Psychiatric Disability Services
of Victoria (VICSERV)

Community Managed Mental Health

An agenda for the future: consultation paper

January 2012

FOREWORD

It is with much pleasure that I present VICSERV's Community Managed Mental Health: *An agenda for the future* consultation paper. This position paper is a major statement about the required elements for reform within community managed mental health services and in government policy and funding. It has been prepared by VICSERV with three aims. First, to provide a roadmap for the development of community managed mental health services in Victoria over the next five years. Secondly, as a resource for VICSERV members in their deliberations about required changes in their organisations and, thirdly, to inform and influence the Victorian and Commonwealth Governments' policy and funding of these services.

This paper has been prepared at a time of significant public discussion about the elements of effective mental health reform. Governments at all levels now recognise the centrality of good mental health to the ability of all people to have a good life and are committed to reform. VICSERV strongly believes that proposed reforms in Victoria must build on the strengths of community based mental health services and constructively address some of the structural weaknesses in the current provision and funding of these services.

Government policy directions are trending towards improving choice and the delivery of more individualised approaches to mental health service provision. VICSERV supports these directions. However, realising these aspirations will require increased capabilities and greater flexibility in the service system. VICSERV believes that the system needs to be reconfigured with major changes in the existing program, funding and planning regimes. This will allow services to respond more effectively and efficiently to the requirements of people with mental health issues, their families and carers. This paper outlines a series of actions to achieve this.

VICSERV has worked collaboratively with the Victorian Department of Health over the last few years in mental health reform partnership groups and on projects. This paper has been informed and enriched by these collaborations and discussions. I wish to acknowledge the importance of discussions with the current and former Mental Health Ministers, their advisers and staff of the Victorian Department of Health in the development of the actions proposed in this paper. There are many areas of agreement about the required elements of reform between VICSERV and the Baillieu Government. VICSERV wishes to continue working with the Baillieu Government in improving mental health services in Victoria.

In releasing this paper VICSERV reasserts its commitment to work tirelessly with its members and the Victorian Government to contribute to real reform and development of community managed mental health services.

Change of the scale needed requires resourcing. VICSERV believes that investment in new services needs to be accompanied by investment in system coordination and integration if required efficiencies are to be achieved. VICSERV will be seeking funds to undertake specific projects and to engage community managed mental health services and other sectors in this agenda for change. Investments that directly reduce the disability and disadvantage associated with mental illness not only enhance people's mental health and wellbeing but also lead to savings by reducing demand for costly health and welfare services.

On behalf of VICSERV I commend this paper to you and encourage all members to read it and discuss the implications at Board and staff meetings. I look forward to lively debates and discussions during the consultation period and continuing to work together to achieve lasting and significant change.

Elizabeth Crowther
President VICSERV

ACKNOWLEDGEMENTS

The VICSERV Committee of Management (the Committee) acknowledges the significant contributions that a number of people and organisations have made to the preparation of this paper.

The Committee would like to thank:

1. The participants in the workshop who developed the concepts and directions outlined in this paper:

   Ray Judd
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   Gerry Naughtin
   Kim Koop
   Caz Healy
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AN AGENDA FOR THE FUTURE – SUMMARY

As an important part of a suite of services responding to the mental health needs of Victorians, community managed mental health services (CMMH) recognise the need for modernisation of their purposes and structures in response to changing community and government expectations.

Psychiatric Disability Services of Victoria (VICSERV), the industry body that represents these organisations, has developed this paper, *An agenda for the future,* to set out an achievable strategy for the development of these services over the next five years.

This paper has been developed to consult with VICSERV members and others with a key stake in the delivery of community managed mental health services. In the preparation of the paper VICSERV has consulted with many individuals and groups over an extended period and participated in a range of reform partnership groups funded by the Department of Health. VICSERV has and will continue to work with the Victorian Minister for Mental Health and the Department of Health toward the development and reform of services.

This paper contains:

- a current analysis of CMMH services
- an identification of key areas for reform
- recommendations for repositioning the CMMH service system.

Following the launch of *An agenda for the future*, a period of consultation will occur.

A final document incorporating members' feedback will be produced and formally adopted by the VICSERV Committee of Management in April 2012.

A shorter version will be available on the VICSERV website in early February 2012.

Context

- Governments at all levels are recognising the unique contribution of CMMH services to people's recovery journey and their ability to make choices about community participation. This recognition is accompanied by supportive policy and substantial funding allocations.
- In the near future, funding for CMMH services is expected to nearly double. At the same time governments, consumers, families and carers are advocating for a move towards fully individualised service offerings. The introduction of a National Disability Insurance Scheme (NDIS) as part of this shift will fundamentally change the way CMMH services do business.
- The current service system has systemic weaknesses that need to be addressed. Changes are needed to create a more rational service system responsive to the needs of individuals and local communities.

The way forward

An agenda for the future outlines a range of actions and specific projects to enable the CMMH service system to be ready for change. Few of these changes can be undertaken by VICSERV alone and most will need to be developed and implemented in close collaboration with the Victorian Department of Health, CMMH service staff, Boards and their consumer and carer representative bodies. The change of scale needed will require purposeful investment. We need:

- A modernised service structure for CMMH services focussed on outcomes and meeting individual needs. This should be supported by updated guidelines and funding models.
- A new name to replace the term PDRSS that better reflects the purpose and function of these services and their distinct governance arrangements.
- Local area planning to identify the correct configuration of services to provide market choice and capacity to meet the changing needs of consumers, families and carers.
- Rationalisation of the CMMH service system. VICSERV considers that there are a number of pathways to reform that need to be considered as part of a rationalisation debate. Some of the outcomes will be driven by organisational choice and circumstance while others will be linked to area planning.
- Attention to building the capability and sustainability of CMMH services to meet the challenges of a new environment.
- A program of activities that build effective governance structures and processes that represent and protect the interests of all stakeholders in the reform process.
- The appointment of an Ambassador for Community Managed Mental Health to drive the agenda for change forward and to position CMMH services as key players at the forefront of the mental health system of the future.
- VICSERV to be resourced to play an expanded role supporting and facilitating service reform activities.

This paper, *An agenda for the future,* offers an up-to-date analysis of the contribution of community managed mental health services, the achievements to date and the challenges ahead.

It is an important contribution to mental health policy development and thinking in Victoria.

For further information about this paper and the consultation process please contact:

The VICSERV policy team on (03) 9519 7000

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1 AN AGENDA FOR THE FUTURE – INTRODUCTION

There are now reasons for optimism that people experiencing mental health issues will receive better services and greater acceptance in Australia.

Governments are proposing large investments and policy shifts that have the potential to fundamentally change the dynamics of mental health service provision. These will provide significant opportunities and challenges for CMMH services.

CMMH providers are rightly proud of their work and contribution to the wellbeing of many Victorians over the years. There is demonstrated ability to deliver effective community-based mental health services and contribute to policy formulation and service initiatives.

Psychiatric Disability Services of Victoria (VICSERV), the peak body representing CMMH services in Victoria, has prepared this paper because:

- it recognises the need for reform to meet changing community and government expectations
- with the election of the Baillieu Government there is a new willingness to address reform
- the significant new investment in mental health by the Australian Government adds urgency to the need for change and service development to ensure the most effective use of this new investment
- CMMH service providers wish to take a lead role in defining the directions and priorities of a service development strategy.

The paper aims to:

- provide a roadmap for the development of community mental health services in Victoria over the next five years
- provide a resource for VICSERV members in their deliberations about required changes in their organisations
- influence the Victorian and Australian Governments' policy and funding of these services.

This paper is primarily about the CMMH service system in Victoria. It also reflects on broader mental health, health and social policy issues. The development of CMMH services must be an integral part of the health reform agenda across Australia.

This paper outlines an agenda for change and presents a framework through which issues and emerging opportunities can be addressed. It offers a framework that enhances and strengthens CMMH services' capacity to deliver existing services. It also seeks to position them for growth and

change. Through action on this framework CMMH providers have the potential to prosper in the new environment.

The leadership role involved will require CMMH providers to act on reform and development. It will also require new partnerships with governments in order to refine policy, systems and infrastructure. This is a major task and opportunity for the next few years. However VICSERV, as the peak body for CMMH services, recognises that unless the sector body takes this leadership and there is agreement about the reforms required, there are risks to the further sustainability of the sector in the medium term.

The analysis in this paper suggests that the next few years will see a shift to a more market-based approach by governments in order to increase consumer choice and control. This will involve organisations in new market dynamics and collaborative service delivery.

There are significant benefits likely to be realised through implementation of the reforms proposed in this paper. There will be financial benefits that can be turned into more and better services. Consumers, carers and families will derive equally important benefits as the burdens imposed by the current service system complexity are reduced. Workers will be more attracted to work in a developing service system.

This paper follows and builds on the leadership provided by VICSERV in the past. In particular, this paper builds on the following publications:

- *Pathways to Social Inclusion: Proposition Papers*[1], which framed thinking on recovery and social inclusion
- Stage One of the Sector Development Project conducted with the assistance of ConNetica Consulting: *The Case for Investment*[2].

The paper also builds on Victorian mental health policy and strategy documents including:

- *Improving Mental Health Outcomes In Victoria — The Next Wave of Reform*[3]
- *The Victorian Mental Health Reform Strategy, 2009–2019*[4].

VICSERV intends to use this paper as the basis for discussion with governments and engagement with its members and other interested stakeholders.*

[1] VICSERV (2008) *Pathways to social inclusion – Proposition papers*, Melbourne
[2] VICSERV (2010) *The Case for Investment – Discussion Paper*, Melbourne
[3] Boston Consulting Group (BCG) (2006) *Improving Mental Health Outcomes In Victoria: The Next Wave of Reform*, BCG
[4] State Government of Victoria (2009) *Victorian Mental Health Reform Strategy Implementation Plan 2009-2019*, Victorian Government Publishing Service, Melbourne

** VICSERV has sought to base the analysis and proposed directions on data wherever possible. Some up-to-date data is not available to the sector. The analysis is based on the best available data.*

2 OVERVIEW - COMMUNITY MANAGED MENTAL HEALTH SERVICES IN VICTORIA

CMMH services focus on people with serious mental illnesses and those facing significant social and economic disadvantage. They provide support to people in managing their mental illness and building their skills for life in the ways they choose.

It is the part of the mental health service system where there is the strongest evidence of commitment to a recovery approach and of the building of skills and systems that underpin effective practice. This is a repository that should be built up, broadened and disseminated.

Key achievements of CMMH include:

- a sustained focus on the needs, perspectives and best interests of consumers
- championing the introduction of recovery as a philosophy and framework for practice and development of conceptual models that inform their practice
- investment in the development of consumer focus and carer engagement in services and basing their work on supporting clients succeeding in areas of their own choosing
- developing innovative family, housing, employment and other leading initiatives
- building capacity through HBOS to support people with very complex needs in the community and, in so doing, allowing people to live outside clinical services
- the development of PARC services in collaboration with clinical mental health services.

These achievements have:

- enhanced the recovery and quality of life of consumers, families and carers
- reduced demand for clinical and other publicly funded services
- demonstrated the capacity and potential of recovery orientated CMMH services.

Approximately 130 CMMH organisations receive funding from the Victorian and/or the Australian Governments for provision of services to people facing serious mental health related issues.

The organisations involved demonstrate a diversity of characteristics. These include:

- organisations with a primary mission to work with people with serious mental health issues. These organisations vary in size

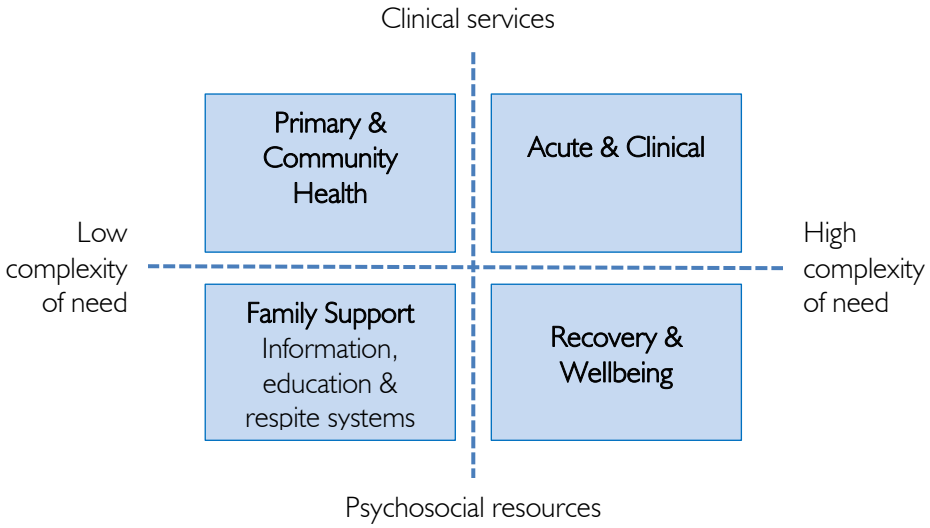
- organisations with a broad health, housing or community services mandate that incorporates a role in supporting people with serious mental health issues
- Aboriginal community controlled organisations
- organisations with a specific interest in particular communities, populations or specific content area.

These organisations are governed by Boards of committed volunteers who make a vital contribution to the capability of their organisations and the work of the sector. CMMH services have evolved in parallel with clinical mental health services.

Victoria has four relatively distinct elements of its mental health service system:

- a primary care based service system provided by GPs, private psychiatrists and allied health professionals working with more common mental health conditions. This service system is largely funded by the Australian Government
- an acute and clinical services system which is primarily Victorian Government funded and provides bed-based, community-based and forensic services
- a family support system that is largely informal although receiving some assistance through respite and other family services
- a CMMH service system providing psychosocial support, recovery services and other support services largely, but not exclusively, to people with complex needs. The sector is funded partly by both the Victorian and Australian Governments. These elements are presented graphically in Figure 1.

Figure 1– Service delivery framework



There are many other service systems, policy interventions and community practices that also contribute to the health and wellbeing of people experiencing mental health issues.

2.1 THE WORK OF THE CMMH SERVICE SYSTEM

The CMMH service system works with more than 20,000 Victorians with serious mental health issues each year. Details on the work are outlined below.

2.1.1 Client profile

Clients are supported across all ages with the age and gender profile shown in the table at Figure 2. The profile is, in part, driven by funding arrangements that have focussed on services to adults, not to children and young people or older Victorians.

Figure 2 - Age and gender profile

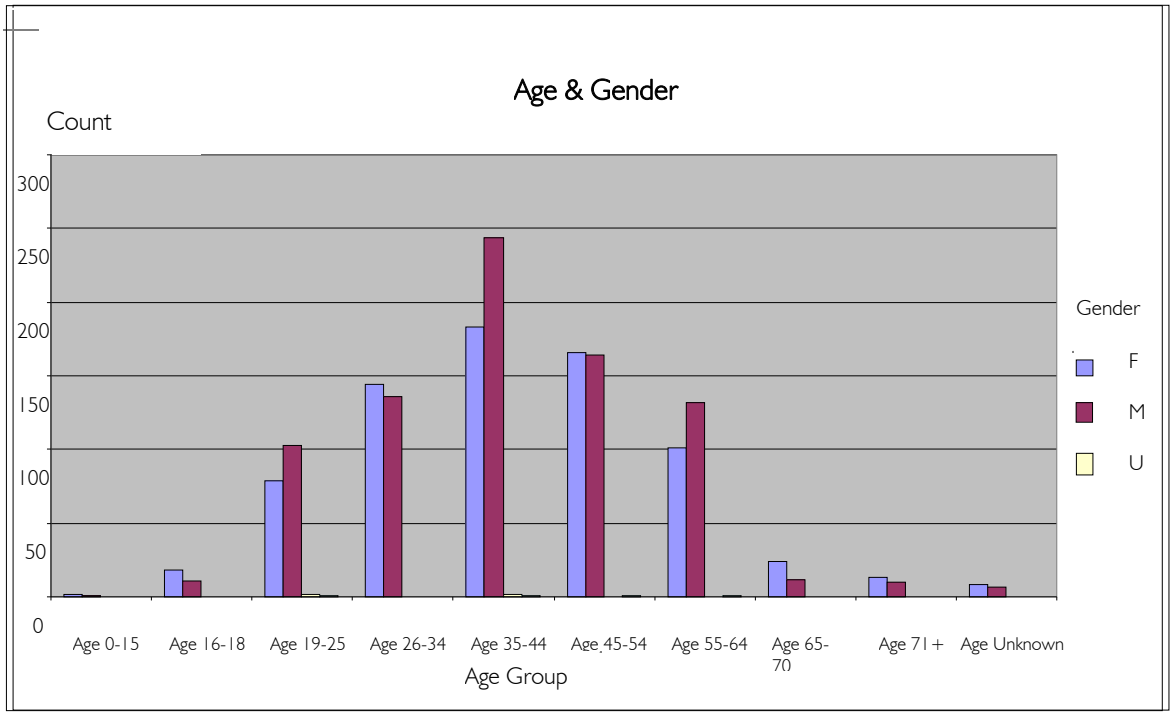
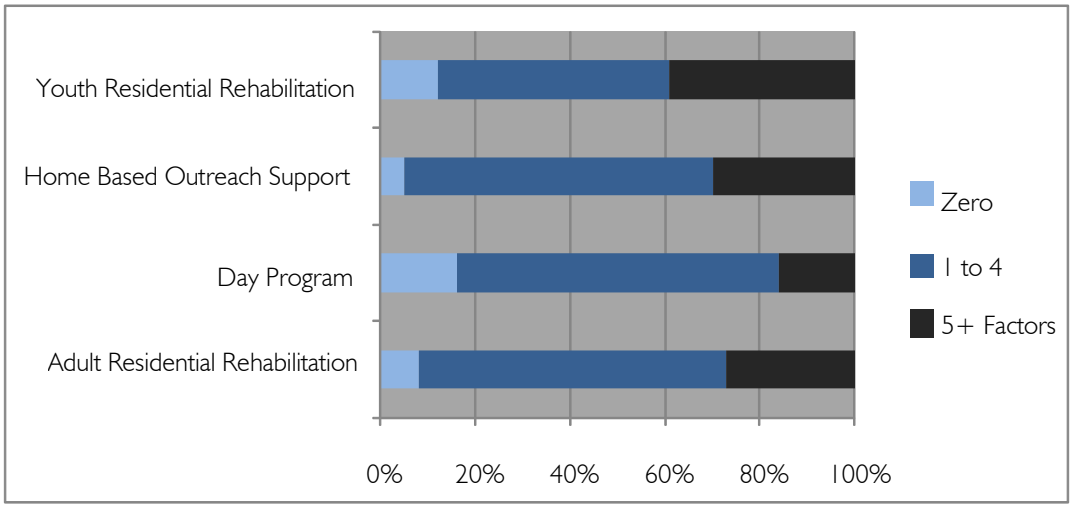


Figure 3 (on the following page) illustrates the complexity of clients in selected service types. This data demonstrates that CMMH services are working primarily with clients who have complex needs via the PDRS funding stream. In most programs, over 25% of clients have four or more complexity factors and less than 15% have no complexity factors.

