

Psychiatric Disability
Rehabilitation and Support
Services Reform Framework

Consultation paper

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Ministerial foreword

The care and support provided by Victoria's community-managed, community based mental health services is a vital part of our health and human services system. These services work with some of the most vulnerable members of our community to create pathways to recovery, wellness, and effective social and economic participation.

Victoria is well regarded for its extensive network of community-managed mental health services, and for the high level of innovation and quality that many of them have demonstrated. Currently, over 100 separate agencies provide support to more than 14,000 individuals across the state each year. State Government funding is provided through what has been known as the Psychiatric Disability Rehabilitation and Support Services (PDRSS) program.

These services are the backbone of mental health care in the community. However, focused reform can make them more effective in a changing service delivery environment: to provide more accessible, flexible, individually tailored support to people and their families in a way that produces real outcomes.

We want to ensure that these services operate as strong partners to clinical mental health services, and as an integral component of local human services systems to connect individuals with primary health, housing, family welfare and community services.

The information and analysis in this document presents a compelling case for reform. It indicates that there are structural challenges to the way these services are organised, the way in which funding is allocated and accounted for, the rigidities of historically defined program streams, and the incentives for joining up effectively with other services.

This consultation paper proposes what these changes could look like to deliver better targeted, better planned and better coordinated services that respond more effectively to individual needs.

These changes can position the community managed mental health sector for the opportunities for innovation, growth and development that we anticipate will come with initiatives such as the National Disability Insurance Scheme.

The reform of the PDRSS funding program is a key priority element of the Victorian Government's agenda for mental health.

In developing this paper, the Department of Health has worked closely with many in the community mental health sector and related sectors, including consumer and carer representatives. I sincerely thank everyone who has been involved in the process to date.

I commend these reform directions to you and look forward to your feedback and further participation in our joint effort to build a strong and sustainable community-managed mental health sector.

The Hon Mary Wooldridge MP
Minister for Mental Health

Executive summary

Features of a reformed system

- improve equity of access across the state to a core set of services that are easy for people and their carers/families to navigate.
- improve consistency of targeting and throughput, with priority given to people who are most disabled by their mental health condition.
- innovative, high-quality services.
- deliver flexible person-centred, family-focused support, rather than rigid program-focused services.
- provide a sharper focus on outcomes in relation to physical and emotional health, social participation, education and employment.
- joined-up support by improving planning, collaboration across community-managed mental health, clinical mental health and other local health and social support services.

The Victorian Government wants to support people with a severe mental illness to manage their own mental health and to better make choices about their support, in partnership with services.

Individuals should have access to high-quality Psychiatric Disability Rehabilitation Support Services (PDRSS) that focus on minimising risk of long-term disability and realising recovery goals as quickly as possible.

We want to build a stronger system in which long-term recovery and support for overall health and wellbeing and social and economic participation are seen as key objectives complementing clinical treatment.

We also want state-funded PDRSS to operate as a more integral part of Victoria's human services system.

This is critical if we are to reduce the often devastating impacts of mental illness, particularly enduring psychiatric disability, entrenched unemployment, homelessness and social exclusion.

Community-managed mental health services have a central role to play in supporting people with mental illness in their recovery journey, in building the individual's resilience and in creating capacity for self-management.

Victoria's longstanding approach to providing community-

based psychiatric disability rehabilitation and support through the not-for-profit sector has played an important role in improving the quality of life of people with a severe mental illness over the past two decades. Elements of the current sector work very well and Victoria is highly regarded nationally as a result of the quality of these services and innovative approaches they have taken to the needs of some of Victoria's most vulnerable individuals.

The Victorian Government currently invests more than \$90 million each year in a set of psychosocial rehabilitation and support functions, known as Psychiatric Disability Rehabilitation and Support services or PDRSS. These services are delivered by a range of community-managed providers including stand-alone mental health services, community health services and community welfare services. In 2010–11 about 14,000 people received a psychiatric disability rehabilitation and support (PDRS) service, delivered through 105 agencies across the state.

A client-focused reform program

The needs of people with a severe mental illness and their families have been central to our thinking in developing the reform framework described in this paper. Change in current service delivery arrangements is needed to improve the experience of people and their families/carers, and to respond to changes in the broader health and human services environment.

The Victorian Government takes seriously its role as the system manager of publicly-funded mental health services, including its role in developing sector capacity and cost-effective delivery.

The reform framework proposes a significant, staged set of changes to achieve the experience we want for people with a mental illness, and the families and friends that support them.

The framework identifies the specific systemic and service delivery improvements needed to build a more efficient and effective system of psychiatric disability rehabilitation support services.

The reform directions will position state-funded providers of community-based mental health services to deliver person-centred, client-directed disability support, driven by and tailored to the individual's changing support needs.

The reform framework is based on analysis of client data and information gathered through consultation with key stakeholders and independent reviews, and advice from a sector-based partnership group.

It also takes into account a proposed National Disability Insurance Scheme (NDIS), reforms in the human services sector, and continued growth in Commonwealth-funded community mental health programs, including functions such as care coordination. There is also a strong parallel with reforms being proposed for the alcohol and other drug sector. Opportunities to better align and, in some circumstances integrate services, will be explored through both reform processes.

Reform is needed to position Victoria's system to take advantage of these developments in the interests of improving outcomes for people with a severe mental illness and their families.

A key objective of the reform framework is to ensure the best possible support services are provided to people with severe mental illness and psychiatric disability for the current level of Government investment. The Victorian Government is committed to working with the sector and the community to help drive the reforms needed to ensure delivery of quality PDRSS for the existing Government funding provided.

The way forward

This paper has been developed to seek a range of stakeholders' views and input on the government's proposed framework for reforming the PDRSS funding program.

Your input will help us to collectively achieve our vision for people with a severe mental illness and their carers/families, acknowledging that community-managed mental health services, the specialist clinical mental health service system, and broader health, social and welfare service systems will play an integral role in shaping and driving the implementation of these reforms in the future.

This consultation paper identifies the key drivers for this change agenda. It then provides a framework comprising three highly interdependent building blocks for the program of reform:

1. *Building organisational and system capability* - a stronger, more sustainable system of area-based service providers delivering high-quality, well governed, efficient and effective services.
2. *Remodelling programs and funding streams* - streamlined and flexible programs/ functions and funding models to deliver person-centred support as part of the move to client-directed, individualised funding.
3. *Streamlined service system configuration* - high quality providers delivering a flexible set of services on an area basis to achieve acceptable standards of access, quality and efficiency.

Specific service system improvements have been identified within each of these reform areas. Critical underlying changes needed to enable service system improvement and build a more efficient and effective support system are also identified.

We recognise that concepts such as client-directed funding can be challenging and complex. The framework therefore proposes a staged change agenda.

The reform agenda would involve building stronger, clearly designated area-based providers who work in close collaboration with specialist clinical mental health services and are an integral part of local health and community service networks. It would involve remodelling, consolidating and streamlining programs and funding streams as part of the move to client-focused and ultimately client-directed funding.

Current service delivery responsibilities will need to be reconfigured and rationalised on an area-based model to support these reforms and drive improved access, quality and efficiency. Any changes to service catchments will need to take into account parallel changes to area mental health service catchments and the establishment of Medicare Locals.

Consultation process and next steps

Providing feedback

This consultation paper provides a proposed framework to support the staged reform and redevelopment of the way PDRSS are provided to people with a severe mental illness in Victoria.

This paper has been developed to seek a range of stakeholders' views and input on the government's proposed framework and to inform the implementation process.

To assist you with your response a series of questions have been posed (see Appendix 2 for the list of questions). These questions are a guide only and are not intended to limit the scope of feedback.

We want to encourage broad consultation about this paper. Written feedback should be emailed to <mhreformstrategy@health.vic.gov.au>, or posted to:

Mental Health Reform Strategy
Mental Health, Drugs and Regions Division
Department of Health
Level 17, 50 Lonsdale Street
Melbourne VIC 3000

The closing date for written submissions is **22 June 2012**.

Next Steps

Following consultation on this paper, government will finalise the reform framework, and develop an implementation plan. A staged implementation program will be undertaken in partnership with the specialist mental health service system, VICSERV and other key stakeholders.

Part A: The case for change

1. Introduction and context

Purpose of this document

This paper proposes a vision and strategic framework for reforming the state-funded PDRSS program in Victoria. It identifies the key issues driving the need for reform and proposes a framework to guide a staged program of change. The paper is being released to seek views and input on these possible changes to help government make decisions about future direction of the program.

The Victorian Government currently invests more than \$90 million each year in a set of psychosocial rehabilitation and support functions that are delivered by a range of community-managed providers including stand-alone mental health services, community health services and community welfare services. These services are commonly referred to as Psychiatric Disability Rehabilitation and Support Services (PDRSS).

State-funded PDRSS are targeted to people aged 16–64 years with a severe mental illness and psychiatric disability. The services support people to live successfully in the community and form a core component of Victoria's specialist mental health service system, complementing clinical mental treatment and care.

In 2010–11 an estimated 14,000 people received a PDRS service, delivered through 105 agencies across the state.

The reform framework proposed in this paper is based on analysis of client data and information gathered through consultation with key stakeholders, independent reviews and advice from a sector-based partnership group.

A new agenda for reform

Protecting the mental health of all Victorians and delivering timely, effective treatment and support to those affected by mental illness is a clear priority for the Victorian Government. The government's key commitments in this area were outlined in its 2010 election platform, the *Coalition Plan for Mental Health*.

The Coalition Plan for Mental Health signalled the need to reinvigorate and rebalance the reform program. As a key next step, a new three year action plan for mental health reform will shortly be released. The action plan acknowledges the broad directions set out in the Victorian Mental Health Reform Strategy 2009-19.

Through this new plan, current effort will be complemented by rigorous, targeted reforms to drive effective and efficient delivery across public, private and community-managed services. This will include significant redesign of key aspects of the system, major legislative change and strategic workforce development.

Reform of the PDRSS funding program is an integral part of this reform program. It will be achieved by supporting innovation and planning for more connected and streamlined pathways to care, and providing choices that respond to individual needs and preferences. Proposed areas of priority focus include building clients' resilience and capacity for self-management, providing more person-centred services (as part of a move to client-directed funding), and more direct and explicit support for social and economic participation to better support people in their recovery journey.

Our agenda for change seeks to build stronger, high-performing community-managed mental health services that complement clinical treatment and operate as a more integral, coherent part of the public mental health service system, as well as being more systematically connected to local health and social services.

Recent state government investment has sought to provide selected providers with a dedicated capacity to respond to people with a mental illness, who have a range of complex, intersecting and high coordination needs in partnership with specialist clinical mental health services and local social services. This will continue to be an area of priority focus for both the state and Commonwealth governments.

The needs of people with a severe mental illness and their families have been central to our thinking in developing the directions proposed in this paper. The longer term vision is to build a service system with the capacity to provide person-centred and person-directed services, linked to individualised funding.

We recognise that concepts such as individualised funding may be challenging and complex and that implementation of such an approach requires careful consideration and a staged change agenda.

The first stage of this reform agenda will involve the following.

1. *Building organisational and system capability* – a stronger, more sustainable system of area-based service providers delivering high-quality, well-governed, efficient and effective services.
2. *Remodelling programs and funding streams* – streamlined and flexible programs/functions and funding models to deliver person-centred support as part of the move to client-directed, individualised funding.
3. *Streamlined service system configuration* – higher quality providers delivering a flexible set of services on an area basis to achieve acceptable standards of access, quality and efficiency.

These reforms will help position Victoria's system to respond to an National Disability Insurance Scheme (NDIS) recently recommended by the Productivity Commission, as well as reforms in the human services system, to improve outcomes for people with a severe mental illness and their families.

In summary, the proposed reforms will:

- **improve equity of access across the state** to a set of PDRSS that are easy for people and their carers/families to navigate
- **improve consistency of targeting and throughput**, with priority given to people who are most disabled by their mental health condition
- **deliver flexible person-centred support**, rather than rigid program-focused services
- **provide a sharper focus on achieving outcomes** in relation to physical and emotional health, social participation, education and employment
- **achieve more joined-up support** by improving planning, collaboration across community-managed mental health, clinical mental health and other local health and social support services.

The way service delivery is structured within a given catchment will have a critical bearing on achieving these client-focused outcomes.

Drawing on analysis, independent review and consultation findings, this paper proposes that current service delivery arrangements be streamlined and reconfigured, and that delivery responsibilities be organised according to an efficient area-based model. This is needed to ensure long-term sustainability and acceptable standards of access, quality and efficiency. Importantly, it will also facilitate area-based service planning to better position funded providers to identify and respond to local population need, and provide a rational basis for future state and Commonwealth investment.

System reconfiguration is a complex undertaking, involving possible governance change and funding adjustments. Any significant change to current service catchments and auspicing arrangements would require shifts in current funding allocations. It will also require new approaches to working relationships between agencies within and beyond the current providers of PDRSS.

Such an undertaking must take into account national health reform and current and planned Commonwealth investment in community-managed mental health services. This will ensure any potential realignment of catchments and the way service delivery is organised optimally positions Victoria to benefit from these reforms and investments. This includes considering catchment alignment with area mental health services (AMHS), taking into account other service catchments such as Primary Care Partnerships, Victorian health planning areas and Medicare Locals. It will also involve consideration of changes in disability and broader human services delivery at both the state and national levels.

In addition to service system reconfiguration and rationalisation, the reform framework also gives priority attention to other key reform enablers, particularly:

- the ongoing development of a sustainable workforce with the skill, competency and capability to deliver high-quality evidence-based services and better manage risk associated with high-need clients
- strengthened accountability through improved governance structures, client information management systems and reporting frameworks that focus on achieving client (health, social and economic) outcomes.

The reform framework also emphasises the role of care coordination in ensuring a person's total care and support needs are assessed, planned and accounted for in a more streamlined and connected way. It also highlights the importance of the broader role of the community in providing a supportive environment for recovery.

Policy context

Since the early 1990s, the Victorian Government has progressively grown its investment in the PDRSS program in recognition of the need to address the impact of mental illness on a person's capacity for day-to-day living and the social and economic disadvantage resulting from the illness itself.

These services are delivered through community-managed providers, many of whom have a long history in working with and advocating for people with a mental illness.

The way Victoria's PDRSS are currently organised has evolved over time, largely in the absence of a coherent long-term policy framework. The lack of a strong focus by government on sector development and accountability, as well as historical funding allocations and uneven growth funding, has also led to structural weaknesses in the way services are currently organised and delivered, and the inequitable distribution of resources across the state.

The result is that service delivery in the majority of service catchments is characterised by multiple providers offering the same or variable programs and significant variation in scale with many providers operating with a small program capacity. The way service provision is currently organised makes improving system efficiency a complex undertaking.

Recent investment by the Commonwealth Government, particularly the distribution of the Personal Helpers and Mentors (PHaM) program, has added to the complexity and fragmentation of the current system.

The *Victorian mental health reform strategy 2009–2019* set out a framework of reform to improve access to coordinated, high-quality community-managed mental health services delivered as an integral part of a specialist tertiary system of care for people with a severe mental illness. The Victorian Government's recently released *Framework for recovery-oriented practice* also acknowledges the valued role and leadership of community-managed mental health services in supporting recovery and wellbeing outcomes for this population group.

The key policy directions for the delivery of the psychosocial rehabilitation function by specialist public mental health services are:

- consolidation of the provision of psychosocial rehabilitation and support services for people with a severe mental illness, while achieving improved efficiency and effectiveness through practice change, system and program development and structural reform
- strengthened interagency partnerships between and across PDRSS providers and public clinical mental health and other health and social support services to improve service access and streamline pathways to care for people with a severe mental illness and psychiatric disability
- support to develop a robust, skilled and sustainable workforce that delivers high-quality rehabilitation and support services and improved mental health outcomes for clients and their families.

A comprehensive process of information/data collection and analysis and program review has been undertaken to inform this paper. A partnership group of key PDRSS providers, VICSERV, clinical mental health services, consumer and carer agencies and key stakeholders provided advice throughout the information gathering and analysis stage of this project.

Key inputs included:

- a PDRSS census¹ that provided detailed information on the 1,700 clients seen by PDRSS on the census collection day; information includes client complexity, service usage patterns and referral pathways
- a consultative strengths, weakness, opportunities and threats (SWOT) analysis of the delivery of psychosocial rehabilitation and support functions by the clinical specialist mental health and PDRSS sectors²
- a formal review³ of Victoria's PDRSS adult and youth residential rehabilitation services and day programs by The Nous Group
- analysis of PDRSS Quarterly Data Collection (QDC) and mapping of PDRSS programs
- a survey of PDRSS agencies by VICSERV⁴
- the VICSERV Strategic sector development report: stage 1⁵
- mapping of Commonwealth investment in community mental health services (the support for day to day living in the community (D2DL) and PHaM programs).

The findings of this analysis and consultation have informed the development of this paper.

¹ Census conducted by the Victorian Department of Health in March 2010.

² SWOT analysis undertaken by Kris Honey of KNH Consulting on behalf of the Department of Health.

³ The Victorian Department of Health contracted The Nous Group to undertake this review.

⁴ VICSERV was contracted by the Victorian Department of Health to undertake this analysis.

⁵ This report was produced by ConNetica Consulting, October 2010 on behalf of VICSERV.

National mental health policy and reform

Under the *National health reform agreement*, reached on August 2011, all Australian governments have agreed to major reforms to the organisation, funding and delivery of health and aged care.

Under this agreement, the Commonwealth Government has committed to the delivery of mental health reform in collaboration with states and territories. The agreement acknowledges the lead role played by states in the reform process and their ongoing role as system managers.

The Council of Australian Governments (COAG) has agreed to develop a 10-year roadmap for mental health reform. The roadmap will set out the agenda for long-term reform of the mental health system, and the priorities and steps for delivering this agenda in collaboration with states and territories.

