
Mental Health and Drugs Division
Department of Human Services
Level 17, 50 Lonsdale Street
MELBOURNE VIC 3000

Tel: (03)-9096 7905

Email: **Gilbert.VanHoeydonck@dhs.vic.gov.au**

Instructions for completion

All submissions should be developed using this submission format. It is anticipated that all requirements can be addressed without the submission exceeding 20 pages.

All parts of the submission format should be completed and the submission lodged before the closing date and time for submissions.

Any additional supporting information should be attached to the completed submission and clearly referenced.

The submission must be signed by an authorised officer of the service provider.

Part 1 — Consortium details

#1 Lead Agency — CAMHS or Adult Mental Health Service

Name of area mental health service			
Health service			
Agency number			
Name of person endorsing the submission			
Title			
Contact person for project queries			
Title			
Telephone number		Facsimile number	
Email			

Consortium Partner #2 — CAMHS or Adult Mental Health Service

Name of area mental health service	
Health service	
Tasks/aspects/scope of work to be undertaken	
Primary contact person for this project	
Title	
Email	

Consortium Partner #3 — Primary health sector agency

Name	
Address	
Tasks/aspects/scope of work to be undertaken	
Primary contact person for this project	
Title	
Email	

Consortium Partner #4 — PDRSS

Name	
Address	
Tasks/aspects/scope of work to be undertaken	
Primary contact person for this project	
Title	
Email	

Other

Name	
Address	
Tasks/aspects/scope of work to be undertaken	
Primary contact person for this project	
Title	
Email	

[Repeat as Required]

Part 2 — Submission

1 Overview

The submission should include sufficient information, using this template, to enable the department to assess the proposal against the selection criteria set out in the previous section.

It should provide an overview of how the demonstration project would work in the area, the extent of service reform being envisaged, the capacity of the consortium to achieve these reforms, including the level of commitment by mental health services and partner agencies to achieving the outcomes. Information provided should address both project management and service reform aspects of the project.

The submission should provide an overview as to how the project would be planned and developed locally, how it would be implemented, managed and monitored in accord with these service specifications. The extent to which a practical, workable, collaborative and sector sensitive approach could be developed in accord with the Service Reform Principles will be a key consideration.

2 Proposed Structure

The submission should relate to the objectives, outcomes and deliverables specified in this brief. The following should be considered in preparing and documenting a submission:

Project management

- project governance and coordination across the consortium;
- respective roles of consortium partners;
- methodology: provide a detailed and considered discussion of the proposed methodology for developing the project work plan and the reform action plan;
- key milestones for activities prepared in accordance with guidance regarding the key dates nominated in this brief;
- how any standards specified in this brief will be satisfied;
- how the projects will work with the Regional Partnership Group and inputs from other service providers will be achieved;
- how inputs from consumers and carers will be achieved;
- departmental resources and inputs required;
- staff recruitment, accommodation, management and development;
- need for capital works; and
- indicative cash flow.

Service redesign

- details regarding the proposed catchment for the project;
- summary of current service arrangements for those 0-25 years (by age group) provided by the consortium including specific population groups;
- issues in existing service provision – reach, scope and access

- anticipated scope of redesign activities, key components, partners to be involved and how this relates to the reform directions in the Mental Health Reform Strategy green paper *Because Mental Health Matters*
- activities, partnerships, networks and infrastructure that would provide a sound foundation for more extensive planning and service reform
- service utilisation benchmarks against which change would be measured
- data collection methods to monitor and measuring patterns of change;
- how collaboration and linkages with other providers across the spectrum of services involved with children and young people 0-25 years would be developed;
- stakeholder input or partnering relationships required and how they will be established and managed;
- how the service redesign demonstration project will integrate with and/or complement services provided by the consortium and other agencies within the service system
- advice on what could reasonably be achieved through service reforms with particular reference to the two priority action areas:
  - Expanded assessment of and responsiveness to pre-school and primary school children who display early signs of social, emotional and behavioural problems; and
  - Improved engagement of adolescents and young adults with a broader range of moderate to severe mental health problems, including co-occurring drug and alcohol problems.