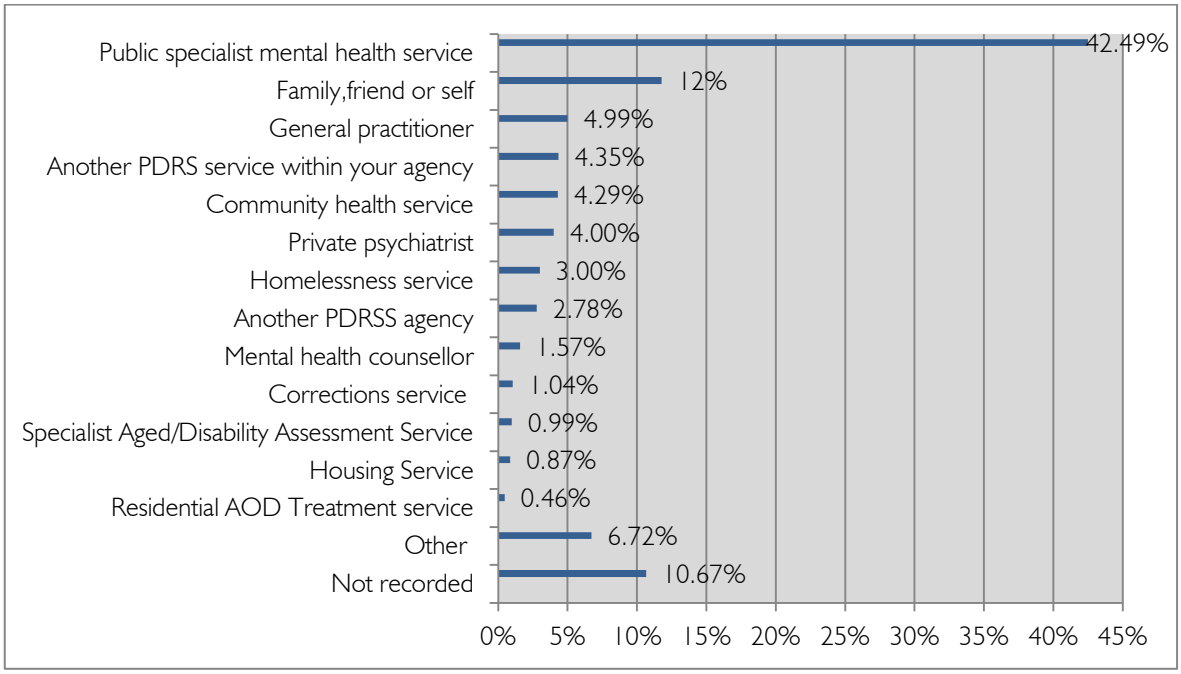
Figure 3 - Complexity profile



2.1.2 Referral source

The CMMH service system plays a major role in the public mental health system but also accepts referrals from a wide range of other services as shown in the table at Figure 4.

Figure 4 - Referral sources



2.1.3 Workforce

The available data indicates a total workforce in excess of 1600 people. This workforce has a diverse range of skills and experience in working with people with serious mental health challenges in a variety of community settings and service contexts.

The complexity of the clients and the significance of the tasks undertaken require a skilled workforce. In 2000 some 70% of CMMH employees were reported as having a tertiary qualification relevant to their task[5]. It is anticipated that the proportion holding relevant qualifications will have increased since then.

2.2 VICTORIAN GOVERNMENT FUNDING FOR CMMH SERVICES

In 2011–12 the Victorian Government appropriated $95.1 million to enable CMMH services to provide support to some 14,000 clients. The services, provider numbers and budget appropriated are outlined in the following table. Most of this data comes from 2009–10.

[5] Victorian Government Department of Health (2009) *Shaping the Future: The Victorian Mental Health Workforce Strategy, Final Report*, Melbourne, p 20

Figure 5 - PDRSS program, provider and budget summary

Program type	Providers	Budget*
HBOS	51 providers operating from 57 sites	$36m
Day Programs	34 providers delivering 58 programs	$18.3m
Youth Residential Rehabilitation services	5 providers using 17 service outlets	$8.4m
Adult Residential Rehabilitation services	3 providers operating from 9 sites	$5m
Supported Accommodation services	8 providers	$3.2m
MSSH	19 providers	$4m
Planned respite	14 providers	$3.5m
Care coordination		$2m
Other — recurrent	69 providers	$6.7m
Other — non-recurrent		$3m

To this base must be added:

- Approximately $10 million per year provided to CMMH services by clinical providers for the management of PARCS.
- The Victorian Government's commitment to invest $11.8 million over four years to support CMMH service development through capacity building initiatives. The details of how this money will be spent are still being resolved.

To put the level of funding for CMMH service purposes in context, the Victorian Government also appropriated $976.1 million for clinical services in 2011–12. This means that only 8.88% of the total mental health budget is spent on CMMH services.

Over the last decade, the share of the Victorian Government Budget allocated directly to CMMH services via the PDRSS funding stream relative to clinical services has declined from 10.62% in 2002–03 to the current 8.88% in 2011–12[6]. The two graphs which follow demonstrate the decline in PDRSS funding specifically and growth relevant to clinical services. This percentage includes the PDRSS funding provided via health care networks.

**The total of funds recorded in this table is $90.1 million, which is less than the amount appropriated in the 2011-2012 State Government Budget. It should be acknowledged that there is an additional $2 million for HBOS and another $3 million to support the reform of CMMH services.*

[6] The figures used in the creation of this table were drawn from the Victorian Government Budget Papers available on the Department of Treasury and Finance website.

Figure 6 - Relative decline in PDRSS spending

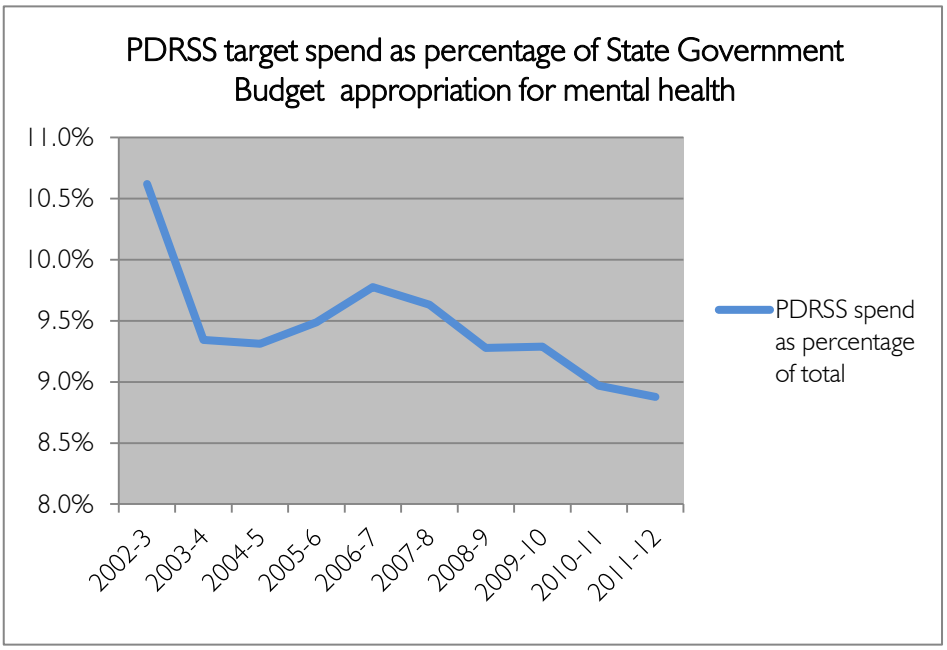
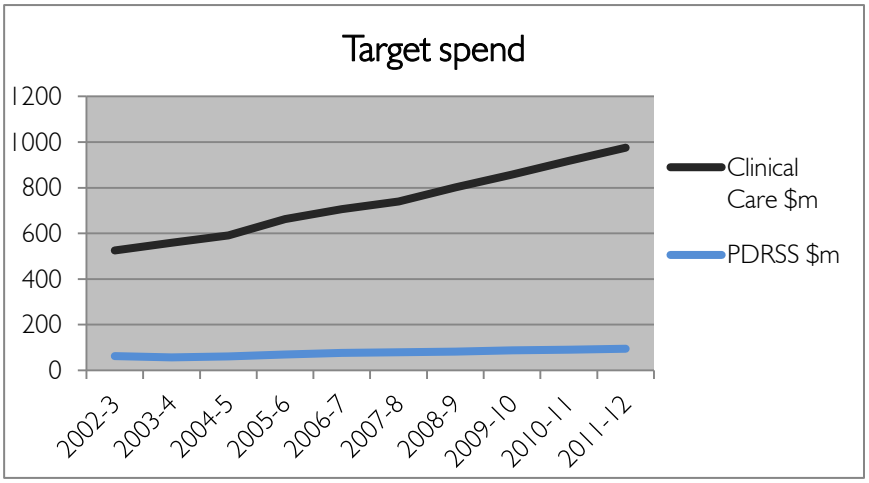


Figure 7- PDRSS funding growth relative to clinical services



The new spending commitment for CMMH services outlined above will not completely redress this trend. The PDRSS funding stream budget in 2014–15 would constitute 9.4% of the State's mental health spend in the absence of further commitments.

The New Zealand Government has used a target of 30% of funds going to CMMH services to drive reform of their mental health service system.

2.3 SERVICE DELIVERY FRAGMENTATION

An analysis of the State Government funding provided to CMMH services undertaken in the preparation of this paper indicates a high level of fragmentation of the existing funding allocations. The fragmentation occurs at three levels:

- budget distribution
- program distribution
- geographic distribution.

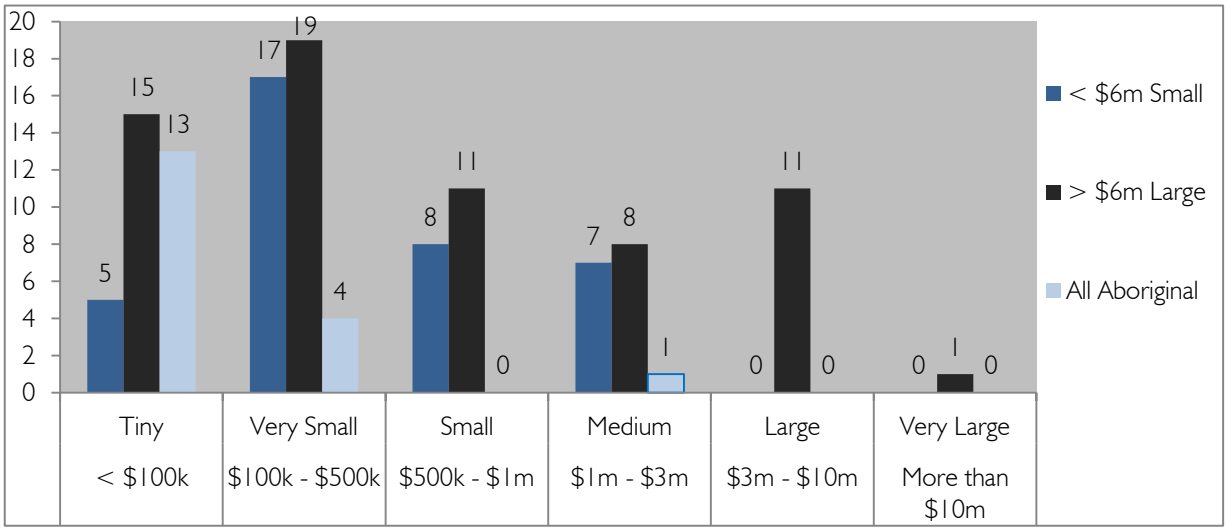
2.3.1 Budget distribution

The following figures (8 and 9) provide details regarding the distribution of State Government PDRSS funding.

Figure 8 - PDRSS funding distribution

	PDRSS Allocation	Tiny	Very small	Small	Medium	Large	Very large	Total
Org size		< $100k	$100k - $500k	$500k - $1m	$1m - $3m	$3m - $10m	> $10m	
Small	< $6m	5	17	8	7	0	0	37
Large	> $6m	15	19	11	8	11	1	65
Aboriginal	All	13	4	0	1	0	0	18
								120

Figure 9 – PDRSS funding distribution by organisation size[7]



The data demonstrate that:

- a significant proportion of the current funding has been allocated in small amounts to organisations regardless of size. Large and small organisations have tiny, very small or small allocations
- seventy-three of the 120 organisations in the count have PDRSS funding of under $500,000. Thirty-three have less than $100,000
- approximately 20 of the small organisations, of which there are 38 in the count, provide specialist or niche services
- the distribution of funding to Aboriginal community controlled organisations is also consistently either tiny or very small.

This does not lead to a specific conclusion regarding either the desirable size of organisations or the size of their budgets. The consumer's access to and journey through an appropriate range of service options should be the guiding principle for funding and service delivery.

While there are no benchmarks there is evidence that organisations need to reach a certain size to efficiently meet overhead costs and to invest in training and evaluation, among other quality assurance strategies.

[7] The data in figures 8 and 9 was sourced from various places. These include materials provided by the Department of Health and FaHCSIA directly and other material published on the Department's website. Supplementary data has also been gathered through accessing organisations' published annual reports and financial statements. Other data has been provided informally. No data was available on some organisations.

The benefits that can be delivered through small program allocations also need to be considered. The Victorian Government does not provide discretionary funding to CMMH services. This means there are specified activity requirements, measures and accountabilities that come with the funds. This limits an organisation's ability to use small amounts creatively.

The data confirm that there is fragmentation across the service system. It is not a story of too many small organisations or too few large organisations; it is a story of systemic fragmentation arising from historic allocation decisions. This analysis demonstrates the need for change from the bottom up and the top down. The system of the future is likely to require organisations to be able to provide a broad range of services tailored to individual and changing needs. This means budget flexibility and the capacity to deliver a number of service types as part of an integrated suite. Referrals would still be needed and they would occur intentionally to ensure consumers receive access to an appropriate range of services. Specialist providers would still be required to respond to people with particular needs and to supplement what the 'generalist' services do.

This issue also goes to the issue of navigation. Fewer organisations with broader and deeper capabilities contribute to ease of navigation, provided that quality, responsiveness and efficiency are not lost as a consequence.

The service system of the future will need to have planning, financial management, ICT and reporting capability to meet the requirements of many funding streams. This will come about because of the diversity of elements in the Australian Government's Mental Health Initiative, the ongoing role of the Victorian Government and individualised reporting under the NDIS.

The purchasing practices of the future will drive efficiency through pricing and accountability arrangements. Organisations will need to have business models and systemic capability to operate efficiently in a competitive marketplace. Consumers and purchasers, government or statutory authorities, such as envisaged in the NDIS, will drive hard bargains.

2.3.2 Program distribution

Figure 10 - Program funding distribution

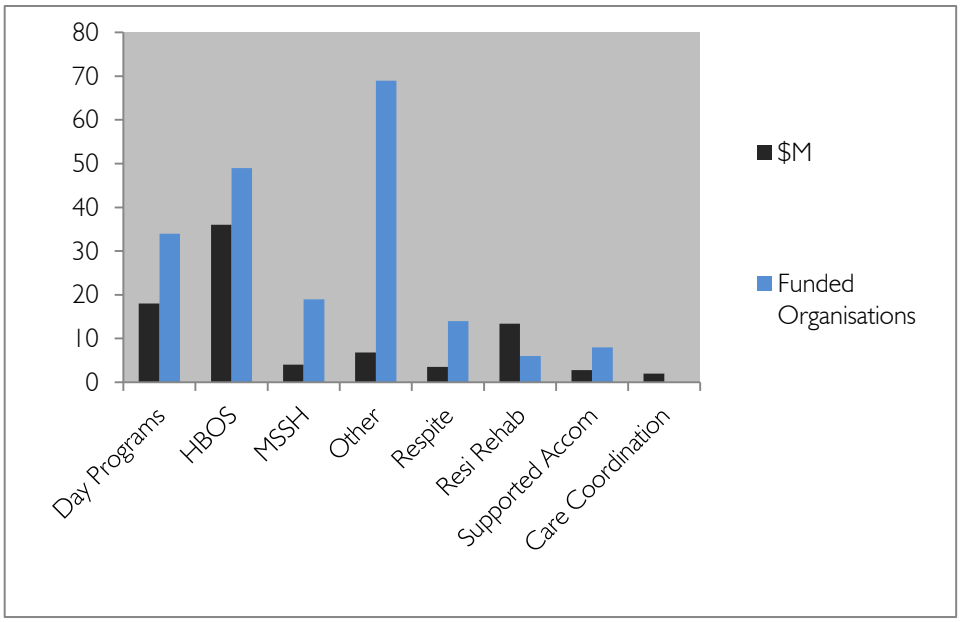


Figure 10 offers an analysis of the current program distribution.

The distribution of funds across programs reflects the historical evolution of CMMH services and the diversity of providers funded over the last 20 years. What is notable from this analysis is the significance of the category 'other' which includes a broad range of programs with diverse program objectives. This reflects the funding of a range of activities with no explicit program logic.

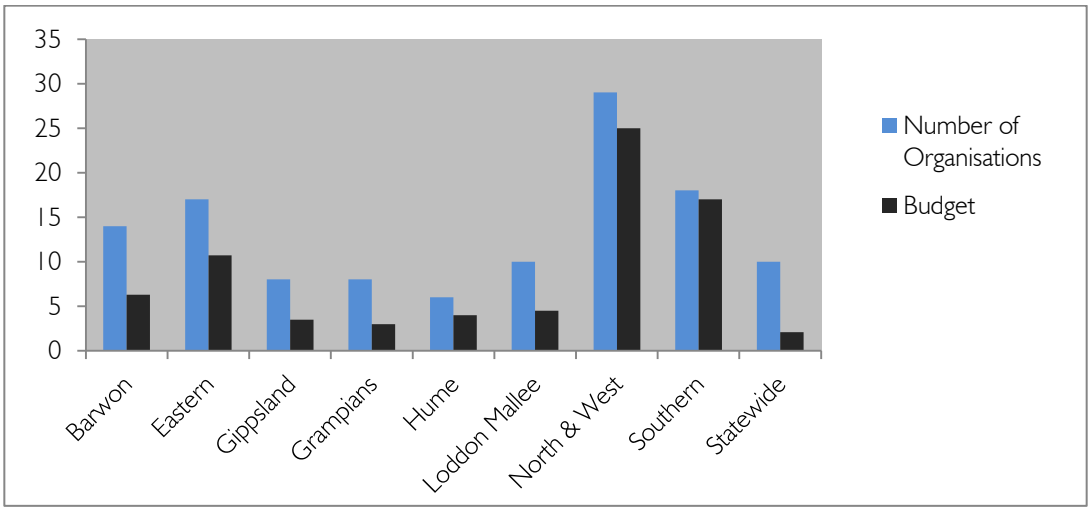
One of the issues that arises from this analysis is whether such diversity helps or hinders service access. The complexity in the range of providers makes navigation of the community managed and wider mental health service system inherently difficult for consumers, families and carers, mental health and other professionals and the general community.

Of note, the total identifiable funding going to Aboriginal community controlled organisations was in the order of $1.6 million or 2.2% of the budget. This exceeds the population pro-rata but may still be inadequate given the level of disadvantage and geographic distribution of Aboriginal and Torres Strait Islander people. Many of the organisations were in receipt of $44–45,000 — enough to fully fund about one half-time position.

2.3.3 Geographic distribution

Figure 11 provides a picture of the geographical distribution of service providers and program funding. There are a lot of organisations in virtually all regions and this must complicate the navigational task of consumers or staff working in their interests to access services.