The 2011–12 federal budget invested \$2.2 billion over five years to support national reform of the mental health system. This includes \$1.5 billion over five years for new measures and \$624 million in investments in mental health made in previous election commitments.

Of this funding, \$549.8 million over five years⁶ has been committed to establish dedicated care coordinators, which will provide an estimated 24,000 people nationwide with a single point of contact for their mental health needs. Medicare Locals and non-government agencies are expected to play a lead role in the implementation of this initiative.

The 2011–12 federal budget also commits \$228 million over five years nationwide to expand the PHaM program and respite services (\$208.3 million over five years nationwide) and the D2DL program (\$19.3 million over five years).

The Council of Australian Governments has also agreed to develop a national partnership in mental health to address priority services gaps. The Commonwealth has committed \$200 million over five years nationwide (through the 2011–12 federal budget) to support the implementation of the national partnership with states and territories.

The national partnership has two priority areas:

- reducing homelessness by supporting people with a severe mental illness to secure and maintain stable accommodation
- reducing the presentation, admission and discharge planning for people with a mental illness in major hospitals and emergency departments.

In addition to investment in community mental health services, there is growing national and federal government interest in shaping this sector, through activities such as the development of a national minimum dataset and *National standards for mental health services* (NSMHS).⁷

National Disability Insurance Scheme (NDIS)

The Productivity Commission has recommended the establishment of an NDIS to provide insurance cover for Australians in the event of significant disability. An NDIS would provide certainty for people with a significant disability that they will receive the high-quality, individualised care and support they need over their lifetime.

The Productivity Commission has also proposed the creation of a National Injury Insurance Scheme (NIIS), which would initially provide access to no-fault lifetime care and support for people with catastrophic injuries acquired in motor vehicle accidents. Coverage would be expanded to include all catastrophic injuries by 2015.

⁶ This funding includes some offsets from existing programs, resulting in a net increase of \$343.8 million over five years nationwide.

⁷ The *National standards for mental health services* were launched in September 2010 following endorsement by the Australian Health Ministers' Council. Implementation of the NSMHS is a mandatory requirement and forms part of the *Australian healthcare agreement*.

The Victorian Government strongly supports the establishment of an NDIS and is driving reform to support its delivery. In its response to the Productivity Commission's draft report on long-term disability care and support, the Victorian Government advocated for people with a severe and enduring psychiatric disability to be eligible for funded supports under the scheme, a recommendation adopted by the Productivity Commission in its final report.

In August 2011 COAG agreed on the need for major reform of disability services in Australia through an NDIS. The Commonwealth has announced that an NDIS will commence in mid-2013. Victoria is keen to host the first stage of implementation of the scheme.

The Productivity Commission proposed that, under an NDIS, eligible people with a disability would receive 'reasonable and necessary' disability support to assist them to participate in the social and economic life of our community. They would be able to exercise more choice and control in their lives through a person-centred, self-directed approach to service delivery, with individualised funding.

The individual would have the power to choose which service provider or providers they would like to assist them to achieve their goals. They would also have the option of directly purchasing services from providers if they wished. Assistance would be available for people who need help to find an appropriate service provider or to manage their individual budget.

Based on the Productivity Commission's recommendations, people who have a severe and enduring psychiatric disability are in scope to potentially receive services through an NDIS. The Productivity Commission has estimated that up to 57,000 people with a severe and enduring psychiatric disability nationwide could be eligible for the scheme.

Services would be delivered within a market-based framework and could be provided by a range of private for-profit and not-for-profit disability service providers. State and territory governments could also continue to provide disability services if they choose.

It is anticipated that existing community-managed mental health services could continue to deliver supports to people with psychiatric disability as part of a broader market of service providers. The market for psychosocial support is likely to expand in response to increased demand for services. It will also be driven by individuals exercising choice over who will provide them with services. Additionally, an NDIS is likely to stimulate demand for mainstream services including primary mental health and health services.

The reform framework detailed in this paper aligns with the directions of an NDIS, and will help prepare the Victorian service system to effectively deliver positive client outcomes through the scheme.

Reform of Victoria's human services

The Victorian Government will introduce changes to the way state-funded community services are delivered to achieve a more coordinated, person-centred response to vulnerable and disadvantaged Victorians and their families. These changes will reduce their risk or experience of entrenched disadvantage and help them develop the social and economic skills needed for self-reliance and independence from human services. Breaking the cycle of intergenerational disadvantage is a key priority of this change program.

As set out in *Human services: the case for change*,⁸ reform to the human services system will involve a move from rigid, siloed programs to a 'joined-up' service model where there is no wrong door for clients. The reforms aim to ensure no matter where the entry point, individuals and their families will get early assistance to connect to the services and support they need. Improving the coordination of community services through holistic case management, coupled to streamlined client pathways, form the basis of the reform program. The reforms will deliver a more efficient, less fragmented and more sustainable human services system.

⁸ Department of Human Services 2011, *Human services: the case for change*, State Government of Victoria, Melbourne.

An integrated system of social care will play an important role in preventing mental health problems, as well as ensuring people in the human services system with mental illness and drug and alcohol problems receive timely, coordinated access to the right treatment and support.

The move to a more person-centred and family-focused approach flagged in this paper is highly consistent with the reform proposed for the human services system. Significant opportunity exists to improve the coordination of care of people with enduring mental health problems who also need or are engaged with community services. Opportunity also exists to strengthen the role of community-managed mental health services in looking after the safety of dependent children who have a parent with psychiatric disability.

The implementation of the PDRSS reform framework will align with the human services reform agenda by streamlining access to an integrated set of functions and strengthening the coordination of care for people who need support from both systems.

Alcohol and drug treatment sector reform

The planned alcohol and drug treatment system reforms will deliver a more consistent, high-quality and coordinated treatment system for Victorians with alcohol and drug problems. It is a critical component of the whole-of-government Victorian alcohol and drug strategy.

The whole-of-government alcohol and drug strategy, including major reforms to the drug treatment system, will play an important contribution to reducing the mental health burden for the community. Better, earlier and more effective treatment of alcohol and drug dependency, combined with a strengthened approach to prevention, will address the close and complex links between mental illness and alcohol and drug misuse.

Treatment reform directions will also address findings of the Victorian Auditor-General's report on Victoria's alcohol and drug treatment system tabled in Parliament in March 2011.

The key objectives for treatment reform are to:

- transform alcohol and drug treatment so it is person-centred, family and culturally inclusive and recovery-oriented
- deliver more consistent, high-quality, evidence-based treatment that is integrated with the other services and supports people need
- achieve a sustainable, responsive treatment system
- Intervene at the earliest possible point, particularly for young people
- build pathways to treatment for hard-to-reach drug users and people who have committed crimes associated with their substance use
- ensure that treatment is delivered through a skilled and competent workforce.

Key reforms will restructure the treatment system and will be implemented over the next few years.

2. System overview

Setting the scene

The Victorian Government currently funds the delivery of the psychiatric rehabilitation and disability support function through specialist clinical mental health and PDRSS.

A total of \$93.5 million per annum of state funding is currently committed to provide PDRSS. The majority of this funding is delivered through non-government organisations across the state. This investment represents approximately nine per cent of total state investment in public mental health services.

Program streams include:

- home-based outreach support (HBOS) (\$38.1 million per annum consisting of \$6.3 million for intensive \$7.7 million for moderate and \$24.1 million for standard levels of support))
- day programs (\$19.1 million per annum)
- care coordination (\$2.1 million per annum)
- youth residential rehabilitation services (166 beds, \$8.6 million per annum)
- adult residential rehabilitation services (103 beds, \$5.2 million per annum)
- supported accommodation services (135 beds, \$3.3 million per annum)
- the mutual support and self help (MSSH) program and planned respite (\$4.3 million and \$3.7 million respectively)
- Other (\$9.1 million per annum). This includes funding for services such as peak agencies and Aboriginal Community Controlled Organisations.

Community-based clinical mental health services, bed-based clinical rehabilitation services (secure extended care units and community care units) and subacute prevention and recovery care (PARC) services also deliver rehabilitation and support functions as part of overall clinical treatment and care provided to clients.

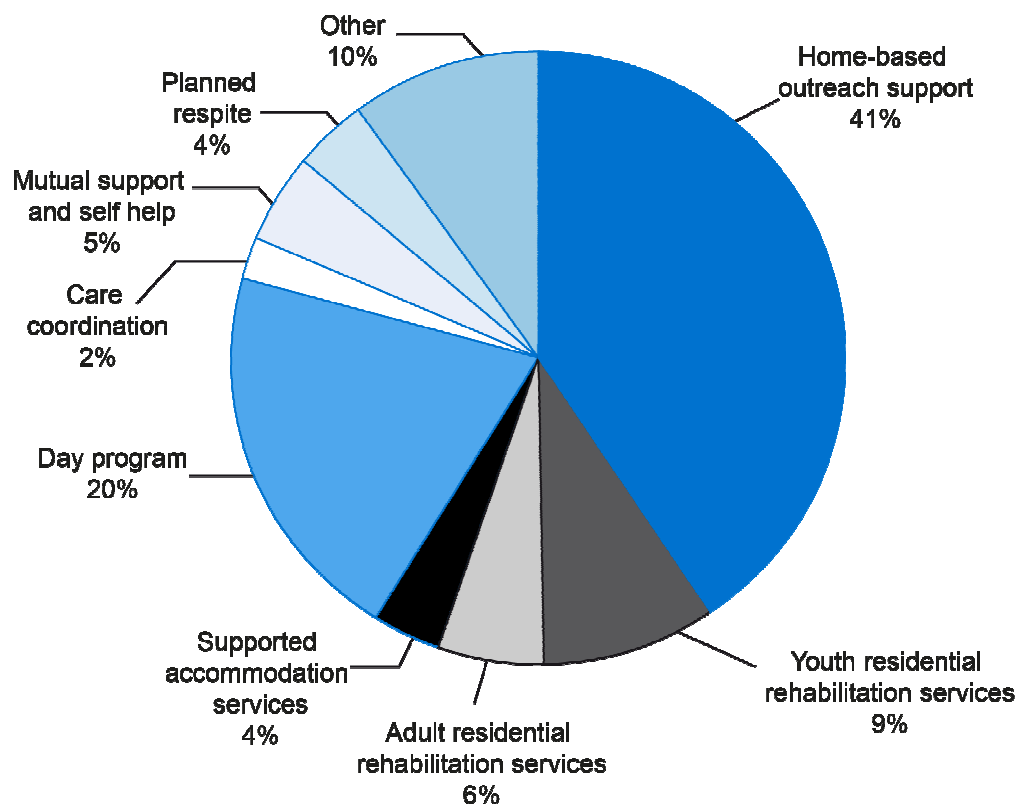
Consistent with government policy supporting closer partnerships between health services and providers of psychosocial rehabilitation services, the majority of health services have sub-contracted the delivery of PARC services to selected state-funded PDRSS providers. For the purposes of this discussion paper, PARC services are out of scope as the delivery of this service model is the responsibility of health services. The potential involvement of community-managed mental health agencies in the delivery of clinical residential rehabilitation services such as Community Care Units is also not addressed.

An estimated 14,000 individual clients received PDRSS in 2010–11.⁹ It is estimated that approximately a third of all clients receive more than one service in a 12-month period.

⁹ Source: 2011–12 PBS, p. 200

Figure 1 provides an indicative breakdown of the total PDRSS funding base by program.

Figure 1: Percentage of total PDRSS funding base by program

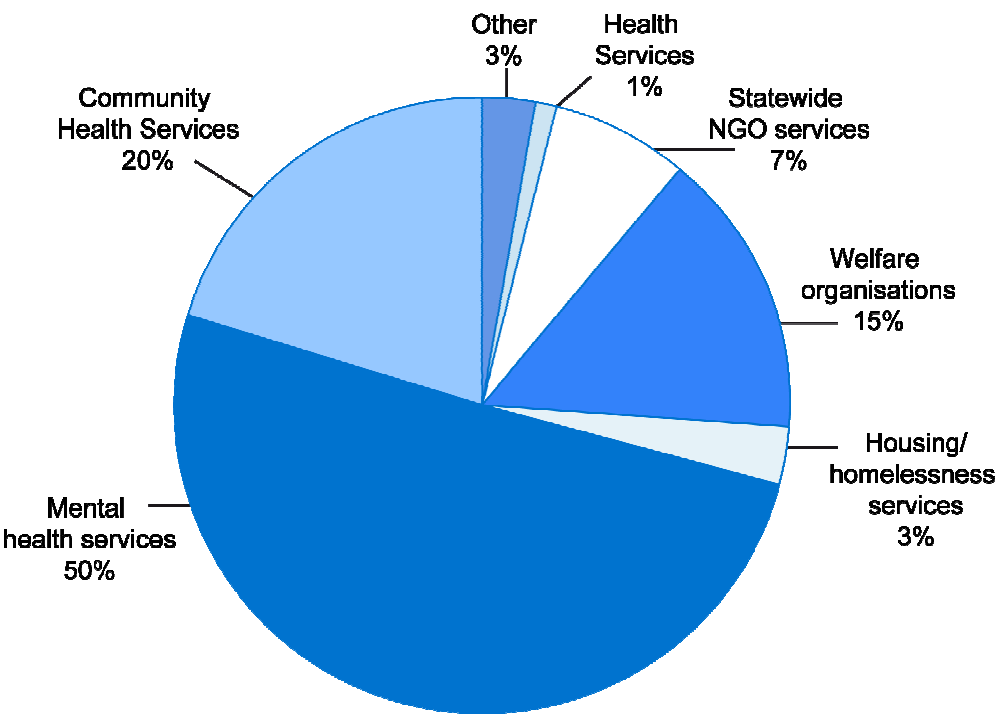


Service delivery platforms

State-funded PDRSS are delivered by a mix of organisation types. These include organisations whose core business is providing mental health services, as well as community health services, welfare agencies and homelessness services.

The majority of PDRSS state funding is delivered by organisations whose primary function is providing mental health services (accounting for 50 per cent of all state PDRSS funding). The next largest service delivery platform is community health services accounting for 20 per cent of funding, with welfare service accounting for just under 15 per cent of all funding. An estimated 3 per cent of all PDRSS program funding is allocated to housing/homelessness services (see Figure 2).

Figure 2: Proportion of state PDRSS funding by service delivery platform



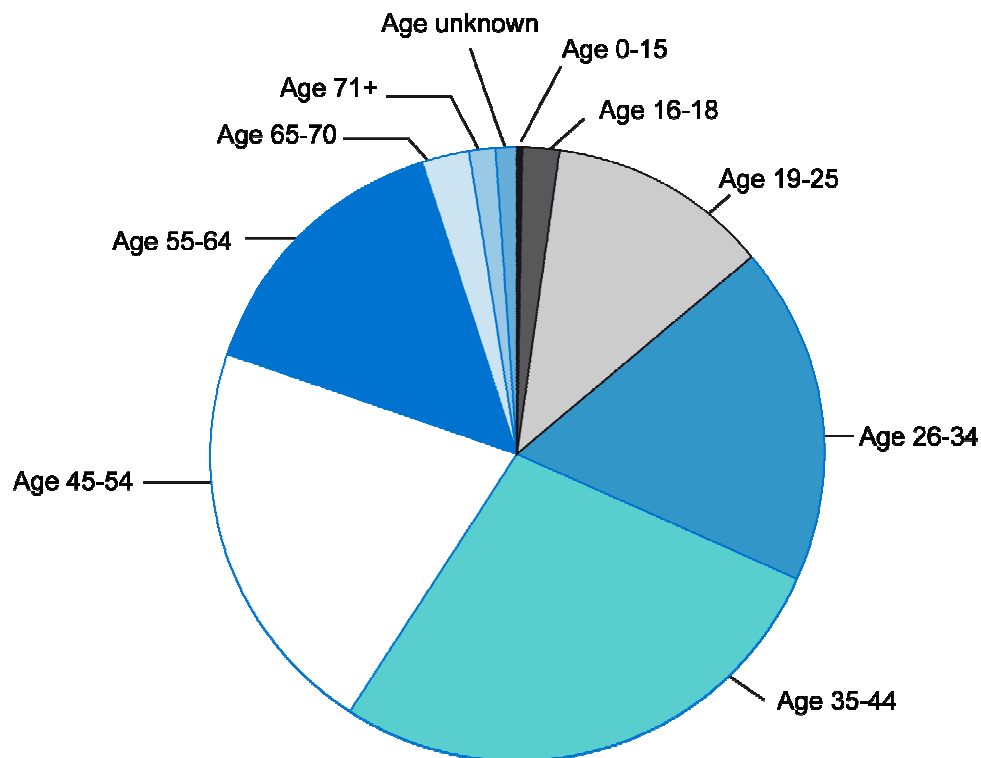
Client profile

Age profile

Figure 3 shows that the majority of clients are aged 26–54 years. Young people aged 16–25 years are relatively low users of PDRSS (14 per cent of all clients). When youth residential rehabilitation services data is excluded, the proportion of all clients aged under 25 years decreases to 9.6 per cent.

The low proportion of clients aged over 65 years is consistent with PDRSS client eligibility criteria that targets people aged 16–64 years.

Figure 3: Age profile of PDRSS clients



Primary diagnosis

Figure 4 depicts that the majority of clients have a primary diagnosis of schizophrenia (47 per cent), followed by depression (12.6 per cent), bipolar affective disorder (8.9 per cent) and personality disorder (six per cent).

Schizophrenia remains the primary diagnosis for clients of all program streams, although there is considerable variability in terms of the proportion of clients with this primary diagnosis. For example, youth residential rehabilitation and adult residential rehabilitation services have a primary diagnosis of schizophrenia for 26 per cent and 79 per cent of all clients respectively.

Figure 5 shows that clients of youth residential rehabilitation services had the highest proportion of clients with a personality disorder (17 per cent of all clients), post-traumatic stress disorder (4.7 per cent) or an eating disorder (4.7 per cent).

An estimated 58 per cent of clients had a drug or alcohol abuse/dependency issue, and 15 per cent of all clients had two or more drug or alcohol abuse or dependency problems.

