Review of the PDRSS Day Program, Adult Residential Rehabilitation and Youth Residential Rehabilitation Services

For the Victorian Department of Health

April 2011

If you would like to receive this publication in an accessible format, please phone 9096 8214 using the National Relay Service 13 36 77 if required, or email: frances.jacovou@health.vic.gov.au

This document is also available in PDF format on the internet at: www.health.vic.gov.au/mentalhealth/reformstrategy/

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

Contents

Glossary

Term	Definition
AMHS	Adult Mental Health Service
AoD	Alcohol and other Drugs
ARR	Adult Residential Rehabilitation
CALD	Cultural and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Service
CCUs	Community Care Units
CRSS	Community Recovery and Support Services
CSDA	Commonwealth/State Disability Agreement
D2DL	Support for Day to Day Living in the Community Program (Commonwealth)
Dual diagnosis	The comorbid condition of a person with a mental illness and a concurrent substance abuse problem
HASI	Housing and Accommodation Support Initiative (NSW)
HASP	Housing and Support Program (Vic)
HBOS	Home-Based Outreach Support
MACNI	Multiple and Complex Needs Initiative
MSSH	Mutual Support and Self-Help
PARC	Prevention and Recovery Care
PDRSS	Psychiatric Disability and Rehabilitation Support Service
PHaMs	Personal Helpers and Mentors
SAS	Supported Accommodation Services
SECUs	Secure and Extended Care Units

Term	Definition
SRS	Supported Residential Services
VICSERV	Psychiatric Disability Services of Victoria; the peak body for PDRSS providers
YRR	Youth Residential Rehabilitation
AMHS	Adult Mental Health Service
AoD	Alcohol and other Drugs
ARR	Adult Residential Rehabilitation

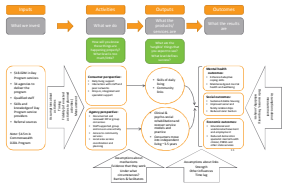
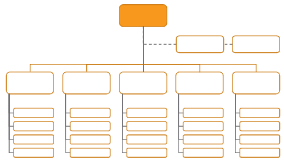
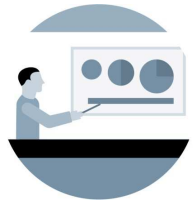
1 Executive summary

Change Psychiatric Disability Rehabilitation and Support Service (PDRSS) Youth Residential Rehabilitation (YRR), Adult Residential Rehabilitation (ARR) and Day Programs to focus on goal-orientated, evidenced-based recovery programs with stronger accountability to and oversight by the State Government. This change will be challenging and require choices but the PDRSS sector is ready. Mass engagement with the sector in the implementation will resolve service design challenges and improve the performance results of these programs.

1.1 Background

The Nous Group (Nous) was contracted by the Department of Health to conduct strategic reviews of the Psychiatric Disability Rehabilitation and Support Service's Youth Residential Rehabilitation, Adult Residential Rehabilitation and Day Programs. The Nous review will inform the Department's Psychosocial Rehabilitation and Recovery Plan. The former Government's blueprint for Victoria's mental health reforms, *Because Mental Health Matters*, emphasised the importance of the PDRSS in the recovery of people with a severe and enduring mental illness. The newly elected Government's mental health policy statement is consistent with this blueprint. The process undertaken by Nous to conduct these strategic reviews is summarised in Figure 1.

Figure 1: Nous approach

1. Developed program logic models	2. Engaged and analysed	3. Explored reform options	4. Provided recommendations
			
Developed program logic models that articulated the assumptions and logic for the PDRSS, ARR, YRR and Day Programs to: • Specify lines of enquiry • Focus the set of review questions • Determine the appropriate assessment approach • Agree on primary data source.	**Gathered an evidence base through:** • Engagement of over 30 stakeholders and three reference groups • Review of more than 100 policy documents and academic reviews • Analysis of 2010 PDRSS Census data, 2009-10 Quarterly Data Collection (QDC) and the PDRSS SWOT analysis report.	**Explored reform options for each of the ARR, YRR and Day Programs and assessed these against three tests for good public policy:** • Substantively valuable • Legitimate and politically sustainable • Operationally and administratively feasible.	**Synthesised findings and recommendations to:** • Inform the future development of the Psychosocial Rehabilitation and Recovery Reform and Development Plan • Ensure lasting change in PDRSS ARR, YRR and Day Programs, processes and people as the recommendations are implemented.

1.2 Current program situation

Since the late 1990s, the Government's $30.87 million investment in the three PDRSS programs (ARR, YRR and Day Programs) has remained steady. This investment has provided psychosocial services for people with a severe and enduring mental illness but has not achieved the recovery outcomes desired for these consumers.

Table 1 outlines an assessment of the performance of the three programs against long-term recovery outcomes identified in program logic models developed for this strategic review. This assessment is based on the literature review, stakeholder consultation and available data.

Table 1: General assessment of recovery outcomes achieved

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

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

1.2.1 Data analysis

The data analysis on the three PDRSS programs shows a range of issues including poor recovery outcomes, homogeneous consumer groups, inconsistent service delivery models, low levels of active support, poor coordination with clinical services, limited family engagement, skewed program distribution across Victoria and uneven structural design of the service system.

Table 2 highlights the key data findings that have informed the review.

Table 2: Key data findings

All three programs	Day Programs	ARR	YRR
• **Recovery** – Increasing recognition for a recovery focus and individual providers are adopting new approaches • **Outcomes** – Current service development models do not deliver recovery outcomes. 69% of consumers are unemployed and the housing situation is unknown for 93% of consumers upon exit. Physical health is not recorded • **Pathways** – There are at least 15 different referral pathways of which 44% are by public clinical specialist mental health services • **Integration** – The PDRSS sector and clinical mental health system are poorly integrated and difficult to navigate for consumers and their carers • **Service partnerships** – More than 90% of partnership activity is health based • **Family and other carers** – Less than 10% of consumers have a reported carer • **Geographic distribution** – Distribution is more by opportunity than design. There is no ARR in regional areas	• **Consumers** – 58% of consumers are 35-55 years old; 57% have schizophrenia; 72% are of Australian origin and most report difficulties with social isolation, daily living, alcohol and drugs • **Service delivery** - Providers are moving away from PDRSS centre-based delivery because of the negative stigma associated with these settings and the need to provide more individualised services to support social inclusion and recovery. There is a trend towards providing services beyond standard business hours • **Activities provided** – 68% of activities are centred on work, domestic activities, self-care, social contact and recreation. There is little variation of activity types across providers • **Service delivery model –** Providers are moving to research-based models such as the Collaborative Recovery Model and the Strengths-Based Model • **Support period** - Almost a third of consumers utilise the Day Program for five years or more	• **Consumers** – 70% of consumers are 26-44 years old, 62% are male, 79% are people with a diagnosis of schizophrenia, and 92% are of Australian origin and most report difficulties with daily living, social isolation, alcohol and drugs • **Service delivery model –** No consistent service delivery model is evident but ARR stakeholders regard ARR as a housing proxy. 83% of consumers list the ARR as their primary residence • **Activities provided** – 69% of activities are centred on work, domestic activities, self-care, social contact and recreation. There is little variation of activity types across providers • **Support period** - According to the PDRSS Census 2010 39%of ARR consumers, at the time of the survey, were being supported for 1-2 years • **Contact time** - The average amount of contact time per week is between 3 to 3.5 hours which is similar to Moderate HBOS • **Funding** – ARR costs approximately	• **Consumers –** 70% of consumers are 19 – 25 years old (with most 19 – 21 years old), 53% are male, 72% have schizophrenia, depression, personality or bipolar disorders • **Reported difficulties –** consumers have the highest reported difficulties which include alcohol and drug dependencies. 47% report unresolved trauma as their prevalent difficulty • **Service delivery model -** No clear and consistent service delivery model • **Activities provided** – 70% of activities are centred on work, domestic activities, self-care, social contact and recreation. There is little variation of activity types across providers • **Support period** - According to the PDRSS Census 2010 34%of YRR consumers, at the time of the survey, were being supported for 6-12 months • **Contact time** - The average amount of contact time per week is 3.5 to 4 hours, which is similar to moderate HBOS • **Funding** – YRR costs approximately

All three programs	Day Programs	ARR	YRR
• **Workforce** - Unable to adequately support the recovery aims of increasing number of complex-needs consumers.	• **Contact time -** The average contact for consumers is 0.16 hours less than the individual support delivered by standard HBOS • **Funding** – The time-based funding model based on group activity limits service innovation and improvement • **Providers** – There are 34 providers whose average funding is $530,000 per annum.	$45,000 per consumer per annum. Moderate HBOS costs $14,500 per consumer per annum • **Providers** – Three organisations provide ARR services. 97 of 103 beds are provided by two organisations, with one organisation providing 81% beds.	$48,000 per consumer per annum • **Providers** - There are five organisations providing YRR services, with 126 of 166 beds provided by one organisation.

1.2.2 Research evidence

The research evidence on the three PDRSS programs is emerging. There is stronger evidence on individual components within each program though there is continued debate on some topics. Nous reviewed over 100 research articles and policy documents.

Table 3 highlights the key research evidence that has informed the review.

Table 3: Research evidence

Component	Finding
Stronger evidence	
Mental Health	There is a compelling evidence base for the provision of daily living skills, psychosocial education and self-management skills for consumers with a severe and enduring mental illness
Structured recovery	Growing recognition and support for meaningful program structures, person-centred support and social participation to deliver recovery outcomes. The recovery approach also has national endorsement.
Early intervention	Analysis of the economic impact of the 'early intervention in psychosis' approaches has demonstrated the positive economic outcomes for early intervention.
Supported employment and education	The critical link between recovery, employment and education, and social inclusion for people with psychiatric disability is well accepted. There is growth in supported education programs in Australia, the US, the UK and New Zealand.
Physical health	In comparison with the general population, people with a severe mental illness have higher rates of mortality and physical morbidity.
Supported housing	Consumer preferences for placement in end-destination 'normal' housing of their choice, with off-site flexible support, have led to new recovery approaches. There are research-based supported housing models for people with a severe and enduring mental illness throughout Australia and overseas.
Families and other carers	There is reliable research specifying the activities mental health providers can utilise to foster recognition of families and carers including staff training, family interventions and carer engagement protocols.
Emerging evidence and debate	
Peer support	The emerging research highlights peer support as a mechanism to help young people to maintain or re-gain social confidence, reduce hospital readmissions and sustain competitive employment.
Young people age range	There is considerable debate on appropriate age ranges for young people but there is recognition that young people aged 16-18 years have specific developmental needs.
Young people and residential recovery	Limited research evidence about the effectiveness of current Youth Residential Rehabilitation services acknowledges the high prevalence of substance abuse and highlights the importance of individualised programs, flexible support sessions and family inclusion. There is evidence to show that an historical attempt to establish end-point housing for young people with a mental illness largely failed due to the service model not meeting the support needs of the young residents.

1.2.3 Stakeholder feedback

PDRSS stakeholder consultations highlight the importance of the three programs and support the need for change. PDRSS providers indicated that they would like more clarity on their role and stronger support and leadership from Government.

Table 4 summarises the feedback from the four key stakeholder groups that has informed the review. Nous also talked with a range of other stakeholders in housing, disability, alcohol and drugs, and the PDRSS peak body.

Table 4: Stakeholder feedback

All three programs	Day Programs	ARR	YRR
• Emphasised the importance of the three programs and holistic recovery support • Raised concerns about inexperienced and insufficient staff, compounded by high turnover which led to poor continuity of care • Highlighted the importance of flexible service delivery hours, consumer-led programs, peer support and connections to housing • Proposed a more equitable geographic distribution of services • Noted the need to continue unstructured drop-in services for the older consumer cohort.	• Emphasised the importance of the three programs • Raised concerns about staff skills and retention levels, system navigation (including links with the clinical system), ageing carers and community stigmatism • Highlighted the importance of involvement of carers and families by services; and access to housing • Proposed consumer-linked funding, accreditation to improve service standards and flexible service delivery hours.	• Questioned the benefit of the PDRSS sector and highlighted the sector's lack of accountability and standards • Raised concerns about PDRSS staff skills, quality of services and access • Noted the different use of language and different mindset when working with consumers.	• Strongly support the need for reform and leadership from Government • Seeking clarity about the role of PDRSS, closer links with clinical, funding structures to change to reflect new service modalities and consistent and relevant data collection tools with feedback from Government to the sector • Supported need to professionalise the workforce and become recovery-outcomes focused • Highlighted the fragmented and unbalanced nature of the provider network with its inequitable geographic distribution of services • Need to find a way to effectively service youth and CALD • Identified employment, education and housing as critically important to a consumer's recovery • Some providers indicated they had already started the reform process within their own organisations.

1.2.4 Nous observations

Nous observed there was growing recognition by the PDRSS sector that they must adopt more structured, evidenced-based, consumer-orientated approaches based on a recovery philosophy and social participation to deliver recovery outcomes.

Table 5 shows how emerging service trends are driving providers to change the way their services are configured.

Table 5: Emerging PDRSS service trends

Service trends	Moving away from . . .	…Moving towards	…Driving changes to service configurations
Recovery philosophy	Unstructured time, unlimited approaches.	Identifying and achieving recovery goals.	• New service delivery formats • New collaborative partnerships to deliver services • New workforce capabilities and key roles • Demand for new funding models.
Meaningful program structures	Ongoing, 'one size fits all' group based program offerings. Loosely structured approaches Non-throughput models. Services structured around a standard length of access.	Individually tailored, goal oriented programs. A sharpened focus on delivering social participation and employment/education. Transition to optimal recovery status for the individual. Flexible program structures enabling consumers to dip in and out of service access when they require varying levels of support, including beyond business hours.	
Consumer-centred support	Doing *for* the consumer. Institutional relationship to consumer. Insular service delivery.	Empowering/doing *with* the consumer. Self-directed support (consumer shares responsibility for achieving outcomes). Facilitate linking the consumer to services which enable recovery. Individualised packages.	

1.3 Recommendations

A comprehensive suite of recommendations has been formulated. These recommendations cover the three programs, and PDRSS more generally.

The program-based recommendations address the core purpose and target group for each program together with the service delivery model and resource mix. The PDRSS-wide recommendations emerged from the identification of common themes across each of the three program reviews that had sector wide applicability. Figure 2 provides a map of the complete suite of recommendations for this strategic review.

Figure 2: Recommendation map

	Recommendation Component	Day Programs	ARR	YRR
Why & With Whom	Target group	✓	✓	✓
	Outcomes *	✓	✓	✓
	Service delivery model	✓	✓	✓
How	Housing Supply		✓	
	Support periods	✓	✓	✓
	Geographic distribution *	✓	✓	✓
	Coordinated services and partnerships *	✓	✓	✓
	Workforce capability *	✓	✓	✓
	Families and carers *	✓	✓	✓
	Funding model	✓	✓	✓
With what	Structural design			

Whole of PDRSS Sector Recommendations		
Sector role and name	Alignment with clinical services	Service innovations

* Program specific recommendations that may also be applicable to the whole of PDRSS.

1.3.1 Day Programs

Day Programs should retain the group-based approach and change from a centre-based program to a consumer-centred, evidence-based recovery program set in mainstream community locations.

The recommendations unique to Day Programs are summarised in Table 6. It is noted that for full effect and reform to be achieved, the wider service design recommendations must be carried out in conjunction with the individual program recommendations.

Table 6: Day Program Recommendations

Component	Summary recommendation
1. **Target group**	Target people 16-64 years old with a severe and enduring mental illness and associated disability who subsequently have trouble with skills of daily living and are at risk of social isolation. The target group should have a better representation from people who have severe mental health issues from across the low prevalence disorder spectrum; from people who are less than 35 years old; and from people who have CALD backgrounds.
2. **Outcomes**	Orient the Day Program service model to deliver an agreed set of consumer-focused, mental health recovery outcomes with a greater focus on mental and physical health, economic participation through education and employment, and social participation. Link consumer outcomes to individual service provider performance; include a performance assessment in funding and service agreements.
3. **Service delivery model**	Adopt evidence-based service delivery models to assist consumers' access to group-based activities in mainstream community settings and extend delivery hours beyond Monday to Friday, 9am – 5pm. The extended delivery hours should include weekends and non-business working hours.
4. **Support periods**	Adopt two types of support periods for this program. The first is for 'no more than 18 months' for younger consumers or those who are accessing services earlier in disability. These consumers should also have the option to re-enter the program at a later stage. The second is 'extended' for consumers with a higher degree of disability.
5. **Geographic distribution**	Conduct a detailed geographic demand study to determine distribution requirements for the proposed service delivery model across Victoria.
6. **Coordinated services and partnerships**	Formalise service coordination mechanisms with specialist clinical mental health, community, social, health and primary care services to scale the treatment and support response to each consumer's need. Establish clear, non-discretionary entry and exit criteria and pathways on an area mental health service basis.
7. **Workforce capability**	Invest in workforce skills based on an agreed set of core competencies, and agreement to a multi-level award structure (consistent with the Fair Work Australia award rationalisation initiative) that reflects the range of professional and non-professional skills requirements.
8. **Families and carers**	Reconnect and engage families and other carers in a consumer's recovery process, including decision-making, planning and activities.
9. **Funding model**	Establish a service-based funding model with financial incentives for achievement of individual consumer outcomes and consider use of 'brokerage funds'.
10. **Structural design**	Establish competitive market conditions to ensure each Day Program is economical in scale and can deliver a quality service.

1.3.2 Adult Residential Rehabilitation

ARR should change from a bed-based transitional support program to a supported housing program where consumers are placed in end-point housing with HBOS.

The recommendations to reform ARR programs are summarised in Table 7. It is noted that for full effect and reform to be achieved, the wider service design recommendations must be carried out in conjunction with the individual program recommendations.

Table 7: ARR recommendations

Component	Summary recommendation
1. **Target group**	Target people 16-64 years old with a severe and enduring mental illness and associated disability who subsequently have trouble with skills of daily living and are at risk of social isolation. The target group should have a better representation from people who have severe mental health issues from across the low prevalence disorder spectrum; from people who are less than 35 years old; and from people who have CALD backgrounds.
2. **Outcomes**	Orient the Day Program service model to deliver an agreed set of consumer-focused, mental health recovery outcomes with a greater focus on mental and physical health, economic participation through education and employment, and social participation. Link consumer outcomes to individual service provider performance; include a performance assessment in funding and service agreements.
3. **Service delivery model**	Adopt evidence-based service delivery models to assist consumers' access to group-based activities in mainstream community settings and extend delivery hours beyond Monday to Friday, 9am – 5pm. The extended delivery hours should include weekends and non-business working hours.
4. **Support periods**	Adopt two types of support periods for this program. The first is for 'no more than 18 months' for younger consumers or those who are accessing services earlier in disability. These consumers should also have the option to re-enter the program at a later stage. The second is 'extended' for consumers with a higher degree of disability.
5. **Geographic distribution**	Conduct a detailed geographic demand study to determine distribution requirements for the proposed service delivery model across Victoria.
6. **Coordinated services and partnerships**	Formalise service coordination mechanisms with specialist clinical mental health, community, social, health and primary care services to scale the treatment and support response to each consumer's need. Establish clear, non-discretionary entry and exit criteria and pathways on an area mental health service basis.
7. **Workforce capability**	Invest in workforce skills based on an agreed set of core competencies, and agreement to a multi-level award structure (consistent with the Fair Work Australia award rationalisation initiative) that reflects the range of professional and non-professional skills requirements.
8. **Families and carers**	Reconnect and engage families and other carers in a consumer's recovery process, including decision-making, planning and activities.
9. **Funding model**	Establish a service-based funding model with financial incentives for achievement of individual consumer outcomes and consider use of 'brokerage funds'.
10. **Structural design**	Establish competitive market conditions to ensure each Day Program is economical in scale and can deliver a quality service.

1.3.3 Youth Residential Rehabilitation

YRR should retain its bed-based transitional facilitates but adopt a more structured, goal-orientated program with strong and active partnerships with clinical, employment, education, community health, housing, and recreational services.

The recommendations to reform Youth Residential Rehabilitation are summarised in Table 8. It is noted that for full effect and reform to be achieved, the wider service design recommendations must be carried out in conjunction with the individual program recommendations.

Table 8: Recommendations for YRR

Component	Summary recommendation
1. **Consumer group**	Target 16 to 25 year olds with a serious mental illness who are at risk of, or are experiencing substantial functional impairment and psychosocial disability. Consumers should be early in illness and recovery, and may have challenges with family support at that time. The target group should also have better representation from people aged 16 to 18 years.
2. **Outcome orientation and performance**	Orient the YRR service models to deliver an agreed set of consumer-focused, mental health recovery outcomes with a greater focus on mental and physical health, economic participation through education and employment, and social participation. Link YRR consumer outcomes to individual service provider performance, including a performance assessment in funding and service agreements.
3. **Service delivery model**	Bed-based residential recovery support with strong and active partnerships covering education, employment, housing, recreation, community services (e.g. youth AOD support programs), and specialist clinical and youth services.
4. **Support period**	Consumers should have access to this program for 12 months and be provided with an average of 6 hours of contact per week.
5. **Geographic distribution**	Conduct a detailed geographic demand study to determine distribution requirements for the proposed service delivery model across Victoria.
6. **Coordinated services and partnerships**	Formalise service coordination mechanisms with specialist clinical mental health, community, social, health and primary care services to scale the treatment and support response to each consumer's need. Establish entry and exit pathways on an area mental health service basis. Due to the complexity of clients coming though the child protection, alcohol and drug, and homeless systems with a serious mental illness some flexibility is necessary with the entry criteria.
7. **Workforce capability**	Invest in workforce skills (including the pilot of peer support workers) based on an agreed set of core competencies. Reach agreement on a multi-level award structure (consistent with the Fair Work Australia award rationalisation initiative) that reflects the range of professional and non-professional skills requirements.
8. **Families and carers**	Reconnect and engage families and other carers in a consumer's recovery process including decision-making, planning and activities.
9. **Funding model**	Establish a service-based funding model with financial incentives for the achievement of individual consumer recovery outcomes.
10. **Structural design**	Establish competitive market conditions to optimise the role of the YRR program within the broader psychosocial recovery system.

1.3.4 PDRSS-wide service design recommendations

Nous has provided three recommendations that may be applicable to the wider sector. These recommendations arise from analysis of the major PDRSS programs and address the sector's role, alignment with clinical services, and the promotion and sharing of service innovations.

The recommendations that may apply to the whole PDRSS sector are summarised in Table 9.

Table 9: PDRSS-wide recommendations

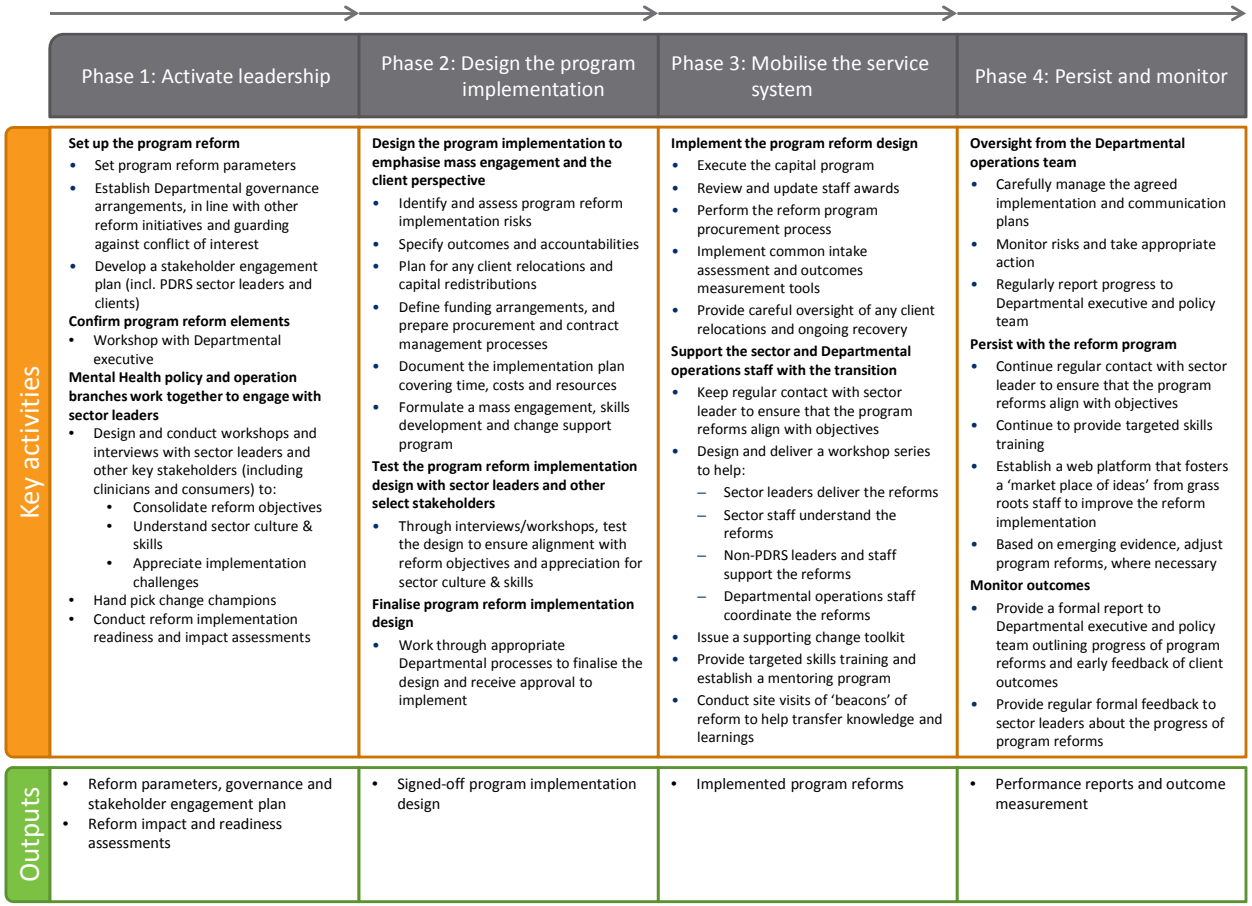
Component	Summary recommendation
1. **Sector role and name**	Position the PDRSS sector as a core component of the specialist mental health system continuum of care. In order to help consumers successfully access the full range of community, health and social services they need to continue or resume living in the community. Re-name PDRSS to Community Mental Health Recovery Services (CMHRS).
2. **Alignment with clinical services**	Align the specialist mental health continuum of care between PDRSS programs and clinical services. This will require shared program outcomes, shared planning and coordination tools, and more formal regional coordination arrangements.
3. **Service innovations**	Share and promote evidence-based service innovations from providers that align to the proposed recovery role and outcome-focus of the sector.

1.4 Transition arrangements

The transition to the recommended reforms will require engagement and active participation of the whole PDRSS sector to unlock service design challenges and to achieve the desired performance results with consumers.

The program reform phases are outlined in Figure 3.

Figure 3: Program reform phases



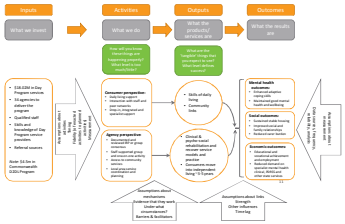
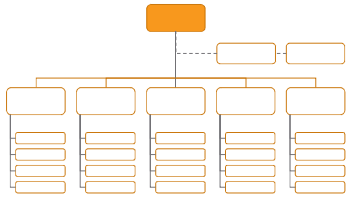
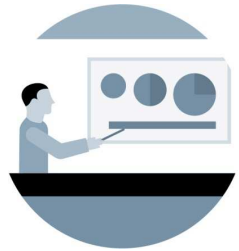
2 Background to the review

2.1 Review process

Based on the Department of Health's request for quotation, Nous conducted a strategic review of the Psychiatric Disability Rehabilitation and Support Service (PDRSS) Youth Residential Rehabilitation (YRR), Adult Residential Rehabilitation (ARR) and Day Programs.

Figure 4 illustrates the review process conducted by Nous.

Figure 4: Review process

1. Developed program logic models	2. Engaged and analysed	3. Explored reform options	4. Provided recommendations
			
Developed program logic models that articulated the assumptions and logic for the PDRSS, ARR, YRR and Day Programs to: • Specify lines of enquiry • Focus the set of review questions • Determine the appropriate assessment approach • Agree on primary data source.	**Conducted stakeholder consultations and reference group meetings to explore the four lines of enquiry:** 1. *Appropriateness* - Reviewed the current role and function of the ARR program 2. *Effectiveness* - Identified what the ARR program service model currently achieves 3. *Contribution* – Current relationship to broader mental health and the social support service system 4. *Efficiency* - Opportunity for alignment with broader mental health reform agenda	**Explored reform options for each of the ARR, YRR and Day Programs and assessed these against three tests for good public policy:** • Substantively valuable • Legitimate and politically sustainable • Operationally and administratively feasible.	**Synthesised findings and recommendations to:** • Inform the future development of the Psychosocial Rehabilitation and Recovery Reform and Development Plan • Ensure lasting change in PDRSS ARR, YRR and Day Programs, processes and people as the recommendations are implemented.