Figure 11- Organisations and funding by region



The consequences of this fragmentation cannot, objectively, be defined. Arguably, the consequences are to diminish benefits to clients and to increase costs to the public.

Victorians expect consistent access to and quality of services, even where their choices regarding services differ. The existing PDRSS funding is relatively equitably distributed across regions. This graph does not address the allocation of CMMH services funded by the Commonwealth.

The implications are that services, as currently configured, are not well placed to meet the challenges and opportunities that will emerge in coming years.

Particular attention needs to be paid to the adequacy of funding for Aboriginal Community Controlled Organisations (ACCOs) given the mental health challenges of our Aboriginal community. ACCOs need sufficient funds to employ capable staff and have the capacity to respond to demand and many do not have sufficient funds at this time. This is a matter that services and the Victorian Aboriginal Community Controlled Health Organisation should work on jointly.

2.4 THE AUSTRALIAN GOVERNMENT CONTRIBUTION TO CMMH SERVICES

It is estimated that the Australian Government currently spends $38 million annually on CMMH services in Victoria. Many of the organisations funded through the State Government also receive funding from the Australian Government.

2.4.1 The funding and program mix

The Australian Government's major programs are:

- The Personal Helpers and Mentors Scheme. The aim of the Personal Helpers and Mentors (PHaMs) scheme is:

  …'to increase the opportunities for recovery for people whose lives are severely affected by mental illness'. This is underpinned by three secondary outcomes of increased:

  - access to appropriate support services at the right time
  - personal capacity and self-reliance, and
  - community participation.[8]

- Day-to-Day Living. The Support for Day-to-Day Living in the Community (D2DL) program provides funding to improve the quality of life for individuals with severe and persistent mental illness by providing an additional 7000 places (nationally) in structured and socially-based activity programs. The initiative recognises that meaningful activity and social connectedness are important factors for people's recovery.
- Mental Health Respite Program. The program provides flexible respite care options for carers and families caring for people with a severe mental illness and for people with an intellectual disability.
- Family Mental Health Support Service. The program targets prevention and early intervention, with a particular focus on Indigenous families and those from a culturally and linguistically diverse (CALD) background.

The Australian Government is already a major funder of CMMH services in Victoria. Its investments have contributed to the CMMH service system's capacity by:

- providing additional service delivery capacity
- providing flexibility, particularly through the requirements of PHaMs, which specifies that people do not need a diagnosis to access the program and can receive services over the long term
- significantly expanding provision for respite and family services.

[8] FaCHSIA (2010) Personal Helpers and Mentors (PHaMs) Operational Guidelines, p 4

The Australian Government will be the major provider of growth funds for CMMH services over the next five years. It announced a major mental health initiative as part of its budget for 2011–12. An additional $1.5 billion will be spent on a range of initiatives over five years[9].

In the fifth year of the strategy (2015–16) the proposed national spend will be $491 million and it is estimated that some $356 million of this will be spent on community-based recovery, psychosocial and social inclusion services.

The major initiatives are included in the following table. The table provides:

- a summary of the initiative
- the five-year national allocation to each initiative
- the proposed final year national expenditure, as this is the largest and potentially ongoing base for service delivery
- an estimate of the potential flow of funds to Victoria if the resources are allocated on a population pro-rata basis across the country. There is no commitment to achieving this outcome. The figures are provided as an indication of the possible outcome.

Figure 12 - Australian Government Initiatives 2011-12[10]

Initiative	National Budget – over 5 years $ million	Final year $ million	Victorian Pro-rata (final year) $ million
Coordinated care and flexible funding for people with severe and persistent mental illness	343.8	146.9	36.7
Expanding community mental health services —PHaMs	208.3	60.2	15
Expanding community mental health services — Family Mental Health Support	61	18.5	4.6
Expansion of youth mental health	197.3	65	16
Expansion of access to allied psychological services	205.9	61.9	15.5
National partnership agreements	201.3	46	11.5

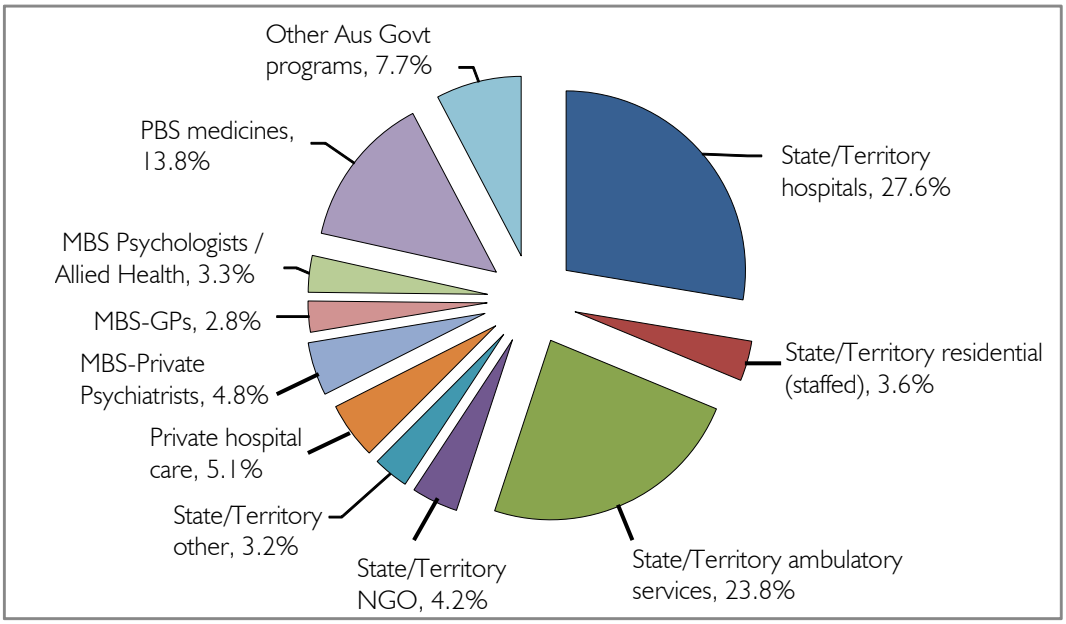
[9]Australian Government (2011) *Delivering better hospitals, mental health and health services, Budget 2011-12*

[10] The figures used in this table are sourced from *Delivering better hospitals, mental health and health services, Budget 2011-12*, p. 24 produced by the Australian Government

This would mean that the Victorian Government would be contributing approximately $104 million per year and the Australian Government in the order of $127 million in 2015–16.

Assessing the relative Commonwealth contribution is more complex as much of the expenditure goes to services for high prevalence disorders. The national picture is outlined in broad terms in the chart below.

Figure 13 - National spending pattern

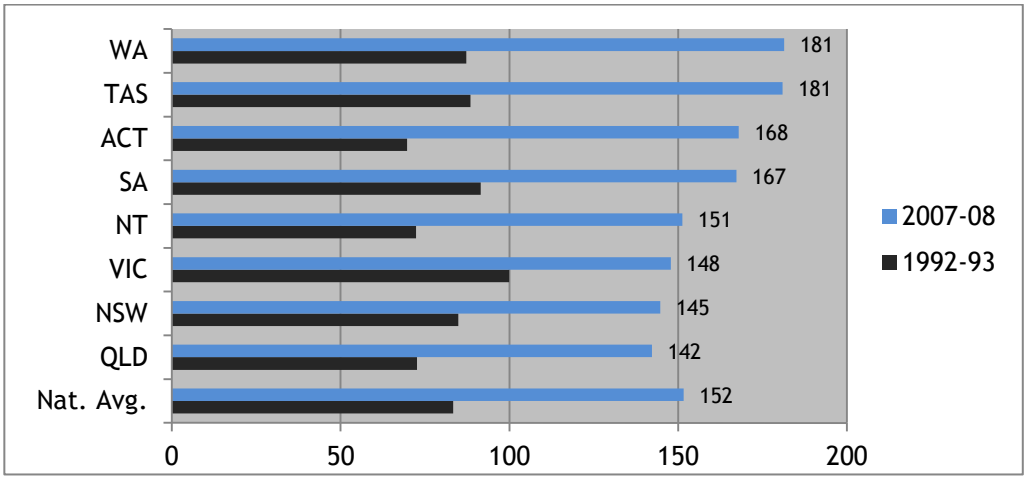


There is little evidence on which to base a judgement about the relative levels of investment required to achieve a balanced and effective service response to this group, but there is a prima facie argument that suggests the commitment to the psychosocial, recovery and support service system reflected in these figures is inadequate.

2.4.2 The resourcing overview

Figure 14 shows the changes in per capita spending by states and territories in 1992–93 and 2007–08. Victoria was the largest spender in the early years but was sixth in 2007–08. Various interpretations of this position are possible. One is that this reflects the efficiencies derived from both the service and management models applied in Victoria. It could also reflect that this issue has been a declining priority for the Victorian Government.

Figure 14 - Per capita spending[11]



It is now anticipated that some level of rebalancing of which government provides what will be achieved through new Australian Government investments outlined above.

This section has highlighted the nature of the current and future funding for CMMH services. It demonstrates a positive outlook over the next five years. It suggests that the diversity of providers is a source of the fragmentation and the difficulties of navigating services for consumers, families and carers, mental health professionals and the general community. It suggests that this issue is a central one for possible reforms of the sector.

2.5 SYSTEM OPERATION

Considerable effort has gone into improving the service system capacity through partnership and collaboration strategies. These changes have generated improvements but have not changed the fundamentals of a system that is difficult to navigate, complex and inefficient to manage.

The primary focus has been to make improvements within current arrangements rather than to assess whether fundamental reform would be required to develop navigable and efficient service systems.

The primary program structure in Victoria is that authorised by the Victorian Government. The Australian Government's investments have been service type specific.

The program structure involves a series of service types, which then inform program guidelines, funding streams and reporting accountabilities. The service types are outlined in Figure 15.

[11] Australian Government Department of Health and Ageing (2010) *National Mental Health Report 2010: Summary of 15 Years of reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2008,* Commonwealth of Australia, Canberra, p 3

Figure 15 - Current Victorian service types

Program type
Home Based Outreach Services
Day Programs
Youth Residential Rehabilitation services
Adult Residential Rehabilitation services
Supported Accommodation services
Mutual Support and Self-Help
Planned respite
Prevention and Recovery Care services
Care coordination
Other

The key program guidelines that define the work of CMMH services are:

- *Victoria's Mental Health Services, Psychiatric Disability Rehabilitation and Support Services Guidelines for Service Delivery*, February 2003
- *PDRSS Young Person's Residential Rehabilitation Program Revised Guidelines and Information*, February 2005
- *Adult prevention and recovery care (PARC) services framework and operational guidelines* 2010.

The content of these guidelines reflects the program structure outlined in the table above. The fact that (apart from the PARC guidelines) these guidelines have not been revised for many years, particularly where there is a growing body of evidence, is problematic.

The strength of the current structure is that there is a component focussed on individual packages (HBOS) and that some 40% of the Budget is allocated to this function.

The service type structure, however, is problematic and will become more so in the future. It is essentially an input focussed definition of services and is silent on the outcomes sought.

This weakness is continued in the reporting arrangements, which also focus on input and activity. The performance reporting requirements focus on:

- contact hours
- bed days
- block grants.

This is reflected in the following table, which outlines the current CMMH services reporting requirements published in the *Victorian Health Policy and Funding Guidelines 2011-12.*

Figure 16 - Current PDRSS reporting and funding[12]

Service element		Funded unit	2011–12 unit price ($)
Aged intensive support		Client	6,717
Care Coordination		Block grant	-
Home based outreach support	Standard (T3)	Client contact hour	101.75
	Moderate (T6)	Client contact hour	101.75
	Intensive (T30)	Client contact hour	50.87
Mutual Support and Self Help (MSSH)	Standalone (high availability)	Weighted block grant	181,209
	Standalone (low availability)	Weighted block grant	Varies
	Individual support referral and advocacy	Client contact hour	31.36
	Information development and dissemination	Block grant	-
	MSSH group support[1]	Contact hour (group)	83
	Groups education and training[1]	Contact Hour (group)	282.78
	Volunteer coordination[1]	Hour	36.34
Planned Respite	In home	Client contact hour	28.33
	Community	Client contact hour	28.33
	Residential	Client contact hour	28.33
Psychosocial Day Programs	Drop in	Client contact hour	15.71
	High cost integrated	Client contact hour	79.38
	Standard integrated	Client contact hour	32.88
	Specialist	Client contact hour	29.01
Residential Rehabilitation	Support	Client contact hour	87.97
	24 hour	Available bed day	153.01
	Non 24 hour	Available bed day	122.31
Special Client Packages		Block grant	-
Supported Accommodation	24 hour On-site small facilities (0-11 beds)	Available bed day	118.71
	24 hour On-site small facilities (> 11 beds)	Available bed day	41.56
	Non 24 hour On-site Cluster (0-11 beds)	Available bed day	77.47
	Non 24 hour On-site Cluster (> 11 beds)	Available bed day	57.60
	Non 24 hour On-site Other facilities (>11 beds)	Available bed day	77.47

Notes

1. *Standalone MSSH statewide specialist (high availability) receives a 50 per cent discount of the standard price.*
2. *The Home Based Outreach (T30) rate is half the HBOS (T3&T6) rate $50.87 because matched hours of direct and indirect service is not assumed. This program is still being evaluated.*

[12] Victorian Government Dept of Health (2011) *Victorian Health Policy and Funding Guidelines 2011-12*, p 162

The introduction of activity-based funding agreed by the Australian, State and Territory Governments this year will be a major driver of change for services. This change will significantly impact CMMH service delivery over the next decade. Within this context, it is important that the current program structure be reviewed within the next two years, to ensure that future initiatives are directed towards evidence-based and well justified service streams rather than only continuing to fund services on the basis of history.

Funding regimes should fund an understandable and useable service system informed by consumer need. The analysis from this paper suggests that system design needs to be a strong focus of the CMMH service system and the Victorian Government's focus over the next three years, to ensure that activity-based funding supports a logical and understandable suite of services that are understood, easily accessible and respond to consumer and carer needs.

2.6 DEMAND

Data on the level of demand is patchy, which is understandable given the stigmatised and hidden nature of mental illness. Available evidence suggests that there is substantial unmet demand.

The Boston Consulting Group reported in 2006 that people with severe conditions not being serviced in any one year constituted some 44% of the relevant population[13].

Based on advice from the Victorian Government, the Productivity Commission estimated that an increase in expenditure of 34% to 40% would be the minimum required to meet expressed demand, and a greater increase in resources would be required to meet the 'under-met' need in current service provision[14].

Anecdotal evidence from consumers and carers has long expressed the frustrations involved in trying to access services.

These data indicate that the Australian and Victorian Governments' commitments to growth for the sector are based on solid grounds.

2.7 PHILOSOPHY AND APPROACH TO SERVICE PROVISION

The philosophy and approach of CMMH services has evolved over the past ten years. Its early focus was on psychosocial rehabilitation. However, over time its focus has broadened to a strong focus on recovery, wellbeing and social inclusion consistent with the National Mental Health Policy. The social model of health and a rights-based approach have formed the underlying philosophy of this part of the service system. This section describes these core elements of service delivery.

[13]Boston Consulting Group (2006) *Improving Mental Health Outcomes in Victoria: The Next Wave of Reform,* BCG, p 21

[14]Productivity Commission (2011) *Disability Care and Support*, *Productivity Commission Inquiry Report,* Canberra, p 782

2.7.1 Recovery focused

Community managed mental health as a whole has developed its practice based on contemporary understandings of recovery and recovery practice. There is now a relatively consistent definition of mental health recovery in Australia.

Definitions of recovery

The definition provided in the National Mental Health Policy 2008 is:

> *A personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually-identified essential services and resources.*

The definition developed by Patricia Deegan, a consumer who contributed greatly in this area, is:

> *Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again… The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work and love in a community in which one makes a significant contribution.*

The definition provided by the New Zealand Mental Health Advocacy Coalition in Destination Recovery is:

> *… A philosophy and approach to services focusing on hope, self-determination, active citizenship and a holistic range of services.*[15]

The Victorian Government recently released a *Framework for Recovery-Oriented Practice* (2011), which identifies nine domains that should be present in mental health services[16].

Importantly for practice, there is also a broad consensus that recovery involves a range of factors. The following quote outlines a list of factors that need to be considered in recovery practice.

Research has found that important factors on the road to recovery include:

[15]Commonwealth of Australia (2009) *Fourth National Mental Health Plan – An Agenda for Collaborative Government Action in Mental Health 2009-2014*, p 26

[16]Victorian Government Department of Health (2011) *Framework for Recovery-Oriented Practice*, Melbourne

- *good relationships*
- *financial security*
- *satisfying work*
- *personal growth*
- *good physical health*
- *the right living environment*
- *developing one's own cultural or spiritual perspectives*
- *developing resilience to possible adversity or stress in the future.*

Further factors highlighted by people as supporting them on their recovery journey include:

- *being believed in*
- *being listened to and understood*
- *getting explanations for problems or experiences*
- *having the opportunity to temporarily resign responsibility during periods of crisis.*

In addition, it is important that anyone who is supporting someone during the recovery process, encourages them to develop their skills and supports them to achieve their goals.[17]

2.7.2 Wellbeing

Wellbeing is critical to a productive and rewarding life. Wellbeing is defined as:

> *A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.*
>
> *Wellbeing is therefore distinct from mental illness. Someone can have symptoms of a mental illness and still experience wellbeing just as a person with a physical illness or long-term disability can. In the same way, someone can have poor mental wellbeing, but have no clinically identifiable mental illness.*[18]

[17] Mental Health Foundation Website: www mentalhealth.org.uk/hel-information/mental-health-a-z/R/recovery/ accessed on 17/8/2011

[18] Department of Health, Mental Health Division (2009) *New Horizons: A shared vision for Mental Health*, Her Majesty's Government, London, p 18

2.7.3 Social model of health

The evidence shows that a social model of health provides a critical underpinning to wellbeing. A social model of health is defined as:

> *…A framework for thinking about health. Within this framework, improvements in health and wellbeing are achieved by addressing the social and environmental determinants of health, in tandem with biological and medical factors…*
>
> *Health is a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity.*[19]

2.7.4 Psychosocial disability

Psychosocial disability is a long-term consequence of a psychological condition and the societal response to that condition.

> *…Refers to the interaction between psychological and social/cultural components of … disability. The psychological component refers to ways of thinking and processing… experiences and… perceptions of the world… The social/cultural component refers to societal and cultural limits for behaviour that interact with those psychological differences/madness as well as the stigma that society attaches to…[the]…label…of… disabled.*[20]

2.7.5 Social inclusion

Social inclusion has become an important part of the practice base of the sector. The Australian Government defines social inclusion in the following terms:

> *Social inclusion recognises that many Australians are excluded from the opportunities they need to create the life they want, and can become trapped in spirals of disadvantage caused by family circumstances, low expectations, community poverty, a lack of suitable and affordable housing, illness or discrimination — often leading to leaving school early, long-term unemployment and chronic ill-health. Some people are at greater risk of multiple disadvantages, such as jobless families, Aboriginal and Torres Strait Islander people, people with disability and mental illness, vulnerable new migrants and refugees, those with low incomes and people*

[19] Victorian Government Department of Health (2011) http://www.health.vic.gov.au/healthpromotion/what_is/determinants.htm, accessed on 20/9/2011

[20] World Network of Users and Survivors of Psychiatry (WNUSP) (2008) *Implementation Manual for the UN Convention on the Rights of Persons with Disabilities*, from the website of the WNUSP, http://wnusp.rafus.dk/

experiencing homelessness. The costs of this social disadvantage are high — to individuals, communities and the nation.[21]

CMMH practice has a strong focus on access to education and employment, housing and primary health care. People dealing with serious mental illnesses commonly need support to deal with a range of issues not defined as 'mental health services'. The evidence shows that these services or interventions are fundamental to recovery and wellbeing. Key issues include:

- access to satisfying work
- the right living environment, including stable housing
- support to develop good physical health
- personal growth and relationships.