Figure 4: Primary diagnosis

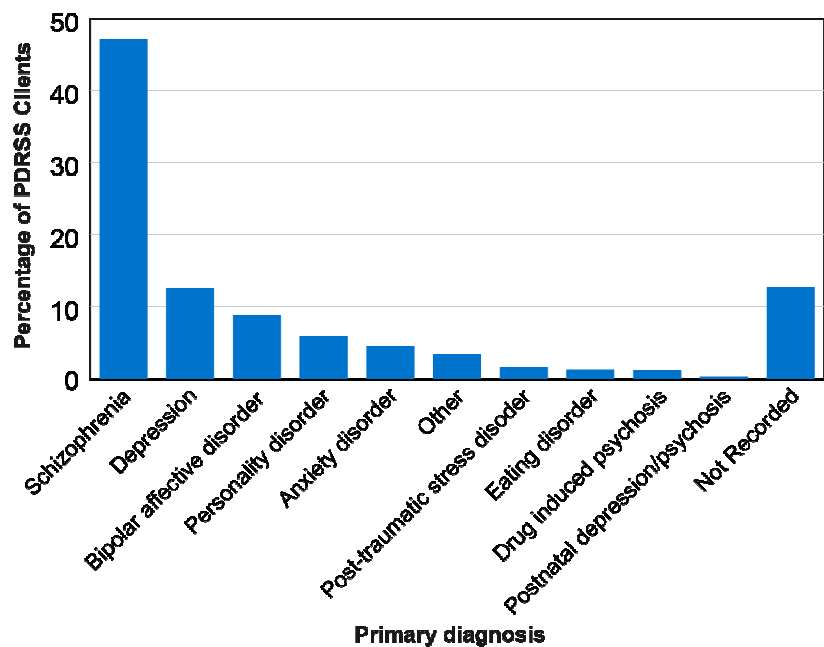
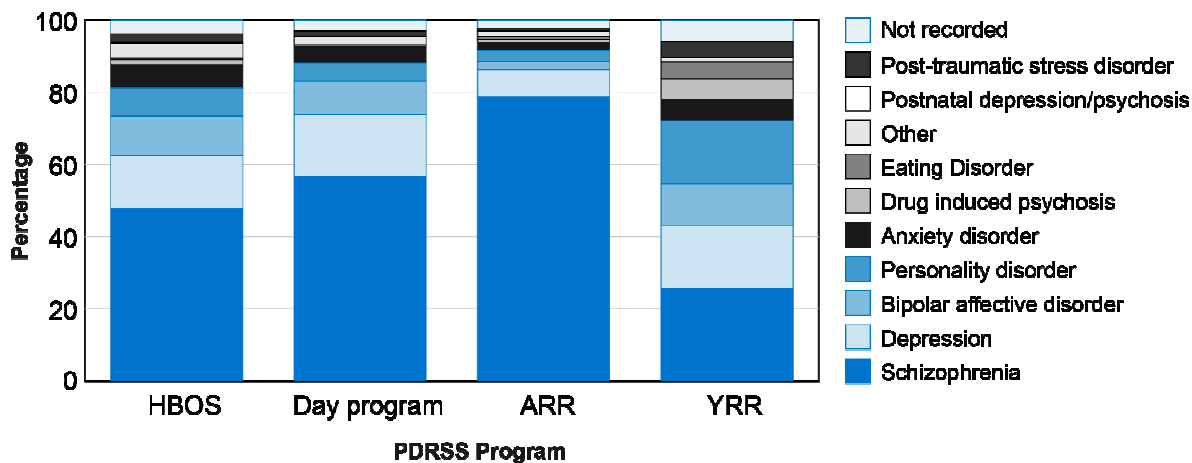


Figure 5: Primary diagnosis by selected PDRSS program



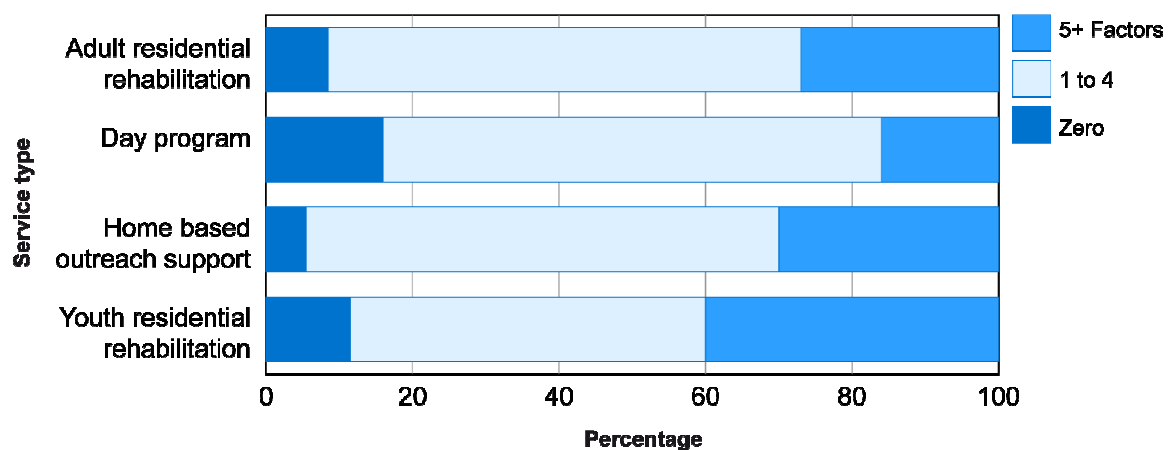
Level of complexity

The 2010 PDRSS census identified that the majority of PDRSS clients have between one and four complex factors.¹⁰ The top 10 most common complexities reported across all services for clients were:

- social isolation
- activities of daily living
- issues related to unresolved trauma
- symptoms that remained treatment resistant
- extensive time required by individual clients to largely maintain their current levels of functionality with little or no progress in improving functionality/capacity for self-management
- chronic physical health problems
- difficulty complying with medication
- problems with intellectual disability/cognition
- problems with alcohol use
- illicit drug use.

Youth residential rehabilitation and HBOS clients have the highest level of complexity (40 and 30 per cent of clients respectively have five or more complex factors). In contrast, clients of day programs have the highest percentage of clients with no identified complex factors (16 per cent of all clients) of all program streams (Figure 6).

Figure 6: Complexity profile of PDRSS clients



Some PDRSS providers report clients' needs are becoming increasingly complex. This may either be due a changing client profile or the services developing a stronger interest and focus on people with more severe and complex mental health conditions and higher levels of psychiatric disability.

¹⁰ The PDRSS census identified 23 complexity/need factors. Respondents could select any number as relevant for individual clients.

Referral pathways

There are multiple referral sources to all program streams. Clinical specialist mental health services are the main accepted referral source to all program types, accounting for an average of 42.5 per cent of all accepted referrals (see Figure 7). Referrals from clinical specialist mental health services to HBOS services have been trending down over the past four years.

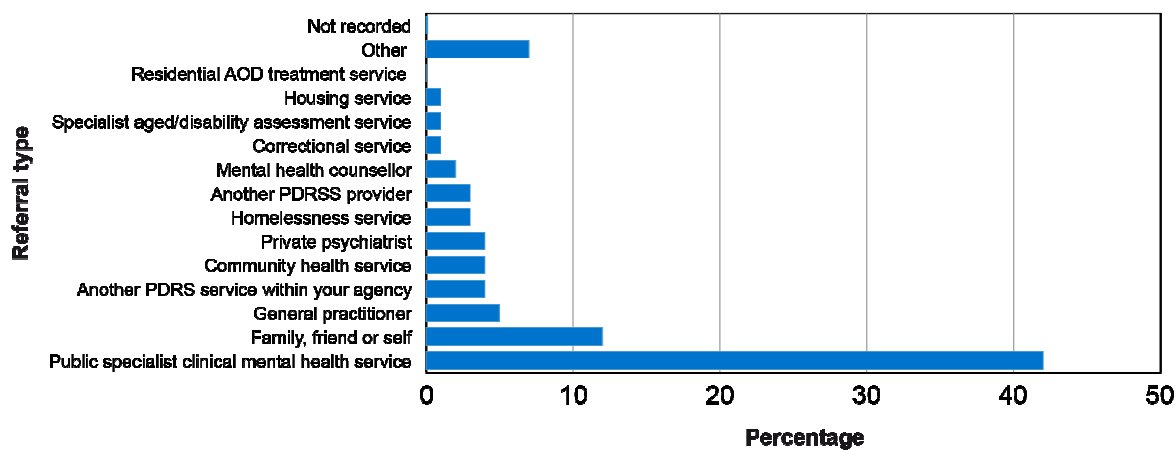
Referrals for family, friends and self account for a fairly significant proportion of accepted referrals to the MSSH program (23.3 per cent) and day program (21 per cent) but less so for HBOS services (10.6 per cent).

Data indicates that accepted referrals from private mental health services – general practice and private psychiatrists – are low, accounting for five per cent and four per cent of all accepted referrals respectively to PDRSS. Accepted referrals from community health services are also relatively low (4.3 per cent of all accepted referrals).

Data also indicates a low level of accepted referral rates within and across PDRSS.

Accepted referrals from homelessness services are low at three per cent of all referrals, with the majority of accepted referrals from this sector directed to youth residential rehabilitation services (10.5 per cent), adult residential rehabilitation services (6.1 per cent) and supported accommodation services (6.9 per cent).

Figure 7: Referral source for accepted referrals



Additional support received

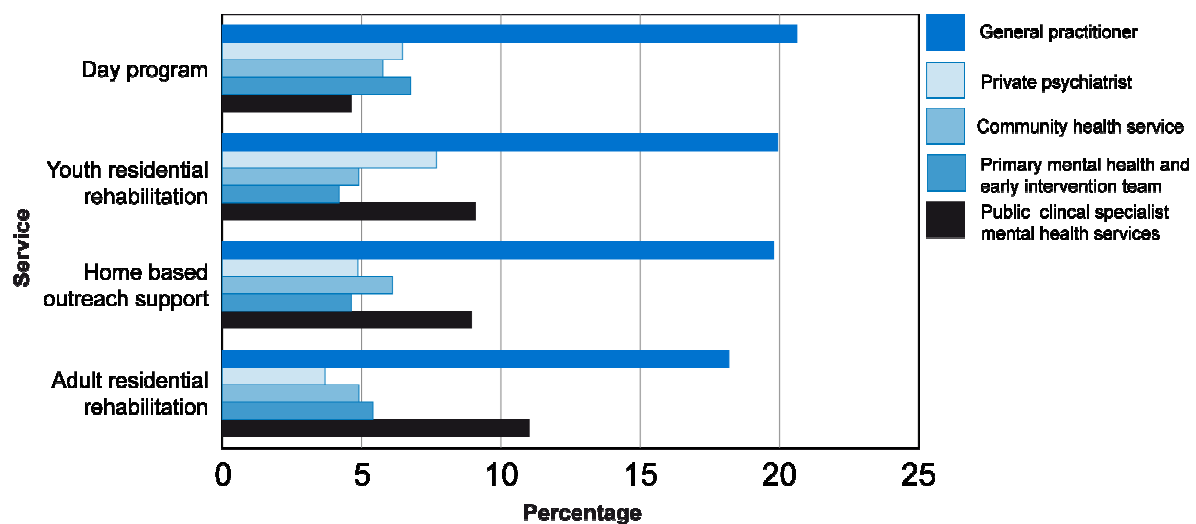
Figure 8 identifies the top five additional services clients of adult residential rehabilitation, youth residential rehabilitation, HBOS and day programs receive. The two top services received by clients are general practice, followed by public clinical specialist mental health services.

Notwithstanding this, a significant majority of clients do not receive GP care as a priority service (80 per cent).

Of note is the relatively small proportion of HBOS, youth and adult residential rehabilitation clients who receive specialist clinical mental health treatment as a priority service (under 10 per cent) and the small proportion who receive treatment from a private psychiatrist as a priority service (5.4 per cent).

Despite the fact that adult and youth residential rehabilitation services accept 66.4 per cent and 51 per cent of all referrals respectively from public clinical mental health services, a significantly smaller proportion of clients (11 per cent and 9.1 per cent respectively) are receiving clinical support from the public mental health sector as a priority service following admission to these bed-based services. This trend also applies to HBOS and day program clients.

Figure 8: Top five priority services received



Living arrangements

The living arrangements of clients are diverse. The top five known living arrangements include living in the family home (22.4 per cent), public rental (21.3 per cent), private rental (13.8 per cent), residential rehabilitation services (13.1 per cent) or are homeless/living in insecure housing (10.7 per cent). Notably, living arrangement for 11.1 per cent clients were unknown.

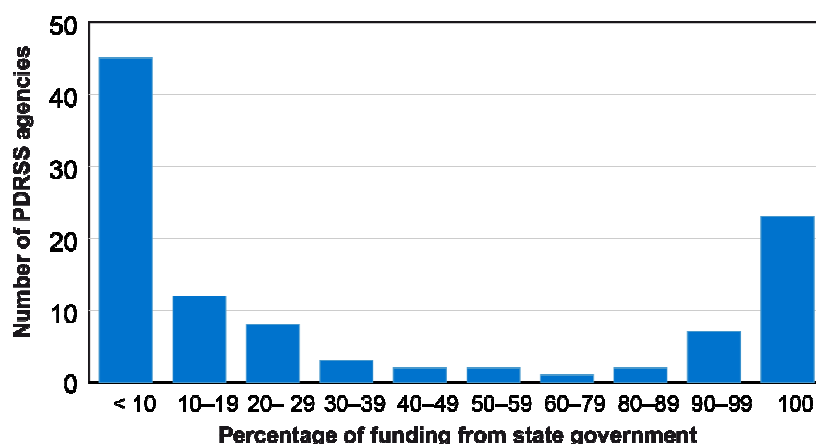
State funding as a proportion of overall state funding base

Figure 9 indicates the percentage of funding received by providers of PDRSS as a proportion of the organisation's funding from **all state government** sources.

For just under half of all organisations funded to provide PDRSS, state funding accounts for up to 10 per cent of their total state funding. For 68 per cent of these organisations, PDRSS program funding constitutes less than 30 per cent of all funding they receive from the government.

This data indicates for a significant proportion of agencies, state PDRSS funding constitutes a relatively small proportion of their overall funding base. For these agencies the quantum of PDRSS funding they receive is not a reliable indicator of overall organisational capacity and viability.

Figure 9: Percentage of funding received by providers of PDRSS as a proportion of total state funding



For 35 organisations, state PDRSS funding makes up a considerable part of their overall state funding base (defined as 50 per cent or more of total state funding base). Of these agencies:

- 12 manage nearly half of all state PDRSS funding (a total of \$45 million per annum)
- 18 manage a relatively small amount of PDRSS funding¹¹ (a total of \$4.5 million per annum, five per cent of all state PDRSS funding).

Twenty-three organisations derive 100 per cent of their state funding from state PDRSS program funding. Of these agencies 16 receive \$500,000 or less per annum in total state PDRSS funding. These organisations mainly deliver MSSH and day program services or have a state-wide focus, for example, the Victorian Mental Illness Awareness Council Inc (VMIAC) and the Mental Health Legal Centre.

¹¹ Defined as \$500,000 or less per annum.

Distribution of PDRSS state funding

Analysis of the distribution of PDRSS funding by AMHS indicates significant variation in per capita expenditure across the state, raising the issue of relative equity. Analysis found no recognisable relationship between socioeconomic disadvantage and level of funding.

Number of providers and scale of provision

Table 1 provides information on the scale of funding allocated to discrete providers for each PDRSS program. This data indicates the considerable variability in capacity and scale of service provision across all program streams.

The funding range by service provider data in this table indicates **total state funding** per individual provider, some of which operate services from multiple sites. While the overall level of provision of multi-site providers for a specific program may deliver efficiency of scale at the organisational level, it is noted at the service delivery level some delivery sites have a relatively small capacity.

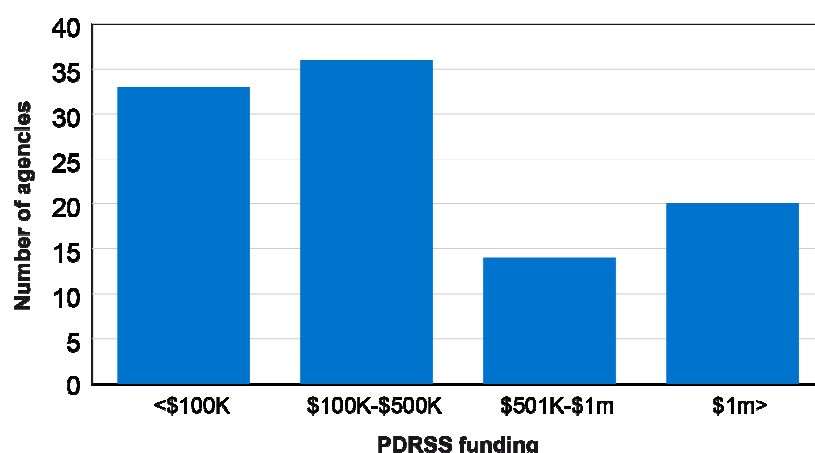
Table 1: Scale of provision by PDRSS program

Program	Number of providers	Funding range by provider	Multisite providers
Home-based outreach services	49 discrete providers 57 sites: 40 metropolitan and 17 rural	\$31k– \$3.93m	Most service providers operate in one service catchment only. A small number of providers deliver HBOS services across a number of catchment areas
Day program	32 discrete providers 39 sites: 22 metropolitan and 17 rural	\$75k–\$1.57m	A small number of providers with a relatively large overall day program funding base deliver services in more than one catchment area.
Mutual support and self help	20 discrete providers ~ 25 sites: 13 metropolitan and 12 rural	\$7k–\$849k	A number of MSSH providers have a specialist focus such as eating disorders, postnatal depression, or are diagnostic specific (such as the Obsessive Compulsive and Anxiety Disorders Foundation of Victoria).
Youth residential rehabilitation services	Five providers of 17 youth residential rehabilitation services Seven rural and 10 metropolitan sites	\$294k– \$612k	There is one major service provider for this program (13 YRR). The balance of YRR are delivered by four service providers operating one YRR each.
Adult residential rehabilitation services	Three providers of nine adult residential rehabilitation services All metropolitan	\$210k– \$945k	There is one major service provider for this program (6 ARR), and two additional service providers across three sites.