3 General issues

Submissions should also provide a risk management framework: identify potential threats that may delay or compromise the demonstration project. Consider workforce issues (for example, staff recruitment and retention), change management issues (such as the potential reluctance of stakeholders to alter their current practice) and administrative problems (such as difficulties in obtaining council approval for a new site) and articulate a fall-back position for problems that have been identified.

The Selection Criteria that will be relevant to the evaluation of this part of your submission relate primarily to Specification 2 (Project outcomes). These criteria are detailed in section 2.8 of this document.

4 Price/cost of submission

The funding to be provided by the department for these projects will be negotiated with the successful consortia. Funding will be dependent upon the size of the project area and the scope and scale of reforms.

The submission should provide sufficient information to enable the department to assess whether investment in the project represents good value for money.

Part 3 — Supporting information

Service providers should describe the nature and extent of any relevant experience.

Lead agencies should disclose sufficient information to demonstrate that they have adequate experience and financial, technical and other resource capabilities to successfully undertake the submission in collaboration with consortium partners. Provide details of relevant supporting documents and attach copies to your submission. If this submission is being made electronically, any non-electronic attachments will need to be mailed or faxed separately.

#1 Profile of lead agency

Range of services currently delivered	
Years of operation in this capacity	

Profile of project partner #2

Range of services currently delivered	
Years of operation in this capacity	

Profile of project partner #3

Range of services currently delivered	
Years of operation in this capacity	

Profile of project partner #4

Range of services currently delivered	
Years of operation in this capacity	

Part 4 — References

All service providers are required to provide referees, whether they have a current DHS service agreement or not.

Referee #1

Company Name	
Postal Address	
Street Address	
Contact Person	
Position/Title	
Telephone Number	
Facsimile Number	
Nature of work performed	

Referee #2

Company Name	
Postal Address	
Street Address	
Contact Person	
Position/Title	
Telephone Number	
Facsimile Number	
Nature of work performed	

Part 5 — Disclosure of submission and agreement information

Part C provides for disclosure of agreement information. If you withhold the disclosure of specific information, you must detail how its release will expose trade secrets or expose your service provider unreasonably to disadvantage. The Department will consider these arguments during the evaluation process and in negotiation with service providers.

Non-disclosure of agreement provisions must be justified under the principles for exemption within Section 34(1) of the *Freedom of Information Act 1982,* providing that information acquired by an agency or a Minister from a business, commercial or financial undertaking is exempt under the Act if the information relates to trade secrets or other matters of a business, commercial or financial nature and the disclosure would be likely to expose the undertaking unreasonably to disadvantage.

1 Trade secrets

In considering whether specific information should be categorised as a trade secret, service providers should assess:

- The extent to which it is known outside of your business
- The extent to which it is known by the persons engaged in your business
- Any measures taken to guard its secrecy
- Its value to your business and to any competitors
- The amount of money and effort invested in developing the information
- The ease or difficulty with which others may acquire or develop this information

Trade Secrets not to be disclosed:

2 Unreasonable disadvantage

In determining whether disclosure of specific information will expose your business unreasonably to disadvantage, you should consider section 34(2) of the FOI Act. Broadly, you should consider whether:

- The information is generally available to competitors
- It could be disclosed without causing substantial harm to the competitive position of the business

Unreasonable Disadvantage disclosure would cause

Part 6 — Acceptance of terms and conditions

Service providers must indicate their understanding and acceptance of each part of this document, including the standard DHS service agreement, by signing in the table below. Where a part of this document is not understood or accepted, service providers must attach a tabulated Statement of Departures with an explanation of why that part is not accepted

If this submission is being made electronically, this page should be faxed or mailed separately.

Acceptance of conditions

Part	Acceptance	Non-acceptance (attach tabulated Statement of Departures)
Part A: General information for service providers		
Part B: Service specifications		
Part C: Conditions applying to this submissions process		
Part D: Template for submissions		

Endorsement

Signature of Authorised Officer for **Consortium**	
Name of Authorised Officer (Print)	
Title/Office Held	
Date	