The existing mainstream systems responsible for housing, employment and health service delivery are not adequately equipped to meet the needs of this relatively specialist group.

2.7.6 Employment / education

Access to employment is a key element of social inclusion, yet most employment initiatives have been poorly targeted in responding to the needs of people with mental illness.

Many people's educational opportunities are disrupted by the onset and effect of their mental health condition. There has been inadequate recognition of the need to address this issue as a part of strengthening people's capacity to gain meaningful employment.

Unsurprisingly, people with a mental illness are no different to the broader population – people with a mental illness want to work, (Secker & Membrey, 2003). Work not only provides an income, but also contributes to a broader sense of self-worth and wellbeing, (Clevenger, 2008). It may even be proposed that work for people with a mental illness takes on a more profound meaning as it becomes a signpost of recovery.[22]

2.7.7 Housing

The recently published report, *Precarious Housing and Health Inequalities: What are the Links?* makes numerous findings about the consequences of precarious housing. The

[21] Australian Government (2011) Social Inclusion Website, accessed at: http://www.socialinclusion.gov.au/about/what-social-inclusion, 18/9/2011

[22] Collister L (2010) 'Participation in Employment and Education', *Newparadigm,* Unfinished Business, summer 2009/10, VICSERV, Melbourne, p 28

report explores the connections between housing and health. The report found, among other things, that:

> *On average, mental health declined or deteriorated as the degree or extent of an individual's experience of precarious housing increased. In other words, the longer an individual was exposed to precarious housing, the worse his or her mental health was likely to be.*[23]

The evidence also shows that stable and affordable housing works.

The evaluation of the Housing and Accommodation Support Initiative (HASI) undertaken by the Social Policy Research Centre of the University of NSW and the Disability Studies and Research Institute (DSaRI) made significant findings regarding the effect of secure and affordable housing for people with serious mental illnesses. The findings include:

- *improvements in psychological wellness – 68% of participants reported an improvement in symptoms, social and living skills, and a decrease in psychological distress*
- *improved physical health – over 50% of participants reported improved physical health from regular access to general practitioners and specialists, as well as improved diet and increased physical exercise*
- *reduced hospitalisation rates, frequency and duration for 84% of participants.* [24]

Similar results have been found in international research including a study by the US Department of Housing and Urban Development, *The Applicability of Housing First Models to Homeless Persons with a Serious Mental Illness.*[25]

[23] Mallet S, Bentley R, Baker E, Mason K, Keys D, Kolars V & Krnjacki L (2011) *Precarious Housing and Health Inequalities: What are the Links?* Hanover Welfare Services, University of Melbourne, University of Adelaide, Melbourne Citymission, Australia, p 47

[24] The quotes were taken from: Social Policy Research Centre, UNSW (2007) Housing and Accommodation Support Initiative Stage 1 Evaluation Report

[25] US Department of Housing and Urban Development (2007) *The Applicability of Housing First Models to Homeless Persons with a Serious Mental Illness,* USA

3 POLICY AND FUNDING CONTEXT

The policy context in which CMMH services operate is changing. Government and community expectations are changing and CMMH services want to position themselves to address these changing expectations. This section considers these policy changes and their implications for the future of CMMH services.

The current mental health policy environment provides a positive outlook for CMMH but also indicates a period of considerable change and challenge. Positive because the issue of mental health is being widely discussed and policymakers are responding with sound initiatives and productive investments. Governments have also made commitments to further development over the next decade. Challenging because the government and the community are expecting more of mental health services and national health reforms will have a significant impact on the understanding, funding and functions of CMMH services.

3.1 VICTORIAN GOVERNMENT

The *Victorian Liberal Nationals Coalition's Policy and Plans for the 2010 State Election Mental Health Policy* demonstrates a positive approach to mental health generally and to CMMH services specifically.

> *This policy represents a comprehensive approach to improve prevention, diagnosis, treatment and ongoing accommodation and support for people with a mental illness. We commit to continue to learn and invest to ensure Victoria is again at the forefront of mental health policy in Australia.*[26]
>
> *Victoria has developed a good PDRSS sector, but further investment is needed to build capacity of organisations providing services to young people, adults and older Victorians. A stronger PDRSS sector will be effective in supporting people and their carers in their homes to manage and recover from their mental illness, and in so doing, reducing the demand for acute services.*[27]

The quotation provides optimism about the future because it builds on well-supported policy, commits to change and leadership, and articulates a commitment to a stronger CMMH service system.

This positive policy environment is yet to shape program, funding and accountability arrangements. A number of factors regarding the current situation deserve comment:

[26] The Victorian Liberal Party and Nationals Party (2010) *The Victorian Liberal Nationals Coalition Plan for Mental Health*, p 3
[27] Ibid p 13

- the commitment to a stronger CMMH service system is encouraging but does not yet define how it will be enacted
- services, largely, operate under program guidelines that are between six and eight years old
- various analyses of the PDRSS funding stream and of CMMH services conducted by the then Department of Human Services and later Department of Health between 2007 and 2011 have identified a range of possible reforms, many of which still require attention[28]. Not all of these reviews have been released for public comment.

The proposed *Victorian Mental Health Act*, recently the subject of consultation, will also have implications for the sector. The effect cannot be fully assessed until the Bill is available. It is likely that the Bill will include:

- an objective related to recovery and, in so doing, define the role of services in supporting physical, social and emotional potential, self-reliance and participation in community life
- provision for the establishment of a Mental Health Commissioner with power to conciliate complaints and to assist service providers to deal with complaints at the local level
- changed powers for the Chief Psychiatrist that will enable that officer to conduct audits including into some CMMH service providers
- powers for the Minister for Mental Health to make Codes of Practice that would define benchmarks for good practice.

3.2 NATIONAL MENTAL HEALTH POLICY

The Australian Government's Mental Health Initiative will provide a significant boost to resources and drive changes to the service system. These new investments build on the programs established over the last five years.

The near doubling of resources in Victoria that will result from these new investments provides major opportunities for CMMH services. There will be scope to meet increased demand and better service people with complex needs.

The following quote demonstrates the breadth of investment in recovery support and that more responsive mainstream service provision is required.

> *As important as clinical treatment is, other services and support in the community are also critical for the recovery of people with mental illness – to participate in social and community life, get and keep a job, improve relationships with family and friends and help manage the tasks of everyday life. The budget includes substantial*

[28] Government of Victoria (2007) *An Analysis of the Victorian Rehabilitation and Recovery Care Service System for People with Severe Mental Illness and Associated Disabilities*

additional funding for community-based mental health support including Personal Helpers and Mentors and essential respite support.[29]

The initiative commits a total of $2 billion over six years to the task of addressing the weaknesses in Australia's mental health response.

In addition to this substantial investment the Australian Government has announced:

- a commitment to a ten-year road map. This recognises that neither the policy settings nor the investment are adequate to the long-term task
- commitments to increased employment participation by people with mental illness
- the establishment of a National Mental Health Commission that will promote best practice, measure the performance of the mental health system and provide cross-sectoral leadership.

Implementation of the Mental Health Initiative is still being planned. The processes for service development and systems for engaging with the community are likely to be relatively open, market-based and to anticipate involvement by for-profit and not-for-profit organisations. Organisations are likely to have to tender and work with new entities such as Medicare Locals.

The Australian Government will become a major funder of services for people with complex mental health related needs. This will change the policy environment in which CMMH services work. The Australian Government will also invest its funds through different processes and structures.

Some of the key changes that are likely to be generated by the Australian Government's initiative include:

- greater usage of individualised approaches mediated through general practice and/or Medicare Locals. This will come about directly through the establishment of the Access to Allied Psychological Service (ATAPS) Program — Tier 3.

Some in the sector have established infrastructures and capabilities to access this source of funding through their general practice relationships and work with private providers already involved in the Better Outcomes Program and the existing ATAPS Program (Tiers 1 and 2). Other organisations will be challenged to develop business models and the internal systems required.

- new models for coordinated care. The Coordinated Care and Flexible Funding for People with Severe and Persistent Mental Illness Program is likely to:
    - contribute to the development of nationally consistent assessment tools and processes
    - be established through open tenders using Medicare Local boundaries

[29] National Mental Health Reform, (2011) *Statement by The Hon Nicola Roxon, MP, The Hon Jenny Macklin MP, The Hon Mark Butler* MP, p 3

- be delivered through care facilitators who will also have access to funds to purchase services.

This program provides opportunities for services as well as challenges. The challenges include:

- engaging on the development of national tools and processes
- operating within new boundaries especially where it is not clear that there will be alignment with existing State Government boundaries, particularly for clinical services
- expanded coverage of '*headspace*'. Through the 2010–11 and 2011–12 Budgets, the Australian Government will expand the number of *headspace* sites from 30 to 90. This near-universal coverage provides an important platform for the development of a robust youth mental health service infrastructure. Some CMMH services are already involved with their local *headspace*. Others will be challenged to contribute to the development of a comprehensive and cohesive youth-focussed service with appropriate clinical partnerships
- Medicare Locals. Reference to the potential for effects on governance, planning and other matters was made earlier.

It is important that CMMH services have an opportunity to contribute to the development of Medicare Locals, given their status as nationally authorised leaders of a primary care planning, purchasing and system coordinators. It is also important that the sector advocate for coherence and collaboration between different governance bodies and levels of government.

The Australian Government's investment and strategy will have unpredictable effects on the fragmentation of the Victorian service system. While the process needs to be transparent, it will be important that those approving tenders or making purchasing decisions take into account the benefits of a rational approach. The CMMH services should be active in communicating these issues to the Government and Medicare Local managers as well as other stakeholders.

This advocacy will be more effective if CMMH services are seen to be taking action to address the existing fragmentation. Taking action on fragmentation in the early stages of the implementation of the Australian Government's Mental Health Initiative will deliver benefits and reduce the risk that individualised funding may destabilise the service system.

3.3 NATIONAL DISABILITY POLICY

National disability policy is important in its own right as well as to the future development of mental health services and the existence of a CMMH service system.

3.3.1 National Disability Strategy

The *National Disability Strategy 2010–2020* sets out a ten-year plan for improving life for Australians with disabilities, their families and carers.

> *The purpose of the National Disability Strategy is to:*
>
> - *establish a high level policy framework to give coherence to, and guide government activity across mainstream and disability-specific areas of public policy*
> - *drive improved performance of mainstream services in delivering outcomes for people with disability*
> - *give visibility to disability issues and ensure they are included in the development and implementation of all public policy that impacts on people with disability*
> - *provide national leadership toward greater inclusion of people with disability*[30].

The strategy uses a definition of disability that is inclusive of cognitive impairment as well as physical, sensory and psychosocial disability.

3.3.2 National Disability Insurance Scheme

The Australian Government recently received the final report on 'Disability Care and Support' from the Productivity Commission. The report proposes a National Disability Insurance Scheme (NDIS) to replace much of the disability and psychosocial services' funding arrangements in Australia.

The Australian Government made the following announcement:

> *The Gillard Labor Government today announced that it will start work immediately with states and territories on measures that will build the foundations for a National Disability Insurance Scheme, following the release of the Productivity Commission's final report into the matter*[31].

[30] COAG (2011) *National Disability Strategy, 2010 -2020*, p 9

[31] Announcement by the Prime Minister on 10 August 2011, accessed at http://www.pm.gov.au/press-office/productivity-commissions-final-report-disability-care-and-support

The Victorian Government has endorsed the NDIS and made the following announcement:

> *Victoria is keen to be at the forefront of the implementation of an NDIS, and the Minister for Community Services Mary Wooldridge has this morning reiterated to Minister Jenny Macklin, Victoria's commitment to implementing the first-stage rollout of the scheme here in Victoria*[32].

The NDIS is a complex proposal and if implemented will change the policy, service system and organisational context of mental health significantly. The scheme will operate on principles and systems that are fundamentally different to the existing arrangements. It is estimated that the scheme will lead to an almost doubling of funds for CMMH services in Victoria.

The proposed insurance model will drive crucial changes in service delivery. Key design features that will influence service provision include:

- National scheme with regional presence. The Productivity Commission's implementation outline recognises that the NDIS would need administrative and other infrastructure dispersed across the country. The geographic boundaries and detailed roles are unclear.

  It is hoped that the boundaries that emerge are aligned with other systems, particularly the clinical service boundaries in operation.

- Entitlement-based funding. The NDIS will introduce an entitlement to funding and will prescribe the level of funding associated with that entitlement. Those deemed eligible under new assessment processes, yet to be agreed, will have an ongoing right to the level of service associated with their individual budget.

  There will be challenges in this for psychosocial disability given the fluctuations inherent in the recovery journey.

- Independent assessment and navigation support. The scheme will depend upon a nationally consistent assessment completed at arm's-length from service delivery. The tools for assessment and the machinery for managing this process are yet to be developed.

  The Commission also proposes that for those who need it, non-government disability support organisations (DSOs) be established to support people in managing their entitlement. These organisations would also be separate from service provision.

[32] Media Release by The Hon Ted Baillieu MP on 10 August 2011, accessed at: www.premier.vic.gov.au

- Choice. The recipient of an NDIS-funded package would have direct control of where and how those funds are spent subject to requirements that it be spent on support services. This will drive the market-based approach.

- Separation from clinical services. Clear separation between NDIS-funded services and health services will be required in order to ensure that there is no cost shifting. CMMH services will have to develop new interfaces, and clinical provision of recovery and rehabilitation services may also need to be defined.

General factors in the NDIS proposal which deserve comment are:

1. The decision to include mental health support was made only late in the inquiry and only after specifically seeking input on that question in the draft report. The Commission's uncertainty regarding the inclusion of mental health means that much of the design and process proposals have been focussed on physical and intellectual disability. There are important parallels and critical differences that the scheme, if established, will have to deal with.

   VICSERV has advocated for the inclusion of psychosocial disability within the NDIS. CMMH agencies will need to demonstrate willingness to trial new processes.

2. The model of individual choice can lead to fragmentation as new entrants see business opportunities and consumers make their own choices. The risk of fragmentation is best managed through a robust and high quality service system. This does not diminish the chances of new entrants but it does set a benchmark for their performance.

3. There are important interface issues between the mental health services offered through the NDIS and those that remain funded by the health service systems. Discontinuities for individuals as well as critical inequities of both access and service may emerge.

4. Complete implementation could take up to eight years. It should also be noted that there is considerable risk that the proposed timeline will not be met either because policy approval is not forthcoming or the detailed work takes longer than planned.

The Victorian Government is keen to be involved in the development of the scheme. It was recently announced that, at the instigation of the Victorian Secretary of Health, the trial has been moved forward one year and that dialogue about the inclusion of mental health commence immediately. This is an important opportunity for CMMH services to influence the development and, in so doing, position themselves to prosper in the future.

3.4 OTHER HEALTH AND HUMAN SERVICES POLICY

A range of complementary policy areas have vital consequences on the effectiveness of mental health policy and the opportunities and wellbeing of people facing serious mental health issues, their families and carers.

3.4.1 National health reform

Considerable attention has been paid to national health reform. All jurisdictions have signed the National Health Reform Agreement[33]. The implications for mental health include the:

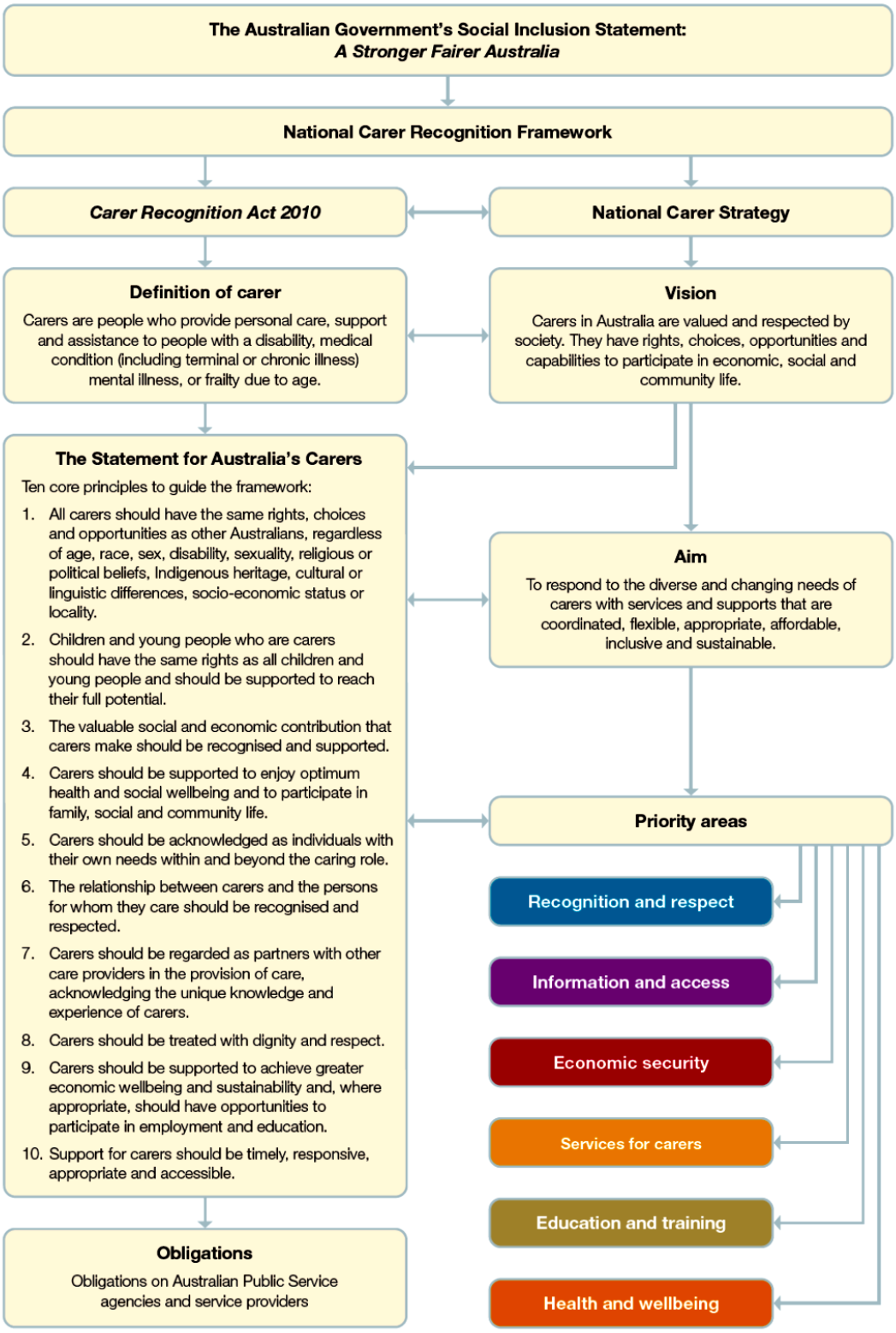
- establishment of Medicare Locals with area planning, service coordination and funds allocation responsibilities
- establishment of a number of national bodies with regulatory, performance reporting and quality responsibilities
- introduction of national activity-based funding with an expectation that it will apply to mental health from July 2013
- introduction of e-health and electronic records.