This data indicates that for state-funded HBOS services, 29 agencies manage less than 16 per cent of total funding, with the majority of HBOS funding (83 per cent) delivered by a relatively small set of providers (20) across the state. State-funded day programs show a similar concentration, with 71 per cent of funding from this program stream delivered by 14 providers of reasonable scale and the balance delivered through 18 providers with relatively low levels of service provision.

Figure 10 provides a breakdown of scale of funding across all PDRSS providers. It illustrates that two-thirds of providers (69 providers) receive \$500,000 per annum or less in state PDRSS funding, which equates to 14 per cent of total state PDRSS funding.

Figure 10: Number of providers and scale of PDRSS funding



Commonwealth investment in community mental health services

The 2011–12 federal budget invested \$2.2 billion over five years to support national reform of the mental health system. This includes \$1.5 billion over five years for new measures and \$624 million in investments in mental health made in previous election commitments.

Of this funding, \$549.8 million over five years¹² has been committed to establish dedicated care coordinators, which will provide an estimated 24,000 people nationwide with a single point of contact for their mental health needs. Medicare Locals and non-government agencies are expected to play a lead role in the implementation of this initiative.

The 2011–12 federal budget also commits \$228 million over five years nationwide to expand the PHaM program and respite services (\$208.3 million over five years nationwide) and the D2DL program (\$19.3 million over five years). It is likely that Victoria's community-managed mental services will deliver a significant proportion of these services.

Support for day to day living in the community (D2DL)

The D2DL program predominately operates in Melbourne metropolitan areas (eight AMHS), with the exception of Hume Region. It does not operate in Barwon-South Western, Grampians, Gippsland or Loddon Mallee Department of Health regions. All providers funded to provide D2DL services are also funded by the state government to deliver PDRSS day program services.

The providers of D2DL services in a given service catchment are largely consistent with state-funded day program providers and, with a few exceptions, there is broad alignment with PDRSS day program service catchments.

The impact of Commonwealth mental health investment on individual service providers' overall day program funding base varies from 15.6 per cent to 38.1 per cent (state and Commonwealth funding combined).

¹² This funding includes some offsets from existing programs, resulting in a net increase of \$343.8 million over five years nationwide.

Personal helpers and mentors program (PHaM)

The PHaM program is funded by the Department of Family and Housing, Community Services and Indigenous Affairs (FaHCSIA).

This program is targeted to people aged 16 years and over whose ability to manage their daily activities and live independently in the community is impacted proportionate to the level of their mental illness. Potential participants, however, do not need to have a formal clinical diagnosis of a mental illness to enter this service. Providers have advised that those found to subsequently not have a mental illness are transitioned from the program to other local health and community support services.

This service model shares similar functions to the state-funded HBOS program. It is delivered through five member teams that include a peer support worker.

Twenty agencies¹³ are funded to deliver PHaM services in Victoria across an estimated 41 sites. The scale of provision per service provider ranges from \$0.475 million to \$4.91 million per annum. PHaM funding presents 44.94 per cent of total combined PHaM/HBOS¹⁴ funding in Victoria. For the majority of state-funded PDRSS HBOS providers in receipt of this funding, Commonwealth PHaM funding constitutes 40 per cent or more of their total HBOS and PHaM combined funding base.

The majority of PHaM providers have one to two service sites (80 per cent); however, a small number of providers (five) are funded to deliver the PHaM program across multiple sites.

Four providers delivering PHaM programs do not receive funding for any PDRSS program activity from the Victorian Government. These four NGO agencies are estimated to receive 12.7 per cent (\$2.64 million per annum) of the total PHaM program funding for Victoria, and operate in areas where there are well-established state-funded PDRS providers.

In 17 of the 41 PHaM delivery sites (41 per cent), the PHaM provider is **not** the provider of state-funded HBOS services. In a number of instances, while the PHaM provider also delivers state-funded HBOS services in the service catchment, they are not providers with large-scale capacity.

¹³ Note: There are 19 PHaM program providers when Inner East Mental Health Services Association is counted as part of Neami.

¹⁴ Based on 2010–11 investment, inclusive of intensive HBOS.

Summary

- PDRSS are delivered from a number of service platforms including providers whose core business is mental health services, as well as community health services, welfare agencies and homelessness services.
- Around a third of PDRSS-funded agencies depend on this program for more than 50 per cent of their overall agency state revenue. Twelve of these agencies manage nearly half of total state PDRSS funding, while 18 agencies collectively manage five per cent.
- PDRSS are targeted at people aged 16–64 years. The majority of PDRS service users are aged 25–64 years. Just under half of clients have a primary diagnosis of schizophrenia.
- MSSH program clients have the lowest levels of reported complexity.
- There are multiple referral sources for PDRSS programs. The majority (42 per cent) of accepted referrals to all PDRSS programs are from clinical specialist mental health services. Private and public mental health referrals make up just under 50 per cent of all accepted referrals.
- Analysis of the distribution of PDRSS funding indicates significant variation in per capita expenditure across the state.
- HBOS and day programs are delivered by a large number of providers, the majority of which deliver a relatively small amount of the overall available funding. Residential rehabilitation services, by contrast, are delivered by a small set of providers.
- Commonwealth-funded psychosocial support programs are largely but not entirely delivered by providers of state-funded PDRSS programs. PHaM providers in numerous catchments are not the provider of state-funded HBOS services in those catchments.

3. Key issues

Analysis and stakeholder consultation have identified the need for significant system reform to build the capacity of providers of PDRS services as an integral part of an area-based system of care.

Consultation with clients and carers indicated they are increasingly seeking flexible, tailored responses that are orientated to achieving their individual goals and aspirations. They also want:

- to be actively involved in decisions related to their support, or the support provided to the person they provide care to, with greater emphasis on building resilience and capacity for self-management
- seamless, easier to access and navigate services that are well connected to clinical treatment and social support services
- greater flexibility on the level and type of support they receive, including more flexible service delivery hours
- improved service standards delivered by a highly skilled, capable and stable workforce
- services to be more family and carer inclusive in recognition of the importance of informal support to the individual's wellbeing and longer term recovery.

Clients and carers consulted as part of The Nous Group program reviews commented on the need for more holistic recovery support, consumer-led programs, access to peer support and a stronger focus on connections to housing.

They also proposed client-linked funding. This is consistent with developments related to the proposed NDIS, which intends to shift service provision towards client-controlled funding packages. This will be a major influence on the delivery of PDRS services in the coming years.

The following areas drive the need for, and focus of, a program of reform.

Service targeting and access

- Greater consistency in targeting and prioritisation of access, particularly to people who are most disabled by their mental health condition.
- Streamlined, easier to navigate client pathways, particularly between PDRSS, clinical specialist mental health, primary healthcare and community welfare services.

Equitable service provision

- Ensure an equitable distribution of PDRSS across the state.

Service delivery configuration and catchments

- Organise effective and efficient service delivery configurations in a given catchment.

Responsiveness to client need and diversity

- Strengthen the focus on and accountability for achieving client-driven outcomes.
- Improve consistency in service delivery approaches and quality.
- Improve responsiveness to diversity, particularly the needs of disadvantage groups such as Aboriginal people, refugees, culturally and linguistically diverse (CALD) communities and homeless people.

PDRSS as part of a broader system of care

- Considerable opportunity exists to improve service coordination and connection, and physical health and social and economic participation through effective collaboration and coordination with local health and social services.

Workforce development and sustainability

- Develop the workforce in the face of an increasingly complex client group, with some agencies experiencing significant recruitment and retention pressures.

Governance and accountability

- Strengthen organisational and clinical governance, accountability and reporting frameworks linked to client outcomes rather than outputs, with performance linked to funding.

Service targeting and access

State-funded providers of PDRS services are part of a tertiary system of mental healthcare that prioritises access to people with the most severe, persistent and disabling mental health conditions. Notably, eligibility is not defined according to specific diagnoses but according to the functional impact of the mental illness on the individual. Access to and targeting of state-funded PDRSS is a critical area of focus.

Many people with a severe and enduring mental illness have comorbid physical health problems, dual disability (acquired brain injury and intellectual disability) and/or co-occurring substance abuse problems. This impairs their daily living skills and functional capacity. Added to this, many experience entrenched social exclusion and disadvantage as a direct result of their illness and its impact on their life circumstances.

While people who are most disabled by their mental health condition are a priority target group, early intervention to reduce, or potentially prevent, the burden of disability associated with a severe mental illness is also a focus.

Improving treatment and support to people with a severe and persistent mental health problems and the coordination of their care is a key focus of both state and national mental health reform.

Data from the PDRSS census suggests clients have less complexity in some program types than would be expected, particularly in day program services. This data also indicates a relatively low level of accepted referral from clinical specialist mental health services, with accepted referrals from this source to HBOS services trending down over the past three years (currently accounting for 42.5 per cent of all accepted referrals). Referrals from private and public clinical mental health providers combined accounts for fewer than 50 per cent of all accepted referrals.

Clinical mental health services and homelessness services anecdotally report difficulty accessing PDRSS for their clients.

It is recognised that the capability and capacity of some PDRSS providers would need to be strengthened to position them to proactively target and respond effectively to clients with higher levels of disability and need, particularly those with symptom instability and challenging behaviours related to personality disorder, trauma, substance misuse, forensic histories and dual disability.

In summary, people with a severe mental illness and their carers/families find it difficult to access and navigate PDRSS due to the following factors.

- *Multiple entry points in a given catchment.* Consultation and analysis has identified the need for clearer, more streamlined entry points to PDRSS to make them easier to access and navigate by clients, carers and referring agencies.
- *Variability in targeting and prioritisation of access.* Providers currently do not use standardised intake screening and in-depth assessment processes, tools and practices.
- *Variable throughput.* The majority of providers do not use standardised criteria and assessment processes to exit clients that no longer require a specialist community mental health service. This reduces system throughput and the ability to accept new clients. The pace and degree to which recovery outcomes are achieved for some individuals also impacts on throughput.
- *Lack of formal mechanisms to prioritise local demand.* The majority of PDRSS do not use transparent, uniform mechanisms for managing and prioritising service demand such as waiting lists, joint clinical–PDRSS intake assessment panels or review and recall systems for clients who may need to re-enter the service.¹⁵

¹⁵ It is noted that providers funded to deliver intensive HBOS are required to establish joint assessment panels to ensure consistent and appropriate targeting.

Further, the mismatch between the client flow between clinical mental health and PDRSS results in clients entering into, and out of, clinical treatment faster than they can enter community-managed mental health services.

The Nous Group's review of day programs and adult and youth residential rehabilitation services undertaken on behalf of the Department of Health in 2011 recommended that clear, non-discretionary entry and exit criteria and streamlined pathways should be established on an area basis for these programs.

Service users and referring agencies also report difficulty understanding the components of the PDRSS funding program. Many providers of PDRSS are not well known, and the use of different names for the same program type further complicates identification of services. Multiple service providers operating in the same catchment add to the complexity. These factors, in combination, create confusion for referring agencies and service users alike.

Service distribution

Historical funding allocations and changes in population profiles over the last 10–15 years has led to the inequitable distribution of resources across the state. As a result some services do not have adequate capacity to effectively respond to demand.

As population-based service benchmarks have not been developed for the provision of psychiatric disability rehabilitation services no comment can be made on what the acceptable level of per capita expenditure should be.

Notwithstanding this, the distribution of PDRSS funding indicates significant variation in per capita expenditure across the state, raising the issue of relative equity. Data¹⁶ indicates the following.

- The estimated per capita 2009–10 expenditure of standard and moderate HBOS services in metropolitan AMHS varies considerably, ranging from \$4.15 per capita to \$14.69, with an average of \$6.96 per capita (see Figure 11).
- The estimated distribution of 2009–10 standard and moderate HBOS services in rural/regional AMHS shows significant but less variation, ranging from \$4.38 per capita to \$10.88 per capita, with an average of \$8.12 per capita (see Figure 12).
- The estimated distribution of 2009–10 day program funding ranges from \$2.07 per AMHS capita to \$6.45 per AMHS capita, with an average per capita spend of \$4.14.

Note: Analysis is provided by AMHS catchment areas, which are the nominal catchments of some PDRSS, but agencies may accept clients from other areas (see figures 12 and 13).

Analysis found no recognisable relationship between socioeconomic disadvantage and per capita expenditure.¹⁷ Demand modelling is required to support area-based planning and future funding decisions, including the possible redistribution of current funding against agreed service benchmarks.

¹⁶ Per capita analysis is based on Victorian Department of Health PDRSS program data (2009–10) and population data of people aged 15–64 years in Victoria. Source for population estimates: 30 June 2009 revised Estimated Resident Population figures, as reported in Population by Age and Sex, Victoria, electronic delivery (released August 2010) ABS. Currency: 2009. 2010–11 data is not available.

¹⁷ IRSED – The rank of the local government area in relation to the Index of Relative Socio-economic Disadvantage. The ABS uses Census data to produce the IRSED. It is based on a range of Census variables considered to reflect levels of disadvantage, including income level, employment status and level of educational attainment. Source: 2006 Census of Population and Housing, ABS. Currency: 2006

Figure 11: 2009–10 per capita expenditure standard and moderate HBOS by area mental health service catchment (metropolitan)

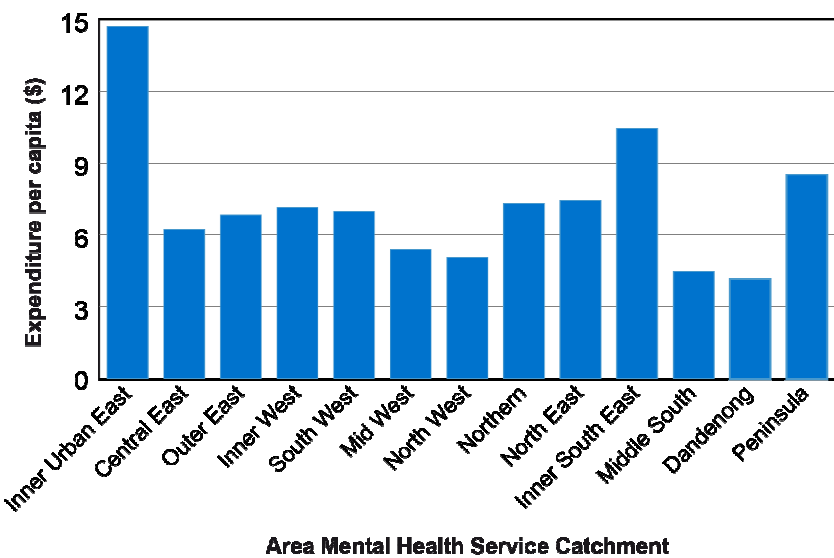
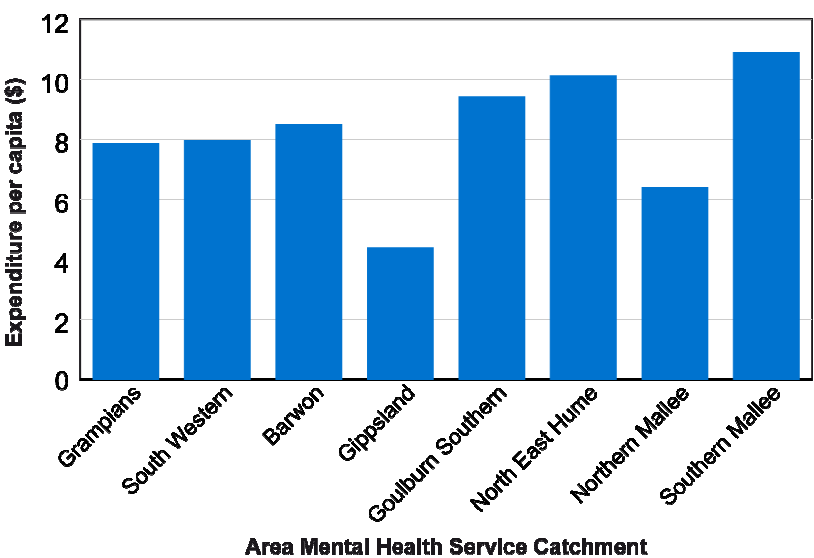


Figure 12: 2009–10 per capita expenditure standard and moderate HBOS by area mental health service catchment (rural)



Summary

- The key systemic issues related to service access and targeting drive the need for:
- clearer, more streamlined entry points to PDRS services to improve access for clients, their carers and families and referring agencies
 - greater consistency in targeting and the prioritisation of access to people with the greatest need
 - a consistent approach to intake, assessment and discharge processes
 - greater emphasis on early intervention for people with a severe mental illness to prevent disability
 - improved coordination between clinical specialist and private mental health providers and broader social support services to facilitate streamlined client pathways to and from PDRS services
 - improved service distribution across the state relative to population need.

Service delivery configuration and catchments

Service delivery configuration

The current configuration of PDRS services is characterised by:

- multiple providers in a given catchment offering either the same program to clients or a limited set of programs – using differing intake/eligibility criteria¹⁸
- a significant number of providers with small-scale capacity, which significantly limits economy of scale, quality and workforce sustainability, and drives higher transaction costs for government
- service mix and capacity across geographical areas being inequitably distributed, resulting in patchy, inconsistent access.

Multiple providers in a given area results in: a lack of continuity and sustained effort; patchy service responses; a complicated service system with reduced capability; and significant variations in responses across regions. As a result, PDRSS in some areas are difficult to access and navigate by clients, carers and referring agencies, and service quality is variable.