2.2 The Psychosocial Rehabilitation and Recovery Plan

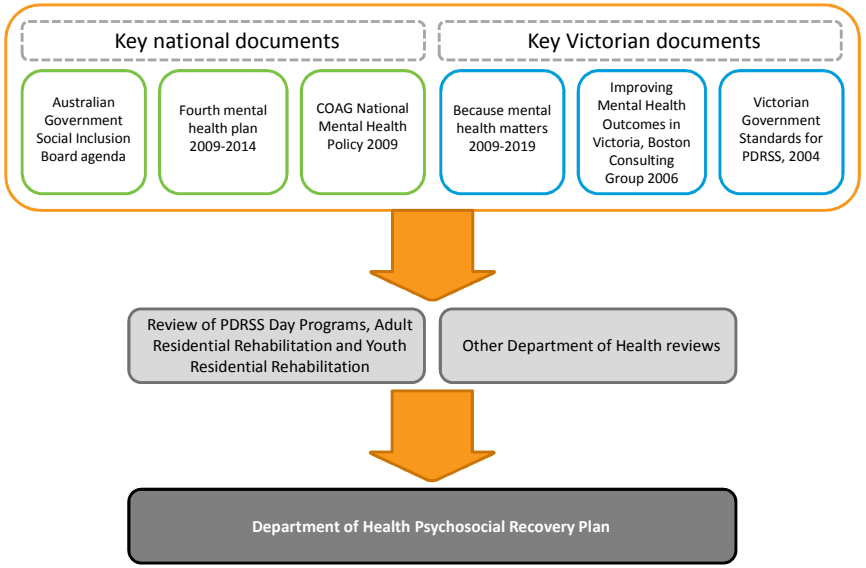
The strategic review of ARR, YRR and Day Programs will inform the Department's Psychosocial Rehabilitation and Recovery Plan.

The Department of Health is developing a comprehensive *Psychosocial Rehabilitation and Recovery Service Reform and Development Plan*. The aim of this plan is to improve recovery and social inclusion outcomes for people with severe mental illness and psychiatric disability. The plan will seek to achieve this outcome by:

- Maximising the value of current and future investment in psychosocial rehabilitation and recovery services
- Identifying action to strengthen interagency collaboration and coordination between the PDRSS and clinical mental health service sectors, and the broader health and social support sectors
- Developing a robust business case and strategy to guide future investment in psychosocial rehabilitation and recovery services over the next five years
- Identifying action required to improve the skills, competency and sustainability of the psychosocial rehabilitation and recovery support service workforce
- Improving accountability for outcomes, including the systematic use of outcome measurement tools and the use of standardised quality improvement processes.

The strategic review of the PDRSS Day Program and Youth and Adult Residential Rehabilitation programs will be undertaken concurrently to inform the development of this plan. Figure 5 highlights the key influences on the development of the Psychosocial Rehabilitation and Recovery Plan.

Figure 5: Key influences on the development of the Psychosocial Rehabilitation and Recovery Plan

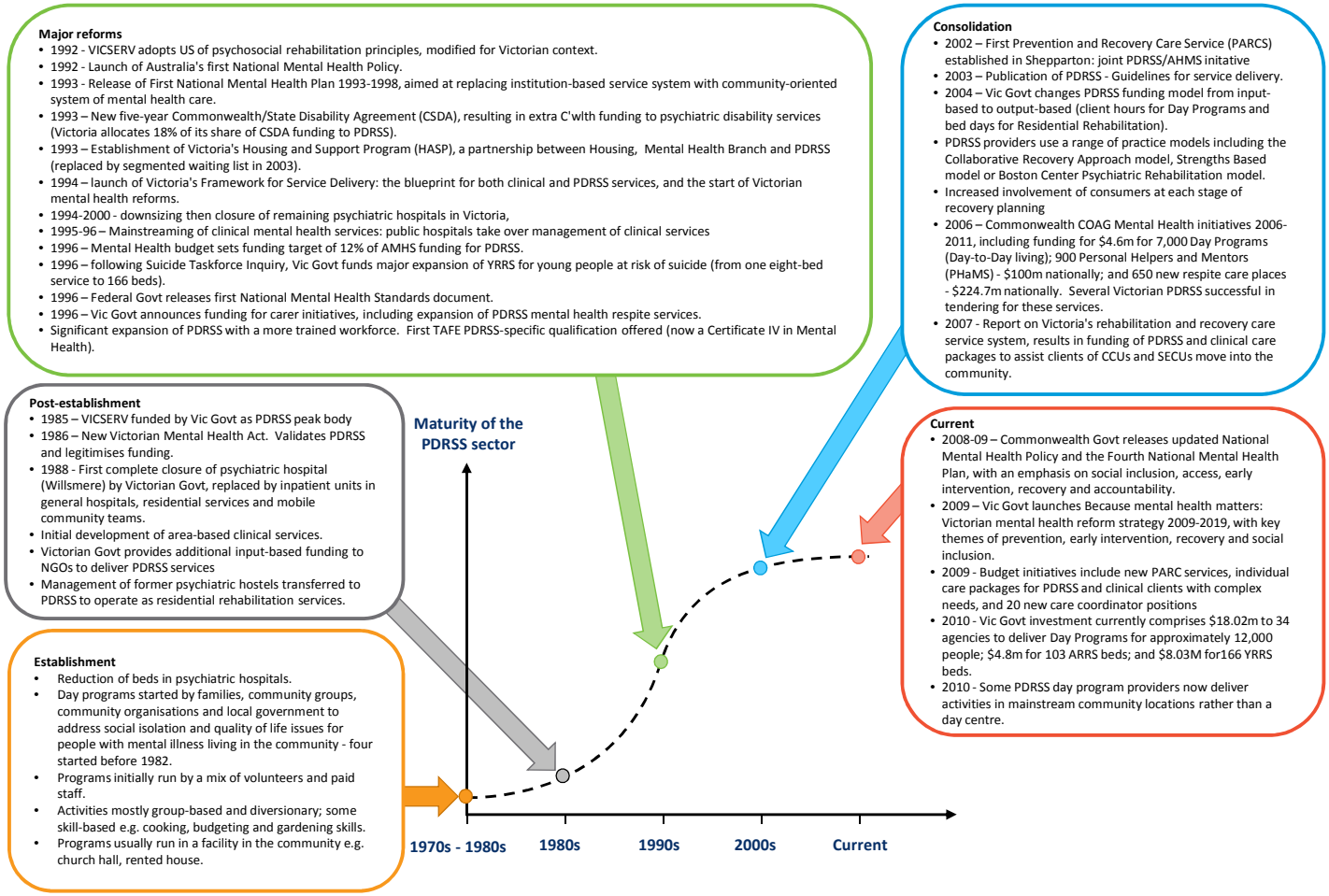


2.3 History of the sector and the three programs

The PDRSS sector has grown significantly over the past 25 years.

The evolution of the PDRSS sector over the past three decades is outlined in Figure 6.

Figure 6: Maturation of the PDRSS sector to current state



2.4 History of Day Programs

The establishment of Victoria's day programs began in the 1960s in clinical services. Psychosocial rehabilitation programs run by non-government organisations commenced as a separate development in the early to mid 1980s. In 2006 the Commonwealth government introduced funding for 'Support for Day to Day Living in the Community' (D2DL) under the COAG Mental Health Initiatives.

Day Programs in Victoria began in the mid 1960s as a component of the new community-based out-patient clinics: Ernest Jones Clinic (EJC) in Preston and Clarendon Clinic in East Melbourne. The EJC day program largely comprised a drop-in centre at the Clinic, whereas Clarendon Clinic operated an on-site industrial therapy workshop in a building alongside the clinical facility, and also ran a group therapy program and a weekly evening social club. In both instances, those attending were former patients at one of the psychiatric hospitals on the Bundoora campus (Larundel, Plenty or Mont Park Hospitals). Malvern Clinic also operated a day program in its premises at Glenferrie Rd, Malvern, with activities largely focusing on arts and crafts, and therapeutic groups.

The debate in the 1960s centred on whether these were day rehabilitation programs or day hospitals. The UK tradition had been to operate day hospitals as an alternative to inpatient admission or as a step-down after discharge for those with acute mental illness, each with the primary function of monitoring the patient's progress and supervising their medication.

In Victoria, a new form of day program emerged in the early to mid 1980s. This was the development by non-government organisations of psychosocial rehabilitation programs in community-based settings in the community. These programs provided firstly, a social outlet for consumers living isolated lives in the community, and secondly, the opportunity to regain everyday practical skills and to learn relevant vocational skills such as gardening and computer literacy. The majority of funding came from the State mental health program, with the Commonwealth providing funding under the Handicapped Persons Program, and local governments also funding some programs. A range of approaches have been used to guide the development of Day Programs, including the Boston Centre's psychosocial rehabilitation approach, the Clubhouse model from Fountain House in New York, and more recently, the Collaborative Recovery model and the Strengths approach.

In 2006, the Commonwealth government introduced funding for Support for Day to Day Living in the Community (D2DL) under the COAG Mental Health Initiatives. D2DL funded extra places for organisations already running Day Programs for people with psychiatric disabilities. Organisations had to submit for funding and tenders were called for areas across all states and territories.

2.5 History of Adult Residential Rehabilitation

The establishment of Victoria's Adult Residential Rehabilitation services has been a gradual process which started in the 1950s.

In the 1950s and 60s, the Victorian State government bought large houses in inner suburban Melbourne to be used as 'half-way houses' or 'hostels' for patients discharged from the metropolitan psychiatric institutions. This was based on the idea that former patients needed time to adjust to living in a community rather than an institutional setting. These hostels were the precursors to the ARR services which are the focus of the current review. Examples are Trelowarren in Armadale and Edith Pardy House in Albert Park.

Former patients stayed in the hostels for three to six months before returning home or moving on to other types of accommodation which were usually commercially-run facilities such as boarding or rooming houses, or 'guest houses' (now called supported residential services - SRS). Properties were also purchased by the State government for longer term accommodation, such as Wynnstay House in Prahran.

In the 1980s, the State government transferred management of the hostels to the Richmond Fellowship of Victoria (now MIND Australia). More properties were added, such as Victoria Lodge (a former motel) and Appleby Crescent (town houses) in Brunswick, and the block of flats in Preston previously called the Rosa Gilbert Flats (now Argos).

In the late 1980s, a new type of residential rehabilitation service was established which was separate from the existing ARR services managed by the PDRSS sector. This facility was created as part of the closure of a large psychiatric institution (Willsmere) in Kew, and comprised a 10 bed residential rehabilitation unit with 24 hour on-site clinical staffing based in the community. It opened in 1988 and became Victoria's first community care unit (CCU).

The most recent reforms occurred between 1994 and 2000 when all the remaining institutions were closed and replaced with locally-based inpatient and community services. Over that period, CCUs were funded and set up in most of the 21 adult mental health services across the state. Those AMHS that did not establish their own CCU had access to CCU beds in a neighbouring AMHS. However, no new ARR services were set up during this period of reform. CCUs played an important role in providing both a transition for patients from extended care wards, and a source of continuing employment for former institutional staff.

Over time, differences between CCUs and ARR services have become less recognisable, especially as many of the first residents of CCUs have moved on. In Shepparton, the Mental Illness Fellowship (MIF) runs the Specialist Residential Rehabilitation Program (SRRP), which comprises four two-bedded units and works in close collaboration with the local AMHS. In effect, the SRRP functions as both ARR and CCU since there is no separation between ARR or CCU in Shepparton.

2.6 History of Youth Residential Rehabilitation

The expansion of residential rehabilitation services for young people in Victoria came from the *Victorian Suicide Prevention Taskforce Report (1997)*.

Before 1997, Victoria had only one residential rehabilitation service for young people. This was Denham House in Hawthorn, run by the Richmond Fellowship of Victoria (now MIND Australia). Denham House provided rehabilitation in a residential setting for up to 10 young people between the ages of 18 and 25 years who had a serious mental illness and associated disabilities. The aim was to assist the young person to develop or regain social and everyday living skills in a supportive group environment with a length of stay of up to 2 years. Some provision was made for outreach support after a young person left Denham House.

Following release of the 1997 Report of Victoria's Suicide Prevention Taskforce, the Government funded several initiatives designed to provide support for people at risk of suicide.[1] One of these initiatives allocated funding to expand Victoria's Youth Residential Rehabilitation Services across the state, based on the Denham House model. Funding was made available to establish 16 additional YRRS in both metropolitan and rural regions. Recommendation 7.16 stated:

'The Victorian Government support the Department of Human Services to establish, in each of its administrative regions, community residential support services and Day Program, linked to Child and Adolescent Mental Health Service and the young adult program within the Adult Mental Health Service, for young suicide attempters who are discharged from hospital and/or not considered in need of hospital care, to provide short- to medium-term care and outreach support services,' (p.126).

An evaluation of the suicide prevention initiatives was undertaken in 1999, but residential rehabilitation services for young people were not included.[2]

In 2004-05, all rural YRR and one service in each metropolitan region were allocated funding to provide additional support for clients with co-existing substance misuse problems (dual diagnosis). This funding was also used by rural services to provide an outreach function to assist clients to transit to community or, in some instances, as a substitute for the bed based response. Selected Mobile Support and Treatment teams also received funding to complement and collaborate with the dual diagnosis positions located in metropolitan YRR services.

2.7 Evaluations of the PDRSS sector

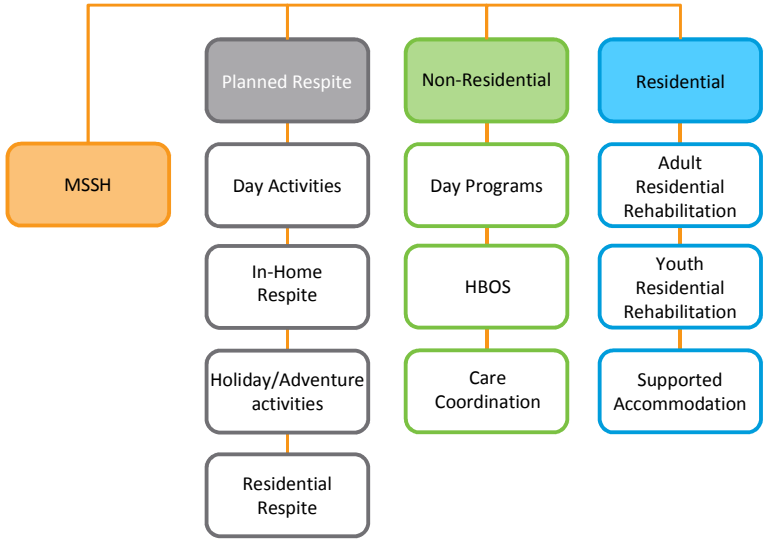
Since their establishment, Day Programs, Adult Residential Rehabilitation and Youth Residential Rehabilitation have not undergone a formal review or evaluation.

The PDRSS sector comprises four broad categories of activities. Figure 7 provides a schematic outline of these activities and service types. This review covers three key service types – Day Program, Adult Residential Rehabilitation and Youth Residential Rehabilitation programs. These three programs account for 38% of total PDRSS funding provided by the Victorian Government. Table 10 summaries this investment.

Table 10: Investment summary

Program component	Total investment	Number of beds/activities
Youth Residential Rehabilitation service	$8.03 million	166 beds
Adult Residential Rehabilitation service	$4.82 million	103 beds
PDRSS Day Programs	$18.02 million	58 activities

Figure 7: Current activities and service types of the PDRSS sector



Since the 1980s, there have been key documents examining parts of the sector; however, there have been no dedicated, evidence-based evaluations of Day Programs, ARR and YRR.

2.8 Public policy context

The new Victorian Coalition Government's Plan for Mental Health 2010 outlines key reforms for the mental health sector and also signals greater investment in clinical and community services provided by PDRSS.

In November 2010, the Liberal Nationals Coalition formed a new Victorian Government. The new Government's plan for mental health reform reiterates the importance of community and PDRSS, with a commitment to additional investment in support services provided by community mental health teams and PDRSS. As part of the plan to improve outcomes for people with a mental illness, the Government has outlined a strategy for greater education and employment participation for people with a mental illness ("*Pathways to Participation"*) and will develop a comprehensive mental health workforce strategy.

In 2009, the former Government released *Because mental health matters*, a strategy for comprehensive mental health reform over the next decade. That reform strategy articulated a stronger role for PDRSS in the overall mental health system with more equal partnerships with clinical services to deliver mental health care and a central role in delivering social inclusion.[3]

PDRSS also play an important role in the national social inclusion agenda. This agenda aims to empower people through participation in employment, education, social networks and community services. Social inclusion is a key aspect of mental health reform agenda for the Australian Government. The aim is to reduce social disadvantage and improve the community participation of all Australians, including those with mental illness and psychiatric disabilities. The Commonwealth Government's Social Inclusion Board identifies the following key elements of social inclusion:

- Learn by participating in education and training
- Work by participating in employment, in voluntary work and in family and caring
- Engage by connecting with people and using their local community's resources
- Have a voice so that they can influence decisions that affect them.[4]

A full list of relevant public policy documents is provided in Table 11.

Table 11: Relevant public policy documents

Relevant Public policy documents
• The Victorian Liberal Nationals Coalition Plan for Mental Health 2010
• National Mental Health Policy 2008
• COAG National Action Plan on Mental Health 2006-2011
• Social Inclusion in Australia, How Australia is faring, Australian Social Inclusion Board Report January 2011
• Because Mental Health Matters, Victorian Mental Health Reform Strategy 2009-2019
• Victorian Mental Health Reform Strategy 2009-2019, Implementation Plan 2009-2011
• CAMHS in communities, Working together to provide mental health care for Victoria's children and young people, September 2006
• Dual diagnosis, Key directions and priorities for service development, 2007
• Care in Your Community - A planning framework for coordinated ambulatory health care, 2006
• Planning framework for public rural mental health services: A framework to guide the enhancement of public rural mental health services over the next five years, Department of Human Services, October 2006

3 Day Programs

3.1 Background to Day Programs

The Day Program is a PDRSS centre-based activity targeted to young people and adults with severe mental illness and psychiatric disability aged 16-64 years.

The majority of Day Program services are mental health centre-based and offer structured or informal drop-in services or combinations of both. Some services are provided on an outreach basis to individual clients.

The Victorian Government currently invests approximately $18.02 million in 58 Day Program activities delivered through 34 PDRSS agencies across the state. Many PDRSS agencies receive funding for more than one type of Day Program activity.

The Commonwealth Government also invests approximately $2.2 million in the Support for Day to Day Living in the Community (D2DL) day program in Victoria as part of the COAG National Mental Health Action Plan. This investment also delivers structured and socially based day programs and is largely delivered through PDRSS.

The aim of Victorian Government funded Day Programs is to create a sense of belonging to a community, provide peer support and an environment where a range of social and daily living skills can be learnt. This service element aims to assist people with a severe and enduring mental illness and psychiatric disability to improve their quality of life by participating in recreational, social, educational and vocational activities. Involvement in a Day Program may also provide support and respite for families and carers.

Appendix A.1 provides the program logic for current Day Programs.

3.2 The change needed for Day Programs

Day Programs should retain the group-based approach and change from a centre-based program to a consumer-centred, evidence-based recovery program set in mainstream community locations.

Table 12 highlights the current situation of Day Programs and provides an outline for a repositioned Day Program within the Victorian mental health system.

Table 12: The change needed for Day Programs

Program components	Moving away from . . .	. . . Moving towards
Why and for whom		
Purpose	• A group-based rehabilitation program for people with a severe mental illness and psychiatric disability aged 16-64 years.	• A consumer-centred recovery program for people 16-64 years old with a severe and enduring mental illness and associated disability who subsequently have trouble with skills of daily living and are at risk of social isolation.
Target group	• A largely homogenous consumer group characterised by being 35-55 years old (58%), with a diagnosis of schizophrenia (57%) and Australian born (72%).	• Better representation from people who have severe mental health issues from across the low prevalence disorder spectrum, from people who are less than 35 years old, and from people who have CALD backgrounds.
Outcomes	• A focus on improved daily living skills that is not measured at a system level.	• Measureable mental health recovery outcomes with a focus on mental and physical health, economic participation through education and employment, and social participation.
Activity profile	• Limited choice of activities with 68% of activities centred on work, domestic activities, self-care, social contact and recreation.	• Consumer choice for activities aligned to individual consumer recovery goals.
How		
Service delivery model	• A range of programs types from unstructured drop-in to highly structured group programs based on various rehabilitation philosophies.	• Structured, group-based recovery programs based on evidenced-based models such as the Collaborative Recovery Model and the Strengths-Based approach.
Support period and contact time	• Guidelines that suggest support for 1-2 years but where almost a third of consumers have been in a Day Program for more than five years. Average contact for consumers is 1.34 hrs per week	• Most consumers accessing the service for no more than '18 months' (with option to re-enter the program at a later stage) but extending access for

Program components	Moving away from . . .	. . . Moving towards
	with less than the 1.5 hrs of individual support delivered by standard HBOS.	consumers with a higher degree of disability.
Operating hours	• Standard operating hours of 9am to 5pm Monday to Friday, and closed over weekends and major holiday periods.	• Extended service delivery hours beyond Monday to Friday, 9am – 5pm to include weekends and non-business working hours.
Delivery location	• Delivery through PDRSS centre-based facilities.	• Delivery through mainstream community settings.
Geographic distribution	• Program distribution throughout Victoria being based on opportunity rather than design and concentrating in Eastern and Southern Metropolitan regions.	• An equitable distribution across Victoria based on consumer demand.
Referral pathways	• Multiple and uncoordinated referral pathways (over 9 different pathways) with unclear selection methods, largely driven by individual provider sites.	• Streamlined and coordinated entry and exit pathways on an area mental health service basis with clear selection criteria.
With what		
Workforce	• Staff skills not being adequate to support the recovery aims of consumers with increasingly complex issues.	• A mix of professional and non-professional staff matched to complex consumer needs, and to the delivery of new service models.
Families and carers	• General exclusion of families and carers in the Day Program activity.	• Connected and engaged families and carers in a consumer's recovery process, including decision-making, planning and activities.
Partnerships	• Pockets of productive non-health based partnerships.	• Partnerships with employment and education, community health, housing, clinical and recreational services that ensure consumers are connected with services that enable recovery and social inclusion through sustainable re-connection with the mainstream community.
Funding model	• A time-base funding model based on group activity.	• Service-based funding with top-up funding for achievement of individual consumer outcomes and a 'brokerage fund'. Consumer outcomes are linked to individual service provider performance.
Structural design	• Small allocations of program funding (average is $530,000 per year) given to 34 providers.	• Consolidated funding allocations per provider to optimise the quality and efficiency of service.

3.3 Recommendations for Day Programs

The recommendations for Day Programs are summarised in Table 13. It is noted that for full effect and reform to be achieved, the three wider service design recommendations must be carried out in conjunction with the individual program recommendations.

Table 13: Summary Day Program Recommendations

Component	Summary recommendation
1. **Target group**	Target people 16-64 years old with a severe and enduring mental illness and associated disability who subsequently have trouble with skills of daily living and are at risk of social isolation. The target group should have a better representation from people who have severe mental health issues from across the low prevalence disorder spectrum, from people who are less than 35 years old, and from people who have CALD backgrounds.
2. **Outcomes**	Orient the Day Program service model to deliver an agreed set of consumer-focused, mental health recovery outcomes with a greater focus on mental and physical health, economic participation through education and employment, and social participation. Link consumer outcomes to individual service provider performance, include a performance assessment in funding and service agreements.
3. **Service delivery model**	Adopt evidence-based service delivery models to assist consumers' access to group-based activities in mainstream community settings and extend delivery hours beyond Monday to Friday, 9am – 5pm. The extended delivery hours should include weekends and non-business working hours.
4. **Support periods**	Adopt two types of support periods for this program. The first is for 'no more than 18 months' for younger consumers or those who are accessing services earlier in disability. These consumers should also have the option to re-enter the program at a later stage. The second is 'extended' for consumers with a higher degree of disability.
5. **Geographic distribution**	Conduct a detailed geographic demand study to determine distribution requirements for the proposed service delivery model across Victoria.
6. **Coordinated services and partnerships**	Formalise service coordination mechanisms with specialist clinical mental health, community, social, health and primary care services to scale the treatment and support response to each consumer's need. Establish clear, non-discretionary entry and exit criteria and pathways on an area mental health service basis.
7. **Workforce capability**	Invest in workforce skills based on an agreed set of core competencies, and agree on a multi-level award structure (consistent with the Fair Work Australia award rationalisation initiative) that reflects the range of professional and non-professional skills requirements.
8. **Families and carers**	Reconnect and engage families and other carers in a consumer's recovery process, including decision-making, planning and activities.
9. **Funding model**	Establish a service-based funding model with financial incentives for achievement of individual consumer outcomes and consider use of 'brokerage funds'.
10. **Structural design**	Establish competitive market conditions to ensure each Day Program is economical in scale and can deliver a quality service.

3.4 Target group

Recommendation: Target people 16-64 years old with a severe and enduring mental illness and associated disability who subsequently have trouble with skills of daily living and are at risk of social isolation. The target group should have a better representation from people who have severe mental health issues from across the low prevalence disorder spectrum, from people who are less than 35 years old, and from people who have CALD backgrounds.

Arguments supporting this recommendation:

- The current consumer profile is 35-55 years old (58%), Australian origin and slightly skewed towards males. This profile does not represent the diversity of the population, particularly in terms of young people and people from CALD backgrounds
- Although diagnosis is not always an indicator of need, Clinicians and Nous's expert advisory panel observed that the predominant diagnosis profile, schizophrenia, in Day Program consumers does not correlate with the range of consumer profiles that may require support through Day Program activities
- Day Program consumers have a relatively low number of complexities. However social isolation, problems with activities of daily living, and alcohol or drug dependence are prevalent.

The current consumer profile is 35-55 years old (58%), Australian origin and slightly skewed towards males. This profile does not represent the diversity of the population, particularly in terms of young people and people from CALD backgrounds.

The target consumer group for Day Programs is people with a serious mental illness aged 16 – 64 years old. PDRSS census data identified that there are very few:

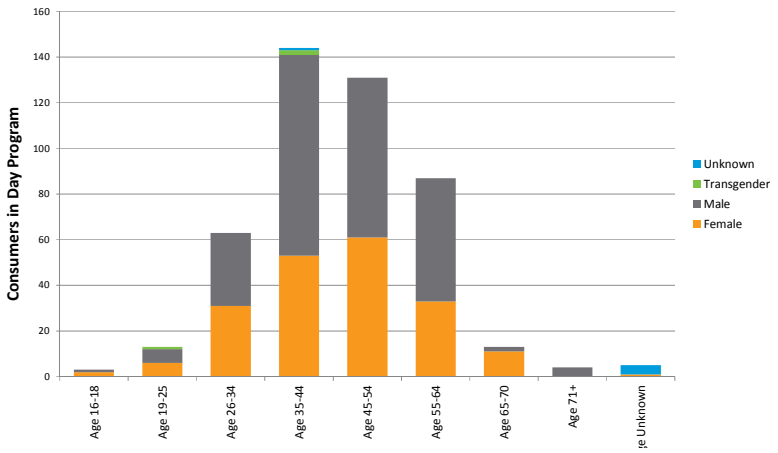
- CALD consumers - 72% of Day Programs consumers are English speaking[5]
- Young people - Young people account for only 4% of consumers in Day Programs. 16-18 year olds are by far the least represented age bracket, and account for only 1% of consumers[6]
- Old consumers - There is also small cohort of consumers (4%) over 65 years old.[7]

Providers that target services to these consumer groups include Pathways Geelong (youth) and Doutta Galla (CALD). These programs have demonstrated that there is demand from these special needs groups but that more flexible and responsive service delivery is required to overcome barriers to access and to meet the specific needs of these consumers.

The gender profile, as shown in Figure 8, is slightly skewed towards males, who account for 55% of Day Programs consumers.[8] Factors identified in Spink's 2000 study of gender issues in Day Programs in Melbourne included higher rates of referral of men, families being less tolerant of males staying at home all day, more men living in boarding houses and needing somewhere to go during the day, and having fewer domestic responsibilities (pp.30-31).[9] Conversely, fewer females attending Day Programs was attributed to women being less likely to be referred, Day Programs being oriented to male activities, and women being put off or intimidated by male behaviour.[10]

Service eligibility for Day Programs will be (as per the PDRSS guidelines) a diagnosed mental illness that is associated with a significant disability. Where consumers are placed will be guided by the AMHS catchment area in which they reside. Eligibility for young people may also need to include those with a mental illness diagnosis and functional impairment.

Figure 8: Day Program – age and gender profile[11]



Although diagnosis is not always an indicator of need, Clinicians and Nous's expert advisory panel observed that the predominant diagnosis profile, schizophrenia, in Day Program consumers does not correlate with the range of consumer profiles that may require support through Day Program activities.