3.4.2 National Carer Strategy

The National Carer Strategy released in early August 2011 provides a broad framework for supporting carers. The following diagram provides an overview of the strategy and its key priorities[34].

[33]COAG (2011) *National Health Reform Agreement, Council of Australian Governments*
[34]Commonwealth of Australia (2011) *National Carer Strategy*, p 13

Figure 17 - National Carer Strategy



3.4.3 Other policy

The operation and governance of Community Service Organisations' (CSOs) delivery are also affected by other public policies. For the purpose of this paper four topics are pertinent. They are:

Employment and income security

The Australian Government has announced:

- an investment of $2.4 million over five years to support employment initiatives specifically for people with mental illness
- reforms to the Disability Support Pension (DSP) to create incentives and obligations that encourage people with a disability into employment. The announcement signals a strong focus on reducing the number of people in receipt of the DSP.

The significant and rapidly growing proportion of people in receipt of DSP with a mental illness has been a key driver of these policy changes. The changes will be important for this population group in the future.

National regulation of the not-for-profit sector

The research report into the *Contribution of the Not-for-Profit Sector* by the Productivity Commission in 2010 focussed attention on the issue of regulation of the not-for-profit sector. The Australian Government is still assessing the role for a national not-for-profit regulator. It is likely that changes to legal status and governance requirements will result.

This process is likely to raise issues for organisations regarding:

- the possibility of taxation changes that would increase costs and potentially reduce revenues
- overall governance arrangements that provide the most appropriate legal framework in a more complex and accountable environment with high financial and risk management expectations of Boards and executive level managers.

3.5 CHANGING FRAMEWORKS

Two major factors will affect the future of CMMH services: individualisation and a shift to a market-based system in service delivery. Both have their unique sets of challenges but also opportunities for which the services need to be prepared if optimal services are to be provided to consumers and their families.

3.5.1 Individualisation

The trend towards individualised approaches is both desirable and consistent with the values base which underpins the CMMH service system. Though CMMH services have had a taste of what this approach will entail with almost half of funded organisations delivering HBOS, few have substantial experience in the assessment, care coordination, client engagement or budget management systems that will be required.

Other current challenges which have the potential to be exacerbated within an individualised approach relate to:

- the application of this approach to people with a serious mental illness. There is a lack of evaluation of the successes of individualised programs in Australia and abroad for this particular group
- the implementation in Victoria, given the state of service development. As indicated in this paper, fragmentation within the sector means some services have greater capabilities than others to meet individual needs.

3.5.2 Market reforms

The Victorian and Australian Governments are supportive of a more market-based approach to service delivery. Some of the new national mental health initiatives will utilise market mechanisms.

The NDIS would further entrench this approach.

CSOs have been increasingly exposed to many of the features of a market in recent years. Governments have introduced competitive models, required performance reporting and tightened price.

CMMH services have been relatively protected from these factors. New initiatives have been subject to selective tender with only existing providers invited to participate, and long-term services have been protected. New entrants have not had significant incentives to move into the CMMH arena.

The NDIS will usher in many market features. They will be introduced into a closed system with many block-funded industry features. In the current environment price is not an issue, products are largely defined by government, which purchases in blocks, and few

people have insights about quality. Availability is managed through gatekeeping, not price or quality.

It is likely that there will be price competition and consumers with views about the services they want and the quality they expect. It is also likely that there will be new entrants.

3.5.3 Efficient pricing

All Australian governments have committed to the introduction of ABF. It is anticipated that the NDIS will also require a systematic analysis on which pricing can be built, even in a market-based approach.

ABF arrangements fund providers based on the activities they undertake. For example, a hospital receives a certain amount of money for each appendectomy it performs. In practice, this is very complex. For each patient 'episode' — for example, a stay in hospital — a range of data (such as diagnosis, age, comorbidity, treatment) is used to assign a 'diagnosis related group' (DRG). Because of the importance of reliable data collection and evaluation, ABF tends to lead to improvements in accountability and efficiency.

Although ABF is widely used around the world for acute care, countries have been slow to adopt it for mental health care. However, several countries including the United States and the Netherlands have recently introduced ABF for acute mental health care. Australia does not currently use ABF to fund any mental health care.

The sector will need to make a number of changes in order to accommodate ABF. These will include:

- the introduction of data systems that can record both clinical and costing information for patient episodes. This will require associated investment in IT and related infrastructure
- new data collection practices. In particular, frontline staff need to be trained in data collection and understand the importance of data collection
- the development of new workforce capacity, since ABF relies upon trained health information managers.

The implementation of such large-scale change in the timeline agreed by heads of government will be a massive undertaking. Regardless of whether the timeline is met or not, the reforms are important to create the accountabilities and disciplines required, and to prepare the ground for the NDIS. ABF will provide clear and strong evidence on the cost of delivering specific services and interventions and will have the capacity to inform the pricing structure of the NDIS.

4 ISSUES AND CHALLENGES

CMMH services face a number of issues and challenges which need to be addressed in an orderly and systematic way. This section identifies the major issues and challenges. Chapter 5 then details VICSERV's thinking about the purpose, scope and future role for the CMMH service system in this changing environment. Chapter 6 identifies key areas for reform. Chapter 7 proposes a series of actions to address these issues and challenges in developing the services for the future.

4.1 OPERATING IN A MARKET RATHER THAN ACTING AS A PUBLIC SECTOR AGENCY

The implications of the introduction of an NDIS and a stronger Victorian Government focus on consumer-driven services will have profound implications for the delivery of services. This will involve a paradigm shift from block-funded to customised service delivery. That is, the delivery of services has been focussed on providing approved or funded programs, which are offered to clients. The accountability to clients, carers, governments and the public has been weak. The features of the future system will be different.

The following table (Figure 18) distils the systemic features of CMMH services now and predicts how they will change in the future.

The shift will focus on:

- client control and oversight of the services they receive supported by independent needs assessment and care coordination where required
- strengthened regulatory arrangements separated from policy
- highly competitive pricing of service payment.

Figure 18 – Systemic change drivers

Feature	Current – closed system	Future – open system
Client status	Beneficiary	Entitled and having choice
Model	Block-funded	Market-based industry
Control [policy, program and funding]	Government department has total authority	Collaborative
System	Complex and navigated through service providers	Simplified with independent navigation support providers
Access	Provider control and gatekeeping	Independently assessed and controlled
Regulation	Grant-based performance reporting against activity. External accreditation not connected to performance reporting	Mix of self-regulated and independent government authorised regulation
Financing	Block program grants	Individual payments and competitive pricing
Sector leadership	Coordinator of and consensus-based advocate for CMMH interests	Leader of self-regulation and development and evidence-based advocate for improved outcomes.

This paradigm shift will mean that the CMMH service system will need to operate in different ways. It has major strengths and capacity but will need to be more flexible and accountable. This change will involve considerable re-engineering of service delivery models and back-of-office systems such as accounting, data collection and access.

There are significant opportunities for services to demonstrate leadership for the next stage of reform and development. Optimal outcomes will be achieved where that leadership is supported through political and bureaucratic engagement.

4.2 SYSTEM FRAGMENTATION – THE NEED FOR A MORE RATIONAL SERVICE SYSTEM

The analysis in this paper, which is reflective of the analyses in other reports, is that the current structure of the CMMH service system is fragmented. It suggests that this fragmentation is not in the best interests of consumers, agencies working with people with mental illness and funders, and that addressing this issue should be a priority reform agenda. Service delivery reforms should be designed to address the fact that too many organisations have too little funding under the Victorian Department of Health's PDRSS funding stream to provide adequate services in the emerging environment. There are three key elements to reform on this issue.

4.2.1 Scale

There are no benchmarks that define the appropriate scale that should apply to CMMH services. The scale argument is not presented simply on the basis that 'bigger is better'. There are points of diminishing returns and factors other than absolute scale, which affect capacity.

Scale, however, provides greater flexibility to customise a service to individual needs, particularly where there are demand pressures and particularly where clients' needs and circumstances change. The emerging context will require that organisations have the ability to adapt their service offering:

- to individuals as their needs change
- to different individuals as they seek services from the organisation.

Such responsiveness to individual needs requires staff with diverse skill sets and knowledge and may require a variety of facilities and other resources.

This capability contributes to effectiveness, provided that the service is evidence informed, the staff skilled and the organisation well managed.

The benefits of scale are, in part, context driven. An organisation with a broad role and multiple funding streams may be able to manage resources to meet the needs of a client with multiple needs. As a consequence, the size of each funding stream may be smaller than otherwise required. Community health centres are examples of this proposition.

The benefits of controlling multiple funding streams are often cited but can be difficult to achieve. The difficulties arise because of the requirements imposed by funders more than through organisational difficulties in aligning resources in pressured environments.

4.2.2 System navigation

The complexity of mental health service systems is widely recognised. The *Victorian Mental Health Reform Strategy 2009–2019* set out to address this. Victoria is not alone in having a fragmented system, as demonstrated in the quotations from three Australian Government ministers earlier in this document.

To some degree a service system providing support to individuals and families with complex and changing needs and circumstances needs to be complex. The current 'design' of the service system, though, is much more complex than responsiveness requires.

The structures that make navigation problematic include:

- limited investments in information systems that empower consumers to make more informed judgements
- governance structures which fragment clinical as well as community managed organisations
- the increasing role of the Commonwealth in funding more services for people facing serious mental health issues increases the navigational issues. The Australian Government is working on national arrangements and building its own national infrastructure and governance machinery
- failure to implement robust assessment, screening, intake and referral processes.

Considerable effort and skill have gone into mental health alliances and primary care partnerships. Gains have been made but they appear unlikely to lead to a more robust service system.

Governments and providers share the obligation to provide more navigable service systems. Simplifying navigation will be essential in an individualised environment, such as that which is emerging through the Australian Government's Mental Health Initiative. The NDIS will also introduce market measures and communication systems that will force change to simplify and clarify navigation systems.

It would be better for the future if positive actions were taken now. The reasons for this are the direct benefits that would result for consumers and because it will facilitate the establishment of a more robust and user-friendly system in the medium term. The Victorian Government, in its role as systems manager, is the lead agent for change and VICSERV is willing to work collaboratively with the government on system design.

4.2.3 Efficiency

On the efficiency side of the argument, overheads attached to managing a budget do not diminish in line with the overall budget. The transactional and accountability costs are proportionately heavy when managing a small allocation but proportionately less onerous for larger allocations.

This proposition also needs to be qualified on the basis that large organisations can develop large administrative bureaucracies that offset any systemic efficiencies. The argument is most powerful when there are disciplines in large organisations that drive lean and efficient corporate functions and systems. It is in the services' and its consumers' interests to capture efficiency gains. A dollar spent inefficiently is a dollar that does not deliver maximum benefit to consumers and the community.

4.3 DEVELOPING MORE CLIENT-FOCUSED SERVICES

Making services more responsive and driven by client need and choice is a driver in Australia and internationally. CMMH services will need to adapt their services and approach to this trend.

4.3.1 Individualisation

The core of individual funding is that it is a portable package of funds allocated for a particular person who is supported to choose how they spend it on their disability support needs. Characteristics of the way individual funding is organised that vary are:

- *who holds and manages the funds*
- *which parts of it are portable*
- *which disability support types it can be spent on from which parts of the market.*

This is the most powerful and important driver of those discussed in this paper. Comprehensive implementation of an individualised approach will change the foundations of the service system and the operating mode of community managed service providers.

Individualisation means:

- the provision of customised services designed for a person's needs and desires
- choice and high levels of control about who delivers and how they deliver the agreed services.

CMMH services already deliver individualised services. Some 40% of the PDRSS funding stream is allocated to HBOS — a form of individual package. HBOS, however, lacks many of the choice and control features of a comprehensive individualised model.

There is a considerable body of national and international literature on this topic. Three sources provide important insights. They are:

- evaluation of the *Individual Budgets Pilot Program Final Report,* Individual Budgets Evaluation Network, hosted by York University, 2008
- Occasional Paper no. 29, *Effectiveness of Individual Funding Approaches for Disability Support*, Social Policy Research Centre, Disability Studies and Research Centre, University of New South Wales, for the Department of Families, Housing, Community Services and Indigenous Affairs, 2010
- Disability Support and Care, Productivity Commission, 2011, particularly Appendices D and E.

The approach proposed in the NDIS makes this a key focus for development. The Australian Government's 2011 Budget announcement also reflects a commitment to providing funding targeted to specific individuals rather than program or group allocations.

The introduction of an NDIS for a significant subset of mental health service users is likely to drive change more broadly across the systems. Development of parallel and inconsistent service systems will introduce new risks of fragmentation and duplication.

4.3.2 Evidence informed practice and defining outcomes

A persistent theme in health policy relates to ensuring services are informed by knowledge and evidence. This theme is as important in mental health as elsewhere.

This is an ongoing challenge for CMMH services. There is evidence that underpins CMMH services' work but it is incomplete. This situation arises because it has been difficult to attract support for research in this field, given the competition for health research funding.

CMMH services will face increasing demands to demonstrate that evidence informs their practice and that they are actively involved in building the body of knowledge available to the field.

Public policy is increasingly focussed upon achievement of defined outcomes. This will mean that CMMH services need to pay increasing attention to the measurement of:

- individual's recovery progress/journey
- the recovery orientation of services
- the recovery effect of services — the contribution that the interventions provided made to assisting individuals with their journey.

4.4 GOVERNANCE OF CMMH SERVICES AND THE RELATIONSHIP WITH OTHER PARTS OF THE MENTAL HEALTH SYSTEM

Mental health service provision rarely happens through organisations acting independently. People commonly need a number of services and live with changing circumstances. They need all elements of the specialist mental health service system to plan and work together as well as with other community services.

The *Victorian Mental Health Reform Strategy 2009–2019* included a specific goal with regard to governance. It was: 'Strengthen mental health service governance to deliver a more connected and holistic response to consumers'[35]. This recognises that existing structures are out of date and that incremental changes have not led to significant improvements.

Actions to enhance the rationality and useability of the service system included in the reform strategy were:

- reassessing catchments and auspice arrangements and aligning boundaries between child and adolescent, adult and aged clinical services
- developing mental health Boards or Committees under the broader auspice of health services.
- working with CMMH services to examine options for streamlining management, including consideration of nominating lead providers.

There has been very limited action on these proposals.

In the meantime, Medicare Locals have been established as part of the National Health Reform Agenda. They have been added to the already complex governance environment. These entities will affect the services provided by CMMH services directly and indirectly.

It is difficult to see how the proposed mental health Boards or Committees could do anything other than add complexity.

The governance reforms relating to catchments, auspices and boundaries within mental health services need to be implemented. This will not lead to simplicity. Parties will need to focus on the principles and practices of networked governance. Networked governance arrangements will need to apply:

- within areas, given the range of bodies involved
- across areas, given that not all services can or should be available in all areas. A level of cross area collaboration will continue to be required, given the catchment scales which apply to some services.

[35] Victorian Government (2009) *Because mental health matters: The Victorian Mental Health Reform Strategy 2009-2019*, p 139

4.5 WORKFORCE ISSUES

Workforce issues are an increasingly significant driver of reform in health and many other industries. Demographic changes and rising competition are driving new thinking about service configuration, sustainability of service models and workforce development issues.

The importance of this issue is highlighted by the fact that there is Australian and State Government focus on the development of mental health workforce strategies.[36]

For CMMH services, issues of particular importance include:

- **Supply challenges.** CMMH services have reported that widespread supply problems and staff turnover constrain the ability of services to operate at capacity. These challenges are particularly marked in rural and regional areas.
- **Professional competencies**. The emerging service models and demands may require different skills and knowledge. The workforce census should provide current information and insights into the workforce, which can be used for planning. An important challenge will be ensuring that the CMMH workforce retains the skills it needs to deliver the services required and applies service and business models that have cost structures that will be affordable in the future.
- **Peer workers**. Research and evaluation on the benefits to consumers and the cultural change peer workers bring to the mental health workforce is emergent and the trend positive. Work on the development of a certificate level training program is proceeding, as are in-service training programs. A strategic approach will be required to integrate the peer skills into the workforce and service models of the future.

VICSERV believes that there is a need for targeted resources for workforce development in the CMMH service system to support and develop the existing workforce and attract new workers that are capable of delivering high quality, contemporary mental health care.

The pay equity case currently before Fair Work Australia may affect the community managed sector. The nature and extent of that effect will depend upon the support provided by governments to meet the costs.

[36] 1. National Health Workforce Innovation and Reform Strategic Framework: Background Paper, (2011) Health Workforce Australia, available at: http://www.hwa.gov.au/sites/uploads/wir-strategic-framework-background-paper-FinalFinal.pdf
2. Rural and Remote Health Workforce Innovation and Reform Strategy: Draft Background Paper (August 2011) prepared by Siggins Miller, available at: https://www.hwa.gov.au/sites/uploads/hwa-rural-and-remote-consultation-draft-background-paper-20110829c.pdf
3. Victorian Government Department of Health, *National Mental Health Workforce Strategy and Plan: Literature & Document Review,* Final draft (May 2010) prepared by Siggins Miller
4. Victorian Government Department of Health, *National Mental Health Workforce Strategy and Plan* (2011) Melbourne

4.6 IMPROVING ENGAGEMENT WITH FAMILIES AND CARERS

Families have foundational roles in the recovery and wellbeing of their family members. Service providers will face increasing expectations regarding family engagement in service provision. There will also be increased focus on finding ways to improve support to families in their care and support roles.

4.7 MANAGING REGULATORY BURDEN

More demanding performance and accountability requirements are likely to be imposed on CMMH service providers as the service system grows and changes.

There is a general trend in health and community services for consumers and the general community to expect higher quality and responsive services.

This trend will be hastened and shaped by the move to individualisation. Individual services, particularly entitlement-based services, generate high expectations. This will differ from the current situation where individuals and families can feel grateful for receiving a service and can be fearful of losing that service if they complain or seek alternatives.

Governments are also likely to become more active in monitoring performance. As government outlays grow, so too does the attention paid to results. Governments have changed roles in a market-based service system. New regulatory processes are likely to be introduced in order to monitor public outlays and protect investments.

This matter is explored in the Productivity Commission's report on the not-for-profit sector and will be an increasing focus in future as the scale and economic significance of not-for-profit organisations is recognised.

The introduction of the new *National Standards for Mental Health Services*[37] and discussions regarding strengthening of organisational accreditation processes are the precursors of a focus on regulatory arrangements suited to a more individualised and market-based service system.

4.8 INFORMATION AND TECHNOLOGY

Information and communication technology (ICT) will become an increasingly powerful driver of services. ICT can support client choice, good practice, workforce flexibility and cost control.

The Australian Government has committed $14.4 million over five years to establish a single mental health online portal that will support the uptake of e-mental health. There is increasing evidence that electronic service models can be effective in resourcing people facing serious mental health issues.