The way service delivery is currently structured is unnecessarily complex and inefficient. From a client point of view:

- PDRS programs and services can be difficult to access and navigate.
- They need to frequently engage with more than one provider to access the range of services they need in their local community.
- Pathways between clinical mental health and PDRSS and within the sector itself are not well coordinated, which impedes continuity of care, particularly at key transition points.
- There is a lack of consistency and clarity regarding how different mental health services fit together, including Commonwealth-funded mental health programs. This makes navigating an already complex system more difficult.

From a service planning, quality and coordination perspective, distribution of service capacity across multiple PDRSS providers:

- limits the capacity of any one PDRSS provider to plan for and provide a 'seamless', flexible response to meet local population need
- makes it difficult to undertake area-based service planning and coordination, an issue further complicated by inconsistencies and lack of clarity in service catchment boundaries
- creates significant challenges for referring agencies, particularly clinical specialist mental health, primary healthcare and social services, requiring them to coordinate access through multiple entry points and maintain organisational relationships with numerous providers.

From an organisational perspective, many services lack the capacity needed to provide adequate practice and organisational governance and staff supervision, achieve minimum standards of quality, maintain information technology (IT) systems, effectively manage performance and comply with monitoring and reporting requirements.

In summary, the number of providers in a given catchment, the significant variation in the scale of individual providers, and variability in the programs provided, makes any consideration of service re-configuration and catchment realignment a complex issue.

¹⁸ PDRSS providers by Department of Health region are listed in Appendix 1.

Impact of scale of current service provision

A significant proportion of providers have small volumes of state-funded service provision. Scale of service provision impacts directly on the capacity of a provider to:

- ensure reasonable access
- sustain a well-trained workforce
- ensure adequate practice governance and achieve minimum standards regarding service quality and workforce capability.

The level of small-scale service provision was noted by The Nous Group in its review of day programs. The Nous Group found that the small funding commitment of many providers presents significant system challenges, particularly achieving and maintaining consistent service quality across providers. Key organisational challenges included the capacity of small-scale providers to adequately invest in the level of workforce development needed to sustain a stable, high-quality workforce and provide viable career pathways.

Notwithstanding these issues, many providers with relatively small service volumes do provide good quality services and innovative responses to client need, including those with complementary services such as Community Health Services and those supporting the needs of specific population groups.

Impact of Commonwealth investment

Recent Commonwealth mental health investment in Victoria, particularly FaHCSIA's PHaM program, has introduced additional complexity in respect to service catchments and the delivery of PDRS services in Victoria.

The lack of current alignment of service directions, catchments and investment of PHaM program with state-funded PDRSS has:

- introduced more entry points, making the mental health service system even more complex for clients, their carers and referring agencies to navigate
- largely failed to optimise the potential to strategically build existing provider(s) of scale in a given catchment
- proliferated funding streams and increased system complexity
- complicated state-funded PDRSS catchments by funding on a different catchment basis.

Service catchments

Catchments remain an important organising framework for the equitable distribution of resources and the delivery of locally accessible public mental health services linked to a range of service partners.

Although many providers notionally use the same catchment boundaries as AMHS there are no uniform catchment boundaries for PDRSS service delivery. Service boundaries may also be a barrier to access in some areas. A clearer consistent set of catchments for PDRSS is required.

As a point of comparison, AMHS are catchment based and organised as sub-units of Department of Health regions. AMHS have a core set of bed and community-based services to ensure sustainability and equity of access. Access to clinical specialist mental health services provided by AMHS is via an area-based, centralised triage function using standardised assessment processes and tools.

Clearer alignment of PDRSS catchment boundaries with AMHS will facilitate area-based service planning and cross-sector coordination. It could also better support both sectors to collaboratively plan for current and future population need, taking into account demographic trends, population growth and movement trends, and population ageing.

Any change to PDRSS catchments should therefore be considered in parallel with any planned changes to AMHS catchments.

Given the role and function of Medicare Locals and the Commonwealth Government's continued investment in community mental health programs, an area-based PDRS service system with catchment boundaries that allow optimal alignment with Medicare Locals should be considered in any planned realignment of both AMHS and PDRSS catchments.

Summary

- The current configuration of the PDRS service delivery arrangements makes it difficult for people with a severe mental illness and their carers to easily access the range of services they need and impacts negatively on their continuity of care.
- Potential and existing clients and carers must frequently navigate access to different providers, with varying entry criteria and service capacity.
- Many PDRSS providers have small levels of service provision – this directly impacts on the capacity of these providers to provide reasonable access, sustain a well trained workforce, ensure adequate practice and organisational governance and achieve improved standards regarding quality and workforce capability.
- Current service delivery structures reduce the capacity of any one organisation to provide a 'seamless', flexible response to client need.
- Alignment of PDRS service catchment boundaries with area mental health services is required to facilitate area-based cross-sector planning and care coordination.

Responding to diversity

Consultation indicated that there is considerable potential to improve responsiveness of PDRSS providers to vulnerable population groups, particularly people from CALD backgrounds, refugees, the homeless, Aboriginal people, people with a co-occurring disability, and people who identify as gay, lesbian, bisexual, transgender or intersex.

Investment in sector capacity to plan for, engage and work proactively with these communities, coupled with support to improve the cultural sensitivity and responsiveness of the workforce, are identified key enablers.

Analysis of selected program streams

Providers of PDRS services strongly identify with the values and philosophy of recovery. Interventions are largely framed on a social model of health approach. Despite this many struggle to clearly articulate a clear view of what recovery-orientated practice should look like and how to translate this consistently into day-to-day practice.

While some agencies utilise evidence-based recovery models, such as the collaborative recovery model, the uptake of such models remains an identified area for development.

The Nous Group's review of the adult and youth residential rehabilitation services and day programs found that while providers indicated they used 'recovery approaches', the majority were unable to articulate defined therapeutic service model(s).

This was identified as a significant factor impacting on the achievement of demonstrable outcomes for clients, particularly in the areas of housing, employment, education, physical health and social inclusion across all three programs.

Table 2 outlines the assessment of adult and youth residential rehabilitation services and day program performance against long-term recovery outcomes.¹⁹

This data indicates that providers of these programs are achieving reasonable outcomes in terms of the individual's functionality and self-management, but are performing less well in the areas of housing, family engagement, education and employment and social engagement.

The Nous Group's program review identified that:

- clients received relatively low levels of active support (relates to residential rehabilitation services)
- services were not sufficiently goal oriented
- services did not adequately deliver recovery outcomes for the majority of clients.

The Nous Group's review recommended all three programs:

- be reoriented to deliver an agreed set of client-focused outcomes with a greater focus on mental and physical health, economic participation through education and employment, and social participation (The Nous Group recommended individual service provider performance and funding be linked to achieving client outcomes)
- use standardised, non-discretionary intake and exit criteria to improve consistency of targeting and throughput
- adopt evidence-based service delivery models
- establish streamlined referral pathways on an AHMS basis to improve client pathways
- be required to develop stronger and more active partnerships and coordination mechanisms with local services covering education, employment, housing, recreation, community services (such as youth justice), health (such as alcohol and drug treatment services and general practice) and clinical mental health services.

Analysis suggests these findings have broad application to the HBOS service model.

¹⁹ These outcomes were identified in program logic models developed for the strategic review of these service elements.

Table 2: The Nous Group's general assessment of recovery outcomes for selected PDRSS programs

Programs	Mental health			Physical health	Social			Economic		Overall assessment
	Enhanced daily living skills	Psychosocial education attainment	Self-management of illness	Good physical and wellbeing	Improved social and family relationships	Stable and affordable long-term housing	Family/carer support and engagement	Educational and vocational achievement and employment	Reduced requirement for intensive clinical support ²⁰	
Day programs									Unable to make assessment	Low-medium
ARR program									Unable to make assessment	Low-medium
YRR program									Unable to make assessment	Medium
Overall assessment	Medium	Medium	Medium	Medium	Low-medium	Low-medium	Low-medium	Low-medium	Unable to make assessment	Low-medium

Key: = Low = Medium = High

²⁰ Neither the stakeholders nor the available data provided a sufficient and strong evidence base to make an assessment about the impact of the three programs on demand for clinical services.

Program-specific recommendations are summarised as follows:

Day programs

- Focus on assisting clients to access group-based activities in mainstream community settings.
- Extend delivery hours beyond Monday to Friday, 9 am to 5 pm. The extended delivery hours should include weekends and non-business working hours.
- Adopt two types of support periods for this program. The first is for 'no more than 18 months' for clients who require time-limited support to access mainstream services. These clients should also have the option to re-enter the program at a later stage. The second is 'extended' for clients with a higher degree of enduring disability.

Youth residential rehabilitation services

- Retain the bed-based rehabilitation model.
- Retain current service delivery arrangements subject to a review of performance against agreed measures and client outcomes.
- Strengthen the interface with referring agencies, particularly clinical mental health services (private and public), child protection, youth justice and drug treatment services.
- Re-develop the service model to a focused, goal-oriented, 12-month program delivered in collaboration with the young person, their family and relevant health, education and social services.
- Significantly strengthen post-discharge planning.
- Establish entry and exit pathways on an AMHS basis.
- Indicative access to this program to be for 12 months and clients to be provided with an average of six hours of active contact per week.

Adult residential rehabilitation services

- Discontinue the bed-based rehabilitation model and invest in a supported housing model. Clients to be provided with scaled mental health support on an outreach basis and supported to access appropriate long-term housing.

The Victorian Government has committed to evaluating the MSSH program, with a view to more effectively incorporating the functions delivered through this program into the mental health continuum of care.

Engagement of family and carers

Consultation undertaken to inform this paper indicates that family and friendship networks in people's lives are not well articulated or understood in current approaches to psychosocial rehabilitation and recovery. There is also greater opportunity for providers to take a more proactive role in ensuring the safety of their clients' children.

The Nous Group's review identified current approaches to engaging and responding to the needs of families and carers as a key weakness. Carers commented that they were not usually consulted in planning and decision making about the person's progress, and this was often justified by providers by the need to abide by confidentiality requirements.

The Nous Group concluded that the challenges carers experienced in these programs were consistent with the experience of carers of other parts of the mental service system in Australia.

Summary

- The use of evidence-based service models and practice is variable.
- Remodelling and refocusing selected programs is required to produce optimal outcomes for service users and ensure alignment with best practice.
- Improving the skills, knowledge and core capability of the workforce to target and support an increasingly complex client group is an area for early action.
- New performance measures are needed to monitor achievement against agreed client outcomes and improve accountability.
- A more explicit focus on social and economic participation outcomes is required across all program elements.

PDRSS as part of a broader system of care

Connectivity between PDRSS and specialist clinical mental health services

While coordination at both the client and service planning levels is improving between PDRSS and specialist clinical mental health services, significant potential exists to achieve better, stronger and more systemic alignment.

Consultation undertaken to inform this paper identified overwhelming interest in stronger alignment and collaborative area-based planning between PDRSS and clinical specialist mental health services on the basis that:

- PDRS services are an integral part of the continuum of care for people with a severe mental illness.
- Optimising recovery outcomes for clients requires an organised and well coordinated coherent system of specialist mental health treatment and support.
- State-funded mental health recovery services are a rationed, specialist response that must be targeted to people with the greatest need.
- PDRSS providers need to be supported to more persistently engage people who do not seek or readily engage with community-managed mental health services.

Factors identified as impacting on the ability of both sectors to better coordinate efforts include:

- lack of alignment of language and philosophy
- lack of clarity regarding role demarcation
- relatively weak network governance arrangements
- the need for collaborative mechanisms to drive integrated, area-based coordination and planning (the number of PDRSS providers in a given area was identified as a key complicating factor in this regard)
- non-alignment of service catchments in some areas
- absence of common IT systems and platforms and unresolved issues around privacy and confidentiality of client information.

Cross-sector collaboration

While there are examples of good cross-sector collaboration, such as PDRSS involvement in the Community Mental Health Planning and Service Coordination Initiative and some Primary Care Partnerships, PDRSS providers as a whole are not well connected to local primary healthcare and community services such as child protection and out of home care services.

This was confirmed by The Nous Group's program review which identified the need for more formalised service coordination mechanisms to better support the recovery and social inclusion of people with a severe mental illness.

The Nous Group also identified that cross-sector collaboration between PDRSS providers and broader health and social services is particularly problematic for vulnerable populations groups such as refugees, Aboriginal people and to a lesser degree people who are homeless.

The Victorian Government's planned human service reforms towards more coordinated person-centred approaches will include stronger cross-sector collaboration and person centred approaches.

The Community Mental Health Planning and Service Coordination Initiative and Primary Care Partnerships will provide valuable insights into the development of future cross-sector collaboration and planning mechanisms.

Summary

- Significant potential exists to achieve better, stronger and more systemic alignment between PDRSS, clinical mental health and primary healthcare services.
- While cross-sector collaboration between PDRSS providers and the broader health and community support service system is improving it is largely not systemic.
- Improving cross-sector linkages and coordination is critical to achieving longer term outcomes for clients and their children in areas such as physical health, social participation, education, employment and housing.
- Early efforts to create effective and sustainable local area network governance across sectors needs early consideration.

Workforce development and sustainability

PDRSS providers, like the health sector more generally, faces significant issues in sustaining a high-quality workforce. As with other community sectors, this sector also has an ageing workforce and experiences a relatively high turnover of staff. Many providers experience difficulties recruiting qualified base-grade workers and middle managers.

Partially in response to meeting demands for service growth, providers are recruiting a significant proportion of staff with no formal qualification or relevant qualifications (23 per cent of support workers and 17 per cent of managers).²¹ As a result there is variability in skills and competency across the workforce. The competencies required to deliver the service and practice improvements detailed in this paper will need to be further developed and built into the existing workforce.

The lack of career pathways has been highlighted as a key problem in retaining staff. Working conditions, such as the lack of portability of entitlements between the public specialist mental health and PDRSS sectors, has also been identified as a factor contributing to the level of attrition.²²

Perceptions exist within the PDRSS workforce that their work is undervalued and that there is a lack of recognition of their skills, capability and contribution. Day program and youth and adult residential rehabilitation providers interviewed as part of The Nous Group's review identified that low staff morale is a key factor in staff turnover and resistance to change in service delivery practices.

PDRSS providers report working with increasingly complex clients. One of the most significant challenges facing the workforce is balancing a recovery approach to treatment and support against the appropriate threshold of risk within a particular service setting. The workforce requires adequate training, supervision and professional development to effectively manage this level of complexity and risk, particularly for people with a forensic history, those who have experienced trauma, people with a personality disorder, coexisting mental illness and substance misuse problems, and dual disability.

Other identified areas for workforce development include strengthening and embedding the requisite competencies to:

- deliver person-centred services
- use evidence-based recovery-orientated practice models
- practice in family-inclusive and culturally-safe ways
- effectively undertake cross-sector planning and collaboration with health and social services
- respond to diversity.

There is growing interest in the peer support function, in Victoria and nationally. Further analysis is required to assess the value of this function in a system of mental healthcare and address the training and workforce development needs of this emerging workforce.

²¹ VICSERV 2010, *Training needs analysis report*, VICSERV, Elsternwick.

²² The *Shaping the future: The Victorian mental health workforce strategy Final report* also identified staff recruitment and retention issues relating to employment conditions such as lack of portability of entitlements.

Improving sector management, leadership and practice governance

Improving management and leadership competencies is an identified area for priority attention.

Addressing this issue will require a multilevel approach that supports:

- workers transitioning to management roles to develop the requisite skills for this function
- middle managers to develop the skills, knowledge, values and attitudes needed to effectively manage and lead the workforce. This includes skills needed to lead practice supervision and support; encourage service cultures that support person-centred and family-inclusive practice; and drive the implementation of new workforce practice and innovation.

A number of approaches are required to build the competency of the mental health workforce to provide high-quality clinical and organisational leadership. These may include:

- shadowing and mentoring emerging leaders
- identifying the specific leadership and coaching activities required to build the repertoire of middle managers
- building cultures that recognise value and encourage leadership competence and adequately support leadership at all levels of the organisation.

Summary

- PDRSS providers face significant issues in sustaining a high-quality workforce.
- The PDRSS sector has an ageing workforce and experiences a relatively high turnover of staff.
- Recruitment of qualified base-grade workers and middle managers is challenging for providers.
- There is significant variability in the level of skill and knowledge of the PDRSS workforce.
- There is significant opportunity to improve leadership skills within the workforce.

Information management and outcome measurement

Client information management systems

Improving data collection to strengthen client care, reporting and performance management at the provider level is an area identified for attention by stakeholders.

There is significant diversity in the current capacity of agencies to access and use client information management systems. Some larger agencies have implemented their own systems. Those based in community health services are mostly moving to HealthSMART applications such as TrakHealth or iPM.

PDRSS agencies are currently required to report PDRSS activity through the Quarterly Data Collection (QDC) information system. The QDC is limited in its ability to provide good-quality, timely data to inform system performance. The QDC does not facilitate outcome measurement.

The Australian Government is undertaking the Mental Health Non-Government Organisation (NGO) National Minimum Data Set Project (NMDS). The aim of the project is to provide nationally consistent information on the mental health NGO sector to inform policy, practice and planning. This data collection will focus on inputs and outputs of service delivery in the short term.

The NMDS could potentially be expanded to collect client-level outcome measurement. The creation of an NMDS may provide useful comparative information regarding the mental health recovery services in Victoria, and complement data collected by the Victorian Government.

The QDC does not link to Client Management Interface/Operational Data Store (CMI/ODS) used by the specialist clinical mental health service system. The Department of Health has been working with selected area mental health and PDRSS providers to pilot the use of CMI/ODS.

Significant opportunity exists to develop a common information management capacity across PDRSS and the clinical specialist mental health service sector more broadly.

Outcome measurement

Outcome measurement is an important way to determine the impact that services achieve on client outcomes over time. The collection of routine outcome measurement is required for all clients of specialist clinical mental health services.