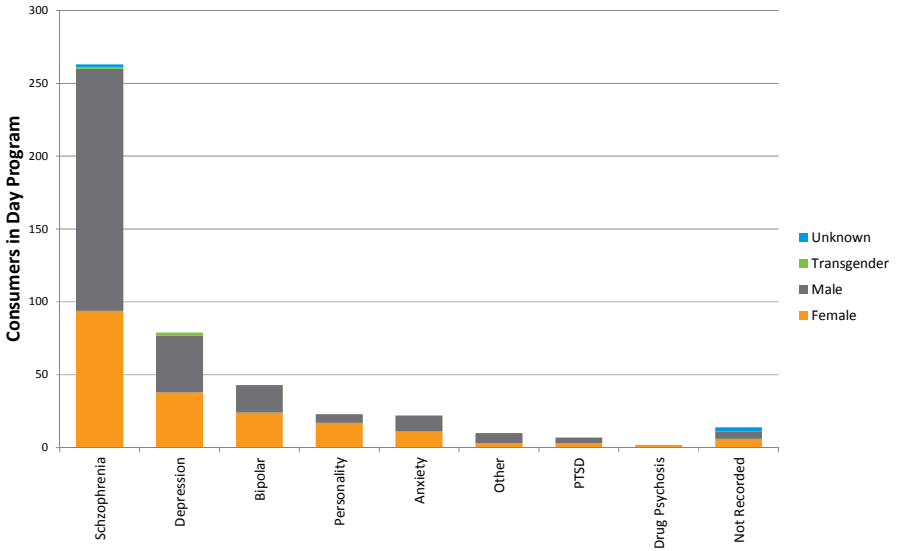
Figure 9 provides the diagnosis profile of consumers in Day Programs captured in the PDRSS census survey.

Schizophrenia is the dominant primary diagnosis for consumers in Day Programs (57%). The next two most common diagnoses are depression (17%) and bipolar disorder (9%).[12] This breakdown is consistent with a 1999 study of low prevalence disorders.[13]

Clinicians and Nous's expert advisory panel observed that the current diagnoses profile of consumers in Day Program services does not necessarily correlate with the range of diagnoses of consumers that, in their experience, may require support to recover from a psychiatric disability. However, schizophrenia does have a higher likelihood of neurological deterioration and non-reversible disability than other diagnoses such as personality disorder.

Clinicians and Nous's expert also noted that they expected to see more consumers with diagnoses of personality disorders and other low prevalence disorders than are currently evident in the profile.

Figure 9: Diagnosis profile of consumers in Day Program



Day Program consumers have a relatively low number of complexities. However social isolation, problems with activities of daily living, and alcohol or drug dependence are prevalent.

Day Program consumers have the second lowest average number of complexities across all PDRSS programs with an average 2.4 complexities per consumer. Only Mutual Support and Self Help consumers have a lower average number of complexities, with an average 1.6 complexities per consumer. *See appendix D.1 for average number of complexities per consumer across all PDRSS programs.*

Figure 10 shows that the majority of consumers in Day Program (84%) experience at least one complex factor. 16% of Day Program consumers have five or more complex factors.[14] The most prevalent complex factor is social isolation, which is experienced by 44% of consumers in Day Program. The next most common complex factor consumers experience is problems with activities of daily living (35%).

Consumers in Day Program have the equal highest rate of consumers with no alcohol or drug dependence across all PDRSS programs. 53% of consumers have no recorded dependence. Figure 11 shows that the most common dependences of Day Program consumers with alcohol or drug dependence are nicotine (19% of consumers), alcohol (14%) and cannabis (10%).

Figure 10: Complexity profile for consumers in Day Programs

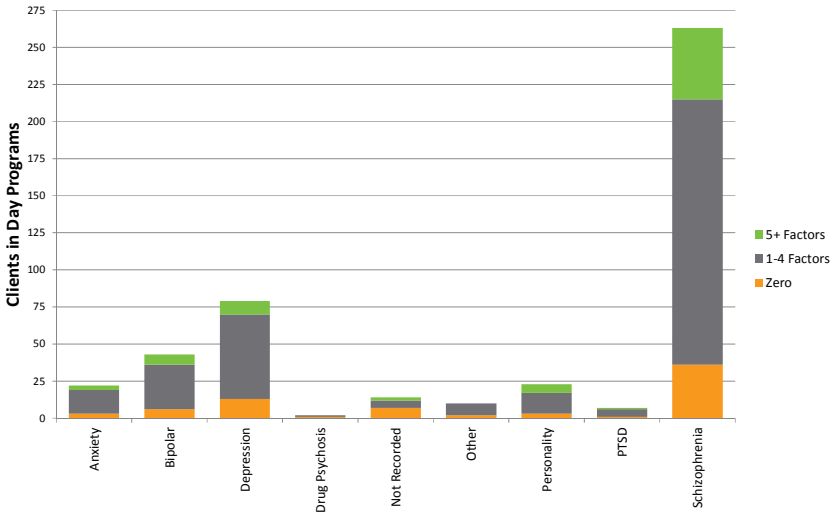
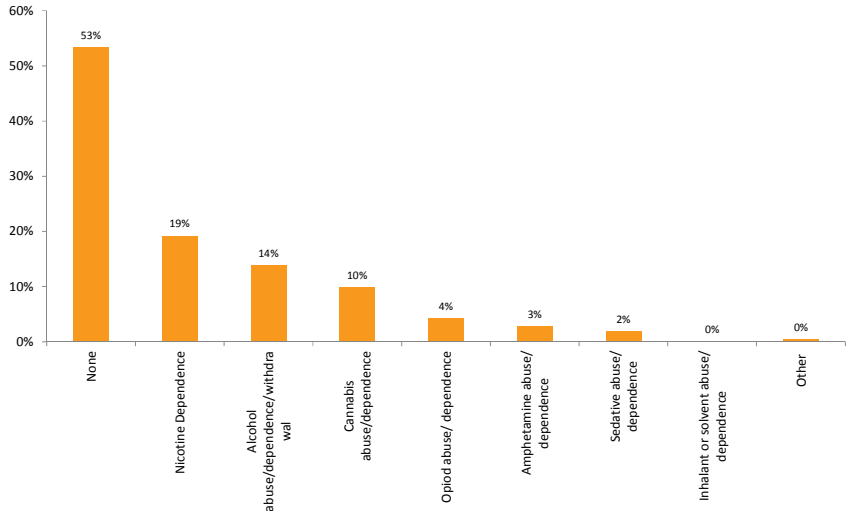


Figure 11: Alcohol and drug dependence profile for consumers in Day Programs



3.5 Outcomes

Recommendation (part a): Orient the Day Program service model to deliver an agreed set of consumer-focused, mental health recovery outcomes with a greater focus on mental and physical health, economic participation through education and employment, and social participation.

Recommendation (part b): Link consumer outcomes to individual service provider performance, include a performance assessment in funding and service agreements.

Arguments supporting this recommendation:

- Day Program providers and consumers commented that the current model for Day Programs does not adequately deliver on improved mental health outcomes or on other recovery outcomes for consumers
- The Department's current output-focused performance framework for Day Programs means that providers are not accountable to deliver recovery outcomes for consumers
- Day Program providers have a strong desire to identify outcomes measures and implement outcome data collection. Three of the nine components of the outcome focus are explored in more detail:
  - *Employment and education* - There is strong evidence to highlight the importance of an education and employment outcome focus for consumers with a severe and enduring mental illness. However, the majority of Day Program consumers are unemployed and providers are mixed in their views about the capacity of their consumers to achieve education and employment outcomes
  - *Physical health* – Population health data show that people with a severe mental illness have higher rates of mortality and physical morbidity than the general population. This is supported by the experience of Day Program providers. Though providers do have relationships with health organisations, data is not collected on each consumer's physical health and physical health is a not a focus of current Day Programs
  - *Housing* - Stable and affordable housing is critical for people recovering from a severe and enduring mental illness. In Day Programs, most consumers live with their family or are in public/private rental accommodation. Housing is not an outcome focus of Day Programs and providers have found it traditionally challenging to establish formal partnerships with public housing providers.

Day Program providers commented that the current model for Day Programs does not adequately deliver on improved mental health outcomes or on other recovery outcomes for consumers.

Both the SWOT analysis and provider consultations identify that many providers use the language of recovery. However, the articulation of recovery outcomes differs across providers. At a departmental level, long-term success measures and recovery aims are not well articulated. Table 14 outlines a qualitative assessment of the performance of the Day Programs against long-term recovery outcomes identified in program logic models developed for this strategic review. This assessment is based on the literature review, stakeholder consultations and available data such as QDC and the PDRSS census survey.

Table 14: General assessment of recovery outcomes achieved for Day Programs

Programs	Mental Health			Physical Health	Social			Economic		Overall assessment
	Enhanced daily living skills	Psychosocial education attainment	Self-management of illness	Good Physical health and wellbeing	Improved social and family relationships	Stable and affordable long term housing	Family/Carer support and engagement	Educational and vocational achievement and employment	Reduced requirement for intensive clinical support[II]	
Day Program									*Unable to make an assessment*	**Low-medium**
Overall assessment	**Medium**	**Medium**	**Medium**	**Medium**	**Low-medium**	**Low-medium**	**Low-medium**	**Low-medium**	***Unable to make an assessment****	**Low-medium**

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

The Department's current output-focused performance framework for Day Programs means that providers are not accountable to deliver recovery outcomes for consumers.

Current data collected for service delivery at a departmental level are output focussed and offer limited insight into the performance of the Day Program. There is a strong desire from Day Program providers to identify outcomes measures and to define what recovery looks like. In comparison to the clinical sector, PDRSS provide little information on service delivery, and collect a very limited set of data. The data collected at a departmental level are limited to outputs and no outcome data are collected. Some organisations use a variety of wellbeing tools such as CAN-C and BASIS-32 to assess consumers' progress towards recovery. However, it is left to providers to select an assessment tool. Data from assessments are not collected at a departmental level. It should be noted that some providers attempt to collect some outcome data, for example SNAP and NAEMI.

The SWOT analysis and clinical and Day Program providers identify that many providers use the language of recovery; however, the articulation of recovery outcomes differs across providers. At a departmental level, long-term success measures and recovery aims are not well articulated.

It is a service delivery requirement for all consumers entering Day Program to work with their case workers and identify recovery goals for the duration of their support period. The Individual Recovery Plan (IRP) that captures these goals forms the core document to plan services delivered to a consumer. However, Nous observed from Day Program documentation that the quality of IRPs developed by Day Program providers differ considerably in quality, particularly in the clarity of goals developed for consumers. Nous also observed that IRPs frequently do not specify goals that will result in measureable and sustainable recovery outcomes for a consumer.

Day Program providers have a strong desire to identify outcomes measures and collect outcome data.

All providers are familiar (to varying degrees) with the process of recovery and desirable recovery outcomes. A consistent, sector-wide definition of recovery outcomes will assist both case workers and consumers to better identify recovery goals for consumers' Individual Recovery Plans (IRPs). The providers have a strong awareness of and agreement about the recovery outcomes that PDRSS programs should deliver. The recommended outcomes are listed in Table 15.

Table 15: Recommended outcomes

Component	Summary recommendation	
1. **Mental Health**	• Daily living skills • Psychosocial education • Self-management of illness and reduced psychological distress.	Improved mental health for consumers remains a key goal of PDRSS services. The sector should aim to reduce the number of negative psychosocial episodes and periods of decline in mental health. This can be achieved by ensuring consumers receive psychosocial education, skills for daily living, self-management of illness and reduced psychological distress. Shean (2009) provides a meta-analysis of psychosocial recovery practices that summarises the compelling evidence base for the components of this outcome measure.[15]
2. **Economic**	• Educational and vocational achievement and employment • Reduced requirement for intensive clinical support, including acute inpatient admissions.	There is strong evidence for the importance of supported employment or education as one of the primary goals of recovery. Such outcomes have been shown to be critical to an individual's recovery.
3. **Physical health**	• Physical health and wellbeing.	The sector recognises that there should be a renewed emphasis on physical health; as this element has not received adequate attention in the past. In comparison with the general population people with a severe mental illness have higher rates of mortality and physical morbidity.
4. **Social**	• Improved social and family relationships • Family/carer support and engagement • Maintain stable and affordable long-term housing.	The key role of families and significant others in consumer recovery is well documented in the Department's policy literature. There is reliable practice evidence on specific activities mental health providers can utilise to foster better recognition of families and significant others and achieve more enduring recovery outcomes for consumers. Housing does not fall under the domain of the Department of Health. However there is an explicit acknowledgement that stable and affordable housing is fundamental to recovery, and while the shortage of public housing in Victoria continues, improved access to housing options will remain a key outcome for PDRSS programs.

Employment and education **– There is a strong evidence base to validate the importance of an education and employment outcome focus for consumers with a severe and enduring mental illness. However, the majority of Day Program consumers are unemployed and providers are mixed in their views about the capacity of their consumers to achieve education and employment outcomes.**

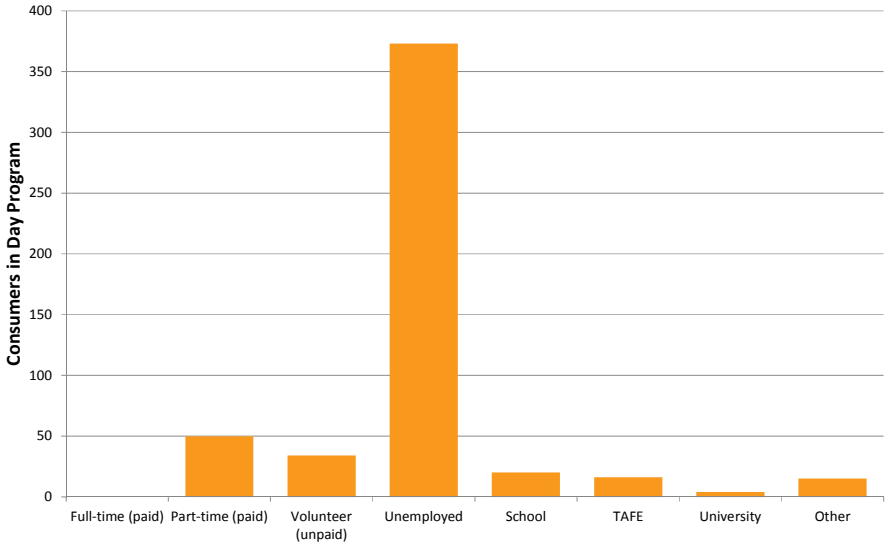
Figure 12 shows that 72% of Day Program consumers are unemployed. 7% of consumers are studying and 16% are either in paid or volunteer work.

Day Program providers were mixed in their views about the capacity of their consumers to achieve educational qualifications and/or become employed. Some providers, such as MIF, were quite sophisticated in their approach and were achieving education and employment outcomes according to their own records.

Most providers were familiar with the research evidence of the improved consumer outcomes from a clear employment and employment orientation and they acknowledged that new skills would be required.

Appendix C.1 and C.2 provide the research base to support a focus on education and employment outcomes for consumers who have a severe and enduring mental illness.

Figure 12: Day Program education and employment participation



Physical health **– Population health data shows that people with a severe mental illness have higher rates of mortality and physical morbidity than the general population. This is supported by the experience of Day Program providers. Though providers have relationships with health organisations, no Day Program data is collected on each consumer's physical health and physical health is a not a direct focus of existing Day Programs.**

Though no formal data are collected on each consumer's physical health, Clinicians and Day Program providers commented that their consumers with a severe mental illness experience more issues with their physical health than the general population. These stakeholder comments are supported by studies that suggest that people with a severe mental illness have a lower life expectancy than the general population and have a higher diagnosis rate of diseases such as diabetes and cardiovascular disease.[16]

The seminal study published in Western Australia, *Duty to Care: Physical illness in people with mental illness* (2001) identifies that people with a mental illness are two-and-a-half times more likely to die from the most common causes of death in Western Australia.[17] The Mental Health Council of Australia cites this study to argue that people with a severe mental illness are more likely than the general population to:

- Have a physical illness, and for that illness to go undiagnosed and untreated
- Engage with high-risk behaviours that impact their physical health, such as smoking (the PDRSS Census indicates high rates of smoking and alcohol/drug dependence across consumers in Day Programs)
- Overlook health promotion behaviours such as exercise and a healthy diets
- Suffer from high levels of stress, frustration and anger due to their mental illness and the associated stigma they experience.[18]

Day Program providers maintain some relationships with health organisations (particularly GPs); however, few providers have productive partnerships with community health services (including dental services, podiatrist, and dieticians). Carers, Clinicians and Day Program providers observed that current partnerships with community health services are not sufficient to adequately address physical health issues. These stakeholders noted that even when there is a partnership with a community health service they typically provide in-reach for only a few hours a week (often only one hour per service), which is not enough time for consumers to receive assistance. These stakeholders did identify that some Day Program providers have assisted consumers to access St Vincent's Hospital's 'Optimal Health' Program which is run over eight weeks and focuses on overall health and wellbeing, how to manage stress and recognise early warning signs. However, due to their mental illness and the way that services are organised, the majority of consumers have difficulty accessing primary health services.

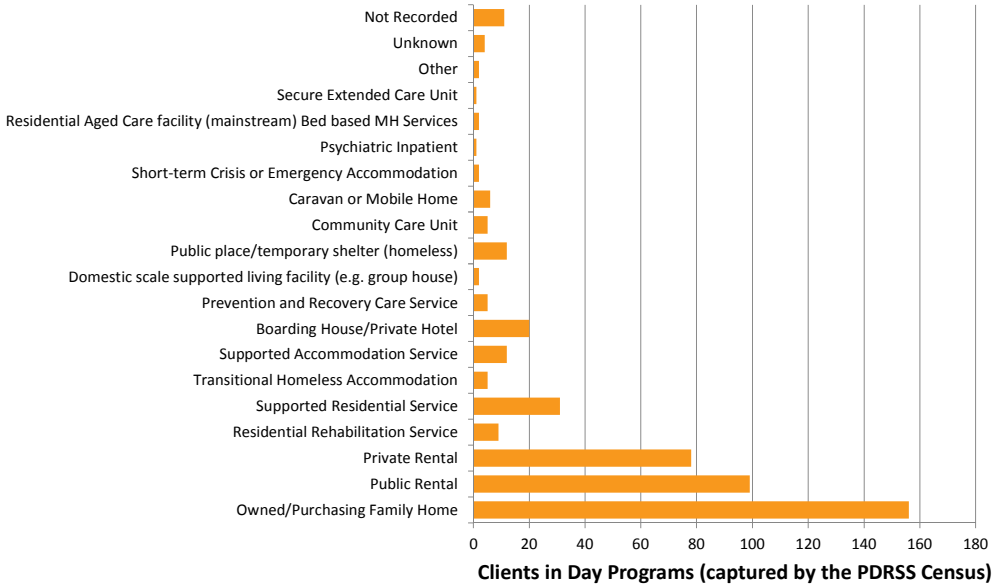
***Housing* - Stable and affordable housing is critical for people recovering from a severe and enduring mental illness.[19] In Day Programs, most consumers live with their family or are in public/private rental accommodation. Housing is not an outcome focus of Day Programs and traditionally providers have found it challenging to establish formal partnerships with public housing providers.**

All stakeholders strongly identified the shortage of stable housing as a significant barrier to consumers in Day Programs achieving the recovery aims of those programs. Over 70% of consumers live with their family or are in public/private rental accommodation.

People recovering from a mental illness identify access to a stable and affordable home as the most critical issue affecting their quality of life and capacity for recovery. It is estimated that over 40% of people with severe mental illness are homeless or housed in tenuous accommodation, often interspersed with periods of hospitalisation and sometimes incarceration.[20]

Appendix C.3 outlines the challenges people with a mental illness face with Victoria's public housing.

Figure 13: Day Programs housing arrangements



3.6 Service delivery model

Recommendation: Adopt evidence-based service delivery models to assist consumers' access group-based activities in mainstream community settings and extend delivery hours beyond Monday to Friday, 9am – 5pm. The extended delivery hours should include weekends and non-business working hours.

Arguments supporting this recommendation:

- Day Program providers currently use different service delivery models but are beginning to adopt more consistent evidence-based service delivery models
- The centre-based location of many Day Programs often creates negative stigma by isolating consumers from the community
- There is strong evidence for group-based psychosocial recovery activities. However, Consumers, carers and providers observe that though there are many providers, there are limited group-based activity types and the 'business working hours' of service hours adversely affects the recovery options for consumers
- The challenges with Day Program service delivery are consistent with the findings in the 2006 VICSERV report, Into Community: Day Program past, present and future.

An illustration of the proposed service delivery model is provided in Figure 14.

Figure 14: Proposed Day Program service delivery model

Community Recovery model

Day Program providers currently use different service delivery models but are beginning to adopt more consistent evidence-based service delivery models.

In the Day Program Review, consumers, carers and providers identified a lack of consistency across Day Programs in the service delivery model. The three models most commonly identified were the:

- Strengths-Based Model
- Boston Rehabilitation Model
- Collaborative Recovery Model.

Consultations in the Day Program Review indicate that the Collaborative Recovery Model and the Strengths Model are replacing the Boston Rehabilitation Model and the Clubhouse Model. For example, Neami and SNAP both use the Collaborative Recovery Model.[III] Appendix C.5 outlines the current evidence base for the Collaborative Recovery Model and the Strengths Model.

In 1992, VICSERV identified fifteen core principles of psychosocial rehabilitation to guide the practice of its member organisations. However, the SWOT analysis found no application of these principles and concluded that this impacts service definition and service integration across the PDRSS sector.[21]

Appendix C.4 outlines the evidence base that supports these two philosophies.

[III] These two organisations are also participating with the University of Wollongong in a five-year NH&MRC-funded research project examining the effectiveness of this model. Their involvement in this project has required that all staff undergo training in use of the Collaborative Recovery Model.

Providers identified that the centre-based location of many Day Programs often creates negative stigma by isolating consumers from the community. Some services are now providing community-based activities with success.

Most Day Programs are delivered primarily through PDRSS centre-based activities. Providers identified that the centre-based location of many Day Programs often stigmatises consumers by isolating them from the community. This view is balanced by consumers who often regard PDRSS as a safe place away from community stigma and judgement.

A number of providers also deliver their Day Program through a 'drop-in' service. It appears this is largely designed to enable informal interaction for a socially isolated cohort, many of whom spent time in institutional settings. At least one organisation has sought assistance from Our Consumer Place, the state-funded consumer resource centre, to develop alternative ways of providing this form of peer support.

Some services are now providing all or mostly community-based activities with success. Providers such as MIF (Bromham Place), Neami and SNAP now offer all Day Program activities within a community setting, rather than at a PDRSS centre. These providers have noted considerable success in the community-based model – particularly in achieving community engagement.

Research evidence for the delivery of Day Program activities through mainstream community settings is provided by Weir and Rosen (1989). They describe the evolution of Living skills centres[IV] in NSW from 1977 to 1989[22]. The centre's objectives were to increase daily living skills, social skills and interpersonal relationships; to educate consumers and their families; to establish and widen their social networks and support systems; and to encourage the use of existing community facilities and resources (p.86).[23] Many activities were centre-based but the majority were undertaken in the community and the consumer's home environment, based on the principle of 'in vivo' learning (p.87).[24] From 1977 to 1989, 750 consumers had attended, with many moving on to paid jobs or voluntary work. However, young people often dropped out due to difficulty in coping with the age range, degree of impairment of other consumers and the large numbers attending the centre (p.89).[25] This problem was resolved through greater use of outreach and an expansion of vocational activities. By 1988, 45 living skills centres had been set up throughout NSW (p.90).[26] [V]

[IV] Living skills centres in NSW are comparable to Victoria's psychosocial rehabilitation Day Program. However, most NSW living skills centres have clinical staff and are managed by local clinical mental health services, whereas in Victoria, NGOs run the PDRSS Day Program.

[V] The NSW Mental Health Coordinating Council's 2002 submission to the NSW Select Committee on Mental Health, observed that many living skills centres in NSW have been replaced by home-based clinical rehabilitation for individual consumers (p.17).

There is strong evidence for group-based psychosocial recovery activities. However, consumers, carers and providers observe that though there are many providers, there are limited group-based activity types and the 'business working hours' of service hours affects the recovery options for consumers.

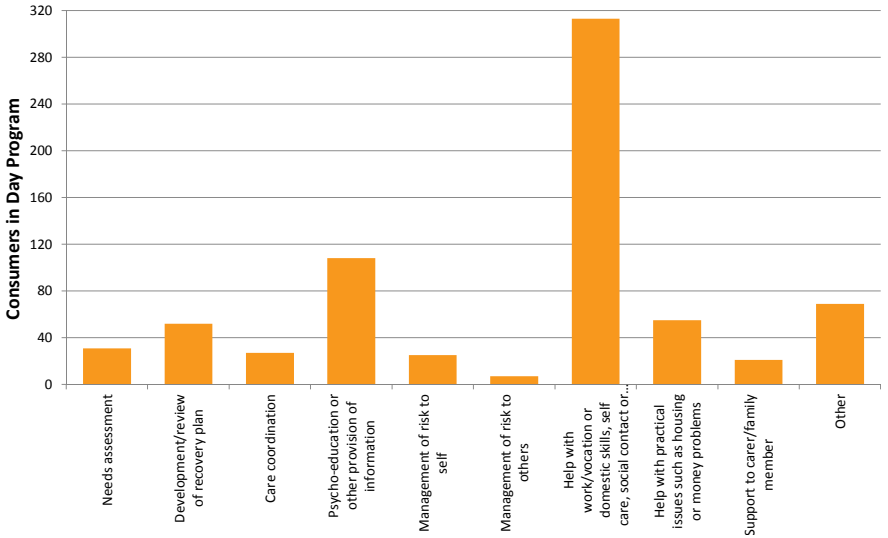
Huxley, Rendall and Sederer (2000) conducted a meta-analysis of psychosocial treatments in schizophrenia and found strong evidence to support group based therapies that focus on social and independent living skills.[27] This analysis has been further endorsed by Kurtz & Mueser (2008) who conducted a meta-analysis of controlled research on social skills training for schizophrenia.[28]

Group activities run by the 58 Victorian Government funded Day Programs include art classes, music classes, cooking classes, budgeting skills and excursions (for example, to community services or events). Figure 15 shows that on a given day, a large proportion of Day Program consumers (68%) require assistance with work, domestic activities, self-care, social contact or recreation. The next most common service provided to consumers is assistance with psycho-education or provision of other information (23%).

There is a broad perception across all stakeholder groups that the Day Programs provide little choice for consumers– particularly in terms of education and employment activities. The SWOT analysis identifies that there is a gap between services offered and those wanted and needed by consumers.[29] In rural areas, there is a view that the limited variety of activities is compounded by the lack of competition for consumers by providers.

Consumers, carers and providers observed that the standard operating hours (9am to 5pm Monday to Friday, and closed over weekends and major holiday periods) excludes consumers who have full-time employment. It also sets attendance at Day Program as the norm rather than encouraging engagement with employment, education and other 'mainstream' activities that occur during business hours.

Figure 15: Activities provided by Day Programs



The challenges with Day Program service delivery are consistent with the findings in the 2006 VICSERV report, *Into Community: Day Program past, present and future*.

The VICSERV report noted operational changes over time, and raised issues regarding their future direction, including recommendations about action[30]. It observed that *'despite an extensive search, very little published research or evaluation on Day Program was found'*. The report concludes that Day Programs '*are no longer necessarily centre-based, group-focussed or offering activities only within standard business hours.*' However, the number of PDRSS providers delivering services in the community is still very limited. Key issues noted in the report:

- The majority of Day Programs exist as stand-alone services
- The lack of a clear definition of Day Program or agreed service practice guidelines
- Concerns about 'drop-in', such as the risk of centres providing 'drop-in' becoming segregated and stigmatising ghettos which isolate consumers from their surrounding community. Conversely, 'drop-in' can be supportive and valued by consumers as a 'safe haven', and for some is a necessary first step on their recovery journey.

A number of other issues raised in this report are highlighted in Table 16.

Table 16: Day program issues

Other day program issues	
• Balance between individual versus group activities • Day program outreach support compared to home-based outreach support • Community access • Links to employment services • Community development and mental health promotion • Workforce matters.	• Consumers with specific needs (younger age groups, CALD consumers, consumers with dual diagnosis) • Consumer participation in service delivery • Working with families and carers • Access in terms of time and place; collaboration with other services such as AMHS and GPs.

3.7 Support period

Recommendation: Adopt two types of support periods for this program. The first is for 'no more than 18 months' for younger consumers or those who are accessing services earlier in disability. These consumers should also have the option to re-enter the program at a later stage. The second is 'extended' for consumers with a higher degree of disability.

Arguments to support this recommendation:

- The majority of consumers in Day Program have remained for longer than the recommended Departmental guidelines of 12 months to 2 years support period.[31] Almost a third of consumers have remained in Day Program for five years or more
- The majority of consumers attend services more than once a week. A large minority of consumers receive more time per contact with services than ARR or YRR consumers. However, the average contact for consumers in Day Program is less than the individual support delivered by standard HBOS.

The majority of consumers in Day Program have remained for longer than the recommended Departmental guidelines of 12 months to 2 years support period.[32] Almost a third of consumers have remained in Day Program for five years or more.

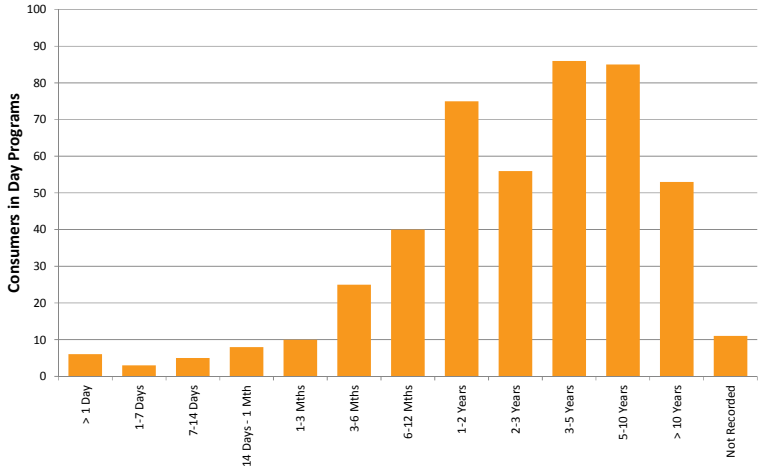
Figure 16 shows the support period for consumers in Day Programs captured in the PDRSS census survey.