[37] Australian Government (2010) *National Standards for Mental Health Services,* Commonwealth of Australia, Canberra

There are sound practice reasons for including these in the repertoire of CMMH services. For some, perhaps many, consumers this will become a preferred mode of service delivery. Electronic service delivery offers flexibility and control. This form of service delivery will also reduce workforce recruitment and retention pressures that will grow in the next decade.

This is not an argument that electronic services are desirable in all situations or for all consumers. It is an argument that the sector will need to develop its capacity on both service delivery and cost effectiveness grounds.

If ICT benefits are to be captured for the benefit of consumers, organisations will need sophisticated technical and service infrastructure as well as expertise to utilise the possibilities. Consumers will have a crucial role in articulating their own needs and in shaping the systems that deliver ICT-based services.

4.9 AREA FOCUS

A key focus of the National Health Reform Agenda is on area-based service systems. Local hospital networks and Medicare Locals are designed to focus the majority of the health system on 'place'.

This is not a contested issue as much of Victoria's health and mental health systems are area focussed. The challenges are to:

- resolve the governance issues arising from differential boundaries in mental health. The need for resolution of the current and problematic governance issues that complicate capacity for area management was clearly identified in the *Victorian Mental Health Reform Strategy 2009–2019*[38]
- adapt to the role and scale of Medicare Locals. Medicare Locals are being given:
    - a broad governance mandate
    - strong system planning and coordination roles
    - funding and resource allocation responsibilities.

  These are new entities with new governance arrangements and it will be important that CMMH services engage with them strategically
- ensure robust and well-informed involvement of CMMH providers. This will contribute to more rational arrangements within the sector and with direct partners as well as inform broader elements of the health system about ways they can contribute to reducing the burden of mental health issues in our community.

Four Medicare Locals have been established to date in Victoria with a further six to commence on 1 January 2012 and five more on 1 July 2012. There will be a total of 62 Medicare Locals nationally with 17 to be based in Victoria.

[38] Victorian Government (2009) *Because mental health matters: Victorian Mental Health Reform Strategy 2009 – 2019*, p 139

Organisations focussed on working with people who face serious mental health issues need to recognise the broad mandate that Medicare Locals appear to have. The original framing as new primary care infrastructure has perhaps led to some organisations regarding the new bodies as less relevant than the current evidence suggests.

5 PURPOSE, SCOPE AND FUTURE ROLE OF CMMH SERVICES

CMMH services need a contemporary statement of the scope of their role and relationships with the other parts of the health system that defines the way that policy is turned into action. Its current mandate was defined over 20 years ago in response to deinstitutionalisation. It needs modernising to meet the requirements of the 21st century and the current wave of mental health reform. This chapter sets out a contemporary statement of its purpose and scope.

The CMMH service system in Victoria is a major contributor to improved mental health outcomes but recognises the need to respond to the changing policy and funding environment. It recognises the need to more distinctly define its role and contribution in the broader service system and define a development agenda for the next five years.

The agenda outlined in this paper is designed to address the structural challenges facing the CMMH service system and to provide a framework for ongoing development.

The agenda proposed will:

- support the development of a robust service system with a commonality of purpose and provision of a more consistent suite of services
- build on the distinctive capacities of the sector to support ongoing performance improvement.

5.1 NEW DEFINITION OF PURPOSE

The CMMH service system is defined at the highest level by the legal status of the entities, non-government bodies and, at this stage, bodies which are not-for-profit.

More importantly, CMMH services are defined by their approach to and focus on service provision. It is proposed that the sector redefines its purpose to be:

> *Working with people who experience severe and persistent mental health issues to reduce the disadvantage and disability associated with mental illness and, in so doing, enhance the consumer's mental health and wellbeing and reduce demand for health, justice and welfare services.*

This means organisations that:

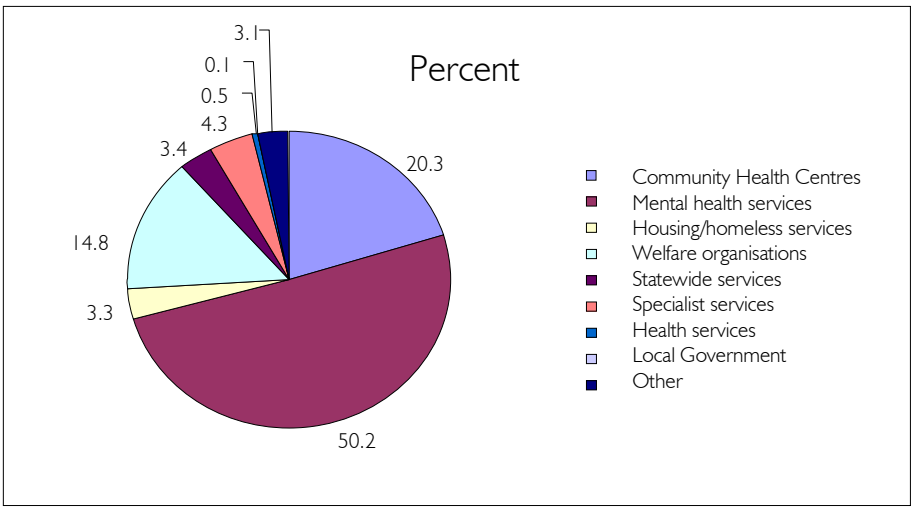
- are committed to provision of evidence informed, professionally delivered psychosocial, recovery and support services
- work with people facing serious mental health issues and engage with their families, carers and local communities to enhance wellbeing and life chances
- have proactive engagements with clinical service providers (public and private) that enable effective referrals and partnerships to support better mental health outcomes
- tackle social exclusion and work to enhance access to mainstream services.

This formulation of words focuses upon purpose and goals rather than upon activities. This is an inclusive definition, which means that numerous non-government bodies can 'sign-up' to contributing to their achievement. It is also an inclusive definition in that it:

- is silent on the issue of the age of clients with which CMMH services can work. This assumes that there are appropriate services and interventions for people of all ages that can be delivered through the CMMH service system
- enables prevention, early intervention and engagement in prevention, albeit through the lens of addressing the needs of people facing serious mental health issues.

There are distinct benefits derived from the diversity of auspice types currently involved in providing CMMH. The graph below demonstrates this diversity.

Figure 19 – PDRSS Funded Auspice Types[39]



[Mental health services refer to agencies that receive 100% of their State Government funding for psychosocial rehabilitation activity.]

[39] Source: Victorian Government Department of Health data (unpublished) provided on 18 August 2011, p 6

5.2 PRINCIPLES AND VALUES

A robust mental health system needs clear principles that underpin its operations.

The *National Mental Health Standards 2010* include a set of principles which are presented at Appendix B. VICSERV proposes that these principles inform future planning as outlined in this paper.

The Victorian Government's 'Framework for Recovery-Oriented Practice' includes numerous principles embedded in each of the nine domains identified. The *Victorian Government's Mental Health Reform Strategy 2009–2019* includes a broader suite of principles, which are reproduced at Appendix A.

VICSERV reaffirms the shared values of CMMH services which are based on existing commitments to:

- human rights
- consumer wellbeing
- consumer choice and control
- evidence informed practice
- innovation and development.

5.3 SCOPE

CMMH services play an important and distinctive role in a much broader suite of services, resources and family and friendship systems that support people in their recovery and mental wellbeing. The environment in which it operates is broadening its focus from being an agent of the public mental health system to being a provider of a distinct suite of recovery and support services in the emerging mental health market place.

It needs to more clearly articulate and market the suite of service offerings it provides to build a better public understanding of how its services can assist people with mental health challenges.

In addition, it needs to develop its interfaces and communications with other parts of the service system.

VICSERV understands that CMMH services need to work with public mental health clinical services, general practice and other primary care providers, private psychiatry, consumer and carer organisations and mainstream services to define the respective contributions of each part of the system moving forward. This section discusses the interface issues with some of these other parts of the health system.

5.3.1 Clinical services

Victoria has the most substantial CMMH service system in the country. In most cases the working relationships between clinical providers and community managed providers is strong and effective. The fact that over 42% of referrals come from clinical services is indicative of the interdependencies that exist between the two parts of the mental health system.

The *Victorian Mental Health Reform Strategy 2009–2019* articulated several commitments regarding the relationships between clinical services and CMMH services. The commitments include:

- more equal partners with specialist clinical services
- close coordination with clinical services, without losing its distinctive approach.[40]

The future CMMH service system's relationship with the clinical sector needs further refinement and development. Key elements of the new relationship would include:

- Rethinking the responsibilities for service management. A CMMH service system, operating under contemporary policy, program and funding arrangements could deliver a broader range of services.

  Consideration should be given to transferring responsibility for a range of CMMH services currently managed by public hospitals and health services. This would provide stronger and more integrated governance and service delivery arrangements.
- Services delivered in partnership. The current arrangements for the delivery of PARCS involve CMMH services as sub-contractors to clinical services. A partnership potentially led by CMMH services would be a productive way to capture the strengths and capabilities of both sectors.
- Clients transferred earlier because of confidence and resources in CMMH. The interfaces do not only operate at the systemic level. Many clients in need of active clinical services also require recovery and psychosocial services.

Well-structured and adequately resourced CMMH services could better meet client needs and contribute to demand management strategies in over-burdened clinical services.

5.3.2 General practice and primary care

People who experience mental illness often face other health issues and many experience premature death[41]. This has long been known, and CMMH services have sought to contribute to improving the general health status of their clients.

[40] Victorian Government (2009) *Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019*, p 59

[41] VICSERV (2008) *Pathways to Social Inclusion. Health inequality: policy and practice failures,* Melbourne

Some CMMH services are also part of the primary care service system and have structural as well as collaborative relationships with general practice.

The general practice and primary care service infrastructure has important and growing roles in supporting the wellbeing of people facing serious mental health issues. The Australian Government's Mental Health Initiative will contribute to an increased role for both general practice and primary care providers — not-for-profit as well as private providers.

CMMH services need to build their capacity and stronger partnerships as more primary care services engage productively with mental health issues.

Linkages with primary care providers and more specialist services involved in supporting people with alcohol and other drug issues are also important.

5.3.3 Informal support and services

CMMH services already have considerable engagement with families and carers. VICSERV currently works closely with consumer and carer mental health peaks.

Numerous reviews have highlighted the importance of family support to the wellbeing of their family member experiencing mental health issues and the stress this imposes on families. Reports also highlight the economic benefits derived from informal care. They also note the risks that demographic, economic and social changes pose to the future of informal care.

There are benefits that derive from increasing support for family-based or other informal care arrangements which justify increased and innovative engagements. CMMH services have both the skills and networks to make it possible to further develop its support for informal care arrangements.

Building more family-focused approaches should be a strong priority for CMMH services over the next decade.

5.3.4 Mainstream service providers

The evidence demonstrates that the mental health and wellbeing of people is fundamentally affected by the social and economic circumstances in which they live. Housing, employment, social networks and general health services, the key social determinants of health, all have effects. While mental health services also make a major contribution, these other matters are often more important.

The evidence also demonstrates that many of the so-called mainstream systems established to support people are not sufficiently responsive to the needs of people dealing with serious mental health issues.

CMMH services need to:

- be actively involved in advocacy for policy settings and implementation strategies that better meet the needs of this group of people
- engage with providers of housing, employment, health and justice services, in particular to support them in working effectively with this group. There are considerable opportunities through partnerships to reshape and better resource service provision.

5.3.5 Information provision

While information provision is not identified in the diagram at the beginning of this section, it is an important function and critical to a number of the interfaces.

The CMMH service system includes a strong, statewide network of organisations funded to provide MSSH to people experiencing mental and emotional challenges. A key role is the provision of information. These organisations utilise volunteers and paid staff that support others by sharing their own lived experience of mental illness and distress.

CMMH services need to:

- facilitate consolidation of the existing ad hoc and competing information strategies being pursued by organisations, given that in this case competition adds little value, confuses potential service users and is inefficient
- build strong relationships with providers outside CMMH and engage with the emerging telephone and electronic systems being developed
- efficiently utilise the information and education opportunities embedded in the Australian Government funding programs.

5.4 OUTCOMES

Commitment to outcomes should be a hallmark of CMMH in the future. Tangible evidence of their achievement will be a measure of success.

There is now widespread discussion about measuring outcomes in mental health. The *Victorian Mental Health Reform Strategy 2009–2019* includes a Mental Health Outcomes Framework[42]. The comprehensive framework is helpful but not the complete answer. It does not adequately identify how policy, interventions and services influence the lives and wellbeing of people affected by mental health issues.

Outputs that guide and then measure service delivery are needed for more rigorous quality control. The emphasis upon practice-based measures does not diminish the need for broader population outcome measures.

[42] Victorian Government (2009) *Because mental health matters: Victorian Mental Health Strategy 2009–2019*, p 25

There are reliable and robust instruments that work in a recovery environment, however, tools to measure individual recovery need further development.

The Australian Mental Health Outcomes and Classification Network (AMHOCN) was commissioned to undertake a review of recovery measures and reported to the Mental Health Information Strategy Subcommittee in 2010[43]. The report noted:

- the need for clarity regarding whether the goal is to measure recovery or the recovery orientation of the service
- that a common or consistent definition of recovery is a precondition of measurement
- there are several recovery instruments available and, while only minor modifications might be required, 'extensive' consultation will be required.

It also noted that further work is required to isolate the specific instrument or instruments which might best be used for this purpose, and the possibility that none is suitable should not be ruled out.[44]

Three high-level outcomes have been identified:

- Mental health status addressed. There is no purpose in sustaining a CMMH service system if it does not make substantial contributions to the mental health of its consumers. This is important even in a context where consumers are acknowledged to have responsibility for their own recovery journey and it is acknowledged that they will face periodic setbacks.
- Recovery support provided. This outcome relates to the need to demonstrate that the services/interventions provided make a tangible difference in the lives of clients, families and carers.
- Capacity to live well in the community. This outcome group relates to the effect that CMMH has on acceptance and inclusion.

Leadership of the work on outcome measures is already happening in the CMMH arena. The sector can continue to use its own knowledge and expertise and work collaboratively with others in Victoria and nationally on this issue.

[43] Burgess P, Pirkis J, Coombs T, Rosen A (2010) *Sharing Information to Improve Outcomes – Review of Recovery Measures,* Australian Mental Health Outcomes and Classification Network

[44] Ibid p 5

5.5 ACCOUNTABILITY

This paper reflects a strong commitment to accountability as a tenet of service reform.

The program constructs, output measures and funding frameworks provide the core structures on which accountability can be based. The paper has argued that all need to be updated and focussed upon outputs.

VICSERV supports the accountability requirements that funded organisations demonstrate that:

- they meet the *National Mental Health Standards 2010*
- they are maintaining their accreditation requirements through a rolling program of service review and evaluation.

6 KEY AREAS FOR REFORM

This chapter sets out key issues for a CMMH services development and reform agenda. It focuses on these key issues while acknowledging a broader range of issues. VICSERV considers that the reforms proposed are significant but needed to ensure a workable and sustainable basis for CMMH over the next decade. This chapter identifies required reforms. Chapter 7 details an action plan to address these reforms.

6.1 PROGRAM STRUCTURE

The existing State Government PDRSS program structure needs modernisation. A new structure is needed to guide change and prepare for the future.

CMMH needs a program framework that:

- enables a focus on not just inputs/activities but also on outputs and outcomes
- focuses on the individual rather than the program as the basis for determining service offerings
- provides a structure that supports meaningful measurement rather than throughputs.

HBOS services are a valuable start towards the program of the future. It is valuable because it focuses on the individual — but it is currently one program stream among eight.

VICSERV advocates that the Victorian Government should commit to the review and redevelopment of a new funding model and service structure and set a target for implementation within two years – that is by the end of 2013, prior to the trial of NDIS models in Victoria.

VICSERV commits to the processes for the development of this new program structure. It notes that program structure reform has been an important part of mental health reform overseas. As outlined in this paper, it has a developed body of thinking about the desired elements of a new program structure and wishes to work with the state government in collaboratively designing a contemporary program structure for mental health services in Victoria.

An example of a program structure that will help CMMH services to move towards individualisation and focus on the outputs follows at Figure 20.

Figure 20 - Service structure

Service Structure					
Relationship					
Developing trust, facilitating recovery and linking with services					
Service Level	Housing & Residential Services	Skills & Engagement	Family Strengthening	Inclusion & Acceptance	Information Provision
Intensive	Provision of or facilitated action to provide housing with support either on a stable or transitional basis	Interventions which enhance social & interpersonal skills & build life skills. Educational attainment & employment	Interventions which reduce stress & enhance family relationships	Interventions which address barriers & attitudes which limit opportunities for inclusion	Peer support & sharing of lived experience. Electronic, hard & telephonic resources
High					
Medium					
Low					
Outputs and outcome measures – to be determined					

The structure can be described as a hybrid. It blends an open hierarchy of need model with a group of specified output groups. This is proposed because the assessment frameworks required to support straightforward individual needs hierarchy are not developed and will take some time to develop. It is also proposed because CMMH services will need time to manage the transition to a fully individualised approach from the existing activity groupings.

All of the existing activity types identified at Figure 15 are encompassed by the service structure above. Specific attention must be paid to the needs of CALD communities and to Aboriginal and Torres Straits Islander people's distinctive needs and circumstances in the documentation of the service framework.

The introduction of a contemporary framework will also support organisations to incorporate services funded by the Commonwealth into their suite of offerings.

6.2 NDIS

It is anticipated that the NDIS will, in due course, move the system to a fully individually focussed framework based on level of need and then supported by standard assessment tools. VICSERV will be seeking commitment from the Victorian Government that mental health will be included in early planning and discussions. VICSERV and member organisations will seek to participate in the review and development of assessment tools.

6.3 AREA PLANNING

As outlined in this paper, considerable work has gone into improving the functioning of service systems across the state. These processes have been less successful than hoped. Key changes identified earlier were:

- the alignment of clinical boundaries for public mental health services, primary mental health and Medicare Locals. This reform needs to proceed as rapidly as possible
- mental health boundaries and other health service boundaries are directly aligned with or use subsets aligned with the recently agreed Medicare Local boundaries. The size of sub-areas should be aligned to reasonable catchments to optimise service system efficiencies
- streamlining of CMMH is acted upon, consistent with the agenda for development outlined in the next section of this paper.

New and more robust area planning processes are required if:

- an easier to use service system is to be introduced
- more rational service delivery arrangements are to be agreed.

These planning processes need to have authority and focus. Authority is required in order to drive change and focus to make sure that specific changes are achieved.

6.3.1 Planning issues

Three questions would inform such planning processes. They are:

1. Does the service area have the service mix and range it needs to respond appropriately to the needs of consumers, families and carers and to address the systemic exclusion that exists?

   This would include consideration of demographic trends in addition to dealing with existing population and demand issues. It would also deal with issues associated with defining the best places and cultures in which to deliver services.

2. What is required to ensure that the system is responsive in the emerging context?

   This question speaks to many issues for the system as it exists now and as it will operate if the NDIS is established. The planning process needs to review the system from pre-access through to final exit and understand the various entry points and pathways that will expedite access and simplify progress. No single model or logic is likely to be effective for all people in all areas.

3. What configuration of services is required to establish an effective system and a market that provides choice and capacity to meet changing expectations by consumers?

This question is critical to an informed process regarding planning and growth. The intent is that area planning processes develop an indicative rather than predictive view regarding the mix of generalist organisations (those able to support consumers, families and carers across a wide range of needs) and specialist or niche providers.