The Victorian Government encourages PDRSS to use the same outcome measurement tools as the specialist clinical mental health services, but this is not a requirement.

Agencies currently use a range of outcome measurement tools. The variety of outcome measurement tools utilised, however, does not enable reliable comparison of achievements of client outcomes from provider to provider.

PDRSS use of the same outcome measurement tools as the specialist clinical AMHS could enable more effective analysis of an individual's progress across the specialist mental health system.

Summary

- Improving data collection to strengthen client care, reporting and performance management at the provider level is an identified area for action.
- Significant diversity exists in the current capacity of agencies to access and use client information management systems. This does not enable reliable comparison of achievements of outcomes from provider to provider.
- The use of outcome measurement is variable within PDRSS. PDRSS utilisation of the same outcome measurement tools as the specialist clinical mental health treatment service could bring significant benefits.

Part B: Framework for change

Victoria's state-funded community-managed mental health services – as an integral part of our system of public and private mental health treatment and care – have a central role to play in supporting people with a mental illness on their recovery journey and the family and friends that support them.

Our shared challenge is to work together in the interests of people with a severe mental illness and their families and carers – many of whom are amongst the most vulnerable people in our community – to shape a new, contemporary system that is person-centred and client-directed.

In recognition of the changes in focus and in line with contemporary thinking, we propose to alter the name of the state-funded program to community mental health support services (CMHSS). We envisage that the community-managed mental health services will play a major role in delivering this function.

We recognise that concepts such as individualised funding may be challenging and complex and that their implementation will require careful consideration and a staged change agenda.

This is an important step if we are to become truly client-centred in both our philosophy and practice.

It is important that the sector positions itself for this change. This change agenda will take into account reforms in the delivery of human services and the introduction of an NDIS.

We must also work together to optimise continued investment by the Commonwealth in community mental health programs to ensure effort is complementary and strengthens the continuum of support available to Victorians with a mental illness.

The first stage of the reform process is to build the capacity and capability of PDRSS providers to deliver a more efficient and more effective response to the needs of people with a severe mental illness and their families.

The complexities and inefficiencies of present service delivery arrangements are best illustrated through the experience of the individual and their family/carers. Table 3 describes a common client experience of the current system and the experience we want clients and their carers to have in future.

Table 3: Changing the client experience

A personal client experience: a current journey →	A person's experience in the future
Characterised by:	Moving towards:
• people and their families/carers not always having the opportunity, knowledge and confidence to be involved in decisions or planning related to their support and there is a limited focus on building the skills needed for self-management and self-efficacy • missed opportunities to better support dependent children of people with severe mental illness and psychiatric disability • a confusing range of entry points and entry criteria to a system of support that is difficult to access and navigate • movement between clinical specialist mental health and PDRSS that is not coordinated, made more difficult because information is not easily shared • support that is not well connected with the person's clinical treatment and care (public or private) or coordinated with broader health, social and welfare services • frequent need to undergo multiple and varied assessments by separate PDRSS providers to access the range of local services available, whose involvement with the person may be quite disjointed from each other • a requirement that the person must 'fit' into existing, rigid program structures • often no opportunity for more time-limited, 'fast tracked' engagement • varying service quality from program to program, agency to agency and location to location.	• improved capacity for self-management, with the knowledge and confidence to make choices about their support • supported and engaged carers and family members • a single point of entry to streamlined, consistent cost-effective and efficient support • high levels of active involvement in their care and support, whether it is planning, coordination or decision making • a person-centred service package designed according to their choices, preferences and changing needs • support that complements, and is coordinated with, their clinical treatment and care • support that is responsive to their physical health, social and economic needs as well as to their mental health needs, and coordinated with health and social services through well-defined service pathways • information within the person's control and, with consent, easily transferred between providers, resulting in improved communication and coordination • high-quality, evidence-based services and practices delivered by a well-trained workforce.

Table 4 provides a system overview of where we are moving from and what we are seeking to move towards.

Table 4: Key sector development and reform directions

Moving from:	Moving towards our vision:
Inequitable access across the state	A planned, strategic approach that addresses, over time, current inequities in service distribution and critical system gaps and pressures across the state
Inconsistent targeting, prioritisation of access and throughput	Streamlined pathways to support Transparent and consistent targeting with priority given to people who are most disabled by their mental health condition Improved throughput
Variable service delivery approaches and quality	Person-centred, individually tailored service responses Service delivery underpinned by evidence-based practice A sharpened focus on, and accountability for, delivering mental health, social participation, physical health, employment and education outcomes
Loose or informal coordination arrangements	Services work together and with clinical specialist mental health services and the broader health and social support system as part of a coordinated response to people with a severe mental illness.
Inefficiently organised service delivery, with multiple providers of differing capacity in a given area and siloed, program-based service delivery	Streamlined, area-based service delivery structures to: • maximise the efficient and effective use of current government and other investment • improve overall service access and continuity of care for clients and their carers • deliver acceptable standards of quality, efficiency and sustainability Area-based providers that can undertake collaborative planning with service partners to understand and respond effectively to population need and provide a rational basis for future government investment
Developing workforce challenged by an increasingly complex client group	A high-performing and sustainable PDRSS workforce with the skill, knowledge, attitudes, values and skills to deliver high-quality, evidence-based recovery-oriented services Capability to better manage risks associated with high-need clients Workforce that is trauma informed, family sensitive and culturally responsive
Focusing accountability on outputs/activities rather than outcomes Service providers receiving funding year after year regardless of performance	Strengthened governance, accountability and reporting frameworks linked to achieving client outcomes Ongoing funding linked to achieving performance benchmarks Data and information management system that inform and drive results Streamlined funding models that drive excellence rather than limit it

Ten features of a reformed system

The reformed system will have the following 10 features:

Improved access and a focus on those most in need

Victorians with a severe mental illness and their families, including those living in regional and rural areas, will have reasonable access to high-quality PDRS services.

Person and family centred

People will be actively involved in planning, coordination and decisions related to their support, and encouraged and supported to manage their own mental health better.

Family and carer involvement will be an integral part of support where appropriate, recognising carer needs and the safety of dependent children.

Individualised support with a focus on improving health, social and economic participation

Clients will be able to make choices about the type, intensity and duration of mental health support they need, in partnership with services.

Services will promote good physical health and social and economic participation, especially for people experiencing entrenched disadvantage.

Responsive to diversity

Practice and service culture will be responsive to diverse needs of people with a mental illness, particularly Aboriginal people, refugees, people from CALD backgrounds, gay, lesbian, bisexual, transgender and intersex people, and people who are homeless.

Responsive and accountable to local needs

Services should be accountable and responsive to the needs of a defined local community, and be transparent in their achievement of agreed client outcomes and targets.

Integrated part of the specialist mental health system and well coordinated with broader health and social services

Effective PDRS services that meet the needs of the community must work collaboratively with public and private mental health treatment services, health and community welfare services.

Evidence-based practice and decision making

Services must strive to ensure service design and practice is based on the best available evidence.

Capable and engaged workforce

The workforce will have the skills, capabilities and confidence to support people's recovery.

Sustainability through efficiency and effectiveness

State and Commonwealth governments and funded providers must work together to build an efficient and effective system of community-managed mental health services, reduce duplication of effort and strengthen the continuum of care.

Ongoing funding based on performance

Ongoing funding will be linked to the delivery of client outcomes.

Continuous improvement and innovation

The government and service providers will support continuous improvement and innovation in the delivery of PDRS services to achieve better outcomes for people with a severe mental illness and their families.

Building blocks for reform

The framework comprises three interdependent areas that provide the building blocks for the program of reform:

- building organisational and system capability
- remodelling programs and funding streams
- streamlining service system configuration.

Specific service system improvements have been identified within each of these reform areas. Critical underlying changes needed to enable service system improvement and build a more efficient and effective system of community-managed mental health services are also identified.

There is a high degree of interdependency between these three areas. Planning for changes will need to keep them closely linked and staged carefully.

1. Building organisational and system capability

- Building organisational capability to provide good governance and quality assurance.
- Creating stronger capacity to:
 - undertake area-based service planning, service coordination and cross-sector collaboration
 - deliver new structures, functions and approaches to facilitate consistent service access, throughput and accountability for client outcomes.
- Development of a more sustainable workforce with the skill, competency, knowledge, values and attitudes to deliver high-quality, evidence-based services.
- Client information management systems to improve monitoring of and accountability for client outcomes.

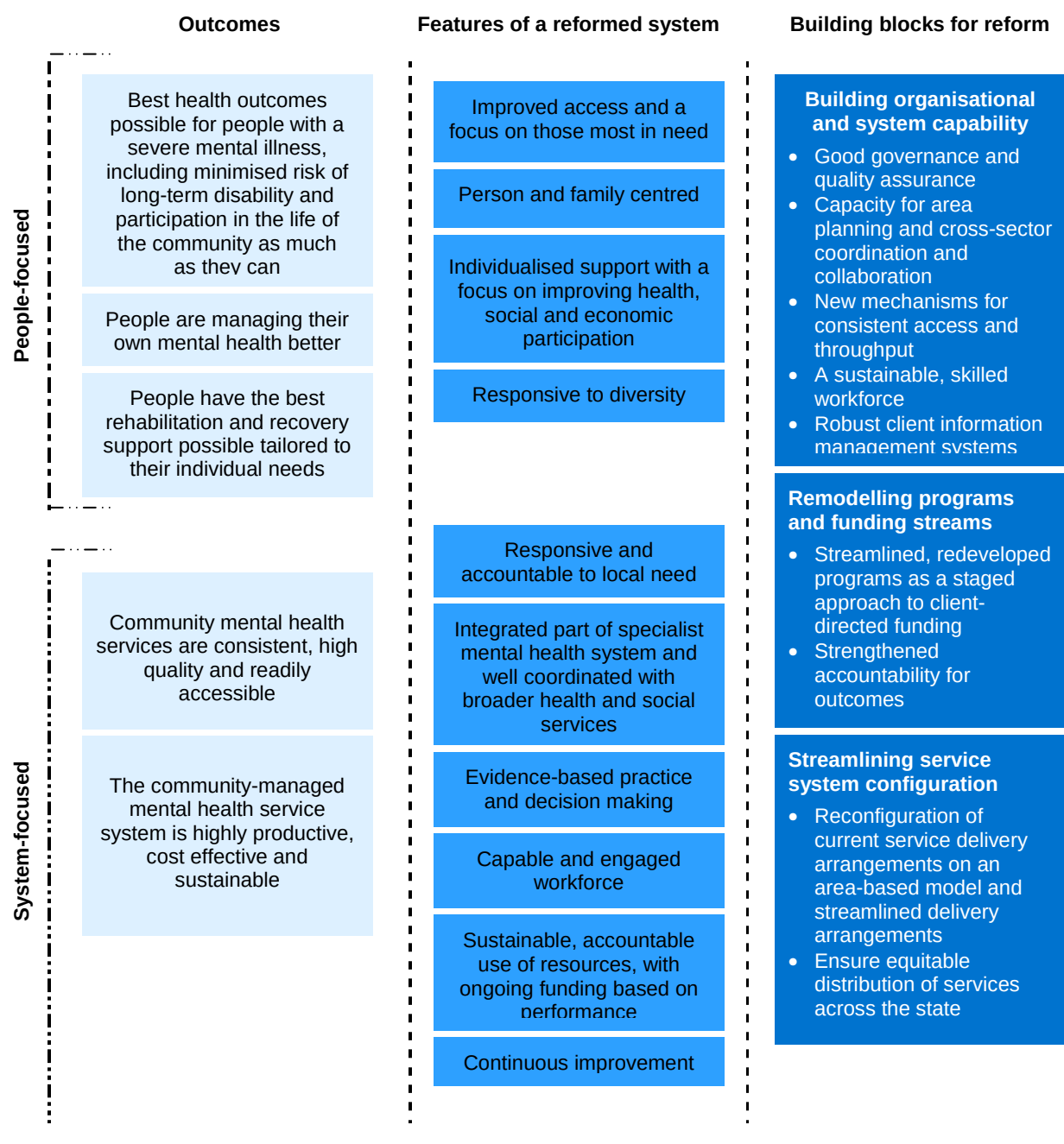
2. Remodelling programs and funding streams

- Streamlined, flexible programs and funding models to make it easier for service providers to innovate and respond flexibly to the changing needs of clients and their families, with the majority of funding for client-directed support packages.
- Remodelling and refocusing selected programs to produce optimal outcomes for service users, improved connectivity with local health and community services, and ensure alignment with best practice.
- Strengthened accountability and transparency for achieving agreed targets and client outcomes.

3. Streamlining service system configuration

- Reconfiguring current service delivery arrangements and streamlining delivery responsibilities on area-based delivery structures to achieve acceptable standards of access, quality and efficiency, and minimise overlap in service responsibilities.
- Building service capacity over time to ensure providers can meet current and future population need and services are equitably distributed across the state.

Figure 13: Outcomes, features and building blocks for reform



Question

Does the framework capture all key aspects of the change required?

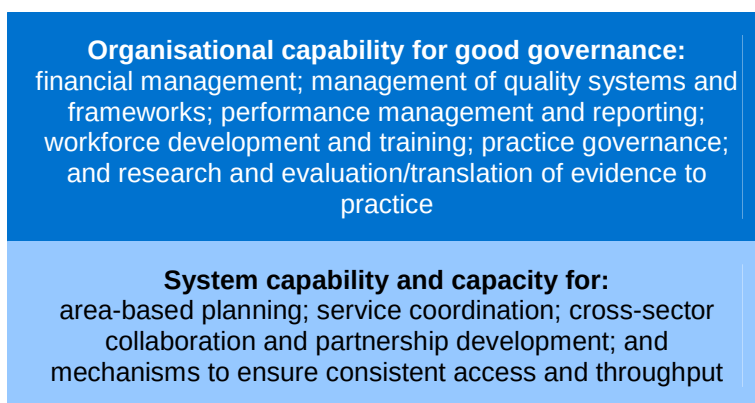
1. Building organisation and system capability

Achieving more consistent access, higher standards of service quality and better planned PDRSS is a priority focus. This will involve the following.

1. Building organisational capability to provide good governance.
2. Creating system capability and capacity to:
 - undertake area-based service planning, service coordination and cross-sector collaboration
 - deliver new functions and approaches to facilitate consistent service access, throughput, responsiveness and accountability for client outcomes.
3. Development of a sustainable workforce with the skill, knowledge, values and attitudes to deliver high-quality, evidence-based services.
4. Client information management systems and data collections that support improved monitoring of and accountability for client outcomes.

These reforms (see Figure 14) will better position the state-funded community-managed mental health services to work productively with the Victorian Departments of Health and Human Services and the Commonwealth on forthcoming mental health and broader social policy reforms. Importantly the reforms will lay the solid foundations required to support the move to client-directed funding, consistent with an NDIS.

Figure 14: Building organisational and system capability and sustainability



Building organisational capacity for good governance

To be efficient, effective and adaptable, individual providers of PDRSS need adequate **organisational capacity and capability** for good governance. This includes:

- financial and human resource management systems
- management of quality systems, including risk management frameworks
- effective management of service performance, including monitoring and reporting requirements
- support for the continuous development of the workforce and provision of quality practice governance
- maintaining mechanisms to engage clients and carers in service development and delivery
- undertaking and collaborating in research and the translation of evidence and knowledge to practice and service design.

The Department of Health will work with PDRSS to strengthen organisational governance following the reconfiguration of service delivery arrangements.

Creating system capability and capacity

Area-based planning and cross-sector collaboration

At the agency level, providers need adequate capacity and capability to systematically undertake area-based planning to better understand and address local issues and population need.

Area-based plans should identify critical service gaps and pressures and improve responsiveness to client and community need and population diversity, including disadvantaged population groups.

The plans should be developed in partnership with mental health services (public and private), broader health and social services, and clients and carers. They should provide the basis for improved service coordination and, by doing this, improve coordination of care for individual clients.

The plans could also inform future state and Commonwealth investment in community-managed mental health services.

Area-based planning and cross-sectoral service coordination is most efficiently delivered by a lead PDRSS provider with the requisite organisational capability and capacity to undertake these functions.

The level of structural reform required to build service providers of adequate capacity to effectively and efficiently plan for, and respond to, local need is discussed in Part B, Service system configuration of this paper.

New area-based functions and approaches

Reform is needed to build a system that manages service delivery on an area basis, with the 'critical mass' needed to innovate and package services in a way that responds to individual client need. This approach aligns with reforms planned for the human services system.

In line with this, a number of new functions are proposed that are most efficiently delivered on an area level. They include the following.

- Area-based intake and assessment to streamline access to PDRSS and improve consistency in targeting. This would align with proposed intake and assessment processes under an NDIS. Such a mechanism could also act as a 'referral portal' to other relevant primary healthcare, specialist clinical mental health, social support and welfare services. This function could also link to, or be part of, standardised intake processes being planned for as part of reforms to the human services system.
- A bed coordination function (as part of the area-based intake service) to better manage access to rehabilitation and supported accommodation beds at the regional level.
- Service coordination to establish and maintain pathways to key health, social and welfare services to support care coordination for individual clients.

These new functions form part of a new stratification of services (see Part B, Remodelling programs and funding streams).

In addition to area-based planning and triage/intake mechanisms, a number of service innovations have been identified to improve: consistency in access and targeting; service quality and consistency; and accountability and transparency for client outcomes. They comprise the following.

Improving consistency in access and targeting

- Standardisation of assessment criteria and processes across all programs and functions.
- Standardisation of exit processes and criteria across all programs and functions to create throughput.
- Improving distribution across the state (to be informed by demand modelling).

Improving service quality and consistency

- Systematic use of evidence-based service models and practice to improve service consistency and quality linked to individual service plans and review/monitoring processes.
- Stronger focus on building the individual's capacity for self-management and the skills and confidence needed to be actively involved in decisions related to their support. The aim is to reduce the individual's experience of disadvantage, supported by practice and culture that is person-centered and carer/family inclusive.
- Development and systematic use of risk management frameworks to better manage risk, particularly risk associated with clients who have complex, high-level needs.