There is a distinct and large cohort of consumers who have participated in Day Program for the long term. 48% of consumers have participated in Day Program for more than 3 years. 30% of consumers have attended Day Programs for more than 5 years and 11% of consumers have attended in-services for more than 10 years. Long-stay consumers are predominantly male and 35+ years old and many of these consumers may be experiencing ongoing effects of institutionalisation.

For consumers who may be experiencing ongoing effects of institutionalisation, providers noted that there was recognition required that for these consumers' the focus is on 'quality of life'. Hence it is understandable for these consumers to use the service indefinitely.

On the other hand, for consumers earlier in illness and disability who are seen as more capable of recovery, service providers noted that was important to limit the time of the support period. Providers believed that 18 months is sufficient time to achieve recovery goals without re-institutionalising and creating dependence.

Figure 16: Support period for consumers in Day Programs



The majority of consumers attend services more than once a week. A significant minority of consumers receive more time per contact with services than ARR or YRR consumers. However, the average contact for consumers in Day Program is less than the individual support delivered by standard HBOS.

Figure 17 shows the service frequency for consumers in Day Programs captured in the PDRSS census survey. A large proportion of consumers (52%) attend services more than once a week. 25% of consumers attend services weekly, which is the next most common frequency of attendance.

Figure 18 highlights the time contact profile for consumers in Day Programs. Day Program consumers receive more time per contact with services than Adult or Youth Residential Rehabilitation consumers. 41% of consumers receive 2-3 hours per contact with the service – the most common recorded average length of contact time. It is assumed that the majority of this contact time is via group-based activities. It should be noted that modelling suggests that the average contact for consumers in Day Program is 1.34 hours per week[33] (see Appendix D.3). This is less than the 1.5 hours per week of individual support delivered by standard HBOS.

Figure 17: Service frequency for consumers in Day Programs

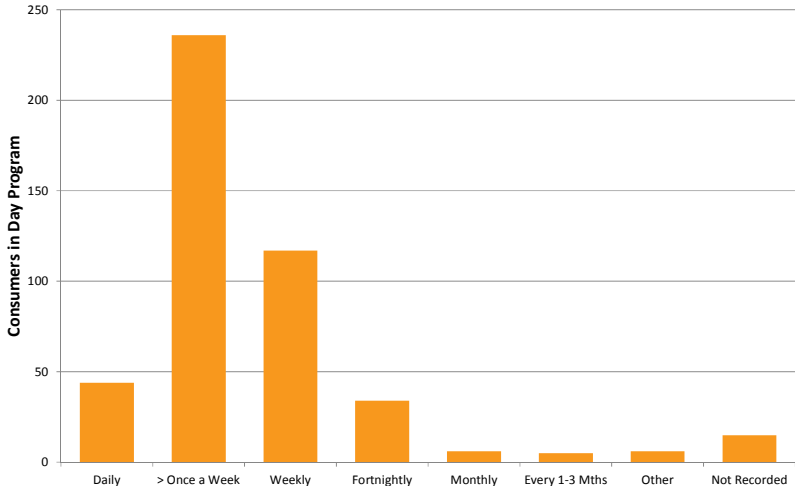
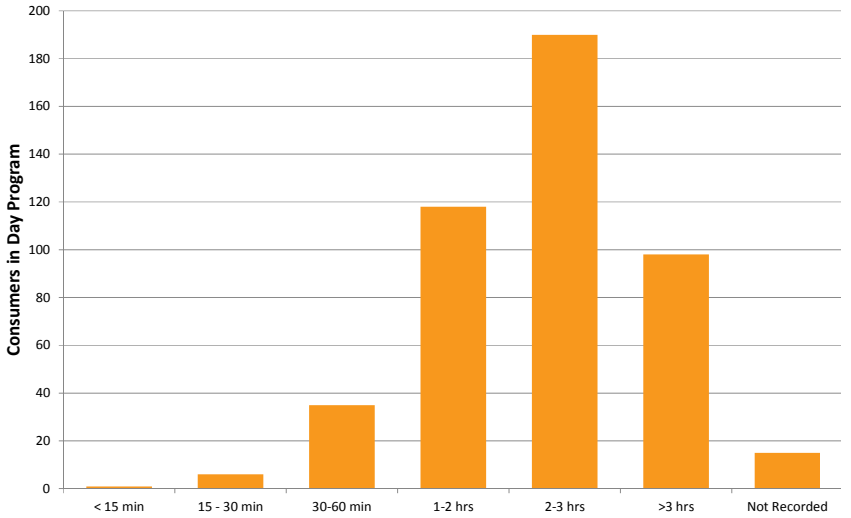


Figure 18: Time contact profile for consumers in Day Programs



3.8 Geographic distribution

Recommendation: Conduct a detailed geographic demand study to determine distribution requirements for the proposed service delivery model across Victoria.

Providers' consultations, departmental conversations and policy documentation indicate that the geographic distribution Day Programs across the state was determined more by opportunity than design. Consequently, there is an uneven distribution of Day Programs. There are also challenges with transport to access these programs; particularly outer metropolitan areas that are poorly serviced by public transport and in rural areas where large distances are also an issue. There is no available data that accurately determines service demand. Waiting lists are not maintained by providers though providers indicate close to 100% utilisation of their services.

Current service distribution across Victoria indicates Day Programs are widely spread. There is volume concentration in North, Western and Southern Metropolitan region. There is comparatively higher per capita representation in Barwon South West and Loddon Mallee. Table 17 outlines the distribution of the three programs in Victoria.

Table 17: Distribution of programs

Catchment	Population	Estimated population with severe mental illness (3% of the total population)	Estimated population with current severe mental illness (30% of the severely mentally ill population)	Day Programs hours delivered	Day Programs hours delivered per capita (by population with a current severe mental illness)
North and Western Metro Region	1,848,643	55,459	16,638	166,463	10.0
Southern Metro Region	1,361,175	40,835	12,251	129,057	10.5
Eastern Metro Region	1,053,316	31,599	9,480	72,554	7.7
Barwon South West	383,857	11,516	3,455	73,827	21.4
Loddon Mallee	318,162	9,545	2,863	43,255	15.1
Hume	275,004	8,250	2,475	26,424	10.7
Gippsland	259,182	7,775	2,333	13,680	5.9
Grampians	213,826	6,415	1,924	23,486	12.2
TOTAL	**5,713,165**	**474,917**	**51,418**	**474,917**	**9.2**

Appendix D.2 provides a spatial map of the distribution of Day programs across Victoria.

3.9 Service coordination and partnerships

Recommendation: Formalise service coordination mechanisms with specialist clinical mental health, community, social, and health and primary care services to scale the treatment and support response to each consumer's need. Establish clear, non-discretionary entry and exit criteria and pathways on an area mental health service basis.

Currently, there is no formal mechanism to coordinate service activity for Day Program consumers. Similarly, while there are examples of productive partnerships, there is scope to substantially improve partnerships to achieve recovery aims for consumers.

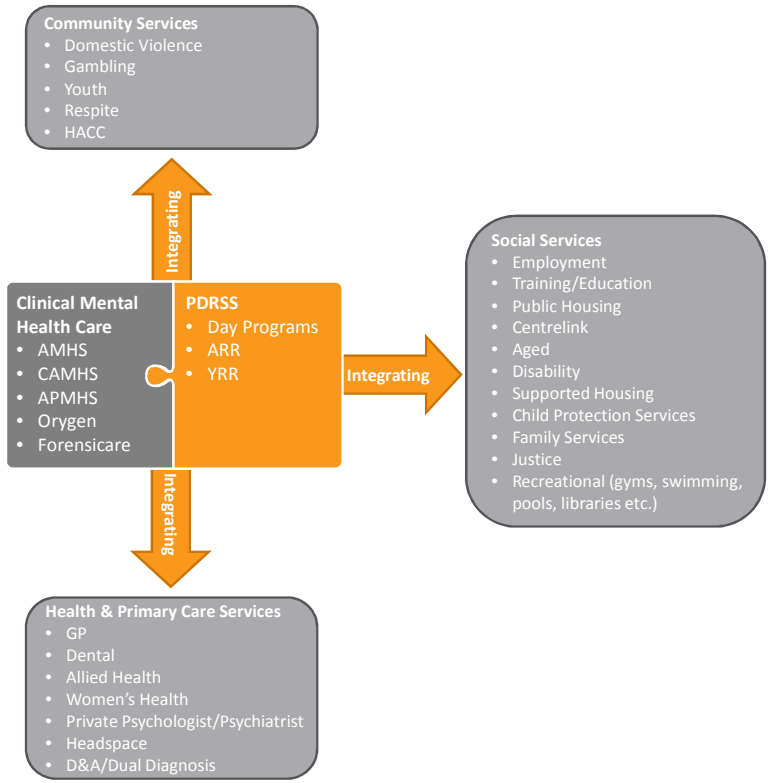
As shown in Figure 19, the treatment and support response by Day Programs should be provided through a flexible process to scale its service to each consumer according to need:

- Scale up - to enable referral to specialist clinical mental health services for a swift and targeted response when a consumer's clinical state worsens (avoiding later, and potentially more traumatic, admissions to clinical services due to further deterioration)
- Scale down – includes a range of transition services (outside of hospital) where consumers can receive varying levels of support to recover and transition back into the community (similar to rehabilitation options available for other physical illnesses).

The new Care Coordination roles funded from the 2009/10 State Budget may be an important enabler of more flexible support services for consumers.

There are also no clear and transparent entry and exit criteria and pathways for Day Program consumers. Hence the proposed Day Program service delivery model will need clear, non-discretionary entry and exit criteria and pathways on an area mental health service basis to ensure better targeting and throughput.

Figure 19: New Day Program transition arrangements



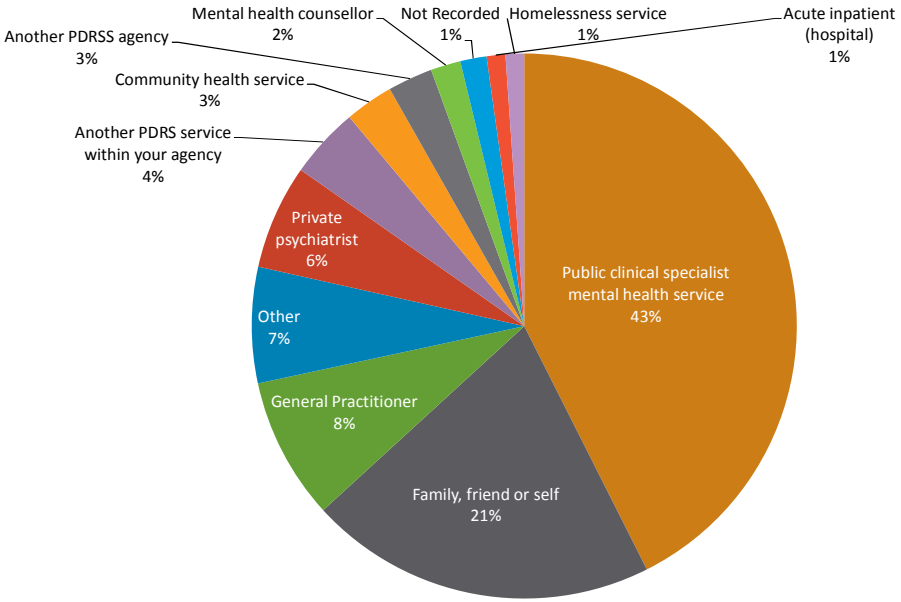
The most common referral pathways into Day Programs are through public clinical specialist mental health services and from family, friend or self. However, there is no formal entry coordination mechanism and the selection method of consumers into Day Program services is not transparent. There is concern expressed about the unknown exit pathways for consumers.

Figure 20 shows the most common referral pathway into Day Programs is through public clinical specialist mental health services (43%). The next largest sources of referrals are friends, family and self with 21% and general practitioners (8%).[34]

The broad range of referral sources indicates a large and complex network of entry and exit pathways into Day Programs. Similar to ARR and YRR, clinicians, providers and the Department observed that there is no formal entry coordination mechanism to get into Day Programs, and the method for selection of consumers into Day Program services is unclear and not standardised. However, these stakeholders emphasised the importance of maintaining the broad set of entry pathways with Day Programs.

It is also unclear where consumers go when they exit the Day Program as there is no data to indicate exit pathways. Providers were unable to clarify the exit destination for consumers. Clinicians noted that once a consumer is referred to a Day Program, they often do not see the consumer until they end up in the emergency department of their hospital. Clinicians and providers observed that this lack of knowledge is concerning, as many of the target consumer group are seen as especially vulnerable.

Figure 20: Referral pathways for Day Program

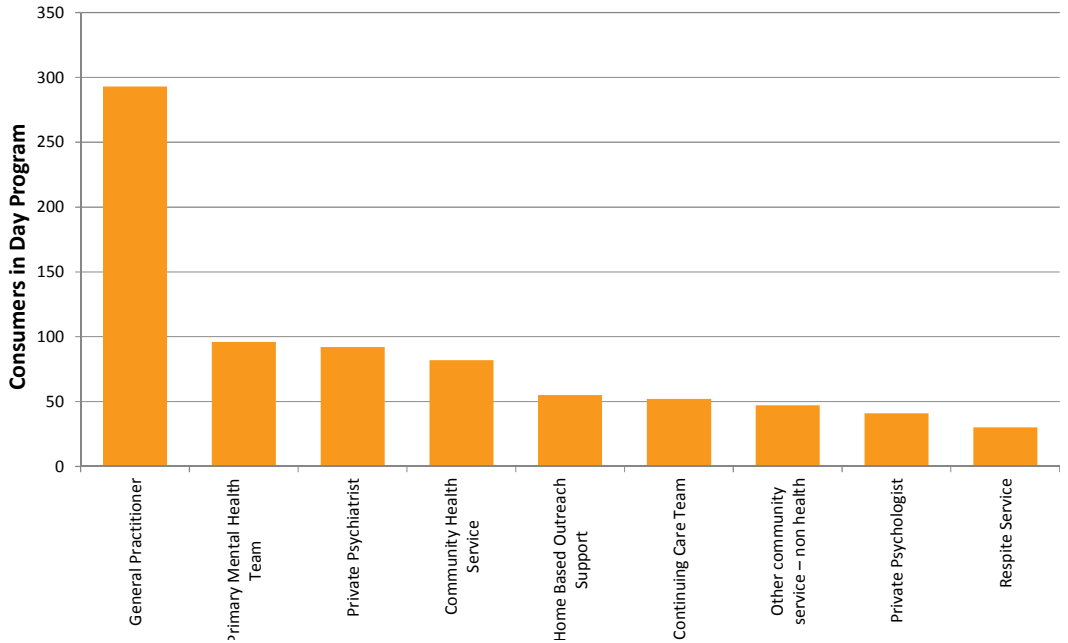


Despite some productive partnerships, further improvement to partnerships will assist recovery aims for consumers. The new Care Coordination roles may be an important mechanism to coordinate support services.

Partnerships between services are critical to the recovery services delivered by Day Programs. Partnerships with employment and education, community health, housing, clinical and recreational services assist consumers to connect with services that will assist recovery and social inclusion through sustainable re-connection with the mainstream community. Providers observed that the new Care Coordination roles may be an important mechanism to coordinate support services from the community, social, health and primary care sectors, including Day Programs.

Figure 21 shows that 9 out of the 10 most used external services by Day Program consumers are health-based. Only a small number of consumers are linked to other community services. Consumers, carers and providers expressed the view that this hinders the recovery process for consumers and the transition back into the community. Clinicians observed that there is an increased burden on clinical services when PDRSS are not operating – problematic as there are also fewer clinical services open during these times.

Figure 21: Day Program health and community service use profile – 10 most used services (other than Day Program)



The SWOT analysis identifies that an effective way to leverage partnerships to achieve outcomes is through a co-location arrangement. In this arrangement, Day Programs are delivered from within other agencies with relevant programs such as community health, social support services, clinical services, employment and child youth and family programs. For consumers, co-location enables fast and direct access to required service.[35] Providers have identified the effectiveness of this approach as akin to a 'one-stop-shop' that improves ease of access for a consumer population who find it difficult to navigate the myriad of available services. However, co-location is only one response to the issue. There are other ways to strengthen partnerships, including through joint protocols, common tools, shared data platforms and shared service delivery.

Table 18 provides a general assessment of partnership arrangements between Day Programs and key services together with examples of productive partnership arrangements.

Table 18: Day Program partnership assessment

Service	General assessment of Day Programs partnership arrangements	Example(s) of partnership arrangement
Employment and education	• Mostly referral arrangements with local employment service or specialist employment consultant in-reach • Some partnerships with job agencies, however little evidence in employment figures that this is producing outcomes • Some Day Program providers employ their own employment specialists and are training them to work in the mental health sector • Some have partnerships with education institutions, and at least one is a RTP offering general adult education certificates.	Mental Illness Fellowship (MIF) has successfully co-located specialist employment consultants within a clinical service. To facilitate this partnership, MIF have received funding from DEEWR. St Luke's Anglicare has co-located with local employment and CASA in a rural community centre. SNAP has established a successful formal partnership with local TAFE (MoU, joint procedures) and if necessary, workers attend with consumers to ensure success.
Housing	• Some relationships with housing associations, however with limited results due to significant structural barriers • Some Day Program providers have become housing providers in their own right to help overcome housing issues.	EACH and McAuley were approached by housing providers to provide nomination rights/support arrangements for local housing options.
Clinical sector	• With several notable exceptions, the relationships with the clinical sector are frequently characterised by poor communication, inadequate service coordination and difficult working relationships • There may also be significant ideological and cultural barriers that prevent better collaboration with the clinical sector. These findings are consistent with the findings from the Department's 2007 Report which noted: *"Clinical and PDRSS service sectors appear to operate relatively independently with few structural points of cross-over and integration resulting in a non-strategic, ad hoc approach to resource allocation."*	Pathways and Barwon Health have joint protocols, common tools, and shared data platforms.

Service	General assessment of Day Programs partnership arrangements	Example(s) of partnership arrangement
Community health services	◦ Mostly time limited contact, on 'as needs' basis ◦ A few Day Programs co-located with, or provide in-reach to, community health services/GPs.	EACH, Doutta Galla and Western Region Health Centre have their origins in community health and provide integrated access to dental, GP and allied health supports.
Community recreation services	◦ Limited number of arrangements with community recreation services e.g. gyms and libraries; however some services have developed strong linkages ◦ However, most contact with recreation services is through excursions.	SNAP plans to co-locate with the GP super-clinic in Sale.
Community services (e.g. homeless, youth, or family services)	◦ Referral arrangements as required ◦ However, limited contact with these services.	Pathways, Peninsula Support Services and Mind co-locate services with headspace services.

3.10 Workforce capability

Recommendation: Invest in workforce skills based on an agreed set of core competencies, and agree on a multi-level award structure (consistent with the Fair Work Australia award rationalisation initiative) that reflects the range of professional and non-professional skills requirements.

Arguments to support this recommendation:

- Day Program changes will be stymied without workforce skills development and a layered award structure
- The current Day Program workforce capacity and capability do not adequately support the recovery of the increasing number of consumers with increasingly complex issues
- There are only limited staff development opportunities and no established core competencies
- The lack of a structured career pathway and remuneration contribute to low staff retention and disrupt consumers' continuum of care. There is also a sense that the Day Program workforce is undervalued and lacks recognition.

Day Program changes will be stymied without workforce skills development and a layered award structure.

The proposed approach to Day Programs will require a changed workforce mix of professional, certificate, and specialist skills in employment and education. As shown in Figure 22, managing collaborative service delivery arrangements with other providers will require new skills for the workforce and higher skilled roles. Workforce recommendations include:

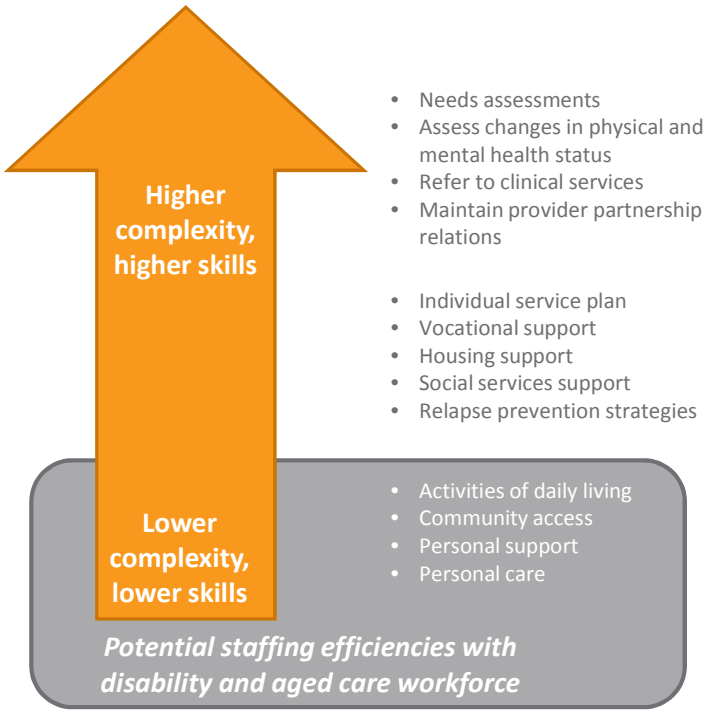
- **Skill development** - Investment in workforce development is required to increase the skill levels of the workforce.

  There are significant concerns expressed by the clinical sector, PDRSS sector, consumers and carers about the capacity of the Day Program workforce to effectively meet consumer needs, or to deliver new Day Program models. The new service models will require a mix of professional and non-professional workforce. Providers who have tried shifting to new service formats have found that the lower skill levels and resistance to change of the current workforce is a barrier to implementing new models.

- **Layered award structure** - PDRSS must develop a layered award structure to reflect the different skills levels, consistent with the Fair Work Australia award rationalisation initiative. The award must have opportunities for advancement if the sector is to retain and grow a skilled workforce.

Restructuring the award levels could enable potential staffing efficiencies with disability or aged care support workers. Some providers are already considering stratifying tasks into professional vs. less skilled roles - the less complex tasks being undertaken by a TAFE-trained worker & the more complex by those with a professional qualification.

Figure 22: Skill development



The current Day Program workforce does not adequately support the recovery goals of the increasing number of consumers with increasingly complex issues. There have only been limited staff development opportunities and no established core competencies.

Providers noted that the increasing complexity of consumers (especially the increasing prevalence of dual diagnosis consumers) requires a more highly skilled and qualified workforce for Day Programs. This view is supported by the SWOT analysis, which identifies workforce capacity and capability to deliver required services as a key threat to the sector as a whole,[36] The SWOT analysis also acknowledges the particular difficulty rural providers experience in attracting adequately skilled staff.

Some providers have implemented a minimum of a bachelor's degree as a prerequisite for employment. Both providers and the SWOT identified the PDRSS specific Certificate III qualification and the PDRSS specific expertise developed by many staff as strengths of the sector.[37] The Certificate III qualification however is a low level qualification.

Although the contribution that VICSERV makes to the development of PDRSS staff was widely acknowledged, both providers and the SWOT analysis identify that there has been limited investment in staff development. Providers observe that the limited staff development opportunities for staff affect the capacity of staff to develop and keep their knowledge up-to-date and relevant to consumers' needs. The SWOT analysis identifies opportunities for training in:

- Person-centred service delivery
- Understanding evidence-based practices
- An outcomes focus
- Practices of family inclusion
- Working with people with complex issues.[38]

Providers also identified a training need for working with consumers with alcohol and other drug dependence, skills in how to connect with housing and employment services, and skills in recovery planning. The SWOT analysis framed this as an opportunity to identify and develop a set of core competencies that are shared across clinical and PDRSS workforces.[39] The establishment of core competencies is a foundation block for a productive workforce.

The lack of a structured career pathway contributes to low staff retention which in turn disrupts consumers' continuum of care. PDRSS providers believe that the Day Program workforce is undervalued and lacks recognition.

Consumers and carers in particular noted a high turnover in staff in Day Programs. These stakeholders acknowledged that Day Program staff are generally hard working and often encounter difficult situations that may lead to stress and 'burn out'. The SWOT analysis also identifies the lack of career structures and development opportunities as key factors in poor staff retention.

Providers observe that the lack of career structures is compounded by the sense that there is inequity in pay between PDRSS and clinical staff. It is generally perceived by Day Program providers that clinical staff are paid 30% more than Day Program staff for similar positions. The exodus of many Day Program staff into the clinical sector is attributed by many providers to this pay differential, a factor also identified in the SWOT analysis. This perception is not shared by clinical stakeholders.

The SWOT analysis also identifies that the PDRSS workforce is undervalued and that there is a lack of recognition of the skills, competence and contribution of the workforce. This observation is supported by the views of Day Program providers who identify that low morale of staff is a key factor in high staff turnover and resistance to change service delivery practices.

Consumers and carers observed that high staff turnover results in low continuity of care which impacts on their recovery. Consumers find that they must re-tell their stories, re-form relationships of trust, and make new connections with each new staff member. This is especially difficult for a population that already struggles to make connections. Staff turnover was cited as disruptive to a consumer's sense of stability and trust.

Providers and carers observed that Day Programs are often characterised as a place for young staff (often graduates) to gain experience before moving to other parts of the system (e.g. clinical). Carers and consumers observed that staff are mostly young (in their early 20s), lack knowledge of the broader system and availability of services and lack the skills to assist high-needs consumers. These stakeholders also identified the difficulties that arise for staff and consumers in Day Programs when young staff have to advise much older consumers about skills of daily living. The perception is that young staff do not have enough life and work experience to provide this advice. It should be noted that the SWOT analysis characterises the PDRSS workforce as ageing and does not identify young staff as an issue for the sector.

3.11 Families and other carers

Recommendation: Reconnect and engage families and other carers in a consumer's recovery process, including decision-making, planning and activities.

Carers commented positively about the contribution Day Programs (and the clinical system) made to helping consumers learn basic living skills, and improve their coping skills. They also noted that Day Programs offer valuable socialising opportunities for consumers.

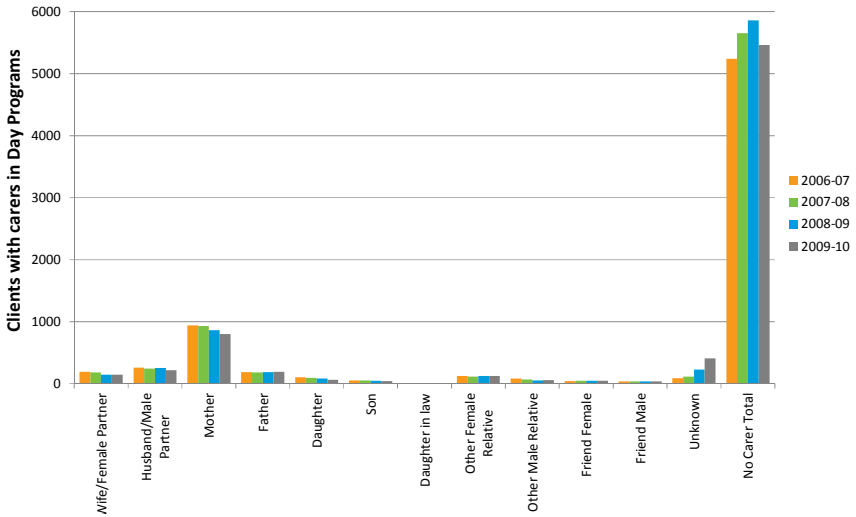
Carers also commented that they were usually not consulted in matters of planning and decision-making about their family member's progress. Day Program staff often justified this exclusion on the grounds of confidentiality. Carers noted that whilst Day Program staff might be involved with a consumer for a few years, families were often involved for their lifetime. Day Program providers interviewed as part of this project acknowledge that family involvement should be more actively sought and fostered.

The key role of families and other carers in consumer recovery is well documented in the Department's policy literature. (See Appendix C.7) There is also reliable research evidence on the specific activities mental health providers can utilise to foster better recognition of families and carers including staff training, family interventions and carer engagement protocols. (See Appendix C.8).

Figure 23 illustrates that many consumers have no identified carer. This highlights the need for Day Program providers to work with their consumers and aid them with reconnecting with their family or significant others.

The challenges carers experience in Day Programs is consistent with their experience of other parts of the mental service system in Australia. (See Appendix C.6).

Figure 23: Day Program carers



3.12 Funding model

Recommendation: Establish a service-based funding model with financial incentives for the achievement of individual consumer outcomes. Consider the use of consumer-orientated 'brokerage funds'.

Arguments supporting this recommendation:

- Current Day Program services are funded on an output basis across four types of activities based on group-based contact time. Many providers commented that this funding model limits service innovation and improvement
- The emerging funding model for people with psychiatric disabilities is client or person-centred funding. This comprises individualised packaging of services, tailored to meet the needs of a particular client. However, PDRSS sector capability, business models and history mean a hybrid approach may be necessary based on a service-based funding model with financial incentives for the achievement of individual consumer outcomes and a 'brokerage fund' for consumers.