6.3.2 Planning process

Planning cannot only be about CMMH services. A substantial focus of the planning process does, however, need to be on the structure and arrangements that will address fragmentation and position CMMH providers for the future.

Definitive proposals as to structure and process are not possible at this time. Discussions with Medicare Locals and work to better align state boundaries are required.

The process needs to:

- focus on consumer outcomes and experience
- assume that significant improvement is required in an area until proven otherwise
- anticipate changes in referral patterns coming into the CMMH service system.

VICSERV acknowledges the considerable efforts that have been undertaken in the community managed, clinical services and primary health service systems. However, changes achieved have been incremental and not been able to address the scale of structural change required. As noted earlier in the report, the introduction of Medicare Locals and the new federal mental health funding initiatives will further exacerbate planning and coordination issues unless there is more timely and effective progress in addressing service planning and coordination issues.

VICSERV considers that a more rational approach to area-based CMMH services planning is a key building block for the future. It recognises the diversity of agencies and auspices involved and the complexity of reaching agreement about the required planning and authorising processes.

6.4 CAPABLE ORGANISATIONS

Helping CMMH services to build the organisational capabilities to deal with emerging demands and expectations is another key issue for reform. Building capable organisations which consumers, governments and partner providers can have confidence in to deliver quality recovery-oriented psychosocial services is a priority.

This section defines a specific set of capabilities that can be used by service providers to review their current capacities and identify areas for capacity building.

It provides a transparent logic that can:

- support CMMH services in leading their own organisational and service improvement efforts in a structured way
- be utilised to support growth and involvement of new providers as a result of growth.
- underpin the processes that will be required if the fragmentation of the service system is to be addressed.

A potential suite of capabilities and the rationale for their inclusion are outlined in the following table (Figure 21).

The starting point for the capability assessment is the *National Standards for Mental Health*. These standards deal with many of the content and organisational matters required to operate a quality mental health service.

Additional capability criteria, some of which overlap with the National Standards, have been selected on the basis that they will guide decisions specifically about the CMMH service system and its needs at this point, and because they target different or more specific criteria than the National Standards.

Figure 21 - Organisational capabilities

Capability	Rationale
Overarching	
The organisation meets the Mental Health Standards.	The standards should become a core accreditation requirement and therefore should be reflected in this capacity assessment.
The organisation's governance and leadership have the relevant skills and knowledge.	The National Standards do not adequately deal with the specific issues of governance competence. The CMMH service system needs to test benchmarks used in other industries.
Client service	
The organisation: • delivers a range of individually tailored services, and/or • provides a specialist/niche service, based on a defined recovery oriented logic	Organisations need to have the ability to deliver individualised and responsive packages using approaches that are informed by evidence. Alternatively, they need a clear and specialist role that complements and supplements the generalist providers.
The organisation has a clearly described business model and suite of products, which: • is consistently applied across the organisation • is informed by evidence.	This capability would require organisations to demonstrate the linkage between their service intentions, service design, program logic and structures.
Organisational robustness	
The organisation's capital base and financial resources are adequate to meet ongoing and contingency situations and to be self-reliant.	Future capability depends upon the robustness of both balance sheet and revenue streams.
The organisation has capacity to recruit and retain a workforce with appropriate psychosocial skills and knowledge.	The focus of this capability relates to the capacity of the organisation to sustain the kind of workforce required by the emerging service requirements.
The organisation's corporate support systems and processes are efficient and appropriate.	The organisations of the future will need technical and operational systems that support the future business models and demands.
Partnerships	
The organisation works with other organisations through partnerships and collaborations. This would include partnerships with governments, research organisations and other stakeholders.	Given the reform agenda and the significance of establishing rational and navigable service systems, this issue requires a higher profile and specific details regarding the organisation's arrangements and intent.

VICSERV considers that a capabilities framework needs to be developed to give guidance to CMMH services about the elements of capability that they need to build and be able to demonstrate. Such a capability framework should be part of the detailed implementation and monitoring of the National Mental Health Standards that flow through the accreditation systems that are formally recognised by government.

The organisational capabilities framework detailed in Figure 21 provides a basis for discussion and development within CMMH services. VICSERV is committed to further developing and refining this framework with its members and other CMMH services to begin to use it as a tool for organisational development. The capabilities provide a framework for cross-sectoral learning and development on organisational governance and service models for the new environment.

6.5 SERVICE RATIONALISATION

Earlier sections of this paper document the evidence that the CMMH service system is fragmented and that funding arrangements are hindering a more rational system configuration. It also demonstrates that there is a widely held view that this problem exists across the mental health service system broadly.

Significantly improved benefits to consumers can only be delivered through rationalisation of the service system, clarity of role and function and a more flexible service infrastructure equipped to deal with the emerging demands.

A more rational approach to service provision is required.

In this section of the paper strategies to reduce fragmentation are considered. The focus of discussion is upon the reform proposed and its implications. Issues related to workforce obligations and interests, industrial coverage, insurance and overhead cost management as well as the concerns and issues which clients, families and carers may have regarding change are acknowledged and will need to be addressed as part of this reform process.

VICSERV considers that there are a number of pathways to reform that need to be considered as part of a rationalisation debate. Figure 22 outlines the range of options that could be considered as the basis for the rationalisation of the CMMH service system. This debate will only be possible in the context of serious reform. A review of funding models and service guidelines will demonstrate that the Department of Health is serious about reform.

The options vary across a voluntary to mandated continuum. VICSERV is aware of the scale and complexity of such a process and considers that there needs to be major engagement of Boards and senior management in considering the options and discussing their feasibility and desirability. Stimulating conversations and debate about the future is a key element of the proposed reform agenda and processes and those that the Department of Health could impose. The options are:

6.5.1 Voluntary relinquishment

In this option the organisation would conclude that better outcomes for clients could be achieved by others with greater flexibility and scope to respond to current and future demands.

It is anticipated that large organisations with tiny or very small PDRSS allocations or small, non-specialist or niche organisations that are struggling in an operational sense will accept this opportunity.

6.5.2 Trade week

This option provides organisations with multiple service outlets to consider whether they are best placed to continue to deliver all of their current services. This option would be applied where organisations have services geographically or programmatically separated from other services, and where another organisation would have capacity to 'absorb' the funds and increase its capacity to customise services as a consequence. This may work both with swaps between organisations or as straight transfers, by agreement.

6.5.3 Voluntary pools

Voluntary pools provide willing organisations with a way to reduce fragmentation through collaborative action. A voluntary pool would be a cooperative venture at the operational level. The pool would create a shared resource from existing funds, which would gain effectiveness through consolidation.

In this option the organisations retain their current status but put in place arrangements that allow specific amounts of funding to be used for mutually agreed purposes. Pools could be created and managed in a number of ways:

- all funds transferred to one organisation
- joint assessment and care coordination with shared service delivery
- a funds holding and shared staffing model where the member organisations release staff to work in the pooled services.

Establishing the rules and managing the interfaces involved in such pools will raise important challenges. The benefits anticipated for consumer flexibility and efficiency will only be delivered if the pool is substantial and stable, and the administrative and professional processes are clearly defined.

6.5.4 Negotiated pools

Negotiated pools differ from voluntary pools in that they arise from an area-based negotiation rather than organisationally initiated change. The mechanisms for operating the pools would be the same as for voluntary pools.

6.5.5 Consortia

Consortia are a formal coming together of organisations with the new entity having formal status rather than the service delivery focussed collaborations involved in the pools options.

Consortia can involve organisations of differing size and role establishing a new legal relationship. In the context of this paper, consortia can be partnerships of equals or an integration of one's services into another's. Mergers have happened periodically in the CMMH service system and are common in other industries.

The establishment of a consortium is a more complex process than in the pooling options and therefore involves more substantial challenges to the organisations involved.

6.5.6 Planned reorganisation

This is a reform strategy that has the capacity to facilitate service improvement through realignment of activity rather than reduction of the number of organisations involved.

This option would enable organisations to reassess their service offering against the contemporary program structure proposed above and the evidence regarding needs and service effectiveness.

At its most extensive, all organisations could be invited to prepare a detailed plan for their CMMH services. This would focus on:

- providing evidence informed service models and specific rationales for any changes from the current service mix and allocations
- demonstrating the capabilities in the table outlined earlier
- demonstrating alignment with the plans and strategies in the geographic areas in which they work.

Reorganisation could also be done incrementally. This could be achieved by:

- asking organisations to identify specific reforms by program or service type
- conducting a rolling program across areas.

6.5.7 Resource efficiencies

This option relates not only to the normal shared services but also to a number of service improvement functions that can be organised and delivered jointly.

The potential benefits of sharing delivery of corporate services do not only accrue to small agencies. Governments, including the Victorian Government, are requiring departments and large statutory agencies to become part of shared service arrangements because of the efficiency benefits that can be delivered. A visible example is CenITex, a shared services agency established to centralise ICT support to government departments and agencies. Other functions that are regularly included in shared services operations include:

- the transactional aspects of human resource management processes
- the transactional aspects of financial management
- property management including fleet services
- procurement.

Shared service models are not a panacea. There are costs and benefits and they seem to work best where there is clear agreement that the parties have common expectations regarding service quality and availability.

A shared services approach is only likely to return a dividend if:

- it is itself business like and efficient. This would mean that the service would work on a cost recovery basis, charging for its services rather than on a fixed cost basis
- it has scale. There is little to be gained unless there is a substantial critical mass. This would mean one or more of the large organisations providing an 'anchor' function. This could be achieved by the organisation agreeing to participate or actually hosting the service
- organisations choosing to participate are able to accurately assess their current costs and service requirements. In the absence of accurate costings at the time of establishment, savings cannot be estimated. Organisations also need to have a clear understanding of their requirements so that a useful service level agreement, defining performance requirements, can be established.

There are a number of functions not normally defined as part of a shared services approach that can also be considered under the broad heading of resource efficiencies. Opportunities for generating such efficiencies include:

- increased use of shared learning and development options
- establishment of consolidated research and evaluation functions
- collaborative information service provision rather than the current independent and sometimes duplicated arrangements.

6.5.8 Mandatory restructuring

Governments have the right to change provider arrangements at the end of a contract period. The mandatory nature of the process means that it can contribute to rationalisation and the generation of new entrants into the service system.

The actual and embedded costs in the transition are substantial. This has been demonstrated with the changes to the national employment service contracts. It is not in the clients', workforce's or the public's interest for this to happen frequently or without clear evidence of the benefits that would be derived, given the disruption caused.

A mandatory restructure would not necessarily lead to current providers being displaced. Current providers start with the advantage of incumbency and knowledge of what is required. A fresh start may provide organisations with a chance to reframe locked-in services.

A targeted approach to mandatory restructuring may be necessary if the voluntary options outlined fail to achieve sufficient success.

Figure 22 - Service delivery reform options

	Option	Description		Application of the building blocks
Voluntary Options	Simplification	Trade week	Funded organisations would be invited to consider options to shift responsibility for specific services to another auspice organisation. This option would enable more rational and consolidated services where idiosyncratic outcomes from history or tendering processes have arisen.	Trades would only be approved if the change is consistent with the area plan and the receiving organisation demonstrates it meets the capability criteria and would utilise the resources consistent with the new framework.
		Voluntary relinquishment	This would involve all organisations with small PDRSS budgets (less than $500,000) being invited to consider relinquishing their funding. VICSERV and the Department of Health have a role to play. The capacity to meet with and engage Boards to discuss the issues of capability and implications of any possible relinquishments is vital.	Relinquished funds would be put into a pool and subsequently reallocated through agreed processes that utilise the area plan and apply the funds to contemporary purposes through organisations that demonstrate that they meet the criteria.
	Flexibility	Voluntary pools	Organisations would be encouraged to create a shared pool of funds with others.	Voluntary pools at either the area or state level would only be approved where the source is agreed, as part of a plan and where any 'reinvestment strategy' is consistent with the framework and through capable organisations.

		Negotiated pools	Organisations could agree to release an amount of funds or a component of their funding as a result of area service system planning processes. The reapplication of these funds would be determined by the area process rather than decisions of organisations as proposed in the voluntary pooling proposal.	Pools created through an area negotiated process are reinvested through agreed means and consistent with the building blocks.
	Restructure	Consortium	Organisations would be invited to either merge or create formal partnerships that build budget and organisational capacity. This would be as part of an active campaign of consolidation, not an *ad-hoc* response to organisational failure.	The establishment of a consortium or partnership can only be approved if the combination meets the criteria.
		Planned reorganisation	Organisations would be required to prepare a plan of their preferred service mix and allocation using the new program guidelines as a tool. A key goal in this process would be to promote increased use of HBOS. This process could apply to the total PDRSS budget held by the organisation or to selected amounts (20%) or program components.	All organisations use each of the building blocks in preparing their proposals.
		Resource efficiencies	Establishment of shared services, learning and development and other collaborative ventures which deliver organisational efficiency benefits.	The 'host' for the administrative mechanism demonstrates that it meets the relevant organisational capability requirements and that there are actual efficiencies for the partners being reinvested in service delivery.

Mandatory Options	Mandatory Restructure		This would involve the government advising organisations that their funding approvals will finish at the end of the current service agreement and the funds will be retendered. This could be applied to: • all organisations • organisations with PDRSS budgets of less than $300k • a percentage of all organisations budget • specific service types.	The Department uses each of the building blocks in reinvesting the funds released.

6.5.9 Summary

VICSERV considers that reducing fragmentation in the CMMH service system is desirable and inevitable. This paper has outlined a series of options for reform to illustrate the range of voluntary as well as mandated strategies to achieve this. As the industry body, it is aware that a number of VICSERV members are considering these issues and thinking about their futures. This section of the paper will be a useful resource for Boards of Management and staff.

Many of the options can be applied simultaneously. Some of the options will work for a number of organisations. The reform process needs to be open to utilising the change mechanisms that work effectively and meet the process criteria outlined earlier.

Many of the options can be advanced through an active collaboration within the CMMH service system. This is a fundamentally important part of the agenda.

All of the change options outlined in Figure 22 require clear authorisation from Boards and the Department of Health as the funding body.

Community service organisations are routinely required to make important strategic decisions regarding the future directions and priorities of their organisations. For those in CMMH, this is one of those times. Change is coming. Addressing the current fragmentation is a vital part of preparing for growth and enhancing CMMH providers' capability to deliver outcomes to people in need.

There is also a certain 'spirit' that drives many community sector organisations: a commitment to the best outcomes for consumers. The processes that support organisations considering their future role in CMMH will need to be sensitive to these varying motivations.

However, these are not easy decisions to make. Workforce, systems, reputation and status are all affected. In many organisations there are passionate people who have made considerable efforts to develop services.

While the organisations that make up the CMMH service system did not cause the fragmentation issue, they can act to reduce it, if not resolve it. For many organisations this requires an objective analysis of the balance of public good and organisational interest.

6.6 NAMING OF SERVICES

The current name of CMMH services, Psychiatric Disability Rehabilitation and Support Services (PDRSS) reflects an historical perspective on the purpose and role of services. Also, it is not easily understood by the general public or other service providers. It is not consistent with national trends where mental health services focus on recovery and increasing social inclusion are referred by the use of the term 'community' to distinguish them from the clinical services that are largely auspiced by hospital networks.

Therefore, VICSERV proposes that the term 'community managed mental health' and/or 'community-based services' be used to replace the term 'Psychiatric Disability Rehabilitation Support Services (PDRSS)' and that the Victorian Department of Health cease using the term PDRSS as a name for its funding stream.

VICSERV also proposes that it work with the Department of Health to consult with services to identify a name that describes the 'sector' and its contemporary role and purpose as outlined in Section 5. As a result, VICSERV, as the peak body, will be renamed.

6.7 ACCESS TO HOUSING

In 2009 VICSERV released a series of linked papers that presented evidence of the social exclusion experienced by people with a mental illness and a series of propositions for increasing social inclusion. The paper on housing called for the following initiatives:

- introduce housing policy and options with an explicit focus on people recovering from severe mental illness
- scalable, flexible models of housing-linked support
- economic modelling of costs/benefits of stable housing
- address the critical issue of ageing carers and housing risks.

While there has been some progress on this issue over the past two years, recent investments in social housing have been inadequate to meet the needs of this highly vulnerable group.

> *… This research has shown supported housing, when compared to treatment as usual in the community that does not include housing, to achieve greater improvements in housing stability, housing choice and control, employment, social networks and subjective quality of life as well as decreases in hospitalisation, psychiatric symptoms and substance use for people with serious mental illness.*[45]

VICSERV reasserts the critical importance of increasing housing options for people with serious mental health issues. It is committed to increasing its advocacy on social housing for people with

[45] Nelson G, Aubry T, Hutchison J (2010) *International Encyclopaedia of Rehabilitation, Housing and Mental Health*, p 6

serious mental health issues and supporting the development of housing and support initiatives in Victoria. There is a need for a more integrated approach to housing and support for people with serious mental illnesses in Victoria.

The Australian Government's Mental Health Initiative includes a partnership component whereby the Australian Government will match funding with states and territories for reform. One of the identified priorities for this fund pool relates to mental health housing. The Victorian Government should consider whether existing resources, both capital and recurrent, could be used to attract the Commonwealth funding and then influence reform.

6.8 FUTURE SYSTEM PLANNING

The reforms and the new service initiatives proposed in this paper will make a significant and lasting difference to CMMH services' influence on consumers, families, carers and the community. The reforms will only go part of the way to positioning the service system for the long-term future outlined.

The NDIS, if approved by governments, will have a transformational effect on service systems and provisions. The sensible position for the Victorian CMMH service system to adopt is to assume that the NDIS will be implemented and to plan accordingly.

Organisations will have to adapt to a very different operating environment if the NDIS is introduced. Early planning will assist that transition.

Proactive planning is also important to the design and operation of the scheme. Advocates for the scheme were primarily focussed on the needs of people with physical and intellectual disabilities. It is telling that the Productivity Commission, in releasing its draft report in February 2011, specifically asked for feedback on whether mental health should be included in the scheme and if so, on what terms.

People with a mental illness have distinctive needs that must be recognised in the design of the scheme. The Victorian CMMH service system has a unique capacity to inform the thinking and planning from a mental health recovery perspective. This comes about because of the size and robustness of the CMMH service system in this state. Active engagement will benefit members.

The Victorian Government has demonstrated its commitment to the NDIS by establishing an Implementation Task Force. This provides a valuable opportunity to work collaboratively with the Victorian Government to ensure that mental health perspectives are brought to bear on the scheme's planning.

It is proposed that CMMH services, via VICSERV, begin working on a number of planning projects. The focus of the projects is to ensure that the sector is positioned to contribute to and act upon the key elements of the NDIS.

COAG agreed to progress quickly the measures agreed as part of the National Disability Agreement that have also been identified as foundation reforms for a National Disability Insurance Scheme, including development of a national assessment framework; nationally consistent service and quality standards for the disability services sector; and a comprehensive national disability services workforce strategy.[46]

The goal is not to duplicate work that will be done around the nation, but to:

- ensure there is well informed thinking about the particular needs of people facing serious mental health issues included in the working structures of governments
- ensure that CMMH organisations are well informed and therefore able to plan their futures.

6.8.1 Assessment framework

There has been little investment within Australia in the development or refinement of assessment tools that provide a rounded picture of individual's needs across a range of support types.[47]

This quote from the Productivity Commission demonstrates the importance of CMMH services' engagement in the development of assessment tools and processes.