The systematic use of standardised tools and implementation of evidence-based service models and practices will be supported by a comprehensive workforce development program. This program will be developed by the Department of Health in collaboration with funded service providers.

As part of the implementation of the PDRSS reform program, there will be clear expectations of the standards and quality assurance frameworks that funded agencies should operate within, including reporting and accountability requirements. Every effort will be made to align with standards applied within the wider health and human services system, in order to minimise compliance burden for providers.

Strengthen accountability and transparency for client outcomes

- Strengthen accountability by developing/refining key performance indicators (KPIs) that better measure intended client outcomes.
- Introduce outcome measurement to support performance monitoring.
- Identify service benchmarks (informed by demand modelling) in consultation with funded service providers to inform the development of a comprehensive performance management framework.

Services will receive ongoing funding subject to achieving agreed standards of performance. This will be linked to quality service frameworks that support continuous improvement.

Questions

What are the most important actions to build organisational and service capability in the:

- *short term (1–2 years)*
- *medium term (3–5 years)?*

Workforce development

The workforce should have the necessary skills, knowledge, values and attitudes to deliver high-quality evidence-based services and work with clients and their carers/families to achieve better person-centred and client-driven outcomes. New or enhanced skill sets will be required to implement new processes such as standardised assessment, risk management plans and evidence-based practice models.

The Victorian Government, in consultation with key stakeholders, is currently developing a workforce development framework for the specialist mental health workforce. This framework will provide a comprehensive platform for the ongoing development of the specialist clinical and community-managed mental health workforce in Victoria.

The following action is proposed to support the development of a highly skilled and sustainable PDRSS workforce:

- Develop a competency framework that will clearly articulate the necessary skills, knowledge, values and attitudes needed to deliver high-quality services to clients and their families. The framework will also inform role design, staff recruitment, remuneration and training.
- Further develop a sustainable training and education platform that supports the coordinated delivery of area-based and statewide training and education across the specialist mental health workforce.
- Develop and deliver
 - training and professional development programs to support the systemic use of evidence-based recovery models that deliver proven outcomes for clients
 - tailored training and professional development programs to improve capability, capacity and confidence of the workforce to work with clients with complex needs such as people with a forensic history, personality disorders, dual diagnosis and dual disability.
- Support the systematic implementation of comprehensive risk management systems, processes and practices. This will involve skill development for managers, supervisors and direct delivery staff.

Invest in leadership development, particularly at a middle management level. Areas identified for improvement include practice/clinical governance, supervision skills, and person-centered and family-inclusive practice. Strategies that directly support existing and emerging leaders, coupled with organisational changes to culture and management practice, will be required to achieve this.

Questions

Are there other workforce development areas that also require focused attention in the short to medium term to better support the delivery of high-quality client and carer/family outcomes?

Client information management systems

Information Technology (IT) has a central role to play in enabling improved management of client pathways and monitoring of, and accountability for client outcomes. Outcome measurement coupled with outcome-focused KPIs that are linked to funding and service agreements will play a key role in supporting continuous improvement, service quality and strengthened accountability.

Stakeholders have provided feedback that the existing QDC tool is inadequate. As we move towards an outcome-focused system we need KPIs and information management systems that can provide timely, robust and reliable data that demonstrates what is being achieved for clients and their families.

As a first step, service providers will be supported to systemically use a consistent set of outcome measurement tools. These tools will provide information about changes clients experience as a result of the mental health support they receive. This will allow comparative analysis of client progress between and across service providers and with specialist clinical mental health services more broadly.

The use of standardised outcome measurement tools and new practice will be supported by a comprehensive workforce development program to be developed by the Victorian Department of Health in collaboration with service providers.

Over the medium term, the Department of Health will continue to work with key stakeholders to develop an outcome-focused data collection set and ensure that requirements can be supported by IT systems available to agencies.

Questions

Are there any outcome measurement tools that state-funded community-managed mental health agencies could uniformly use?

2. Remodelling programs and funding streams

This reform area focuses on:

- developing streamlined, more flexible programs and funding models to make it easier for service providers to innovate and respond flexibly to the changing needs of clients and their families, with the majority of funding for client-directed support packages
- remodelling and refocusing selected programs to produce optimal outcomes for service users, improve connectivity with local health and social services, and ensure alignment with best practice
- strengthened accountability and transparency for achieving agreed targets and client outcomes.

Current PDRSS delivery structures are based on overly rigid programs – this reduces the capacity of individual services to respond flexibly to the needs of people and place.

As part of a staged approach we want to streamline the current program-based service delivery model to:

- achieve a more flexible combination of funding streams so providers can more readily 'package' support for individual clients
- support clients to be able to make real choices about their support, in partnership with services (this will involve facilitating client-driven decision making with a strong focus on building capacity for greater self-management)
- ensure services are more responsive to increasingly complex conditions, particularly for clients who require a high level of coordinated care and those with high-risk behaviours
- develop providers with the critical mass to 'package' services for individual clients and ensure the type, intensity and service duration needed to efficiently produce optimal outcomes for individuals
- build service providers of adequate scale in order to respond efficiently and effectively to service demand.

This action will support the move to individualised service packages and client-directed funding. These directions are consistent with similar moves in some other parts of the human services system, and are already well advanced in the disability services sector. Importantly, this action will position state-funded community-managed mental health providers (in an open provider market) to deliver client-directed services through an NDIS.

To achieve this we need to change the way service delivery is currently organised. This includes stratifying functions on a state-wide, regional and local area basis.

As depicted in Figure 15, the proposed stratification includes the following.

State-wide services, which will include peak bodies and specialist support services with a state-wide focus, such as:

- VICSERV
- The Victorian Mental Illness Awareness Council
- The Victorian Mental Health Carers Network
- State-wide specialist support services such as Forensicare, Spectrum and the Victorian Dual Disability Service²³
- State-wide information and referral services.²⁴

²³ This would require these services to extend their focus to providers of community mental health services.

²⁴ A number of agencies currently provide these functions through the MSSH program.

Specialist regional functions comprising:

- a new intake/assessment function²⁵
- a new area-based service planning function
- cross-sectoral service coordination and collaboration
- bed-based residential rehabilitation services
- bed-based supported accommodation services.

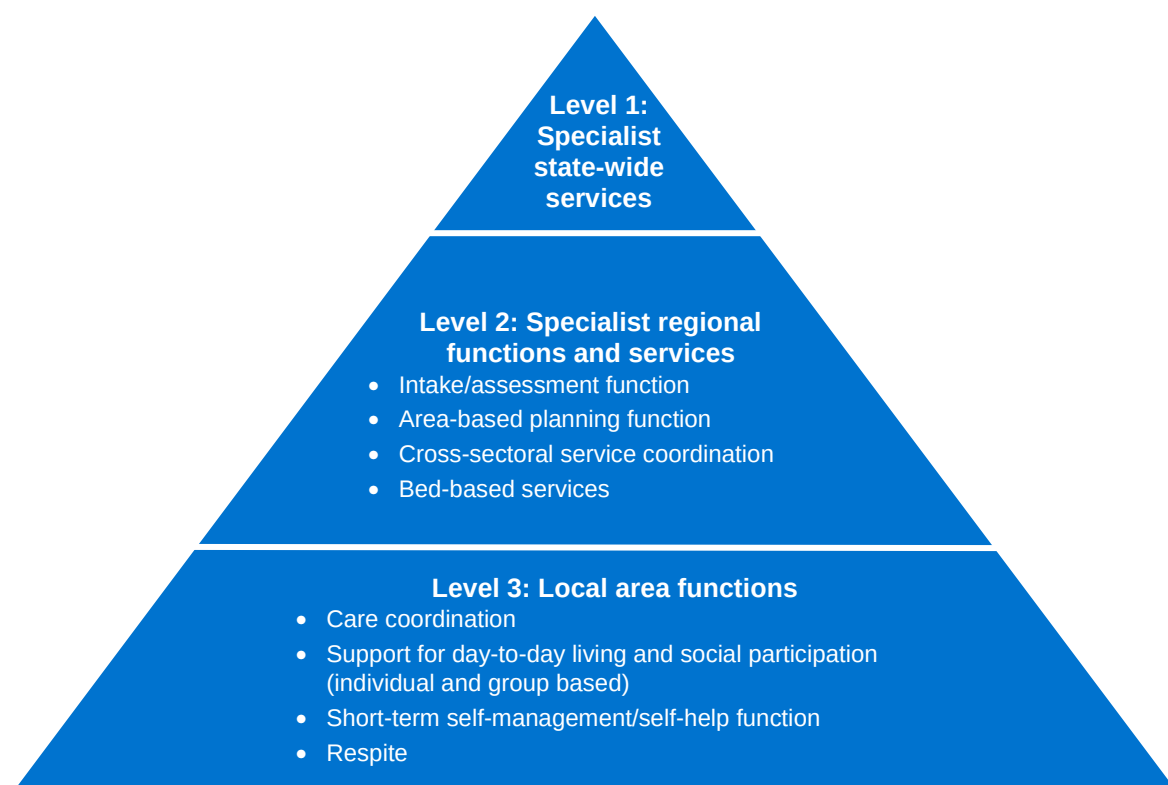
Local area service delivery functions comprising streamlined, more flexible program streams/functions that are responsive to outcomes sought by clients and their carers/families including:

- care coordination
- support for day-to-day living and social participation (individual and group based)
- a short-term self-management/self-help function
- respite/carer support.

These functions will be increasingly organised around the key outcome domains of self-management, daily living skills, physical health, social participation and education/employment.

Specialist local area programs, such as Aboriginal mental health services, will be delivered in close partnership with PDRSS providers.

Figure 15: Proposed stratification of services/functions



²⁵ Intake/assessment function to be developed taking into account the Department of Human Services: case for change and existing AMHS triage functions.

The following staged approach is proposed.

Stage 1: Agencies will be funded to deliver the agreed profile/mix of streamlined programs/functions in a specific catchment

Scope would be given to providers to package supports for clients based on their individual service plan (ISP), drawing on a suite of funded programs/functions as per Figure 15. In addition, individual service providers would have an agreed level of flexibility to pool funding streams and shift funding between streams to package services in a way that efficiently and effectively supports the delivery of the client's ISP.

Services could be delivered on an individual and group basis, depending on client preferences.

This stage will require service delivery arrangements to be streamlined, necessitating a degree of rationalisation that will result in reallocation of funding in some instances. This issue is discussed in Part B, Service system configuration.

Stage 2: Move away from program-based service delivery to client-directed funding

As part of stage 2, service providers will be funded by the government to deliver the client's ISP within an agreed budget. Funded providers would be required to deliver agreed client outcomes and targets in a given catchment.

Eligible clients would be identified through an independent intake/assessment service(s) that would work with the individual and their carers to identify the package of services they need (which would form the basis of the ISP).

The move from a set of 'siloed' programs to individualised funding will require a significantly higher level of accountability and transparency on the part of service providers. Opportunity would exist for services to 'specialise' in certain areas such as employment support.

The next step is full delivery of a client-directed funding model. Support coordinators are often a feature of this model – their role is to assist the individual to make decisions on how to spend their support budget. They are commonly not (and preferably not) a service provider.

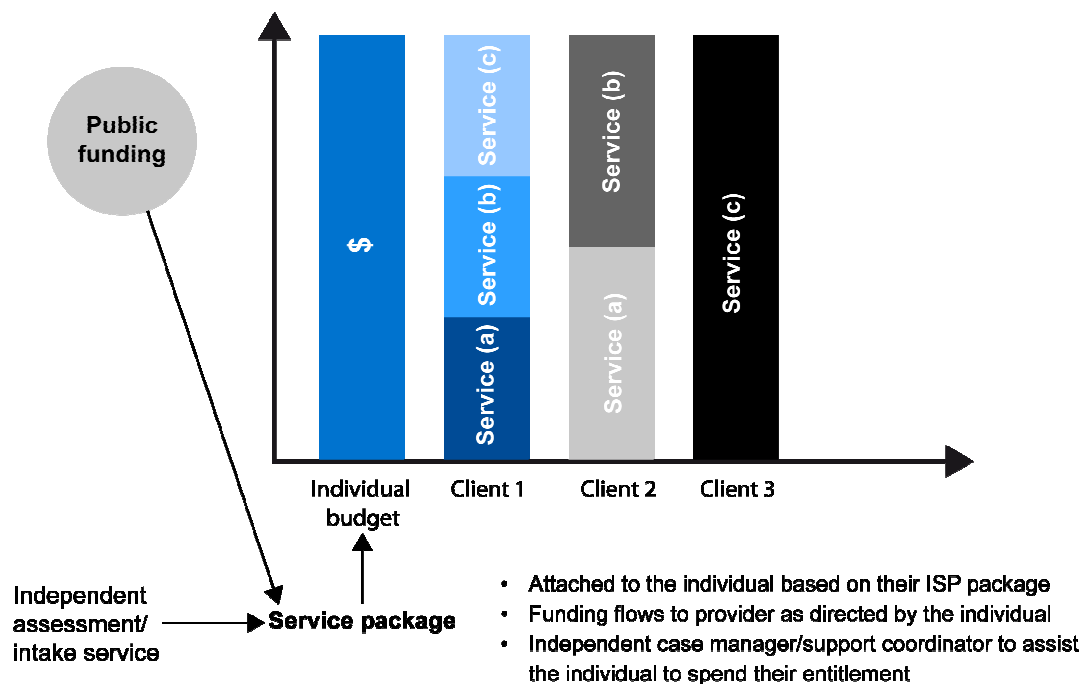
The Productivity Commission's recommendations for an NDIS set out some features of this model. Notably, an NDIS would likely move away from a set 'program menu' approach to service delivery approaches that are built around the needs of the individual.

The key features of such a model could include the following.

- Eligible people would be assessed and allocated funding based on their 'reasonable and necessary' support needs. In collaboration with a support planner, the individual determines how best to use their funding to support their agreed goals. Assistance could also be available for people who need help to find an appropriate service provider(s) or to manage their individual budget.
- The individual would have the power to choose which service provider or providers they would like to assist them to achieve their goals. They would also have the option of directly purchasing services from providers if they wished.
- Services would be delivered within a market-based framework and could be provided by a range of private for-profit and not-for-profit service providers. State and territory governments could also continue to provide services if they choose.
- The funding would be attached to the individual and flow to the provider(s) as directed by the individual (for example, the individual could 'cash out' their support package and directly purchase services from the provider, purchase services through a financial intermediary or request that the service provider be paid by the funder directly).

Figure 16 is an example of this service model.

Figure 16: Example of a basic individual client-funded model



Questions

Do you agree with this configuration of services/functions as described in Figure 15? If not, what are your major concerns?

What is your view on the staged approach towards a client-directed funding model? What issues should be taken into account to support the move to such a model?

Remodelling and refocusing selected program

Consultation and review indicates that the following endorsed recommendations from The Nous Group review are also applicable to the HBOS function:

- triage access through a regional intake mechanism to improve consistency of targeting
- use of standardised, non-discretionary discharge criteria
- referral pathways on an area basis
- the need for an evidence-based model of care
- stronger alignment with specialist clinical mental health services
- more formalised relationships with local health and social support services
- reorientated service models to deliver client-directed activities and outcomes, with a greater focus on mental and physical health, economic participation through education and employment, and social participation
- funding and service agreements that link individual service provider performance to the achievement of client outcomes.

In addition to the implementation of the above recommendations, the following program-specific actions are proposed, informed by The Nous Group's review (refer Table 5)..

Table 5: The Nous Group's recommendations for day programs and youth residential rehabilitation services

Function	Action proposed
Day programs	• Retain capacity for funded service to deliver group-based activity. • Strengthen orientation to supporting clients to access individual and group-based activities in mainstream community settings. • Introduce two notional support periods of: – 18 months for clients with capacity to improve self-management (noting that these individuals can re-enter the program) – an extended period of support for clients with enduring disability with limited capacity for self-management.
Youth residential rehabilitation services	• Retain bed-based rehabilitation model. • Retain current service delivery arrangements subject to a review of performance against agreed measures and client outcomes. • Redevelop service model to a focused, goal-oriented 12-month program delivered in collaboration with the young person, their family and relevant health (including drug and alcohol treatment services), education, employment and social services (such as housing and youth justice services). • Significantly strengthen post-discharge planning. • Strengthen interface with referring agencies, particularly clinical mental health services (private and public), child protection, youth justice, and drug treatment services. • Focused period of support for twelve months with an average of 6 hours of contact per week.

In respect to adult residential rehabilitation services, The Nous Group identified a lack of evidence supporting the effectiveness of transitional bed-based rehabilitation services and that the current adult residential rehabilitation model did not deliver adequate client recovery outcomes. The Nous Group identified significant evidence existed to support the move away from a transitional residential rehabilitation model to the provision of flexible mental health outreach services linked to the individual, with a focus on supporting them to access long-term affordable housing.

On this basis, The Nous Group recommends discontinuing the bed-based adult rehabilitation model. These recommendations are supported in broad principle, subject to further analysis and sector consultation.

As indicated previously it is proposed that all bed-based rehabilitation services be treated as specialist regional services. Consistent with this, it is proposed that formal mechanisms for out-of-area referral be established for bed-based rehabilitation and supported accommodation services to ensure equity of access and appropriate targeting.

Funding for youth rehabilitation services will be allocated on a fixed-term basis on a revised specification of service. The program will be reviewed to determine if it is achieving the intended client outcomes towards the end of this period. The outcomes of this performance review will determine the future direction for this service model and associated service delivery arrangements.

Home-based outreach support function

The Victorian Government has progressively introduced a new tier of intensive support into the HBOS program to strengthen the provision of daily living support. The aim of this strategy is to:

- strengthen the capacity of the funded services to support, in partnership with clinical specialist mental health services, people with a severe mental illness, high-level disability and high coordination needs
- build a broader continuum of support that is flexible and able to be scaled up or down in intensity dependent on the needs of the individual.