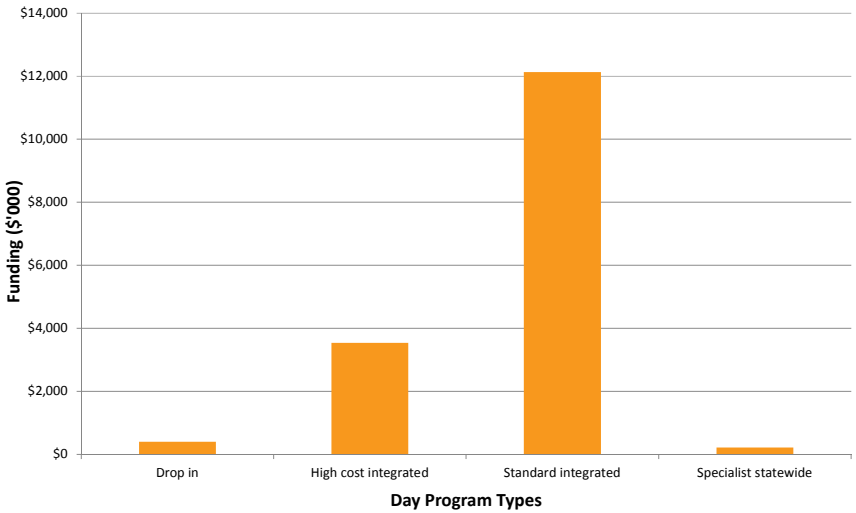
Current Day Program services are funded on an output basis across four types of activities based on group-based contact time. Many providers commented that the funding model limits service innovation and improvement.

Providers are currently funded for activity hours across four types of activities: drop-in, standard Day Program, high cost Day Program and specialist Day Program services. The Victorian Government invests $18.02 million of recurrent funding in Day Program. The Commonwealth Government provides an estimated $2.2 million per annum for a type of day program called Support for Day to Day Living in the Community. Figure 24 shows how the Victorian Government allocates its funding across the four Day Program activity types.

Provider consultations indicated that they do not always differentiate between the four different Day Program activity funding types and do not design activities accordingly. However, the department has not clearly articulated the differences between the activity funding types or followed up to see what they are doing.

Concerns were raised about PDRSS provider behaviour with the time-based funding model in a volume-based group setting. Providers indicated that in some circumstances they have held BBQs to attract large groups of consumers. This helps to acquit their time commitments. They also expressed frustration with the inflexibility of this volume-based approach to innovate and improve their services. It was suggested that group activity is useful but should be based on the individual recovery plans of consumers. Under this situation, group sizes could be better tailored.

Figure 24: Day Program funding types



The emerging funding model for people with psychiatric disabilities is the client or person-centred funding approach. This comprises individualised packaging of services, tailored to meet the needs of a particular client. However, PDRSS sector capability, business models and history mean a hybrid approach may be necessary based on a service-based funding model with financial incentives for the achievement of individual consumer outcomes and a 'brokerage fund' for consumers.

In Victoria, the client-centred approach with individual care packages, is used by Disability Services and by the Multiple and Complex Needs Initiative (MACNI). Mental Health is also making use of this approach, after trialling it through three Integrated Rehabilitation and Recovery Care Service (IRRCS) pilots in metropolitan Melbourne from 2007. Following the success of these pilots, the 2009-2010 State Budget included funding for the Intensive HBOS initiative. This initiative provides psychosocial support packages for a specified number of high needs clients.

The Commonwealth Government is also pursuing the individual service package approach. In the 2010/11 federal budget, funding was allocated for new service packages for people with 'severe mental illness' living in the community. These packages are for clinical & non-clinical services, and it is claimed that up to 25,000 people across Australia will benefit (Australian Government 2010-11 Health and Ageing Portfolio Budget Statements p.319).[40]

Other countries have also adopted the personalised approach to care delivery, including consumers having control of their own budget. For example, in England and Wales there is strong interest in developing more personalised approaches to the provision of care for people with a mental illness, also known as the 'consumer-controlled package of care approach'.[41] This includes consumers having control of a budget for services to meet their needs, or devolving this to a broker or other agent, including one nominated by the consumer.[42]

For Day Programs, the adoption of a client or person-centred funding approach may be unrealistic in the short-to-medium term. PDRSS sector capability, business models and history mean that a hybrid approach is necessary. It is suggested that a service-based funding model with financial incentives for the achievement of individual consumer outcomes be adopted with 'brokerage funds' for consumers. This approach helps providers maintain some cash flow certainty but rewards those providers who can more effectively achieve recovery outcomes with their consumers. The option of a 'brokerage fund' is an additional supplement for a consumer that can accelerate the achievement of recovery goals. This hybrid approach will need some careful consideration to ensure:

- 'Skimming' does not occur. That is, providers do not just work with the most recovery-ready clients
- The right payment incentives are defined for each type of recovery outcome
- There is clarity in the use of brokerage funds for consumers.

This hybrid approach has been utilised with success in the Commonwealth Government's Disability Employment Scheme and the Jobs Service Australia employment system.

3.13 Structural design

Establish competitive market conditions to ensure each Day Program is economical in scale and can deliver a quality service within the broader psychosocial recovery system.

Arguments supporting this recommendation:

- The Day Program service system set up by the Department through competitive tendering poses risks for the Government
- Optimal market design is a significant decision by Government. Selective tendering or accreditation appear to be the most viable design options. However, more detailed analysis is required before a final market design option can be agreed.

The Day Program service system set up by the Department through competitive tendering poses risks for the Government.

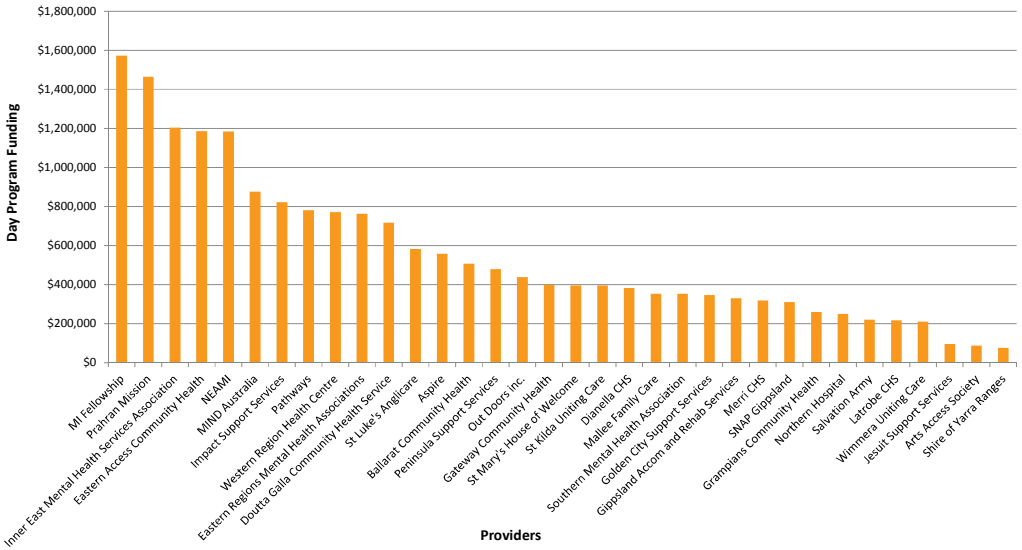
There are 34 Day Program providers contracted to deliver 58 activity types. Figure 25 shows that the funding of these providers ranges from $1.5 million to $75,000 for programs. Five providers receive recurrent funding in excess of $1 million, while three providers receive less than $100,000.[VI]

Both providers and the SWOT analysis identified that a strength of this sector is that it provides 'value for money' services in comparison to the clinical system. The SWOT analysis argues that it does this by leveraging community-based services and resources, and by attracting 'significant volunteer and philanthropic contributions'. However, many providers and the SWOT analysis identify that there are too many providers and this is a weakness.[43] The issues with small funding allotments to many providers include:

- Challenges with consistent service quality across providers
- Limited service provisions by some providers
- Limited capacity to invest in workforce development or to provide a viable career path.

Any new service design for Day Programs should better manage the size of each Day Program to improve the efficiency and service quality of the sector. Furthermore, any consolidation of current Day Program funding allocations to providers should be designed to ensure stability of service to consumers.

Figure 25: Day Program funding by provider



[VI] Note that this funding is for 2009-10 for 34 providers. There are 37 providers for 2010-11.

Optimal market design is a significant decision by Government. Selective tendering or accreditation appear the most viable design options. However, more detailed analysis is required before a final market design option can be agreed.

Market design is an increasingly critical responsibility of Government. The Victorian Government has partly outsourced the provision of services for people with a mental illness to the community sector. This has created a new market for the delivery psychosocial recovery services. The benefit of market design for mental health consumers includes:

- Development of new service options or access to previously rationed Government services
- Incentives for innovative PDRSS providers to increase quality and drive down costs.

The analysis of market design for Day Programs has highlighted that current market design is not achieving these benefits. Government needs to rethink its 'rules of the game' by aligning its policy goals with sustainable business practice of PDRSS providers. In developing these rules, Government needs to consider the population profile, regional and metro geography, workforce capability, service pricing, performance incentives and the interconnection of the Day Program with other programs.

Table 19 outlines market design options for Day Programs:

Table 19: Market design options

Market mechanism	Explanation	Assessment
Retendering	Publically retender all current contracts with sunset clauses.	Traditional – This is the current process and has created skewed markets.
Selective tendering	Select a small number of providers and run a closed tendering process with sunset clauses.	Better control – Allows Government to maintain better control of provider size and quality.
Accreditation	Establish an accreditation scheme with providers required to meet a series of minimum standards e.g. AusAID, Australian Aged Care.	Quality assurance – Provides Government with a safe guard of minimum provider standards.
Social Impact Bonds	Issue individual bonds to providers and pay a premium (i.e. interest) upon expiration for recovery outcomes achievers. NSW Government – Juvenile Justice and Mental Health.	Radical – This is only being trialled but is aimed at 'wicked' social problems in complex service systems such as mental health. It operates more like a public/private partnership.

4 Adult Residential Rehabilitation

4.1 Background to Adult Residential Rehabilitation

Adult Residential Rehabilitation Program is a bed based PDRSS program targeted to young people and adults with severe mental illness and associated psychiatric disability aged 16-64 years.

The Victorian Government currently invests approximately $4.8 million in bed based PDRSS Adult Residential Rehabilitation (ARR) services. The 103 beds are delivered through a total of nine ARR sites across the state. All of the nine services are located in metropolitan Melbourne.

The Adult Residential Rehabilitation program is funded to provide transitional support to assist clients to achieve their goals for independent living. The service model focuses on supporting clients to:

- Improve their capacity to manage and be responsible for their behaviour and self care
- Enhance their adaptive coping skills and decrease self-harming behaviour
- Enhance their social skills and daily living skills to maximise their ability to live independently in the community
- Develop and maintain links with the community, family and social networks
- Create educational and vocational opportunities.

Adult Residential Rehabilitation services offer either:

- 24 hour on site support, with capacity to provide staff sleepovers
- Less than 24 hour support, where staff support is available only during business hours and after hours supervision is not required.

Appendix A.2 provides the program logic for ARR.

4.2 Change needed for ARR

ARR should change from a bed-based transitional support program to a supported housing program where consumers are placed in end-point housing with HBOS.

Table 20 highlights the current situation of ARR and provides an outline for a repositioned ARR within the Victorian mental health system.

Table 20: The change needed for ARR

Program components	Moving away from . . .	. . . Moving towards
Why and for whom		
Purpose	• A bed-based transitional support program for people with a severe mental illness and psychiatric disability aged 16-64 years.	• A supported housing program for people 16-64 years old with a severe mental illness and associated disability.
Target group	• A largely homogenous consumer group characterised by being 26-44 years old (70%), male (62%), with a diagnosis of schizophrenia (79%) and Australian born (92%).	• Consumers who are in early stages of illness or recovery, are homeless or at risk of homelessness, and have families and other carers who are unable to provide accommodation.
Outcomes	• A focus on assisting clients to achieve their goals for independent living.	• Measureable mental health recovery outcomes with a focus on mental and physical health, economic participation through education and employment, and social participation.
Activity profile	• Limited choice of activities with 69% of activities centred on work, domestic tasks, self-care, social contact and recreation.	• Consumer choice for activities aligned to individual consumer recovery goals.
How		
Service delivery model	• No clear and consistent service delivery model but most regard ARR as a housing proxy. 83% of consumers list the ARR as their primary residence.	• Consumers are placed in appropriate end-point housing with HBOS.
Support Period and contact time	• 39%of ARR consumers, at the time of the PDRSS Census, were being supported for 1-2 years • Average contact for consumers (between 3 to 3.5 hours per week) being similar to individual support delivered by moderate HBOS.	• Based on the achievement of consumer recovery outcomes with the HBOS packages generally reducing in intensity over 12 -18 month periods.
Operating hours	• Either 24 hour on site support (with capacity to provide staff sleepovers) or less than 24 hour support (where staff support is available only during business hours and after hours supervision is not required).	• Service delivery hours based on current HBOS guidelines.

Program components	Moving away from . . .	. . . Moving towards
Delivery location	• Delivery through PDRSS residential bed-based, congregate facilities.	• Delivery location based on the agreed arrangements between the consumer and support worker including living alone or with others, private or public.
Distribution	• Program distribution in metropolitan Melbourne being based on opportunity rather than design. There are no regional ARRs.	• An equitable distribution across Victoria based on consumer demand.
Referral pathways	• Over 13 different, uncoordinated referral pathways with unclear selection methods, largely driven by individual provider sites and personal relationships.	• Streamlined and coordinated entry and exit pathways on an area mental health service basis with clear selection criteria.
With what		
Workforce	• Staff skills not adequate to support the recovery aims of consumers with increasingly complex issues.	• A mix of professional and non-professional staff matched to complex consumer needs and to the delivery of new service models.
Families and carer	• General exclusion on families and carers in the ARR activity.	• Connecting and engaging families and carers in a consumer's recovery process including decision-making, planning and activities.
Partnerships	• Pockets of productive non-health based partnerships.	• Partnerships with employment and education, community health, housing, clinical and recreational services to ensure consumers are connected with services that enable recovery and social inclusion through sustainable re-connection with the mainstream community.
Funding model	• A bed-based funding model.	• The HBOS funding model but with incentives for the achievement of individual consumer recovery outcomes • Consumer outcomes linked to individual service provider performance.
Structural design	• Only three organisations providing ARR services, with 97 of 103 beds provided by two organisations, with one organisation providing 81% beds.	• Distributed funding allocations per provider to optimise the quality and efficiency of service.

4.3 Recommendations for ARR

The recommendations to reform ARR programs are summarised in Table 21. It is noted that for full effect and reform to be achieved, the three wider service design recommendations must be carried out in conjunction with the individual program recommendations.

Table 21: ARR recommendations

Component	Summary recommendation
1. **Target group**	Target 16 - 64 year olds with a severe and enduring mental illness and associated psychiatric disability. Increase targeting of consumers who are early in disability, homelessness or at risk of homelessness; and have families and other carers who are unable to provide accommodation. The target group should have better representation from women and CALD consumers.
2. **Outcome orientation and performance**	Orient the ARR service models to deliver an agreed set of consumer-focused, mental health recovery outcomes with a greater focus on mental and physical health, economic participation through education and employment, and social participation. Link ARR consumer outcomes to individual service provider performance, including a performance assessment in funding and service agreements.
3. **Service delivery model**	Adopt a supported housing model where consumers are placed in appropriate end-point housing with HBOS. End-point housing can be houses or units, public or private, and with or without other like-consumers.
4. **Support period**	Once a consumer has secured long-term, end-point housing they should receive HBOS packages consistent with the current HBOS guidelines. These packages should reduce in intensity over 12 -18 month periods based on the achievement of consumer recovery outcomes.
5. **Geographic distribution**	Conduct a detailed geographic demand study to determine distribution requirements for the proposed service delivery model across Victoria.
6. **Coordinated services and partnerships**	Formalise service coordination mechanisms with specialist clinical mental health, community, social, health, and primary care services to scale the treatment and support response to each consumer's need. Establish clear, non-discretionary entry and exit criteria and pathways on an area mental health service basis.
7. **Housing supply**	Sell the existing capital stock and use the funds generated to acquire a financial and legal interest in the new end-point housing sites with in-perpetuity tenant nomination rights acquired from Victorian Registered Housing Associations.
8. **Workforce capability**	Invest in workforce skills based on an agreed set of core competencies, and agree on a multi-level award structure (consistent with the Fair Work Australia award rationalisation initiative) that reflects the range of professional and non-professional skills requirements.
9. **Families and other carers**	Reconnect and engage families and other carers in a consumer's recovery process, including decision-making, planning and activities.
10. **Funding model**	Incorporate within the HBOS funding model but with incentives for the achievement of individual consumer recovery outcomes.
11. **Structural design**	Establish competitive market conditions to optimise the role of the ARR program within the broader psychosocial recovery system.

4.4 Target group

Recommendation: Target 16 - 64 year olds with a severe and enduring mental illness and associated psychiatric disability. Increase targeting of consumers who are in early stages of disability, homelessness or at risk of homelessness; and have families and other carers who are unable to provide accommodation. The target group should have better representation from women and CALD consumers.

Arguments supporting this recommendation:

- The current consumer profile indicates that consumers are typically 26-44 years of age and a majority are male
- The vast majority of consumers speak English as their primary language and some providers consider that ARR does not cater well for consumers from CALD backgrounds
- The dominant diagnostic profile in Adult Residential Rehabilitation is schizophrenia. Clinicians and Nous's expert advisory panel observed that this does not match the expected range of consumer profiles that may require recovery support through Adult Residential Rehabilitation
- ARR consumers experience additional complex difficulties in association with their mental illness. These difficulties include problems with activities of daily living, social isolation, and alcohol or drug dependence. Providers indicate that these issues lead many ARR consumers to be homeless or at risk of homelessness, and create conditions in which families and other carers are unable to provide accommodation prior to their entry into the program
- There is compelling research that emphasises the economic advantages of a sustained early intervention response for people with severe and enduring mental illness and associated disability. Importantly, 'early in disability' should not be interpreted to mean a focus on 'younger consumers' or 'high prevalence disorders'.

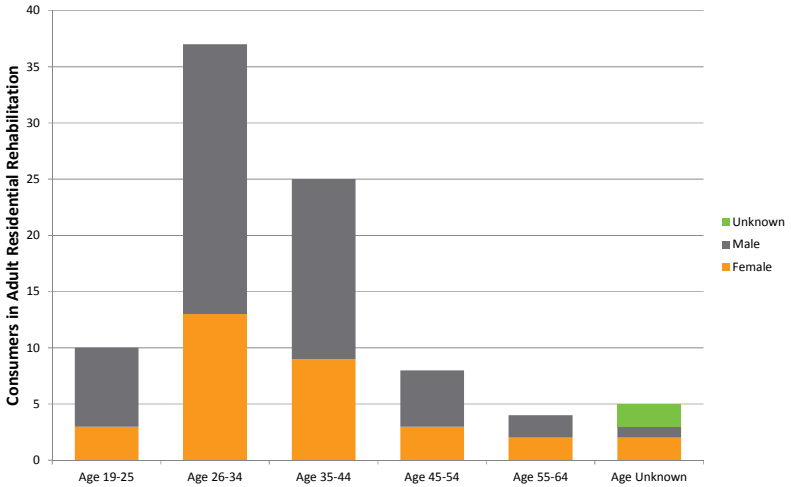
The current consumer profile indicates that consumers are typically 26-44 years of age and a majority are male. Some providers consider that ARR does not cater well for consumers from CALD backgrounds as the vast majority of consumers speak English as their primary language.

The current target consumer group for ARR services is people aged 16 – 64 years old with a serious mental illness requiring residential support. Some providers suggested that this age categorisation overlaps with YRR and should be 18 – 64 years.

Based on PDRSS census data, Figure 26 shows that men account for 62% of consumers in Adult Residential Rehabilitation.[44] There is no evidence to explain why the consumer profile is skewed towards males. A large proportion of the consumer population (70%) are aged 26-44 years old. The age profile of consumers in Adult Residential Rehabilitation is younger than that of Day Programs but similar to HBOS.[45]

There are currently few CALD consumers in Adult Residential Rehabilitation. QDC data showed that 92% of consumers in residential rehabilitation services[VII] speak English as their primary language.[46] Some providers expressed the view that ARR services generally do not cater well for CALD consumers and there is potential for improvement in the targeting of these consumers.

Figure 26: Adult Residential Rehabilitation consumers – age and gender profile



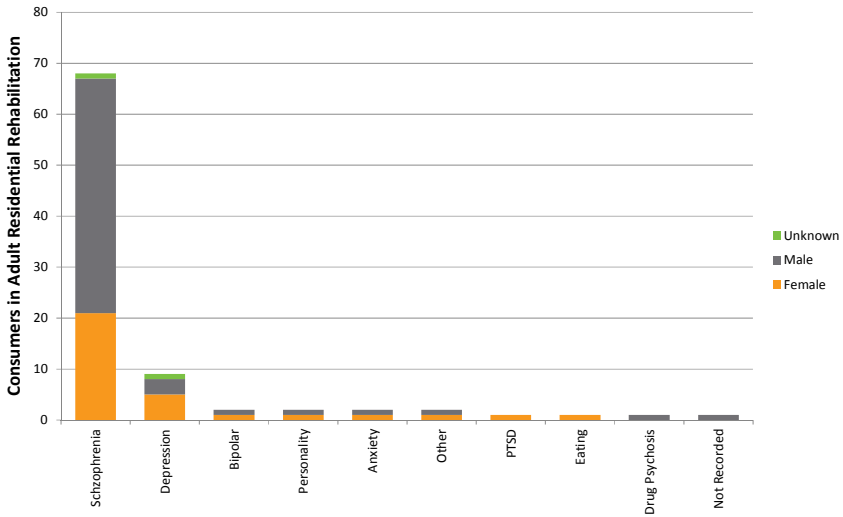
[VII] PDRSS data collected through the Quarterly Data Collection (QDC) does not differentiate between residential rehabilitation services. For the purpose of analysis, it is assumed that the profile presented in the QDC data is consistent across all residential rehabilitation services.

The dominant diagnostic profile in Adult Residential Rehabilitation is schizophrenia. Clinicians and Nous's expert advisory panel observed that this does not match the expected range of consumer profiles that may require recovery support through Adult Residential Rehabilitation activities.

Figure 27 shows that 79% of consumers in Adult Residential Rehabilitation have a primary diagnosis of schizophrenia.[47]

Clinicians and Nous's expert advisory panel observed that the current diagnostic profile of consumers in Adult Residential Rehabilitation services does not necessarily reflect the expected range of diagnoses. They expected to see more consumers with diagnoses of bipolar disorder, personality disorders and other low prevalence disorders than are currently evident in the profile. However, schizophrenia does have a higher likelihood of neurological deterioration and non-reversible disability than other diagnoses such as personality disorder.

Figure 27: Consumers in Adult Residential Rehabilitation – diagnosis profile



ARR consumers experience additional complex difficulties in addition to their mental illness. These difficulties include problems with activities of daily living, social isolation, and alcohol or drug dependence. Providers indicate that these issues lead many ARR consumers to be homeless or at risk of homelessness, and to have families and other carers who are unable to provide accommodation prior to their entry into the program.

Figure 28 outlines the complexity profile of ARR consumers. The majority of these consumers experience additional difficulties in association with their mental illness, with 92% of consumers having at least one associated difficulty and 27% with five or more. Consumers in ARR services experience an average 3.3 difficulties which is lower than consumers in HBOS who experience an average 3.7. The most prevalent difficulty for ARR consumers is problems with activities of daily living, experienced by 49% of consumers. The next most common difficulty is dealing with social isolation (31%).

Figure 29 highlights the alcohol and drug dependence profile for ARR consumers. These consumers have a high rate of no alcohol and/or drug dependence (53%). The most common dependences are nicotine and alcohol (28% of consumers), with 18% of consumers who are alcohol dependent or undergoing withdrawal.

Providers indicate that in addition to a person's severe and enduring mental illness, the high number of difficulties and rates of alcohol and drug dependence lead many target ARR consumers to be homeless or at risk of homelessness, and to have families and other carers who are unable to provide accommodation prior to their entry into the program.

Figure 28: Complexity profile for consumers in ARR

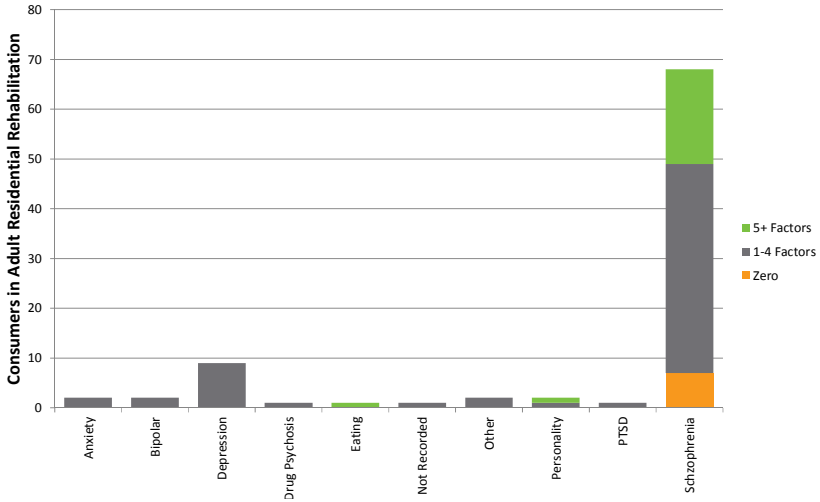
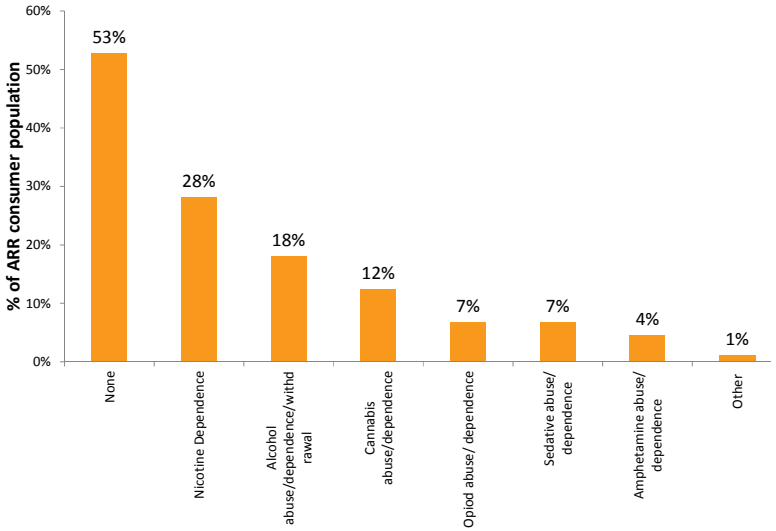


Figure 29: Alcohol and drug dependence profile for consumers in ARR



There is compelling research that emphasises the economic advantages of a sustained early intervention response for people with the most severe and enduring mental illness and associated disability. Importantly, 'early in disability' should not be interpreted to mean a focus on 'younger consumers' or 'high prevalence disorders'.

The most recent UK analysis of the economic impact of the 'early intervention in psychosis' approach demonstrates the positive economic outcomes for early intervention. Knapp et al (2010) conducted a UK study on assessing the economic impact of early intervention services for people with psychosis. The research relied on service use data and reported on studies which have done more independent follow-ups. It presented credible evidence for the positive economic outcomes of early intervention. The results included:

- Substantially reduced costs of lost employment
- Lower costs for homicide and suicide.

The authors note, however, that the long-term economic impact of early intervention depends on readmission rates after a client is discharged from the early intervention team. The study examines the longitudinal results of the LEO & OPUS studies in London & Denmark respectively, see Table 22.

There is no known economic analysis that takes into account the extra expenses involved in setting up and running a separate service delivery system like the Victorian mental health model.

Table 22: Summary of LEO and OPUS studies

Study	Description	Conclusion
OPUS study	A five-year follow-up of the OPUS study in Denmark was performed by Bertelsen et al (2008). The EI intervention lasted for two years and consisted of assertive community treatment, family involvement and social skills training for 275 patients.	At two years there were significant differences in favour of EI for psychotic symptoms and functioning.
LEO study	In a follow-up to the LEO study in south London, Gafoor et al (2010) examined admissions in the period 3.5-5 years after entry to the study.	After controlling for patent characteristics it was found that EI patients spent on average of two more days in hospital than standard care patients. The authors suggest that EI does not have a long-term effect and when patients are discharged back to standard care they have similar outcomes to others. Knapp et al (2010) make it clear though that the initial savings are not lost.

The implication of this international study for ARR is that consumers of this program should be targeted early in their disability. Importantly, early in disability should not be interpreted to mean a move away from the current target group and to focus on 'younger consumers' or 'high prevalence disorders'.

4.5 Outcome orientation and performance

Recommendation (part a): Orient the ARR service models to deliver an agreed set of consumer-focused, mental health recovery outcomes with a greater focus on mental and physical health, economic participation through education and employment, and social participation.

Recommendation (part b): Link ARR consumer outcomes to individual service provider performance; include a performance assessment in funding and service agreements.