The potential tools identified by the Commission primarily focus on disabilities rather than psychosocial disabilities. The Commission, however, sets some ground rules by acknowledging:

- the importance of assessments recognising the 'aspirations' of the consumer
- that the assessment process is an intervention that can contribute to the wellbeing of the person involved.

It is proposed that CMMH services, in consultation with governments:

- review the six tools identified by the Commission for relevance and appropriateness to those with psychosocial disability and explore other potential tools
- utilise existing services to test potential tools in practical situations
- develop models for and approaches to working with independent assessors. This would include skills and capabilities as well as approaches.

[46] COAG Communiqué 19 August 2011, p 4

[47] Productivity Commission (2011) *Disability Care and Support*, *Productivity Commission Inquiry Report* No. 54, Canberra, p 320

6.8.2 Information technology

The reform and development strategy can only be fully implemented if supported by contemporary information management systems.

Client information, performance reporting and, particularly, financial reporting will need to change and be enhanced. The Victorian Government has begun but has not advanced the development of a new mental health data system; work on such a system is now urgently required.

The introduction of new assessment processes and efficient pricing mechanisms will be contingent on improved client, activity and costing data and cannot be achieved using the existing mix of electronic systems and classification structures that exist in the current CMMH service system.

This is a priority and will involve detailed planning and substantial engagement, as well as end cost.

6.9 RESOURCING THE CHANGE PROCESS

VICSERV is in a strong position to support and assist its members and other CMMH service providers in responding to the reform agenda outlined in this paper. In releasing this paper VICSERV reasserts its commitment to work tirelessly with its members and the Victorian Government to contribute to real reform and development.

VICSERV is a strong industry body that has represented CMMH services in Victoria at a state and national level for over 25 years. It has a high level of engagement with services and is well respected for its policy and training work with, and on behalf of, services. It has the potential to play a major leadership role in the proposed reform process if resourced to do so.

VICSERV operates in four key areas:

1. Providing policy advice and representing CMMH services
2. Information sharing and communication
3. Service development and sector support
4. Education and development of the CMMH and community sector workforce.

Figure 23 - Key areas of operation

The program of activities outlined in this paper is consistent with VICSERV's role and function as a peak body.

Plans are only productive if they can be implemented. The agenda outlined involves a major commitment — of leadership, resources, time and money.

There are limited resources and capabilities within the sector now. This is not to suggest that there is not substantial skill and knowledge that can be brought to bear, or that the organisations involved do not have access to some resources that can be applied.

Given the existing service delivery demands and the internal change management challenges required, it would be unrealistic to expect that either a large body of people or funding can be released.

Change of the scale needed requires resourcing, VICSERV believes that the investment in new services needs to be accompanied by investment in system coordination and integration if resource efficiencies are to be achieved. VICSERV will be requesting an increase in the core funding it receives from the Victorian Government. It will also be seeking funds to engage community managed CMMH services and other sectors in this agenda for change.

The following section includes an action plan to take forward the service reform agenda.

7 ACTION PLAN FOR REPOSITIONING THE COMMUNITY MANAGED MENTAL HEALTH SERVICE SYSTEM

7.1 OVERVIEW

An agenda for the future provides a framework for CMMH in Victoria. It also offers a challenging and multi-faceted change agenda.

The agenda is designed to reposition CMMH services and, in so doing, establish:

- a robust CMMH service system with an independent and shared identity recognised for the value it provides to consumers and its ability to work collaboratively with other providers
- the leadership and structures to deliver effective and flexible services while also engaging with governments on policy, strategy and regulatory directions.

The agenda indicates VICSERV's willingness to take an expanded leadership role in addressing issues and in guiding the development of a service system capable of meeting the challenges of the future. For VICSERV to achieve some of the aspirations of this report, it will require member support and acknowledgement by the Victorian Government of the reform agenda. There are many opportunities but also risks. The major risk is inaction on the big reforms and system changes.

The Productivity Commission's report on the NDIS recognises the importance of supporting and resourcing significant change:

> *Given the magnitude of the proposed changes, it will be important for the NDIS to provide adequate support to both people with disability, and to specialist providers, as they adjust to the new system*[48].

There are many reasons why governments should support the agenda and the action plan proposed. The benefits of doing so include:

- improved outcomes for consumers, families and carers
- efficiencies that can be invested in responding to demand
- reduced costs in clinical and other publicly funded services systems, such as the justice and health systems.

7.2 PRIORITIES

A broad program of work is required if the changes are to be delivered in a timely way.

[48] Productivity Commission (2011) *Disability Care and Support, Productivity Commission Inquiry Report* No. 54, p 474

7.2.1 System design — a new program framework

The preparation of a new program framework is fundamental to service improvement. VICSERV advocates that the Victorian Government should commit to the immediate review and redevelopment of a new funding model and service structure. This should include the current arrangements for the delivery of PARCS and Community Care Units (CCUs).

The framework presented in high-level form in this paper is designed to assist progress towards a fully individualised hierarchy. The framework seeks to ensure that existing activities, whether Day Programs, MSSH, respite services or residential programs, are included. It does, however, seek to reframe these in the context of individual service need. It is also intended to support changes in the mix and range of services, not simply to upgrade the documentation and maintain the status quo.

The framework as outlined in this paper will need:

- refinement after consultation
- elaboration in guidelines that enables service reform and practice improvement
- development of measures that inform performance reporting requirements
- alignment with funding requirements.

7.2.2 ICT Infrastructure

The priority infrastructure requirement relates to ICT development. CMMH organisations cannot meet the requirements for performance reporting discussed, and the introduction of new assessment and efficient pricing mechanisms will depend upon the availability of consistent and comparable data.

The Victorian Department of Health should lead this work with sectoral engagement and in consultation with other governments, given the medium-term national implications. VICSERV recommends that the Department of Health advances work on the development of a new mental health data system. This will enable the collection of more comprehensive client information and service information (including services not funded by the Victorian Government), performance and financial reporting.

7.2.3 Individual packages trial

The existing investment and knowledge embedded in the HBOS program provides a valuable base for developing expanded and improved approaches. Trials are underway in IHBOS and SECU Diversion and the learnings from these will be important for the future. A controlled trial, led by the Department of Health working specifically with people facing serious mental health challenges that introduces some of the additional features of individualisation would assist CMMH providers now and into the future.

The purpose of this initiative is to ensure that Victoria is at the forefront of national planning for individual packages to meet individual needs in the context of both the Australian Government Mental Health Initiative and the NDIS.

7.2.4 Area planning

VICSERV advocates that the Victorian Department of Health should commission a project to trial local area planning with the aim of achieving a configuration of local CMMH services that improves navigation for consumers, carers, CMMH workers and the broader service system, to match service offerings to identified needs and ensure that the service system is responsive in the emerging context of the introduction of more individualised services and the NDIS.

Area planning will need a significant investment of effort and resources. This investment will be in developing a process which:

- is rigorous
- engages stakeholders
- does not overload the service system.

7.2.5 Building stronger organisations for the future

Community managed mental health services are at a crossroads. Service providers recognise the need for service reform at the same time as they are experiencing significant and sustained growth in funding. *An agenda for the future* proposes a strategy for building stronger mental health services that addresses these two significant challenges. It outlines a roadmap for achieving the required change in an effective and orderly manner over the next 5 years.

In the medium to long term the reforms proposed in this paper and those flagged by the government will lead to a vastly improved CMMH service system for consumers, families and carers. A more efficient and rationalised service system will inspire confidence in funding bodies and lead to increased resources to meet demand.

VICSERV will seek funding to participate in the range of reform activities outlined in this paper and to undertake defined projects with CMMH services. Of particular importance is the development and implementation of an organisational capabilities framework.

VICSERV will also seek an increase in its core funding for statewide support and training in line with the growing size and complexity of the CMMH service system and workforce and with its own and the governments' ambitions for the future development of these services.

7.2.6 Governance

Changes in service funding and new models of service delivery will require new approaches to governance. A significant review of governance arrangements, and support to enable new approaches, is needed to enable future development of CMMH services.

The Department of Health, agencies and VICSERV have a role to play in clarifying and strengthening governance of the CMMH service system.

VICSERV advocates for a program of governance activities and projects, which clearly articulates the role of various stakeholders and identifies appropriate funding to support the process of change.

7.2.7 Ambassador

A program of works as proposed will require public conversations about ideas in this paper, listening to the views of consumers, carers and service providers and attending to media interest in this reform process.

VICSERV considers that the appointment of an Ambassador to CMMH would assist the more technical aspects of the proposed reform agenda.

The Ambassador could also ensure representation of CMMH at high level strategic committees such as the Mental Health Reform Council.

VICSERV will seek the support of the Victorian Minister for Mental Health to identify and appoint an independent person to act as an Ambassador for Community Managed Mental Health across and within the CMMH service system and at a state and national level as required.

Critical to the success of this role will be suitable funding and a clear authorising environment.

7.2.8 Evaluation

The changes proposed in this paper are significant and a modest investment in evaluation will ensure that learnings can be systematically drawn out as the work proceeds. Evaluation will also inform change in other parts of the mental health system and jurisdictions.

7.3 SUMMARY OF RECOMMENDATIONS

1. That the Department of Health develops a new program structure for CMMH services including:
    - reviews of all CMMH program guidelines and funding models (HBOS, Day Programs, Youth and Adult Residential Rehabilitation Services, Supported Accommodation, MSSH and Planned Respite)
    - a new name to refer to PDRS services and funding stream. VICSERV believes the term 'community managed (and/or based) mental health services' better reflects these services' governance arrangements and aligns with national trends. It will also be important to identify a name which reflects the purpose and function of these services.
    - a new mental health data system to enable the collection of more comprehensive client information and service information (including services not funded by the Victorian Government), performance and financial reporting.

2. That the Department of Health commissions a Local Area Planning project focussed on CMMH services to be staged over three years.

3. That the Department of Health develops an individual packages trial to ensure Victoria is well placed to implement this model in the context of both the Australian Government Mental Health Initiative and the NDIS. The work should build on IHBOS and SECU Diversion trials.

4. That VICSERV is funded to undertake a range of projects and activities with CMMH services designed to build stronger, more capable service provider organisations.

5. That the Department of Health reviews VICSERV's core funding to ensure VICSERV can adequately respond to the growth and increased demand for state-wide support and workforce training and development.

6. That the Victorian Minister for Mental Health and VICSERV collaborate to identify and appoint an independent person who can act as an Ambassador for CMMH across the CMMH service system and the wider service system at a state and national level as required.

7. That VICSERV, in collaboration with the Department of Health, consult with service providers, consumers and carers to identify a new term to replace PDRSS, that describes the role and purpose of services and that better describes organisational arrangements.

8 CONCLUSION

This paper has demonstrated that CMMH plays an important role in the lives of many consumers, carers and families. It helps people deal with the direct consequences of mental illness and to address the social and economic disadvantages that are often associated. CMMH services in Victoria have led on many important reforms.

CMMH services are entering a new phase in their history. Mental health and CMMH in particular are high on governments' agendas. This has been backed up by significant funding commitments and policy. This will change the leadership dynamic, governance processes and funding. CMMH services will be challenged to develop more sophisticated and diverse relationships and partnerships in order to prosper and make a leadership contribution.

The NDIS will be transformational if it is introduced. It has the potential to almost double the size of the CMMH service system, it will also embed fundamentally different drivers, systems and accountabilities. The sector will be an industry in its own right and part of a new national enterprise.

This paper outlines an agenda for a fundamental reform to the current CMMH service system. It proposes a series of actions to develop a new service system from the top down and the bottom up. The existing program structure, the configuration of CMMH providers in specific areas, the fragmentation that is caused by too many agencies receiving too small allocations and organisational capability are all targeted for transformation.

Transformation will require CMMH services' leadership from their peak body and high levels of organisational maturity. They will also require extensive bureaucratic and government engagement as they seek funding and support to implement the actions outlined in this paper. VICSERV believes that the benefits to people affected by mental illness as a result of this reform will amount to a significant return on investment.

The agenda for change outlined in this paper requires bold and decisive action from leaders across the CMMH service system and governments. The time to act is now!

ABBREVIATIONS USED IN THIS REPORT

ABF	Activity Based Funding
CALD	Culturally and Linguistically Diverse
CCU	Community Care Unit
CMMH	Community Managed Mental Health
CMMH service system	Community Managed Mental Health Services referred to collectively
CSO	Community Service Organisation
HBOS	Home Based Outreach Support
ICT	Information and Communication Technology
IHBOS	Intensive Home Based Outreach Support
MSSH	Mutual Support and Self Help
NDIS	National Disability Insurance Scheme
NFP	Not for Profit
NDIS	National Disability Insurance Scheme
PARC/S	Prevention and Recovery Care / Services
PDRSS	Psychiatric Disability Rehabilitation Support Services
PDRSS	Psychiatric Disability Rehabilitation Support Services referred to collectively
SECU	Secure Extended Care Units

TERMINOLOGY USED IN THIS REPORT

Community managed mental health (CMMH) services are those services funded by the Victorian Government Department of Health under the Psychiatric Disability Rehabilitation and Support Services (PDRSS) funding stream. They have been referred to as PDRSS or collectively as the PDRSS sector. They may also provide Commonwealth mental health services and other health and community services.

Use of the title of a funding stream does not accurately reflect the broad range of funding sources that many agencies access to deliver mental health services. Nor does it reflect the distinctive governance structure of the services which are run by voluntary Committees of Management to provide recovery-based services to voluntary clients in their own homes or as close to them as possible. The terms PDRS and psychosocial disability rehabilitation support services are not immediately meaningful to consumers and carers in the context of the services they receive. VICSERV will now use the term 'community managed (and/or based) mental health' rather than PDRSS. This will also provide consistency with the nomenclature of similar services across Australia.

Where PDRSS is used in this report it is to identify the specific financial contribution made to community managed mental health agencies by the Victorian State Government. PDRSS funded programs include: Mutual Support and Self Help (MSSH), Home Based Outreach Support (HBOS) and Intensive HBOS, Planned Respite, Psychosocial Day Programs, Residential Rehabilitation, Supported Accommodation and Prevention and Recovery Care (PARC) services.

Clinical services or the clinical sector refers to the part of the Victorian specialist mental health service that is managed by public hospitals. They provide assessment, diagnosis, treatment, clinical case management, inpatient care and a range of residential and community-based options. CMMH services work closely with clinical services.

TABLE OF FIGURES

APPENDIX A: THE VICTORIAN GOVERNMENT'S MENTAL HEALTH REFORM STRATEGY – 2009-2019

Psychiatric Disability Rehabilitation Support Services

The Psychiatric Disability Rehabilitation Support Services (PDRSS) sector operates under a broad recovery framework, adopting a whole-of-person approach and a model of care that stresses the importance of social factors in mental health and wellbeing. The sector is governed by NGOs and other community agencies and funded to deliver a range of community-based services.

We expect that over coming years this sector will consolidate its role and become a more equal partner with specialist clinical services in the overall system of mental health care, and a central part of the social inclusion thrust of reform. Over time, this will require capacity building and changes to staffing profiles. As a result of these changes and other factors, the name PDRSS may no longer be adequate —a new name emphasising psychosocial recovery might be more suitable.

The strategy signals the need for the PDRSS sector to be more closely coordinated with clinical services, without losing its distinctive approach. This will be assisted by joint planning, professional training and development, and shared management of some activities.

The sector will be supported and encouraged to build on the strength in its diversity and local focus, while working to become less fragmented and clearer about the scope of its activities. A sound evidence base should underpin effective psychosocial support and sector development.

The sector is well placed to play stronger roles in a wider range of psychosocial and intermediate 'step-down' care (both bed based and outreach), and in care coordination for consumers needing sustained care and support. There are also opportunities for the PDRSS sector to be more active at the 'front end' of the care pathway, delivering early interventions that help avoid the need for acute services.

APPENDIX B: NATIONAL MENTAL HEALTH STANDARDS 2010 —PRINCIPLES OF RECOVERY ORIENTED MENTAL HEALTH PRACTICE

The purpose of principles of recovery oriented mental health practice is to ensure that mental health services are being delivered in a way that supports the recovery of mental health consumers.

1. Uniqueness of the individual

   Recovery oriented mental health practice:

   - recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community
   - accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life
   - empowers individuals so they recognise that they are at the centre of the care they receive.

2. Real choices

   Recovery oriented mental health practice:

   - supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored
   - supports individuals to build on their strengths and take as much responsibility for their lives as they can at any given time
   - ensures that there is a balance between duty of care and support for individuals to take positive risks and make the most of new opportunities.

3. Attitudes and rights

   Recovery oriented mental health practice:

   - involves listening to, learning from and acting upon communications from the individuals and their carers about what is important to each individual
   - promotes and protects individual's legal, citizenship and human rights
   - supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to the individual
   - instils hope in an individual's future and ability to live a meaningful life.

4. Dignity and respect

   Recovery oriented mental health practice:

   - consists of being courteous, respectful and honest in all interactions
   - involves sensitivity and respect for each individual, particularly for their values, beliefs and culture
   - challenges discrimination and stigma wherever it exists within our own services or the broader community.

5. Partnership and communication

   Recovery oriented mental health practice:

   - acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them
   - values the importance of sharing relevant information and the need to communicate clearly to enable effective engagement
   - involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations.

6. Evaluating recovery

   Recovery oriented mental health practice:

   - ensures and enables continuous evaluation of recovery-based practice at several levels
   - [ensures] individuals and their carers can track their own progress
   - [enables] services [to] demonstrate that they use the individual's experiences of care to inform quality improvement activities
   - [ensures] the mental health system reports on key outcomes that indicate recovery including (but not limited to) housing, employment, education and social and family relationships as well as health and wellbeing measures.

These recovery principles have been adapted from the Hertfordshire Partnership NHS Foundation Trust Recovery Principles in the UK.

APPENDIX C: VICTORIAN MENTAL HEALTH REFORM STRATEGY 2009–2019 PRINCIPLES FOR REFORM

Guiding principles for reform

Consumer-centred service provision

Recognising that the interests and preferences of consumers should inform all aspects of service development and delivery, addressing the full range of needs that contribute to a person's long-term overall health and wellbeing. The aim is an equal and active partnership between consumers and professionals based on rights and responsibilities, respect and empowerment.

Family and carer inclusion

Involving carers and family members in care planning and delivery, respecting their lived experience, knowledge and the care they provide, and responding to their increased vulnerability as a result of their caring role.

Population-based planning

Planning services on the basis of the needs of, and affects, the whole community (and defined sub-groups), and across the spectrum of severity. This approach will help ensure that effort is invested where the greatest benefits can be realised, while maintaining a clear focus on those with the most intense and urgent needs for support.

Social model of health

Acknowledging that mental wellbeing is determined by social and psychosocial as well as biological and medical factors. This suggests a greater focus on risk and protective factors such as housing, employment, socio-economic status, education, and family and peer relationships, together with the effect of trauma, stigma and discrimination.

Equity and responsiveness to diversity

Recognising that social and economic disadvantage and discrimination can contribute to and exacerbate mental health issues and hinder recovery; and that the diversity of the Victorian community requires a range of approaches and supports focused on rurality, ethnicity, Aboriginality, gender and sexuality.

Evidence-based practice

Developing responses based on identified client needs and the best available evidence on effectiveness through research and evaluation to inform practice knowledge, ensuring that the system can respond rapidly to new knowledge when it becomes available.

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