The Victorian Government in collaboration with the Commonwealth Government will continue to expand the daily living support services with the aim of building area-based providers of sufficient scale with capacity to respond to service demand in a timely, efficient and effective manner. In addition to areas previously stated, action will also be taken to:

- reorientate the service model to deliver client-directed activities and outcomes, with a more explicit focus on mental and physical health, economic participation through education and employment, and social participation
- address inequity of distribution across the state (to be informed by demand modelling)
- ensure individual providers can offer HBOS at a range of levels of intensity and embed the care coordination function in the service model.

The Victorian Government will work with the Commonwealth to strategically realign current and future investment in the PHaM program in order to optimise combined state and Commonwealth investment in community-managed mental health services, and streamline and strengthen the continuum of support for people with a moderate to severe mental illness.

Questions

What is your view regarding future directions for government investment in the adult residential rehabilitation service model?

Do you have any concerns regarding the proposed directions for:

- HBOS and day program functions
- youth residential rehabilitation services.

Care coordination function

The Victorian Government is trialling a new care coordination initiative. This service model involves creating dedicated care coordination positions to support people with a severe and enduring mental illness who have multiple needs to access and remain engaged with the range of health, community and social services they need.

The evaluation of the care coordination initiative will be completed in October 2013. This will inform the future directions of this service model and the role of PDRSS in delivering this function. This analysis will take into account:

- the impact of Commonwealth investment in care coordination through the Partners in Recovery initiative to commence in 2012
- the case management/support coordination function that may be introduced through an NDIS
- opportunities for the care coordination function to link with reforms in the human services system, commencing with a case management trial being undertaken by the Victorian Department of Human Services.

Mutual support and self help

The Department of Health will formally review the role and function of the MSSH program and the peer support function more broadly. This review, to be undertaken in 2012, will determine future directions for this service model.

Respite services

The Commonwealth Government funds the majority of respite services across the nation. The Victorian Government currently invests \$3 million per annum in PDRSS planned respite services for carers of people with a mental illness. This service response is not available state-wide.

Questions

Given the Commonwealth Government's significant role in providing respite services, should the Victorian Government continue to fund PDRSS planned respite services? Is yes, what would be required to improve responsiveness of this service model to the needs of carers? Should respite services be available as part of an integrated support 'package' for clients and their carers?

Specialist sub-regional services – responding to diversity

We will work with funded providers to improve their responsiveness to diversity, particularly Aboriginal people, refugees, people from CALD backgrounds, people who identify as gay, lesbian, bisexual, transgender and intersex, people who have a co-existing disability, and people who are homeless.

The needs of these population groups will be identified through area-based service planning. PDRSS providers will be required to develop implementation plans in partnership with relevant local stakeholders to ensure the needs of these groups are appropriately prioritised.

We will assess the impact of current investment in PDRSS in meeting the needs of Aboriginal people and their communities. This analysis will be undertaken in consultation with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), the Victorian Aboriginal Health Service, Aboriginal-community controlled organisations, the specialist mental health service system and other relevant stakeholders. The outcomes of this process will determine action required to improve the mental health and wellbeing of this population group.

Question

What specific service system improvements are required to strengthen capacity to respond more effectively to diversity?

Age eligibility

Young people

The current age eligibility for PDRSS includes people aged 16–64 years. The majority of service delivery is adult focused, with only 13.6 per cent service users aged 16–25 years. When youth residential rehabilitation services are excluded, just under 10 per cent of all PDRSS clients are aged under 25 years.

In addition, selected community-managed mental health agencies currently provide mental health recovery services in three youth PARC services.

AMHS provide an integrated clinical and psychosocial approach to treatment and support for young people. Notably there is also an established youth services platform that currently provides a range of supports to young people with mental health problems.

Consultation and The Nous Group review indicates the current models of care may not be adequately tailored to the developmental needs of young people and that young people would benefit from a stronger focus on early intervention to prevent or reduce long-term disability associated with a severe mental illness.

This raises the issue of whether:

- state-funded PDRSS are the most appropriate platform for delivering community mental health support services for young people, or
- service models and practice need to be revised to better meet the developmental needs of young people.

Questions

Should state-funded PDRSS continue to provide services for young people aged 16–25 years? If not, how could young people be better supported and by what other agencies?

If PDRSS continue to support this age group, what key service system improvements are needed to improve service responsiveness to young people and their families to reduce long-term disability?

Older persons

A very small percentage of older people aged over 64 years receive PDRSS (three per cent). This is consistent with the current eligibility criteria that targets clients aged 16–64 years.

The specialist clinical mental health system and the aged care system are the key providers of rehabilitation and recovery services to older people with a severe mental illness or psychiatric disability. Some stakeholders argue that these service responses are not adequately meeting the mental health recovery needs of older people.

The Victorian mental health reform strategy proposes greater flexibility around age criteria for service delivery so that people may receive the most developmentally appropriate support based on their assessed needs as opposed to their chronological age. It is noted that the Commonwealth-funded PHaM program is targeted to people aged 16 years and over.

The reform strategy also recommends raising the nominal entry point to specialist aged persons services from 65 to 70 years of age in acknowledgement that mental health problems are occurring later in life and to provide alignment with age criteria used by aged care assessment teams.

Supporting older people at critical transition points in their care, such as moving from the adult specialist mental health service to the aged care system, requires careful, integrated care and planning to prevent people falling through the gaps.

This raises a number of issues including:

- whether eligibility for PDRSS should be extended to people aged over 65 years and under what circumstances with regard to the role of state-funded aged persons mental health services and the broader aged care sector
- the need for service models and practice to be revised to better meet the needs of older people, including transition planning.

Question

Should the age eligibility for PDRSS be extended to people over 65 years of age? What implications would this have for current service delivery capacity and practice for community-managed mental health support service providers and the broader specialist aged mental health and aged care service sectors?

3. Service system configuration

Changes are needed to current service delivery arrangements and service delivery responsibilities to ensure people get the right support in an efficient, effective and equitable way.

As described in Part A, the way the service delivery is currently structured is unnecessarily complex, resulting in reduced capability, variable quality and inefficiency.

Sustainable service delivery reform cannot be achieved without some structural reform to current service delivery structures.

The number of providers of PDRSS in a given catchment, the significant variation in the scale of individual providers and the way programs are delivered, makes any consideration of service re-configuration and catchment realignment a complex issue.

In some areas, there is a case for reductions of the total numbers of providers of PDRSS while ensuring enough flexibility and specialised services.

There is also a lack of consistency and clarity regarding how different mental health services fit together. This makes navigating an already complex system more difficult.

The shift to area-based delivery structures and streamlined delivery responsibilities will provide people with improved services that are delivered in a more efficient and effective way. It will support the development of high-performing services with the organisational capacity needed for cross-sector planning and collaboration and good governance. A streamlined, more robust, sustainable set of providers will also position community-managed mental health services to respond proactively to the changes that will flow from an NDIS.

As a parallel process, alignment of catchment boundaries with AMHS will also be required to facilitate area-based planning, cross-sectoral collaboration and improve care coordination.

Guiding principles for area-based planning and service reconfiguration

The government believes that the process of reconfiguration requires a planned and tightly managed process over a defined period. Re-organisation will be based on providers demonstrating capabilities to deliver quality services efficiently against agreed criteria.

A reformed service-delivery market for providing PDRSS will be designed on the following principles.

Change process

The process for achieving service delivery reforms should be fair, transparent and open.

Auspice/service delivery arrangements

Eligibility to deliver state-funded PDRSS should not be restricted to the current funded provider market.

Service delivery arrangements in an area-based catchment must be demonstrably efficient and effective, and any overlap of responsibilities/duplication of effort should be minimised.

Diversity in service providers

PDRSS will continue to be auspiced through a range of agency types.

Diversity in service providers is required to support innovation, efficiency and quality benchmarking, and reduce the potential for any one or a very small set of providers to dominate service provision across the state.

Alignment with broader health catchments

Alignment of AMHS and PDRSS service catchments to maximise care coordination opportunities and facilitate joint local area planning is preferred.

Service catchments should be realigned to take into account the catchments of Victorian health planning areas, Primary Care Partnerships and Medicare Locals.

Area-based self-sufficiency and consistency

State-funded regional functions will be delivered by a lead provider for each region.

A consistent set of core mental health support functions/services should be offered and organised on an area basis in a manner that will achieve optimal service efficiency, streamlined access, workforce sustainability, strengthened accountability and improved service quality.

Access to a core set of PDRS functions no matter where you live

Clients will have reasonable access to a core set of PDRS functions/services and will not be disadvantaged on the basis of where they live.

Optimal catchment and service size

The size of the consolidated service delivery structures should optimise efficiencies, allow for capacity to provide a full range of functions, and be viable and sustainable. Preference would be for larger rather than smaller areas, of up to about 500,000 population in metropolitan regions and 200,000–300,000 in rural regions.

Responsive to demographic trends

Any system reconfiguration should consider current inequities in the distribution of supply, taking into account socioeconomic disadvantage and population growth projections.

Right to choose service provider

Catchments will be planned on the assumption of service user preference for the closest service; however, there will not be enrolled populations for catchments, and clients will have the option of choosing to use a service(s) in another area.

Access to specialist services

Cross-service arrangements for specialised regional functions (such as youth residential rehabilitation services) should be facilitated.

Questions

What scope of change in the number and roles of providers is required on an area basis? What is the optimal combination or bundle of delivery capacity an agency needs in accordance with the stated principles?

Should the delivery of state-funded PDRSS be opened to broader health and human services providers?

Should reconfiguration be staged (region by region) or undertaken as a state-wide process?

Commonwealth-funded community-mental health services

Commonwealth funding to support people with a mental illness in Victoria is welcomed. Discussion will be conducted with the Commonwealth Government with the view to optimising the potential for a well planned, integrated set of community-based mental health services within an agreed area-based catchment.

Consultation process and next steps

Providing feedback

This consultation paper provides a proposed framework to support the staged reform and redevelopment of the way PDRSS are provided to people with a severe mental illness in Victoria.

This paper has been developed to seek a range of stakeholders' views and input on the government's proposed framework and to inform the implementation process.

To assist you with your response a series of questions have been posed (see Appendix 2 for the list of questions). These questions are a guide only and are not intended to limit the scope of feedback.

We want to encourage broad consultation about this paper. Written feedback should be emailed to <mhreformstrategy@health.vic.gov.au>, or posted to:

Mental Health Reform Strategy
Mental Health, Drugs and Regions Division
Department of Health
Level 17, 50 Lonsdale Street
Melbourne VIC 3000

The closing date for written submissions is **22 June 2012**.

Next Steps

Following consultation about this paper, government will finalise the reform framework and develop an implementation plan. A staged implementation program will be undertaken in partnership with the specialist mental health service system, VICSERV and other key stakeholders.

Appendix 1: PDRSS providers by Department of Health region

Barwon-South Western – Health	Aspire, A Pathway to Mental Health Inc. Barwon Disability Resource Council Inc. Dhauwurd-Wurrung Elderly & Community Health Service Inc. Geelong Mental Health Consumers Union Inc. Geelong Mood Support Group Inc. Gunditjmara Aboriginal Co-operative Limited Karingal Inc. Kirrae Health Service Inc. Mental Illness Fellowship Victoria Mind Australia Pathways Rehabilitation and Support Services Limited The Salvation Army (Victoria) Wathaurong Aboriginal Co-Operative Limited Winda-Mara Aboriginal Corporation
Eastern Metropolitan – Health	Anglicare Eastern ARAFEMI Victoria Inc. EACH Eastern Health Eating Disorders Foundation of Victoria Inc. Jeshimon House Community Housing Association Inc Mental Illness Fellowship Victoria Mind Australia Neami Limited Obsessive Compulsive and Anxiety Disorders Foundation of Victoria Inc. Out Doors Inc. Prahran Mission Shire of Yarra Ranges The Compassionate Friends – Victoria Inc. The Salvation Army (Victoria) Villa Maria Society
Gippsland – Health	Latrobe Community Health Service Mental Illness Fellowship Victoria Mind Australia Ramahyuck District Aboriginal Corporation SNAP Gippsland Inc. The Salvation Army (Victoria) Yarram and District Health Service
Grampians – Health	Ballarat and District Aboriginal Co-operative Limited Ballarat Community Health Ballarat Health Services Centacare, Catholic Diocese of Ballarat Inc. Goolum-Goolum Aboriginal Co-operative Limited Grampians Community Health Western Region Health Centre Ltd Wimmera Uniting Care

Hume – Health	Gateway Community Health Goulburn Valley Family Care Inc. Mental Illness Fellowship Victoria Mercy Centre, Lavington Limited Mind Australia Mungabareena Aboriginal Corporation Rumbalara Aboriginal Co-operative Limited
Loddon Mallee – Health	Bendigo and District Aboriginal Co-operative Ltd Bendigo Health Care Group Cobaw Community Health Services Limited Golden City Support Services Inc. Loddon Mallee Housing Services Limited Mallee Family Care Inc. Mildura Aboriginal Corporation Mind Australia Murray Valley Aboriginal Co-operative Limited Njernda Aboriginal Corporation Robinvale District Health Services St Luke's Anglicare
North & West Metropolitan – Health	Action On Disability Within Ethnic Communities Inc. Anglicare Victoria ARAFEMI Victoria Inc. Australian Community Support Organisation Inc. Baptcare Ltd Bethlehem Community Inc. Carers Association Victoria Inc. Dianella Community Health Doutta Galla Community Health Service Fintry Community Inc. HomeGround Services Jesuit Social Services Limited McAuley Community Services for Women Mental Illness Fellowship Victoria Merri Community Health Services Limited Mind Australia Neami Limited North Richmond Community Health Limited North Yarra Community Health Norwood Association Inc. Out Doors Inc. PANDA – Post and Ante Natal Depression Association Inc St Mary's House of Welcome The Reach Foundation The Salvation Army (Victoria) The Victorian Foundation for Survivors of Torture Inc. Victorian Aboriginal Health Service Co-operative Limited VincentCare Victoria Western Region Health Centre Ltd Women's Information Support and Housing in the North Inc

Southern Metropolitan – Health	Alfred Health Arts Access Society Inc. Australian Community Support Organisation Inc. Central Bayside Community Health Services Limited Dandenong & District Aborigines Co-operative Limited ERMHA Inc. GROW Hanover Welfare Services Impact Support Services Inc Inner South Community Health Service Limited Mental Illness Fellowship Victoria Mind Australia Peninsula Support Services Inc Pahran Mission Sacred Heart Mission Inc. Southern Mental Health Association Inc. St Kilda Uniting Care
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Note: There are a number of agencies funded through the PDRSS stream that are not provided on a strictly regional basis, including Psychiatric Disability Services of Victoria (VICSERV), Victorian Aboriginal Community Controlled Health Organisation, Victorian Mental Health Carers Network, Victorian Mental Illness Awareness Council, Our Community, Melbourne School of Health Sciences, Mental Health Foundation (Victoria), Mental Health Legal Centre, VITS Language Link and some Mutual Support and Self Help services.

Appendix 2: Questions

Framework for Change

Does the framework capture all key aspects of the change required?

Building organisational capacity for good governance

What are the most important actions to build organisational and service capability in the:

- *short term (1–2 years)*
- *medium term (3–5 years)?*

Workforce development

Are there other workforce development areas that also require focused attention in the short to medium term to better support the delivery of high-quality client and carer/family outcomes?

Client information management systems

Are there any outcome measurement tools that state-funded community-managed mental health agencies could uniformly use?

Remodelling programs and funding streams

Do you agree with this configuration of services/functions as described in Figure 15? If not, what are your major concerns?

What is your view on the staged approach towards a client-directed funding model? What issues should be taken into account to support the move to such a model?

What is your view regarding future directions for government investment in adult residential rehabilitation service model?

Do you have any concerns regarding the proposed directions for:

- *HBOS and day program functions*
- *youth residential rehabilitation services.*

Planned respite services

Given the Commonwealth Government's significant role in providing respite services, should the Victorian Government continue to fund PDRSS planned respite services? Is yes, what would be required to improve responsiveness of this service model to the needs of carers? Should respite services be available as part of an integrated support 'package' for clients and their carers?

Specialist sub-regional services – responding to diversity

What specific service system improvements are required to strengthen the capacity to respond more effectively to diversity?

Age eligibility

Should state-funded PDRSS continue to provide services for young people aged 16–25 years? If not, how could young people be better supported and by what other agencies?

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Guiding principles for area-based planning and service reconfiguration

What scope of change in the number and roles of providers in an area is required? What is the optimal combination or bundle of delivery capacity an agency needs in accordance with the stated principles?

Should the delivery of state-funded PDRS services be opened to broader health and human services providers?

Should reconfiguration be staged (region by region) or undertaken as a state-wide process?

Name of the state-funded Psychiatric Disability Rehabilitation Support Services (PDRSS)

Do you agree that the state-funded programs currently called Psychiatric Disability Rehabilitation Support Services (PDRSS) should be renamed to community mental health support services (CMHSS)?

(Note that this name change refers to the state-funded program and is not intended to describe or name a sector).

Abbreviations

AMHS	area mental health services
AOD	alcohol and other drugs
CALD	culturally and linguistically diverse
CMHSS	community mental health support services
COAG	Council of Australian Governments
D2DL	Support for day to day living in the community
FaHCSIA	Department of Family, Housing, Community Services and Indigenous Affairs
HBOS	home-based outreach support
ISP	individual service plan
MSSH	mutual support and self help program
NDIS	National Disability Insurance Scheme
NGO	non-government organisation
NIIS	National Injury Insurance Scheme
NMDS	National Minimum Data Set
NSMHS	National Standards for Mental Health Services
PARC	prevention and recovery care
PDRS	psychiatric disability rehabilitation and support
PDRSS	Psychiatric Disability Rehabilitation and Support Services
PHaM	personal helpers and mentors program
QDC	Quarterly Data Collection (tool)