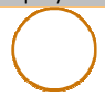
The arguments to support these recommendations are:

- ARR providers and consumers commented that the current model for ARR does not adequately deliver on improved mental health outcomes or on other recovery outcomes for consumers
- The Department's current output-focused performance framework for ARR means that providers are not accountable to deliver recovery outcomes for consumers
- ARR providers have a strong desire to identify outcomes measures and implement outcome data collection. Three of the nine components of the outcome focus are explored in more detail:
  - *Employment and education* –There is reliable evidence to underscore the importance of an education and employment outcome focus for consumers with a severe and enduring mental illness. However, the majority of ARR consumers are unemployed and providers are mixed in their views about the capacity of their consumers to achieve education and employment outcomes
  - *Physical health* – Population health data shows that people with a severe mental illness have higher rates of mortality and physical morbidity than the general population. This is supported by the experience of ARR providers. Though providers do have relationships with health organisations, no ARR data is collected on consumers' physical health and physical health is a not a direct focus of current ARR programs
  - *Housing* - Stable and affordable housing is critical for people recovering from a severe and enduring mental illness[48]. In ARR, most consumers record their rehabilitation facility as their primary residence. Providers commented that provision of housing for their consumers leaving ARR is one of their greatest challenges, and providers have found it traditionally challenging to establish formal partnerships with public housing providers.

ARR providers and consumers commented that the current model for ARR does not adequately deliver on improved mental health outcomes or on other recovery outcomes for consumers.

Both the SWOT analysis and provider consultations identify that many providers use the language of recovery; however, the articulation of recovery outcomes differs across providers. At a departmental level, long-term success measures and recovery aims are not well articulated. Table 23 outlines a qualitative assessment of the performance of ARR against long-term recovery outcomes identified in program logic models developed for this strategic review. This assessment is based on the literature review, stakeholder consultations and available data such as QDC and the PDRSS census survey.

Table 23: General assessment of recovery outcomes achieved for ARR

Programs	Mental Health			Physical Health	Social			Economic		Overall assessment
	Enhanced daily living skills	Psychosocial education attainment	Self-management of illness	Good Physical health and wellbeing	Improved social and family relationships	Stable and affordable long term housing	Family/Carer support and engagement	Educational and vocational achievement and employment	Reduced requirement for intensive clinical support[VIII]	
ARR Program									*Unable to make an assessment*	**Low-medium**
Overall assessment	**Medium**	**Low-medium**	**Medium**	**Low-medium**	**Low-medium**	**Low-medium**	**Low-medium**	**Low**	***Unable to make an assessment****	**Low-medium**

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

The Department's current output-focused performance framework for ARR means that providers are not accountable to deliver recovery outcomes for consumers.

Current data collected for service delivery at a departmental level are output focussed and offer limited insight into the performance of ARR. There is a desire from ARR providers to identify outcomes measures and to define the parameters of recovery. In comparison to the clinical sector, PDRSS provide little information on service delivery, and collect a very limited set of data. The data collected at a departmental level are limited to outputs and no outcome data are collected. Data from assessments are not collected at a departmental level; however, some providers do attempt to collect some outcome data.

It is a service delivery requirement for all consumers entering ARR to work with their key workers and identify recovery goals for the duration of their support period. The Individual Recovery Plan (IRP) that captures these goals forms the core document to plan services delivered to a consumer. However, Nous observed that the quality of IRPs developed across ARR differs considerably, particularly in the clarity of goals developed for consumers. Nous also observed that IRPs frequently do not articulate goals that will result in recovery outcomes for a consumer.

The ARR providers have a strong desire to identify outcomes measures and implement outcome data collection.

All providers are familiar (to varying degrees) with the process of recovery and desirable recovery outcomes. A consistent, sector-wide definition of recovery outcomes will assist key workers and consumers to clearly identify recovery goals for consumers' Individual Recovery Plans (IRPs). The providers are in strong agreement about the recovery outcomes that ARR should deliver. The recommended outcomes are provided in Table 24.

Table 24: Recommended outcomes

Mental Health Recovery Outcomes	Components	Rationale
1. **Mental Health**	• Daily living skills • Psychosocial education • Self-management of illness and reduced psychological distress	Consumers achieving outcomes in improved mental health is a key goal of PDRSS services. The sector should aim to reduce the number of negative psychosocial episodes and declines in mental health. This can be achieved by ensuring consumers receive psychosocial education, skills for daily living, self-management of illness and reduced psychological distress. Shean (2009) provides a meta-analysis of psychosocial recovery practices that summarises the compelling evidence base for the components of this outcome measure.[49]
2. **Economic**	• Educational and vocational achievement and employment • Reduced requirement for intensive clinical support including acute inpatient admissions	There is reliable evidence to highlight the importance of supported employment or education as one of the primary goals of recovery. Such outcomes have been shown to be critical to an individual's recovery.
3. **Physical health**	• Good physical health and wellbeing	The sector recognises that there should be a sustained emphasis on physical health and family/carer support and engagement. These elements have not received adequate attention in the past. In comparison with the general population, people with a severe mental illness have higher rates of mortality and physical morbidity.
4. **Social**	• Improved social and family relationships • Family/carer support and engagement • Maintain stable and affordable long-term housing	The key role of families and significant others in consumer recovery is well documented in the Department's policy literature. There is good practice evidence on the specific activities mental health providers can utilise to foster better recognition of families and significant others and achieve more enduring recovery outcomes for consumers. Housing does not fall under the domain of the Department of Health. However, there is an explicit acknowledgement that stable and affordable housing is fundamental to recovery. Maintaining access to housing options will remain a key outcome for PDRSS programs.

This revised outcome orientation is consistent with the draft outcomes framework originally published in *Because Mental Health Matters*, the Victorian Mental Health Reform Strategy 2009-2019. This framework outlined three levels of outcome broadly based on the National Health Performance Framework: Health and Community Outcomes; Determinants of Mental Health; and Performance of the Service System.

Employment and education **- There is strong evidence to support the importance of an education and employment outcome focus for consumers with a severe and enduring mental illness. However, the majority of ARR consumers are unemployed and providers are mixed in their views about the capacity of their consumers to achieve education and employment outcomes.**

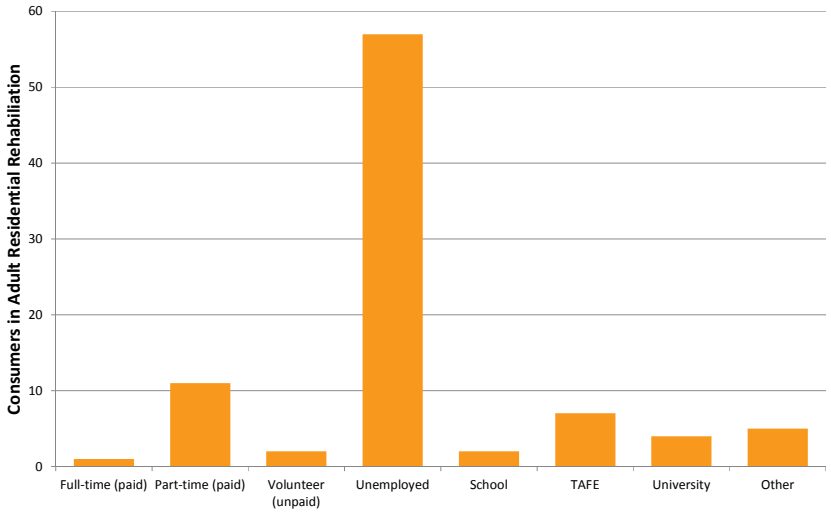
Figure 30 shows that 64% of ARR consumers are unemployed. Only 15% of consumers are in education and 16% are employed in some capacity.

ARR providers were mixed in their views about the capacity of ARR consumers to achieve education and employment outcomes. Some providers, such as MIF, were quite sophisticated in their approach and were achieving outcomes according to their records.

Most providers were familiar with the research evidence of the improved consumer outcomes from a clear employment and employment orientation and they acknowledged that new skills would be required.

Appendix C.1 and provide the research data to support an education and employment outcome focus for consumers who have a severe and enduring mental illness.

Figure 30: ARR education and employment participation



***Physical health* - Population health data shows that people with a severe mental illness have higher rates of mortality and physical morbidity than the general population. This is supported by the experience of ARR providers. Though providers do have relationships with health organisations, no ARR data is collected on consumers' physical health and physical health is a not a focus of current ARR programs.**

Although no formal data are collected on consumers' physical health, Clinicians and ARR providers commented widely that consumers with a severe mental illness experience more issues with their physical health than the general population. These stakeholder comments are supported by studies that suggest that people with a severe mental illness have a lower life expectancy than the general population and have a higher diagnosis rate of diseases such as diabetes and cardiovascular disease.[50]

The seminal study published in Western Australia, *Duty to Care: Physical illness in people with mental illness* (2001) identifies that people with a mental illness are two-and-a-half times more likely to die from the most common causes of death in Western Australia.[51] The Mental Health Council of Australia cites this study to argue that people with a severe mental illness are more likely than the general population to:

- Have a physical illness which is undiagnosed and untreated
- Engage with high-risk behaviours that impact their physical health. The PDRSS Census indicates high rates of smoking and alcohol/drug dependence across consumers in Adult Residential Rehabilitation
- Overlook health promotion behaviours such as exercise and a healthy diet
- Suffer from high levels of stress, frustration and anger arising from their mental illness and the stigma they experience.[52]

ARR providers do have relationships with health organisations (particularly GPs). However, few providers have productive partnerships with community health services such as dental, podiatrist, and dietician services. Carers, clinicians and ARR providers observed that current partnerships with community health services are not sufficient to adequately address physical health issues. These stakeholders noted that even when there is a partnership with a community health service, the service typically provides in-reach for only a few hours a week (often only one hour per service), which is not sufficient for consumers to receive adequate assistance.

***Housing* - Stable and affordable housing is critical for people recovering from a severe and enduring mental illness.[53] In ARR, most consumers record their rehabilitation facility as their primary residence. Providers commented that sourcing housing for their consumers leaving ARR is one of their greatest challenges. Providers have found it traditionally challenging to establish formal partnerships with public housing providers.**

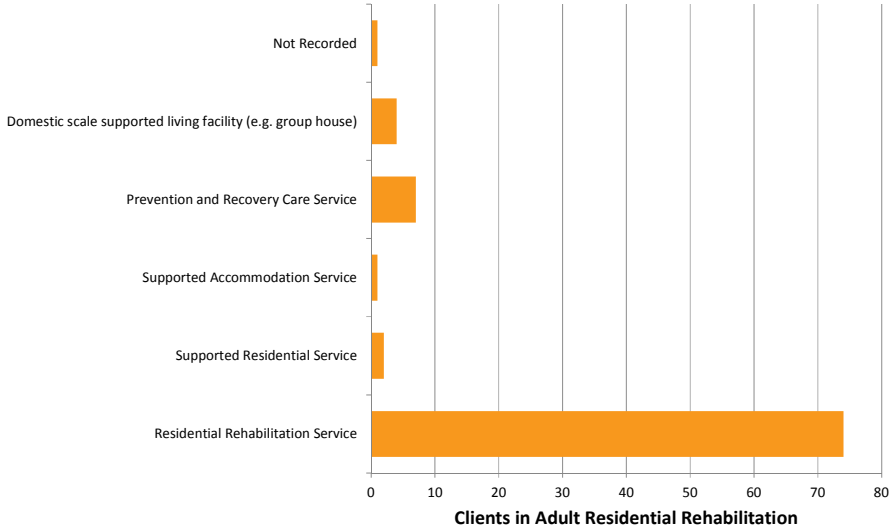
ARR providers and consumers clearly identified the shortage of stable housing as a significant barrier to the achievement of recovery aims of ARR consumers. Figure 31 highlights that more than 80% of consumers in ARR record their rehabilitation facility as their primary residence.

Providers commented that one of the most critical issues for their consumers leaving their ARR programs is locating suitable housing. Many providers acknowledged that ARR programs offered pseudo housing solutions for their consumers and emphasised the difficulty their consumers faced in finding stable and affordable long-term housing.

People recovering from a mental illness identify access to a stable and affordable home as the most critical issue affecting their quality of life and capacity for recovery. It is estimated that over 40% of people with severe mental illness are homeless or housed in tenuous forms of accommodation, often interspersed with periods of hospitalisation and sometimes incarceration.[54]

Appendix C.3 provides an outline of the challenges with Victoria's public housing for people with a mental illness.

Figure 31: Housing arrangements



4.6 Service delivery model

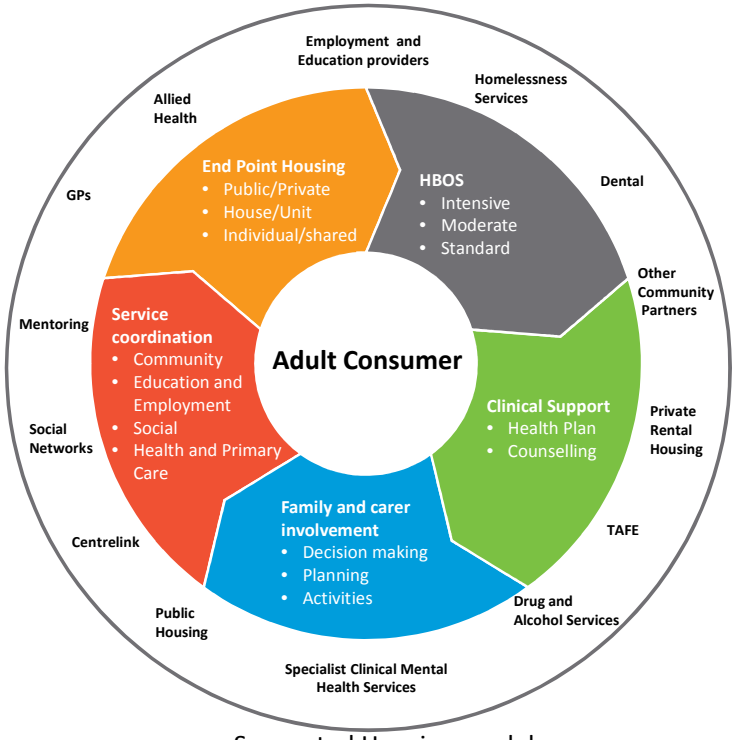
Recommendation: Adopt a supported housing model where consumers are placed in appropriate end-point housing with HBOS. End-point housing can be houses or units, public or private, and with or without other like-consumers.

Arguments supporting this recommendation:

- There is no clear and consistent model or outcomes framework from Government to guide service delivery. This has led each individual site, even within providers, to adopt and adapt their own service delivery model
- Many providers and consumers regard ARR's primary service as a housing proxy. Most ARR consumers list their housing situation as the ARR in which they reside
- Over 80% of Victorian PDRSS consumers state that temporary housing is not their preference. Over 65% state they want to live on their own or with their spouse/children. Consumer research has affirmed a preference for the supported housing recovery approach compared with residential rehabilitation
- There is no evidence in support of transitional residential rehabilitation in a congregate setting for adults. The strongest research shows that consumers have a greater chance of achieving recovery aims when provided with flexible recovery focussed support within their own 'normal' home. This is often called 'supported housing'
- Several Australian states have implemented and evaluated 'supported housing' programs with positive outcomes found. These programs include Victoria's Housing and Support Program, NSW's Housing and Accommodation Support Initiative and Queensland's Project 300.

An illustration of the proposed service delivery model is provided in Figure 32. Appendix E provides a summary of HBOS and its three tiers – Intensive, Moderate and Standard.

Figure 32: Proposed ARR service delivery model



Supported Housing model

There is no clear and consistent model or outcomes framework from Government to guide service delivery. This has led each individual site, even within providers, to adopt and adapt their own service delivery model.

Existing ARR sites are metropolitan based and structured as clusters of 6 to 15 beds. Four sites deliver non-24 hour (non-clinical) PDRSS staffed services for 46 beds and five sites deliver 24-hour (non-clinical) PDRSS staffed services for 57 beds. Site visits and consultations indicated that each individual site adopted their own service delivery model.

There are a number of common service delivery elements to most sites. Figure 33 shows that 69% of consumers require assistance with work, domestic skills, self-care, social contact or recreation. The next most common type of service provided to consumers (46%) is assistance with practical issues such as housing or money.

To facilitate connections with the local community and prepare consumers for the transition from ARR, providers commented that their individual sites have different relationships with clinical services, education and training institutions, employment services and local community services. Figure 34 shows that 9 out of the 10 most used services are health-based, and only a small number of consumers are linked to other community services. These statistics highlight the physical health focus of most ARR external relationships.

In rural areas where there are no ARR services, providers reported that rural consumers may receive intensive or standard HBOS services. These providers also commented that access to stable housing remains an issue in rural areas and that they observed consumers living in sub-optimal hostels and caravan parks.

Figure 33: Adult Residential Rehabilitation health and community service use profile – 10 most used services (other than Adult Residential Rehabilitation)

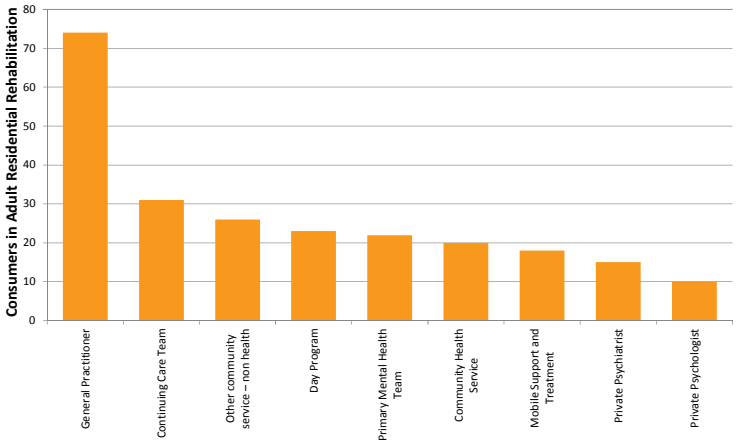
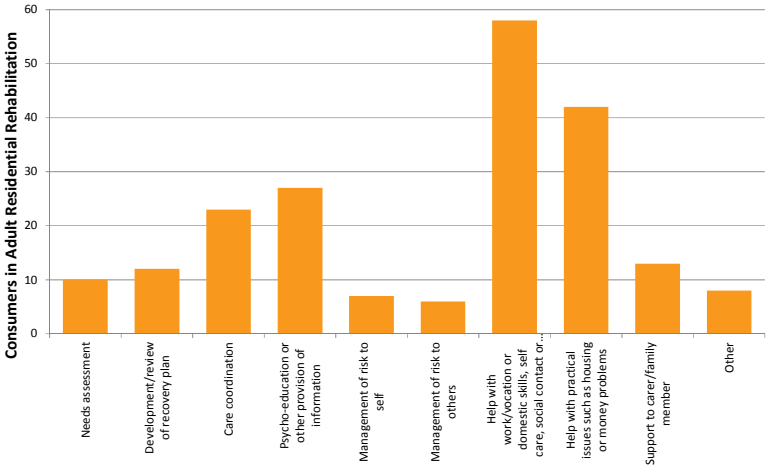


Figure 34: Services provided by Adult Residential Rehabilitation



Many providers and consumers regard ARR's primary service is a housing proxy. Most ARR consumers list their housing situation as the ARR in which they reside.

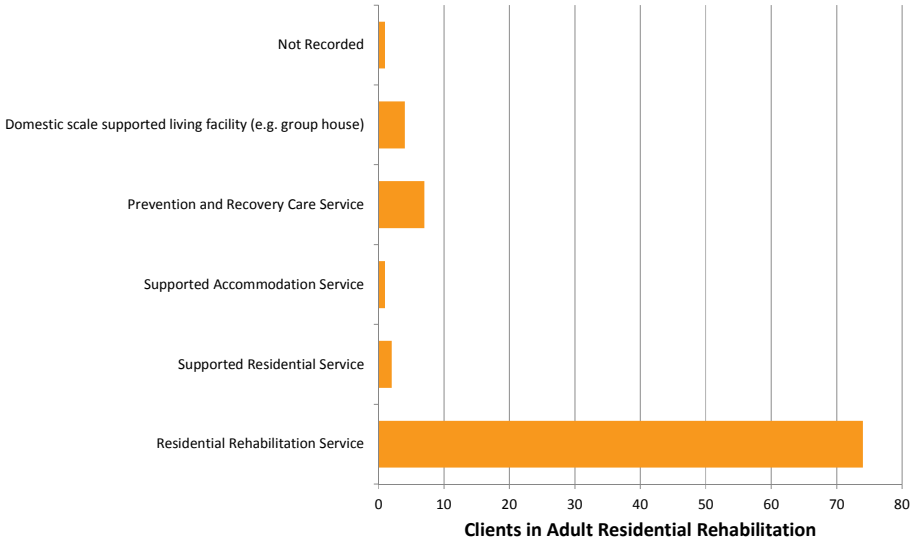
The PDRSS Census indicates that 83% of Adult Residential Rehabilitation consumers list their housing situation as residential rehabilitation services, see Figure 35. The housing arrangements of a further 11% are listed as 'other bed-based' which include SRS, SAS and PARC.

ARR providers were unable to provide additional comment on the usual housing circumstances of these consumers. However, providers did comment that the ARR did serve as a housing solution for many of their consumers. Consumer consultations supported this. They noted that ARR represented "*stable and affordable housing*".

The challenge with ARR acting as a housing proxy was summarised in the consumer consultations:

"*…the more comfortable people get in their service (especially residential rehabilitation), the less likely they want to leave the service*."

Figure 35: Housing situation of ARR consumers



Over 80% of Victorian PDRSS consumers state that temporary housing is not their preference. Over 65% state they want to live on their own or with their spouse/children. Consumer research has affirmed the preference for the supported housing recovery approach compared with residential rehabilitation.

Most consumers indicate a preference to live in mainstream housing and not with people with a mental illness. However, some housing and support programs have been set up in a block of bed-sits or one-bedroom apartments for example, *Habana* in Alma St, St Kilda. A research study commissioned by Mind, MI Fellowship and NEAMI (2010).[55] Found that over 80% of PDRSS consumers who live in short-term residential rehabilitation or temporary housing state that this is not their preference. 67.6% state they want to live on their own or with their spouse/children.

Evidence from Australia, Canada, US and UK asserts consumers' preference for their choice of housing with off-site flexible support. Table 25 outlines the research studies on consumer preferences and outcomes post residential rehabilitation discharge.

Table 25: Consumer preferences

Research study	Finding
Macpherson (2004) reviewed the main forms of supported accommodation for people with mental health problems in the UK.[56]	The authors noted that consumers expressed a preference for 'independent accommodation that allows for privacy' and 'access to flexible levels of support when needed, as opposed to support being provided as part of their accommodation' (p.182).
Tanzman (1993) reviewed studies from 1986 to 1992 on consumer preferences.[57]	The author found that consumers consistently reported they would prefer to live in their own house or apartment, and to live alone or with a chosen partner, and not with other mental health consumers. In addition, they preferred support from staff who were off-site but available on call.
Chopra et al (2010) assessed the long-term outcomes for the original cohort of 18 residents of the Footbridge Community Care Unit (CCU), a residential psychiatric rehabilitation unit at St Vincent's Mental Health Melbourne.[58] A review of case records and interviews was conducted for each member of the cohort 8 years after admission to the CCU. Members of the cohort were living in a variety of settings after discharge from the CCU.	The authors founds that despite significant gains during the period of residential rehabilitation in the CCU, by the time of follow-up most individuals were leading restricted lives characterised by a lack of stable residential and social supports. Most residents reported positively on the support provided in the CCU although subsequent experiences of moving repeatedly from one setting to another were adverse. Five key unmet needs were identified: promotion of independence; stability in accommodation; stability in social networks; consistency of care; and addressing experiences of loss.
Vandevooren et al (2007) conducted an evaluation of the outcomes for 25 individuals with severe psychiatric disabilities one year after discharge from a Canadian community-based residential treatment and rehabilitation program.[59]	Evaluation of a Canadian adult residential program showed positive consumer outcomes one year after discharge. However, the program provided clinical treatment as well as rehabilitation, so is more akin to Victoria's Community Care Units than Adult Residential Rehabilitation services. Results indicated that following the program, participants lived for significantly longer periods in the community in more independent settings and functioned at higher levels than in the six years prior to participation in the program.

There is no evidence to support transitional residential rehabilitation in a congregate setting for adults. The strongest research evidence shows that consumers have a greater chance of achieving recovery when provided with flexible recovery focussed support within their 'normal' home. This is often called 'supported housing'.

There is no strong evidence that adult rehabilitation works better in a transitional, congregate setting. Howat (2004) noted that in the UK, *'there has been no systematic review of residential rehabilitation and continuing care with respect to numbers of units, defined functions, resources or therapeutic regime. There is uncertainty about policy and an evidence base for deciding on how many beds and of what kind is lacking*' (p.269).[60] Thornicroft and Tansella (2004) reported that there is no evidence of the cost-effectiveness of different types of residential care and no completed systematic review (p.287).[61] A Canadian study showed positive consumer outcomes one year after discharge from residential rehabilitation.[62] However, a recent Australian study identifies the challenges following discharge from residential rehabilitation. There is an argument based on research and expert opinion that supports congregate, transitional living arrangements for young people because it offers peer support and developmental opportunities for those who might have missed out on these experiences thru illness in their teens.

Table 26 outlines the research studies into new recovery approaches where the common component is placing consumers in end-destination 'normal' housing of their choice, with off-site flexible support.

Table 26: Research into new recovery approaches

Research study	Finding
Carling (1993) reported on the replacement of residential treatment programs by the supported housing approach in the US and presented a meta-analysis of related publications about the new approach.[63]	Carling noted specific features of successful, supported housing programs. These include organising finance, helping consumers to find housing which matches their preferences and ongoing flexible support.
Carling (1995) found that previous evaluations of US residential care lacked an assessment of the effectiveness of the 'residential continuum' approach, in which the consumer moves through residential services providing different levels of support (pp.33-36).[64]	Evaluations showed transitional residential programs 'fall considerably short of helping people to achieve lasting community integration'. (pp.33-36).[65] Instead, the model shown to be most effective is for consumers to live in normal housing of their own choice, with support provided by workers based off-site and varied according to need (pp.206-276).[66]
Gulcur et al (2007) compared the level of community integration between two groups of people with psychiatric disabilities.[67] The first group comprised 99 consumers, who were provided with apartments in the community, with support services provided flexibly based on consumer choice (the Housing First approach). The other group, with 126 consumers, were in congregate residential services organised on the continuum of care principle.	Choice and being housed in normal housing were both associated with significantly higher levels of social and psychological integration.
Stefancic and Tsemberis (2007) found evidence of the success of the 'housing first' approach.	The success of the 'housing first' approach is where the consumer is placed in final destination housing, rather than in transitional accommodation, and then provided with a flexible range and level of support services according to need.[68]

Several Australian states have implemented and evaluated 'supported housing' programs with positive outcomes found. These programs include Victoria's Housing and Support Program, NSW's Housing and Accommodation Support Initiative and Queensland's Project 300.

Victoria's Housing and Support Program (HASP) began in 1992, after removal of the independent living requirement for access to public housing. Prior to 1992, to be eligible for public housing, a person had to demonstrate that they could live independently. This created a barrier for people with a mental illness. Once this criterion was dropped, it became possible for people with a mental illness to apply for public housing. After this change, the Victorian Office of Housing established the Housing and Support Program (HASP) in partnership with departmental consumer programs, including mental health, disability and aged care.

Under HASP, the mental health program identified areas across the state with inadequate public housing, and the Office of Housing spot-purchased or purpose-built units in those areas. The mental health branch then funded non-government PDRSS organisations to provide off-site support for mental health consumers moving into this public housing. HASP operated from 1992 to around 2003, resulting in provision of approximately 750 public housing places and associated support for people with psychiatric disabilities.

A number of research studies were conducted about HASP and its program participants. The findings and success factors in supporting housing programs are provided in Table 27.

Table 27: HASP evaluations

HASP study	Finding	Success factors
Robson (1995) undertook a qualitative evaluation of the Housing and Support Program in 1994-95, based on interviews with 35 consumers who had moved into supported housing, and their support workers from the relevant PDRSS.[69]	The program had been successful in enabling high-need consumers to gain access to public housing and sustain their tenancies. Consumers expressed high levels of satisfaction with their housing and the level of support provided, though Robson noted those living alone were more satisfied than those in shared housing (p.70).[70] All support workers considered that consumers' mental health had improved since moving into the program (p.77).[71]	Provision of low-cost stable public housing, linked to flexible support from PDRSS workers.
O'Brien et al (2002) reviewed current knowledge with particular emphasis on people with a mental illness.	The project acknowledged the success of Victoria's Housing and Support Program (HASP) in supporting people to maintain stable housing who had very high needs upon entry to the program.	People with significant psychiatric disabilities can maintain stable housing providing they have:[72] • Housing appropriate to the nature of their disability • Support and clinical care from trusted providers • Strategies in place to deal with issues which might put their housing.

HASP study	Finding	Success factors
O'Brien et al (2002) interviewed 50 people aged between 25 and 50 years with psychiatric disabilities who had obtained stable rental housing appropriate to their needs, had support from a PDRSS but were not participants in Victoria's Housing and Support Program.	Participants in this study and in the HASP review stressed the difference that stable and appropriate housing made to their lives. They pointed to increased independence, improved social networks and better mental health. However, the HASP group were more likely to be happy with their housing and to plan to stay, whereas lack of security of tenure meant the study group were uncertain about the future of their current housing. The HASP group were more likely than the other group to prefer not to share, although the reasons for this difference were not clear.	For study participants the PDRSS worker played a key role in finding and maintaining stable housing which took account of the consumer's particular needs, and in supporting the person to obtain other services. Identifying and addressing risks to housing tenure were also part of the worker's role. Participants identified the following as important to the satisfaction they had with their housing arrangements: • Be close to public transport • Shops and family • Liking the area • Enjoying living alone or sharing with another.
Chester et al (2005) conducted 15 in-depth interviews with people with a serious mental illness who were residents in a housing and support program in Gippsland, Victoria.[73]	*Not applicable.*	Two themes emerged: • Stable housing is critical for recovery • Despite a universally positive response to their housing situation, residents found this was not enough to secure meaningful relationships.
Carter (2008) reported a research project which followed up 28 former extended care patients from a Melbourne psychiatric institution who were moved into supported housing before the institution closed[74]. The patients ranged in age from early 20s to early 50s, had been diagnosed with schizophrenia or related conditions and were assessed by clinical staff as being unable to cope in the community without intensive support.	The project found that the program *'has been effective in enabling a cohort of people who live with significant and ongoing disability associated with mental illness to sustain tenancies and live in the community over a period of twelve years'* (p.29).	Several elements were identified as core to this success: • Access to housing that is affordable, located in close proximity to public transport and shops, and in communities that are accepting of diversity, where consumers live only with companions of their choosing • When consumers wished to move away from share arrangements, other suitable properties were found for them • Properties are dispersed throughout the local area and do not attract the stigma that may be associated with housing in clustered settings or housing that is co-located with support services • Consumers sign a standard lease with a community housing agency that specialises in providing housing to

HASP study	Finding	Success factors
		people with disabilities • Consumers know that their dwelling is their own, and that tenure will not be lost if their support needs change. In addition, the nature of the support provided to the consumers was also seen as critical to the program's success: • Neami provides support that is responsive to consumers' changing needs, and continues for as long as is needed • Support is directed by priorities identified by the consumer, enabling them to create their own recovery process • Consumers are confident that support will 'always be there for me' when they need it • Consumers have access to support from familiar and responsive clinical services when they need it.

HASI began in 2002 as a partnership between NSW Health, Housing NSW and Accommodation Support Providers (ASPs) which are community-managed, non-government organisations. HASI was designed to assist people with mental illness to participate in the community, experience improved quality of life, prevent homelessness and, most importantly, assist in the recovery from mental illness. It aimed to achieve these goals by linking people with mental illness to clinical mental health services, secure housing and accommodation support. HASI currently supports around 1,167 consumers across NSW. The partnership in the area targeted for a particular HASI initiative involves the local AMHS, housing office and an NGO which has successfully tendered to provide accommodation support. A Victorian PDRSS (Neami) has won a number of these tenders.

The HASI program has been evaluated regularly since its inception and found to be successful in improving consumer outcomes. These include obtaining and maintaining stable low cost housing; better mental health, improved social relationships and greater involvement in community activities, education and employment. However, many consumers remained concerned about their physical health problems and some experienced social isolation. HASI has made the difference to the lives of consumers by providing access to secure housing, and regular supportive contact from accommodation support workers.

At a system level, key ingredients in HASI's success include the partnership between NSW Health and Housing NSW. At the local level, this has enabled access to public and community housing for people with serious mental illness, to clinical mental health services for treatment and to accommodation

support. Other factors include clear delineation of clinical and non-clinical roles and responsibilities, effective communication between stakeholders at all levels, and effective local governance. Unlike Victoria's HASP, HASI funds accommodation support at different levels of intensity designed to match consumers' assessed needs. The range covers low, high and very high support packages.

The 'Project 300' in Queensland began in 2005 and relocated 300 people with long term mental illness from psychiatric institutions back to the community. Each person had a service package tailored to their particular needs. An evaluation by Meehan et al (2007) found the ingredients to the success of this project included case management, stable housing and flexible disability support.[75]

4.7 Support period

Recommendation: When a consumer has secured long-term, end-point housing they should receive HBOS packages consistent with the current HBOS guidelines. Based on the achievement of consumer recovery outcomes, these packages should reduce in intensity over 12 -18 month periods.

Arguments supporting this recommendation:

- The recent IRRC pilot suggests a substantial gain in recovery is achievable within 12 months
- Current weekly direct contact hours do not reflect an intensive residential support setting. ARR operates more like a version of moderate HBOS
- Indirect support in the current transitional setting does not negate the adverse affects for ARR consumers having to move through a hierarchy of accommodation. Consumers who do require structured 24/7 staffing are in Supported Accommodation Services (SAS). SAS is regarded as a 'slow stream rehabilitation' service and targets a different consumer group compared to ARR consumers.

According to the PDRSS Census 2010 39%of ARR consumers, at the time of the survey, were being supported for 1-2 years. The recent IRRC pilot suggests a substantial gain in recovery from Intensive HBOS is achievable within 12 months.

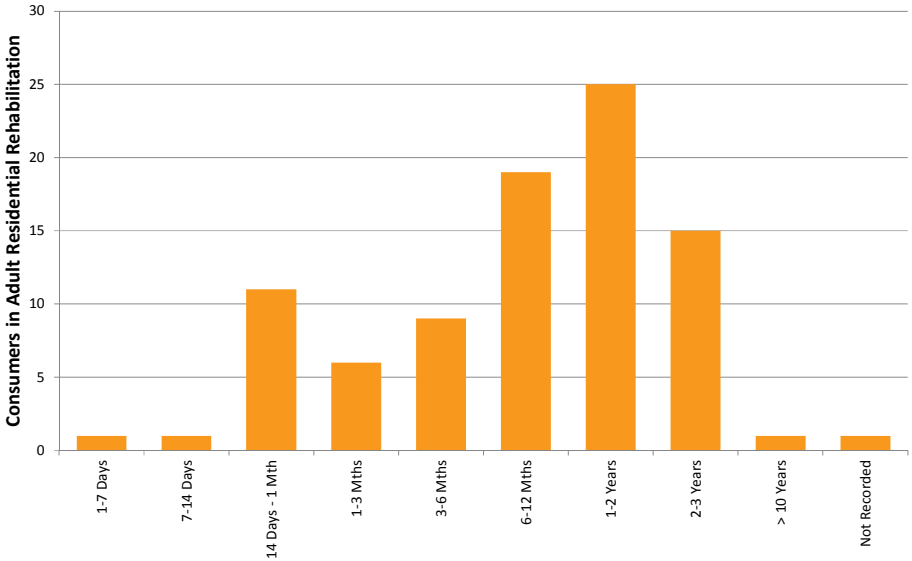
According to the PDRSS Census 2010 39% of ARR consumers, at the time of the survey, were being supported for 1-2 years (see Figure 36).[IX]

There are a small proportion of consumers who were being supported in ARR for longer than the recommended support period; 17% of consumers remaining in ARR services between 2-3 years. Providers observe that this group may have stayed for longer than the recommended support period due to difficulties securing stable housing upon exit.

The previous IRRC pilot and current Intensive HBOS initiative provide the best guidance on the level of support and duration. The IRRC pilot evaluation suggested that a substantial gain in recovery is achievable within 12 months.[76]

Clinicians and providers believe up to 18 months of recovery support is appropriate for the suggested consumer target group. This period maintains a conservative approach for the proposed new model and reduces the risk of re-institutionalisation. There is no definitive research evidence on recovery support periods for ARR.

Figure 36: Support period for consumers in Adult Residential Rehabilitation



[IX] It should be noted that the recommended support period is 18 months to 2 years; PDRSS Census collects data for 12 months to 2 years. The number of clients in residence for the recommended support period is therefore approximate.

Current weekly direct contact hours do not reflect an intensive residential support setting. ARR operates more like a version of moderate HBOS.

There are 57 ARR beds funded for 24-hour support and 46 beds for non-24 hour support. Figure 37 shows that 69% of consumers receive services at least once a day, and Figure 38 shows that 69% of consumers receive less than one hour per contact. Providers indicate that contact is a combination of group and individual time with staff.

The challenge for the existing ARR model is that the average amount of contact time per week equates to between 3 to 3.5 hours which is similar to Moderate HBOS. Based on ARR funding levels and the residential component of ARR, the minimum amount of consumer contact should be at least 6 hours per week.

Figure 37: Service frequency for consumers

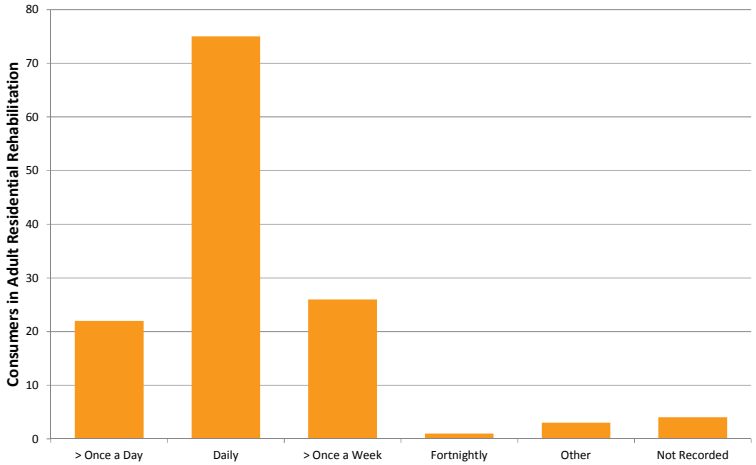
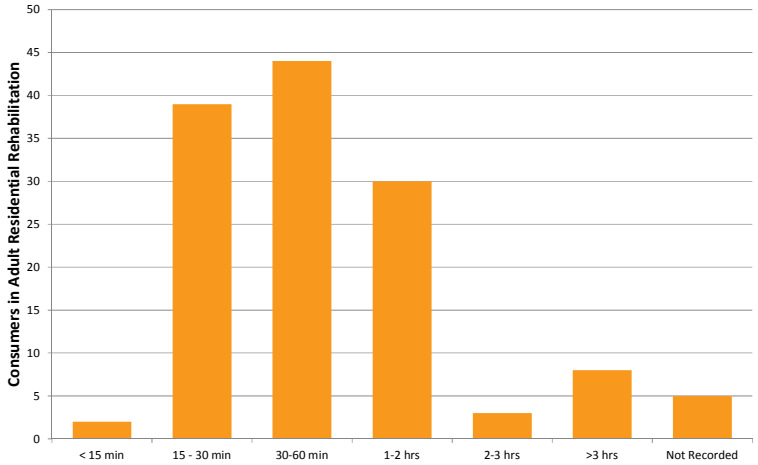


Figure 38: Time contact for consumers



Indirect support in the current transitional setting does not negate the adverse affects for ARR consumers having to move through a hierarchy of accommodation. Consumers who do require structured 24/7 staffing are in Supported Accommodation Services (SAS). SAS is regarded as a 'slow stream rehabilitation' service and targets a different consumer group compared to ARR consumers.

Consumers stated that ARR provides a "*safe and supportive community environment*". However, this does not justify retaining ARR which provides short to medium term transitional residential rehabilitation. The evidence points to the most effective rehabilitation for the targeted ARR cohort being in the setting where the consumer will be living in the longer term, and also to the negative effects of consumers having to move through a continuum or hierarchy of accommodation. The IRRC Intensive HBOS pilot showed that even consumers with the most severe mental illness can make progress without the indirect support provided through 24-hour on-site support.

Furthermore, there is a distinct cohort of consumers who benefit from structured 24/7 staffing. These are the consumers who are in Supported Accommodation Services (SAS such as Victoria Lodge and Kinkora which are regarded as 'slow stream rehabilitation' services. The current challenge is that there are too few beds in SAS (like ARR, there has been no growth in SAS since the mid-late 1980s). The most recent developments, 'Rooming House Plus' in Queens Road Albert Park and Elizabeth St 'Common Ground', are for a mixed population rather than consumers with psychiatric disabilities. The latter consumers often get lower priority than others as they are perceived as having more demanding needs.

4.8 Geographic distribution

Recommendation: Conduct a detailed geographic demand study to determine distribution requirements for the proposed service delivery model across Victoria.

Providers, consultations, departmental conversations and policy documentation indicate that the geographic distribution of ARR across the State has been determined more by opportunity than design. As a consequence there is an uneven distribution of ARR programs. There is no available data that accurately determines service demand. Providers do not maintain waiting lists despite close to 100% utilisation of their services.

Current service distribution across Victoria indicates that ARR beds are only located within the North and Western Metropolitan and Southern Metropolitan regions. There are no ARR services in rural areas. Table 28 outlines the distribution of ARR in Victoria.

Table 28: Distribution of ARR programs

Catchment	Population	Estimated population with severe mental illness (3% of the total population)	Estimated population with current severe mental illness (30% of the severely mentally ill population)	ARR (beds)	ARR beds per capita (by population with a current severe mental illness)
North and Western Metro Region	1,848,643	55,459	16,638	60	0.36%
Southern Metro Region	1,361,175	40,835	12,251	43	0.35%
Eastern Metro Region	1,053,316	31,599	9,480	-	-
Barwon South West	383,857	11,516	3,455	-	-
Loddon Mallee	318,162	9,545	2,863	-	-
Hume	275,004	8,250	2,475	-	-
Gippsland	259,182	7,775	2,333	-	-
Grampians	213,826	6,415	1,924	-	-
TOTAL	**5,713,165**	**474,917**	**51,418**	**103**	**0.20%**

Appendix D.2 provides a spatial map of the distribution of ARR across Victoria.

4.9 Service coordination and partnerships

Recommendation: Formalise service coordination mechanisms with specialist clinical mental health, community, social, health and primary care services to scale the treatment and support response to each consumer's need. Establish clear, non-discretionary entry and exit criteria and pathways on an area mental health service basis.

Currently, there is no formal mechanism to coordinate services for ARR consumers. As shown in Figure 39, the treatment and support response by ARR should be provided through a flexible process according to need:

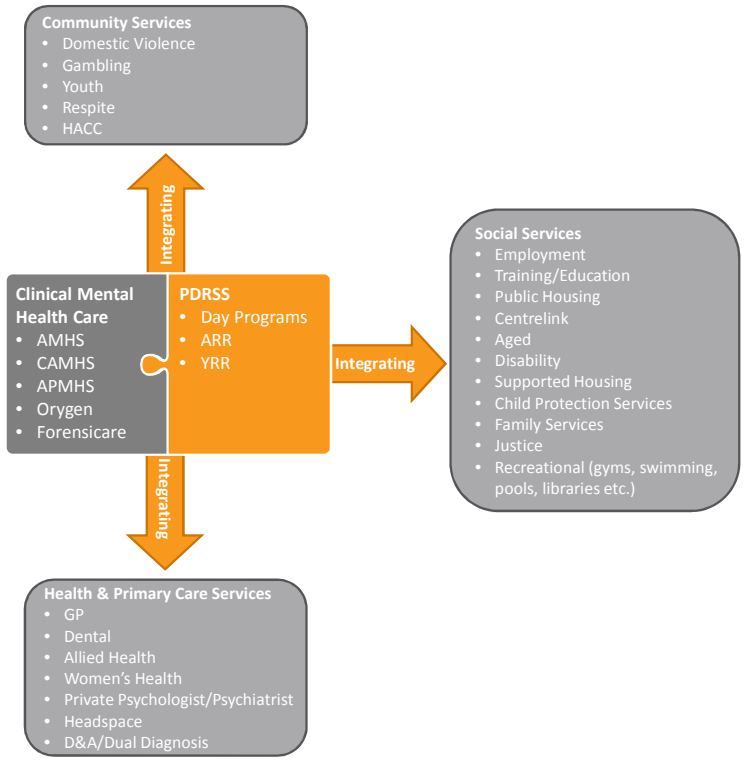
- Scale up - to enable referral to specialist clinical mental health services for a swift and targeted response when a consumer's clinical state worsens (avoiding later, and potentially more traumatic, admissions to clinical services)
- Scale down – includes a range of transition services (outside of hospital) where consumers can receive varying levels of support, including 24/7 if required, to recover and transition back into the community (similar to rehabilitation options available for physical illnesses).

There are no clear, non-discretionary entry and exit criteria and pathways for ARR consumers. Intake into the proposed ARR service delivery model should be based on accommodation supply, with local PDRSS and AMHS to jointly coordinate intake for end-point housing and CCU beds for an area. PDRSS should work with housing providers to obtain long-term, stable housing and work with AMHS to jointly coordinate intake for end-point housing and CCU beds for an area and the scaling of HBOS.

Based on the proposed ARR service delivery model, some consumers may not be ready for direct placement in housing as housing supply is challenged by this approach. Hence, transitional CCU beds run by clinicians and with joint PDRSS and AMHS intake coordination will enable those consumers to manage their transition into their own home with ongoing support.

The proposed ARR service delivery model will also need well coordinated exit pathways based on area mental health service parameters. No such pathways currently exist and exit pathways for consumers are unknown.

Figure 39: New ARR transition arrangements



The most common referral pathway into ARR is through specialist clinical mental health services. However there is no formal entry coordination mechanism and the selection method for consumers into ARR services is not transparent. There is concern expressed about the unknown exit pathways for consumers.

Figure 40 shows that the most common referral pathway into Adult Residential Rehabilitation is through public clinical specialist mental health services (56% plus 10%).[77] Acute inpatient (hospitals) and PARC are part of the public clinical specialist mental health service.

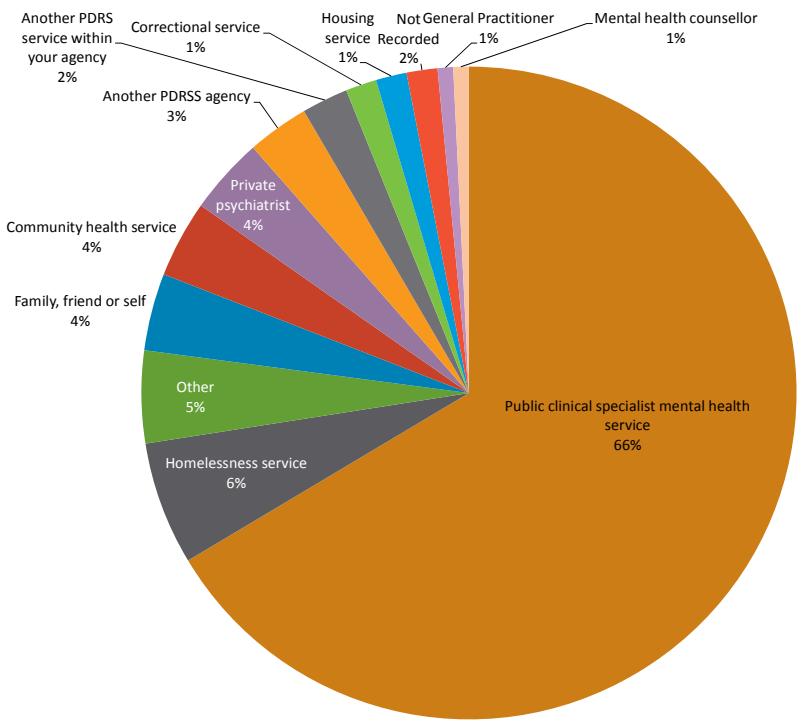
There is a view that clinical services and PDRSS operate in silos, and rarely share information with other providers and other services within the PDRSS sector. Clinicians, providers and the Department identified that closer coordination with the clinical sector and its CCUs will facilitate better recovery outcomes for ARR consumers. However, there may also be significant ideological and cultural barriers that prevent better collaboration with the clinical sector. These findings are consistent with the findings from the Department's 2007 Report which noted:

"Clinical and PDRSS service sectors appear to operate relatively independently with few structural points of cross-over and integration resulting in a non-strategic, ad hoc approach to resource allocation."[78]

Clinicians also expressed the view that the method for selection of consumers into ARR is unclear, and that individual sites have different selection criteria. Clinicians observed that the definition for target consumers (diagnosis, requirements etc.) is not specific enough and does not provide enough guidance for clinicians to identify the type of consumers who would benefit from ARR, nor does it provide guidance for how consumers should be selected into services.

Clinicians and carers also note that organisations and service types are not well known enough, and it is difficult to know what services are available for a consumer.

Figure 40: Profile of Referral pathways for clients in Adult Residential Rehabilitation



Current partnerships arrangements with other service providers are underdeveloped and are largely driven by individual ARR sites.

Partnerships with employment and education, community health, housing, clinical and recreational services aim to connect consumers with services that will enable recovery and social inclusion through sustainable re-connection with the mainstream community. Providers, carers and consumers observed that, while there are examples of productive partnerships, overall there is scope to substantially improve partnerships to achieve recovery aims for consumers.

Table 29 provides a general assessment of partnership arrangements between ARR and key services together with examples of productive partnership arrangements.

Table 29: Partnerships arrangements for ARR

Service types	General assessment of ARR partnership arrangements	Example(s) of partnership arrangements
Employment and education	• Mostly referral arrangements with local employment services or specialist employment consultant in-reach • Some partnerships with job agencies, however little evidence in employment figures that this is producing positive outcomes • Some arrangements with education institutions (especially TAFEs), but little evidence of positive outcomes.	Mental Illness Fellowship (MIF) has successfully co-located specialist employment consultants within a clinical service. To facilitate this partnership, MIF have received funding from DEEWR.
Housing	• Some relationships with housing associations, however with limited positive outcomes due to significant barriers.	
Clinical sector	• Some contact with the specialist clinical mental health sector – but mostly for incidents requiring CATT and for ongoing clinical case management.	Opening Doors (MIF and Alfred) have joint service delivery, joint protocols, and shared decision-making around access and resource allocation.
Community health services	• Mostly time limited contact, on 'as needs' basis.	
Community recreation services	• Poor arrangements with community recreation services • Any contact with recreation services is mostly in format of excursions.	MIND self-funds access to gyms/libraries for residential rehabilitation consumers.
Community services (e.g. homeless, youth, or family services)	• Referral arrangements as required • However, limited contact with these services.	MIND has recently established a partnership with the Youth Substance Abuse Service (YSAS) and has set up a Family and Carer Reference Group. MIND is leading a three year demonstration program funded by the Department of Families, Communities, Housing and Indigenous Affairs called Mind Building Family Skills Together.

4.10 Housing supply

Recommendation: Sell the existing capital stock and use the funds generated to acquire a financial and legal interest in the new end-point housing sites with in-perpetuity tenant nomination rights acquired from Victorian Registered Housing Associations.

Arguments to support this recommendation:

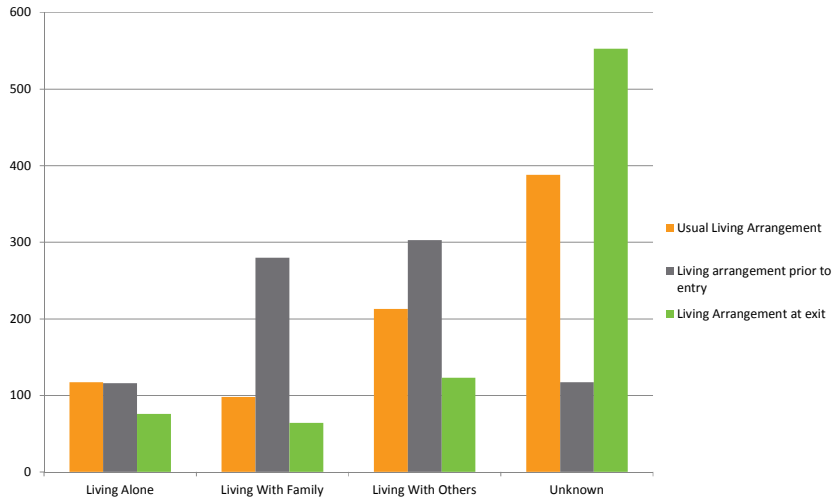
- Securing and maintaining stable housing is difficult (regardless of whether it is public or private) and providers are unsure about the living arrangement of ARR consumers upon exit
- Though retaining the existing ARR properties may be appropriate based on other demands within the Department (for example, new sites for PARCS), it is not a viable option for ARR. This provides the best access to additional resources, funds and skills to build a scaled housing response.

Securing and maintaining stable housing is difficult (regardless of whether it is public or private) and providers are unsure about the living arrangement of ARR consumers upon exit.

Providers note that they spend a significant amount of time assisting consumers to find and maintain stable housing. However, QDC data (see Figure 41) shows that providers are largely unaware of the living arrangement of their consumers upon the consumer's exit. Nonetheless, there are difficulties in partnering with housing associations to find suitable and sustainable housing for consumers. This is largely due to the lack transparency of the process for housing allocation.

Providers identified that housing associations consider consumers with mental illness too difficult to deal with. This observation is supported by the recent Victorian parliamentary inquiry into public housing which found that people with a mental illness in particular find it difficult to qualify for public housing through the segmented waiting list.[79] The inquiry also identifies that people with mental illness are under-represented on public housing waiting lists.[80] It should be noted that the inquiry recommends a new waiting list segmentation model that reallocates Department of Health consumers in 'mental health Residential facilities' and consumers who are homeless into the '1st priority group' segment.[81]

Figure 41: Living arrangements for ARR consumers pre and post exit



Retaining existing ARR properties may be appropriate based on other demands within the Department (for example, new sites for PARCS); however, it is not a viable option for ARR. The best approach is to sell existing properties and leverage new investments. This approach provides the best access to additional resources, funds and skills to build a scaled housing response.

Even though the Department is not a housing provider, its ownership of ARR properties gives the Department choices to source viable housing solutions for its consumers. At least six of the ARR properties are owned by the Secretary of the Department of Health at an estimated market value of over $20 million. Table 30 outlines four options for the Department to help source end-point housing for its ARR consumers. Under the two sales options, this will require the approval of DTF and DPC.

Table 30: Housing supply options

Mental Health Recovery Outcomes	Components	Rationale
1. **Retain the current properties**	One option is to retain the current properties and to recognise the risks and consequences.	**Not viable** - Though this option may be appropriate based on other demands within the Department (for example, new sites for PARCS); it is not a viable option for ARR. The infrastructure is no longer suitable for the program's purpose, i.e. transitional housing arrangements. Providers also identified that some of the properties are ageing and require significant renovation to make them fit for modern purposes. Consumers and carers commented that ageing and sub-standard properties affect the recovery process. For consumers, outdated décor and peeling paint adds to the sense of low morale.
2. **Sell existing properties and direct investment**	High value, existing residential properties would be sold and the funds generated invested into new sites (owned by the Secretary of the Department of Health).	**No scale** – This will give the Department direct control and an investment fund equivalent to the current market value of its existing infrastructure but no scale.
3. **Sell existing properties and leverage new investments**	High value, existing residential properties would be sold and the funds generated invested into acquiring a financial and legal interest in the new sites with in-perpetuity tenant nomination rights acquired from Victorian Registered Housing Associations. This requires a partnership with Victorian Registered Housing Associations and/or partnership with the National Rental Affordability Scheme (NRAS).	**Best volume response** – Provides access to additional resources, funds and skills to build a scaled response to end-point housing for the target consumer group. New partnerships will be required – this may be a complicating factor but necessary given the size and scale of the housing challenge.
4. **Explore private rental options**	The Mental Illness Fellowship has been allocated $3.2m in funding over three years from the new Victorian Government to pilot a new approach to housing for people with a mental illness. Utilising the private rental market, they will secure 50 one bedroom rental homes across Victoria specifically for people with a mental illness. Rent subsidies, support for furnishing and associated home-based support packages will also be provided to the person with a mental illness.	**A niche response** - This is not a volume response and has risks because not all target consumers are appropriate for placement in private rental.

4.11 Workforce capability

Recommendation: Invest in workforce skills based on an agreed set of core competencies, and formulate a multi-level award structure (consistent with the Fair Work Australia award rationalisation initiative) reflecting all professional and non-professional skill requirements.

Supporting arguments:

- The proposed ARR program changes will be stymied without workforce skills development and a layered award structure
- The current ARR workforce capacity and capability cannot adequately support the recovery goals of consumers with increasingly complex issues. There have only been limited staff development opportunities and no established core competencies
- The lack of a structured career pathway and remuneration contribute to low staff retention and disrupts consumers' continuum of care. The ARR workforce is perceived to be undervalued and lacking recognition.

Proposed ARR program changes will be stymied without workforce skills development and a layered award structure.

The proposed approach to ARR will require a new mix of specialist skills in employment, education, and housing. As shown in Figure 42, managing collaborative service delivery arrangements with other providers will require new skills for the workforce and higher skilled roles. Workforce recommendations include:

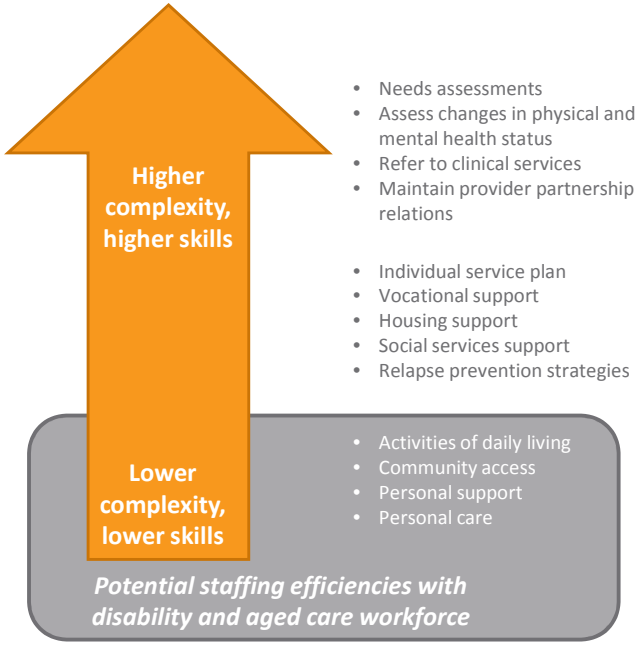
- **Skill development** - Investment in skill development will increase the skill levels of the workforce.

  There are significant concerns expressed by the clinical sector, PDRSS sector, consumers and carers about the capacity of the ARR workforce to effectively meet consumer needs, or to deliver new ARR models. The new service models will require a mix of professional and non-professional staff. Providers who have tried shifting to new service formats have found that the lower skill levels and resistance to change of the current workforce are barriers to implementing new models

- **Layered award structure** - PDRSS must develop a layered award structure to reflect the different skill levels, consistent with the Fair Work Australia award rationalisation initiative. The award must provide opportunities for advancement if the sector is to retain & grow a skilled workforce.

Restructuring the award levels could enable potential staffing efficiencies with disability or aged care support workers. Some providers are already considering stratifying tasks into professional vs. less skilled roles - the less complex tasks being undertaken by a TAFE-trained worker & the more complex by those with a professional qualification.

Figure 42: Skill development



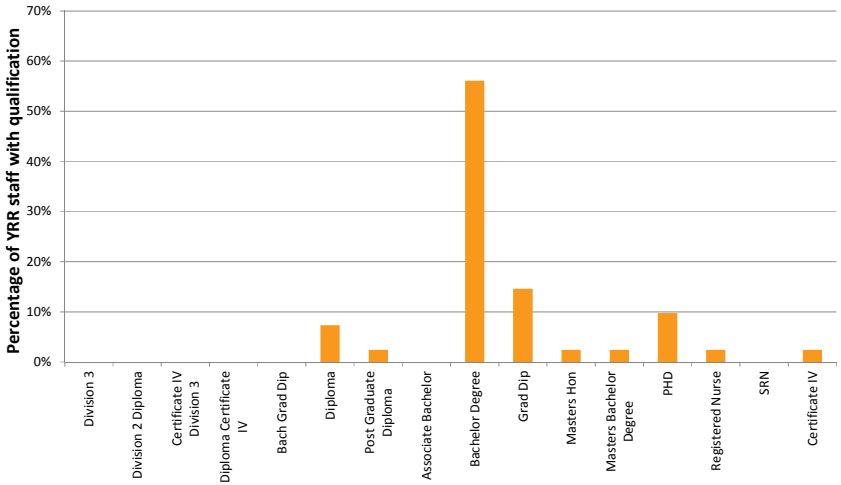
The existing ARR workforce capacity and capability do not adequately support the recovery goals of consumers with increasingly complex issues. There have only been limited staff development opportunities and no established core competencies.

The SWOT analysis identifies the existing workforce capacity and capability to deliver required services as a key threat to the sector.[82] Providers noted that increasing complexity of consumers' issues (especially the increasing prevalence of dual diagnosis consumers) requires a more highly skilled and qualified ARR workforce. The SWOT analysis also acknowledges the particular difficulty rural providers experience in attracting adequately skilled staff.

ARR providers have recognised these skill concerns and have implemented a minimum of a Bachelor's degree as a prerequisite for employment. Figure 43 highlights the qualifications of ARR staff at MIND. It shows that 56% of staff have Bachelor degrees, 15% have a graduate diploma and 10% have a PhD. Providers and the SWOT also identified the PDRSS specific Certificate III qualification as an important baseline skill for ARR workers.[83]

Even with the contribution of VICSERV, it is widely acknowledged that there has been limited investment in staff development. Providers observe that this adversely affects the capacity of staff to develop and maintain up-to-date knowledge relevant to consumers' needs. The SWOT analysis identified opportunities for training in humanistic approaches and person-centred service delivery, understanding evidence-based practices and an outcomes focus, practices of family inclusion and working with people with complex issues.[84] Providers also identified a training need for working with consumers with alcohol and other drug dependence, how to connect with housing and employment services and skills in recovery planning. The SWOT analysis framed this as an opportunity to identify and develop a set of core competencies that are shared across clinical and PDRSS workforces.[85] The establishment of core competencies is a foundation block for a productive workforce.

Figure 43: Qualifications of MIND ARR staff



The lack of a structured career pathway contributes to low staff retention which in turn disrupts consumers' continuum of care. The ARR workforce is perceived to be undervalued and lacking recognition.

Consumers and carers in particular noted a high turnover in staff across the three programs. These stakeholders acknowledged that ARR staff are generally hard working and often encounter difficult situations that may lead to stress and 'burn out'. The SWOT analysis also identifies the lack of career structures (including development opportunities) as key factors in poor staff retention.

Providers observe that the lack of career structures is compounded by a perceived inequity in pay between PDRSS and clinical staff. It is generally perceived by ARR providers that clinical staff are paid 30% more than ARR staff for similar positions. The exodus of many ARR staff into the clinical sector is attributed by many providers to this pay differential, a factor also identified in the SWOT analysis. This perception is not shared by clinical stakeholders.

The SWOT analysis identifies that the PDRSS workforce is undervalued and that there is a lack of recognition of the skills, competence and contribution of the workforce. This observation is supported by the views of ARR providers who identify low morale of staff are a key factor in high staff turnover and a resistance to change service delivery practices.

Consumers and carers observed that high staff turnover results in low continuity of care which impacts on their recovery. Consumers find that they must re-tell their stories, re-form relationships of trust and make new connections with each new staff member. This is especially difficult for a population that already struggles to make connections. Staff turnover was cited as disruptive to a consumer's sense of stability and trust.

Providers and consumers observed that ARR is often characterised as a place for young staff (often graduates) to gain experience before moving onto to other parts of the system (e.g. clinical). In particular, carers and consumers observed that staff are mostly in their early 20s, lack knowledge of the broader system and availability of services, and lack the skills to assist high-needs consumers. These stakeholders also identified the difficulties that arise for staff and consumers in ARR when young staff have to advise much older consumers about skills of daily living. The perception is that young staff do not have enough life and work experience to provide this advice. It should be noted that the SWOT analysis characterises the PDRSS workforce as ageing and does not identify young staff as an issue for the sector.

4.12 Families and other carers

Recommendation: Reconnect and engage families and other carers in a consumer's recovery process, including decision-making, planning and activities.

Carers commented positively about the contribution ARR (and the clinical system) made to helping consumers learn basic living skills, and improve their coping skills. They also noted ARR offered valuable socialising opportunities for consumers.

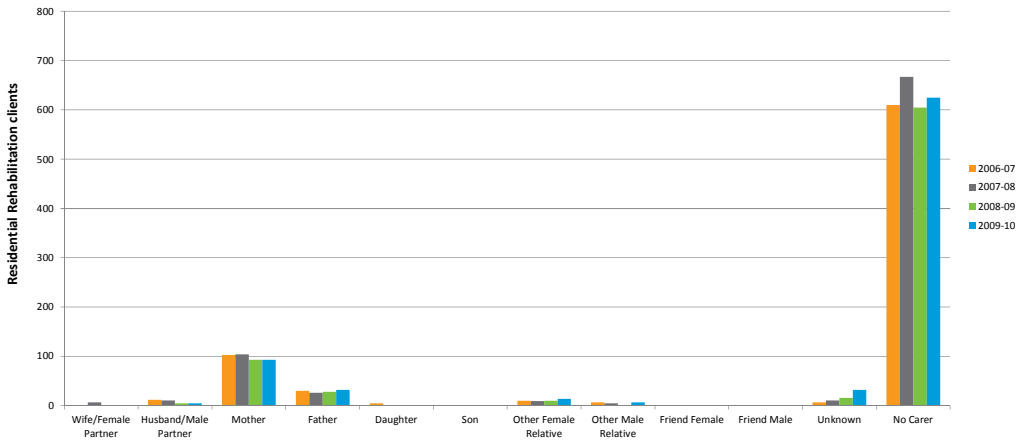
Carers also commented that they were usually not consulted in matters of planning and decision-making about their family member's progress, which ARR staff often justified on the grounds of confidentiality. Carers noted that whilst ARR staff might be involved with a consumer for a few years, families were in for the long haul. ARR providers interviewed as part of this project acknowledge that family involvement should be more actively sought and fostered.

The key role of families and other carers in consumer recovery is well documented in the Department's policy literature. (See Appendix C.7) There is also reliable research evidence on the specific activities mental health providers can utilise to foster better recognition of families and carers including staff training, family interventions and carer engagement protocols. (See Appendix C.8)

Figure 44 illustrates that many consumers have no identified carer. This highlights the need for ARR providers to work with their consumers and aid them with reconnecting with their family or significant others.

The challenges carers experience in ARR is consistent with their experience of other parts of the mental service system in Australia. (See Appendix C.6)

Figure 44: Residential Rehabilitation carers



Note: CDS data combines ARR and YRR carer data.

4.13 Funding model

Recommendation: Incorporate within the HBOS funding model but with incentives for the achievement of individual consumer recovery outcomes.

ARR services are funded on an output basis, based on bed-days. The State Government provides $4.88 million of recurrent funding for ARR services. Both providers and the SWOT analysis identify that a strength of ARR is that it provides 'value for money' services compared with clinical beds. Appendix E demonstrates the cost difference between clinical beds and PDRSS residential rehabilitation beds. However, it must also be acknowledged that those using clinical bed-based services have more complex clinical needs.

The challenge for the existing ARR model is the cost implications of its service profile:[X]

- ARR costs approximately $45,000 per consumer per annum
- Moderate HBOS, for a similar number of contact hours per week, costs $14,500 per consumer per annum.

The Government should also consider provider incentives for the achievement of individual consumer recovery outcomes. This model ensures a consumer–orientation to funding and an incentive for providers to achieve recovery outcomes with consumers.

[X] The costs provided in this analysis relate to direct program funding by Government. A full cost analysis of the programs has not been performed. It should be noted, however, that similar daily living costs such as rent and food are incurred by the consumer regardless of the program.

4.14 Structural design

Recommendation: Establish competitive market conditions to optimise the role of the ARR program within the broader psychosocial recovery system.

Arguments supporting this recommendation:

- The ARR service system set up by the Department through competitive tendering poses risks for the Government
- Optimal market design is a significant decision by Government. Selective tendering or accreditation appear to be the most viable design options. However, more detailed analysis is required before a final market design option can be agreed.

The ARR service system set up by the Department through competitive tendering poses risks for the Government.

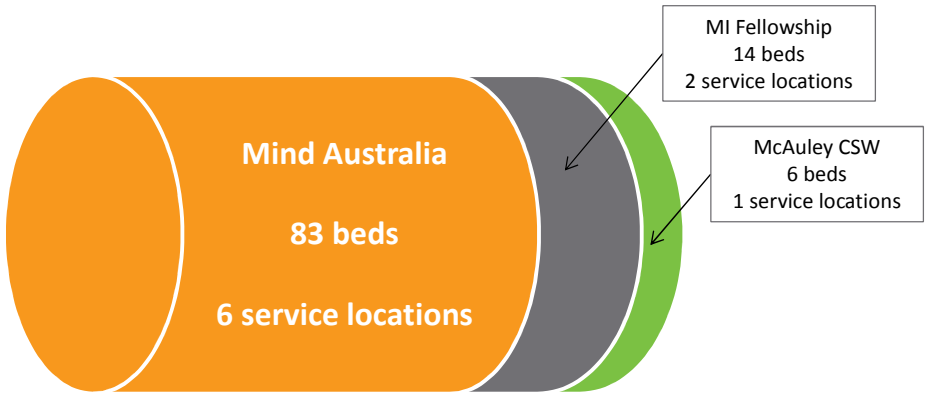
Figure 45 shows there are only three organisations providing ARR services, with one organisation providing 81% of the beds. This is effectively a monopoly system. A continued monopoly in ARR services poses risks for the Government, including:

- Inflated service delivery prices resulting in less efficiency of the Government's funding dollar
- Poor response to consumer demands, resulting in lack of choice and range of services
- Anti-competitive behaviour, including potential for larger providers to coerce smaller providers
- Referral of disproportionate level of authority to a single provider resulting in undue influence over the rest of the sector and any strategic direction set by the Department.

Providers also identified situations of consortium where the larger provider sub-contracts smaller providers to deliver services for which the larger provider receives the funding. This situation reduces the efficiency of the funding dollar, where more funding is diverted away from delivering services for consumers towards operational expenditure across two organisations.

The Commonwealth Government's experience with aged care highlights a further risk. The Government initiated a tender process for a range of services into the oligopoly aged care market however the two major providers for the majority of aged care services chose not to tender. This situation has required the Commonwealth Government to re-think its strategy and terms of reference for the tender as it is now reliant on these two providers participating.

Figure 45: Distribution of ARR beds across provider organisations



Optimal market design is a significant decision by Government. Selective tendering or accreditation appear the most viable design options. However, more detailed analysis is required before a final market design option can be agreed.

Market design is an increasingly critical responsibility of Government. The Victorian Government has partly outsourced the provision of services for people with a mental illness to the community sector. This has created a new market for the delivery psychosocial recovery services. The benefit of market design for mental health consumers includes:

- Development of new service options or access to previously rationed Government services
- Incentives for innovative PDRSS providers to increase quality and drive down costs.

The analysis of market design for ARR has highlighted that current market design is not achieving these benefits. Government needs to rethink its 'rules of the game' by aligning its policy goals with sustainable business practice of PDRSS providers. In developing these rules, Government needs to consider the population profile, regional and metro geography, workforce capability, service pricing, performance incentives and the interconnection of the ARR program with other programs. Table 31 outlines market design options for ARR:

Table 31: Market design options

Market mechanism	Explanation	Assessment
Retendering	Publically retender all current contracts with sunset clauses.	*Traditional* – This is the current process and has created skewed markets.
Selective tendering	Select a small number of providers and run a closed tendering process with sunset clauses.	*Better control* – Allows Government to maintain better control of provider size and quality.
Accreditation	Establish an accreditation scheme with providers required to meet a series of minimum standards e.g. AusAID, Australian Aged Care.	*Quality assurance* – Provides Government with a safe guard of minimum provider standards.
Social Impact Bonds	Issue individual bonds to providers and pay a premium (i.e. interest) upon expiration for recovery outcomes achievers. NSW Government – Juvenile Justice and Mental Health.	*Radical* – This is only being trialled but is aimed at 'wicked' social problems in complex service systems such as mental health. It operates more like a public/private partnership.

5 Youth Residential Rehabilitation

5.1 Background to Youth Residential Rehabilitation

Youth Residential Rehabilitation (YRR) Program is a bed based PDRSS program targeted to young people with serious mental illness aged 16-24 years.

The Victorian Government currently invests approximately $8.03 million in bed based Youth Residential Rehabilitation services. The 166 beds are delivered through a total of 17 YRR sites across the state.

According to the YRR Service guidelines (2005) the program provides transitional support to assist clients to achieve their goals for independent living. The service model focuses on supporting clients to:

- Improve their capacity to manage and be responsible for their behaviour and self-care
- Enhance their adaptive coping skills and decrease self-harming behaviour
- Enhance their social skills and daily living skills to improve their ability to live independently in the community
- Develop and maintain links with the community, family and social networks, educational and vocational opportunities.

Youth Residential Rehabilitation services offer either:

- 24 hour on site support, with capacity to provide staff sleepovers
- Less than 24 hour support. In these services staff support is provided on an extended hours basis. Hours of staffing availability vary across YRR services.

Appendix A.3 provides the program logic for YRR.

5.2 Changes needed for YRR

YRR should retain its bed-based transitional facilitates but adopt a more structured, goal-orientated program with strong and active partnerships with employment, education, community health, housing, clinical and recreational services.

Table 32 highlights the current situation of YRR and provides an outline for a repositioned YRR within the Victorian mental health system.

Table 32: The change needed for YRR

Program components	Moving away from . . .	. . . Moving towards
Why and for whom		
Purpose	• A bed-based transitional support program for people with a serious mental illness and psychiatric disability aged 16-24 years.	• The retention of a bed-based transitional support program for people with a serious mental illness and psychiatric disability aged 16-25 years.
Target group	• A largely homogenous consumer group characterised by being 19-25 years old (70%) though most are 19-21 years old, evenly male/female, having schizophrenia, depression, personality or bipolar disorders (72%).	• Consumers who are early in illness and recovery, and may have challenges with family support at that time. The target group should have better representation from people aged 16 to 18 years.
Outcomes	• A focus on assisting clients to achieve their goals for independent living	• Measureable mental health recovery outcomes with a focus on mental and physical health, economic participation through education and employment, and social participation.
Activity profile	• Limited choice of activities with 70% of activities centred on work, domestic skills, self-care, social contact and recreation.	• Consumer choice for activities aligned to individual consumer recovery goals.
How		
Service delivery model	• No clear and consistent service delivery model.	• Bed-based residential recovery support with strong and active partnerships covering education/ employment, housing, recreation, community services (e.g. youth mentoring and AOD support programs), and specialist clinical and youth services.
Support period and contact time	• 34%of YRR consumers, at the time of the PDRSS Census,, were being supported for 6-12 months • Average contact for consumers between 3.5 to 4 hours per week which is similar to individual support delivered by moderate HBOS.	• Utilise this program for a maximum of 12 months • Providing contact to consumer for an average of 6 contact hours per week.
Operating hours	• Either 24 hour on site support (with capacity to provide staff sleepovers) or less than 24 hour support (where staff support is provided on an extended hours basis).	• The retention of either 24 hour on site support (with capacity to provide staff sleepovers) or less than 24 hour support (where staff support is provided on an extended hours basis).

Program components	Moving away from . . .	. . . Moving towards
Delivery location	• Delivery through PDRSS residential bed-based facilities.	• Delivery through PDRSS residential bed-based facilities.
Geographic distribution	• Program distribution across Victoria with the majority of YRR beds located within the North and Western Metropolitan region.	• An equitable distribution across Victoria based on consumer demand.
Referral pathways	• Multiple and uncoordinated referral pathways (over 11 different pathways) with unclear selection methods, largely driven by individual provider sites and personal relationships.	• Streamlined and coordinated entry and exit pathways on an area mental health service basis with clear selection criteria.
With what		
Workforce	• Staff skills not being adequate to support the recovery aims of an increasing number of consumers with increasingly complex issues.	• A mix of professional and non-professional staff matched to complex consumer needs, and to the delivery of new service models.
Families and carers	• General exclusion of families and carers in the YRR activity.	• Connected and engaged families and carers in a consumer's recovery process, including decision-making, planning and activities.
Partnerships	• Pockets of productive non-health based partnerships.	• Partnerships with employment and education, community health, housing, clinical and recreational services to ensure consumers are connected with services that enable recovery and sustainable re-connection with the mainstream community.
Funding model	• A bed-based funding model.	• Service-based funding with incentive funding for the achievement of individual consumer recovery outcomes. Consumer outcomes which are linked to individual service provider performance.
Structural design	• Five organisations providing YRR services with 76% beds provided by one organisation.	• Distributed funding allocations per provider to optimise the role of the YRR program.

5.3 Recommendations for YRR

The unique recommendations to reform YRR are summarised in Table 33. It is noted that for impact to be achieved, the four wider service design recommendations must be carried out in conjunction with the individual program recommendations.

Table 33: Recommendations for YRR

Component	Summary recommendation
1. **Consumer group**	Target 16 to 25 year olds with a serious mental illness who are at risk of or experiencing substantial functional impairment and psychosocial disability. Consumers should be in early stages of illness and recovery, and may have challenges with family support. The target group should also have better representation from people aged 16 to 18 years.
2. **Outcome orientation and performance**	Orient the YRR service models to deliver an agreed set of consumer-focused, mental health recovery outcomes with a greater focus on mental and physical health, economic participation through education and employment, and social participation. Link YRR consumer outcomes to individual service provider performance. Include a performance assessment in funding and service agreements.
3. **Service delivery model**	Bed-based residential recovery support with strong and active partnerships covering education, employment, housing, recreation, community services (e.g. youth AOD support programs), and specialist clinical and youth services.
4. **Support period**	Consumers should have access to this program for 12 months and be provided with an average of 6 hours of contact per week.
5. **Geographic distribution**	Conduct a detailed geographic demand study to determine distribution requirements for the proposed service delivery model across Victoria.
6. **Coordinated services and partnerships**	Formalise service coordination mechanisms with specialist clinical mental health, community, social, health and primary care services to scale the treatment and support response to each consumer's need. Establish entry and exit pathways on an area mental health service basis. Some flexibility is necessary with entry criteria due to the complexity of clients coming though the child protection, alcohol and drug, and homeless systems with a serious mental illness.
7. **Workforce capability**	Invest in workforce skills including a pilot of peer support workers, based on an agreed set of core competencies. Reach agreement on a multi-level award structure (consistent with the Fair Work Australia award rationalisation initiative) that reflects the range of professional and non-professional skills requirements.
8. **Families and carers**	Reconnect and engage families and other carers in a consumer's recovery process, including decision-making, planning and activities.
9. **Funding model**	Establish a service-based funding model with financial incentives for the achievement of individual consumer recovery outcomes.
10. **Structural design**	Establish competitive market conditions to optimise the role of the YRR program within the broader psychosocial recovery system.

5.4 Target group

Recommendation: Target 16 to 25 year olds with a serious mental illness who are at risk of or experiencing substantial functional impairment and psychosocial disability. Consumers should be early in illness and recovery, and may have challenges with family support. The target group should have better representation from people aged 16 to 18 years.

Arguments supporting this recommendation:

- The current consumer profile indicates most are 18-21 years of age and is slightly skewed towards males. There is a view by some providers that YRR does not cater well to consumers who are less than 18 years of age, indigenous or from CALD backgrounds
- There is more variation in consumers' primary diagnosis in Youth Residential Rehabilitation than in Day Program and Adult Residential Rehabilitation. This variation reflects alignment to the intended YRR targeting
- YRR consumers experience the highest number of difficulties and the highest rates of alcohol and drug dependence of all PDRSS. Providers indicate that these issues lead many YRR consumers to have challenges with family support prior to entry into the program
- There is debate about the desirable age range for a residential rehabilitation service for young people. Initially YRR services targeted young people aged 16 to 24 years, but the upper age limit has now been brought into line with broader policy
- There is compelling research that emphasises the economic advantages of a sustained early intervention for young people with serious mental illness and associated disability.

The current consumer profile indicates most are 18-21 years of age and is slightly skewed towards males. There is a view by some providers that YRR does not cater well to consumers who are less than 18 years of age, indigenous or from CALD backgrounds.

Based on PDRSS census data, Figure 46 shows that males account for 53% of consumers and 43% are female. The remaining 4% are transgender or unknown. Overall, males aged 19 to 25 years comprise the largest cohort (43%). The age profile of YRRS consumers shows that 70% are aged between 19-25 years with service providers reporting that the majority are 19 to 21 years old. QDC data shows that 20% are aged from 16-18 years. Of this group, 10% are aged 16-17 years.

There is also a cohort who are older than the upper target of 25 years. All are women aged 26 to 34 years and they comprise 9% of those using YRRS. It is not clear from the data why these women are using a young person's service.

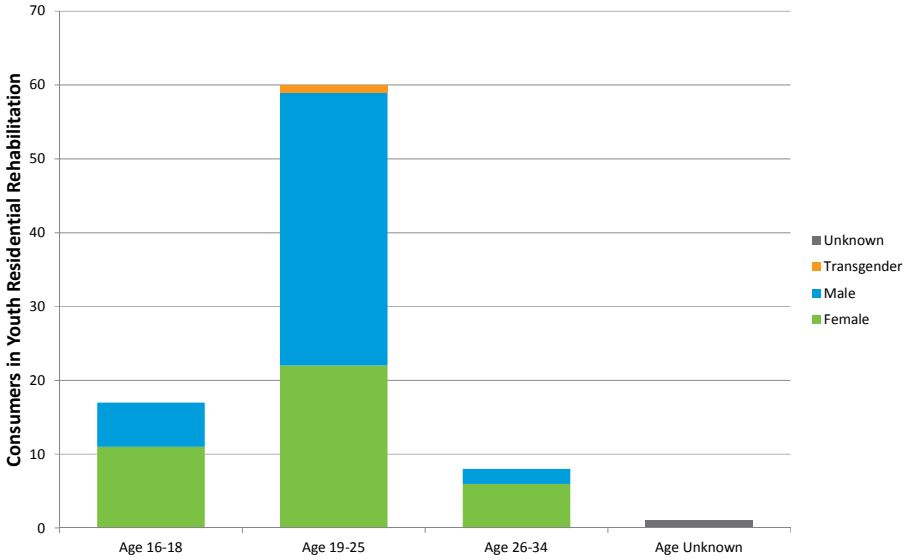
Clinicians, providers and Nous advisors highlighted the different developmental needs of sub-groups within the 16 to 25 year age bracket, and the issues these differences sometimes cause in a residential setting. Nous advisors noted that 16 and 17 year olds are the most vulnerable group and could expect greater representation.

Providers also observed that YRRS generally do not cater well for indigenous or CALD consumers, and that there is potential for improvement in making services relevant to these groups.

The service data do not allow an analysis of cohort trends in different YRRS, such as whether some services have a higher proportion in a particular age group, and whether this reflects local demand factors.

A Service eligibility guideline for PDRSS is a diagnosed mental illness associated with a significant disability. Where consumers are placed is determined by the AMHS catchment area in which they reside.

Figure 46: Youth residential rehabilitation consumers – age and gender profile[86]



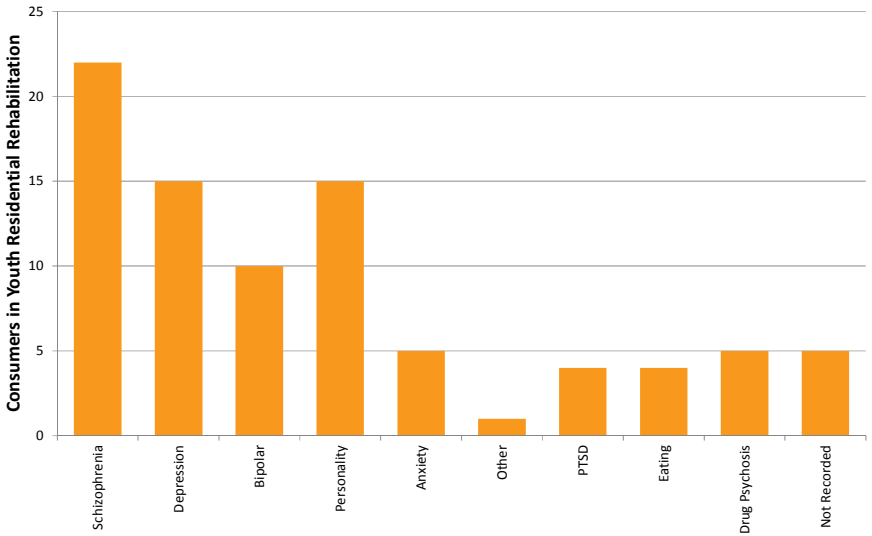
There is more variation in consumers' primary diagnosis in Youth Residential Rehabilitation than in Day Program and Adult Residential Rehabilitation. This variation reflects alignment to the intended YRR targeting.

Figure 47 shows that the highest prevalence of mental illness amongst Youth Residential Rehabilitation consumers is schizophrenia, with 26%. Other prevalent diagnoses are:

- Depression (17%)
- Personality disorders (17%)
- Bipolar disorder (12%).

Clinicians and Nous's expert advisory panel commented that the variation in diagnoses is what they expected, particularly as many of these disorders first appear at 18-25 years.

Figure 47: Consumers in Youth Residential Rehabilitation – diagnosis profile[87]



Consistent with the intended YRR targeting, YRR consumers experience the highest number of difficulties and the highest rates of alcohol and drug dependence of all PDRSS. Providers indicate that these issues lead many YRR consumers to have challenges with family support prior to entry into the program.

Figure 48 shows YRR consumers experience an average of 4.3 difficulties in addition to their mental illness which is the highest of all PDRSS. 88% of consumers in Youth Residential Rehabilitation have at least one difficulty, and 40% have five or more difficulties.[88] The most prevalent difficulty is unresolved trauma (e.g. sexual abuse, grief) which is experienced by 47% of consumers (78% for females). *See appendix D.1 for average number of complexities per consumer across all PDRSS programs.*

Youth Residential Rehabilitation consumers also have the highest rates of alcohol and drug dependence across PDRSS. Figure 49 shows that the most common dependencies are nicotine (30%), alcohol (30%) and cannabis (21%). The PDRSS Census counts 40% more dependencies than consumers, indicating that a significant proportion of consumers have multiple dependencies. 37% of consumers are recorded as having no alcohol and drug dependence.

Providers indicate that in addition to a young person's serious mental illness, the high number of difficulties and rates of alcohol and drug dependence lead many YRR consumers to have challenges with family support prior to entry into the program.

Figure 48: Complexity profile for consumers in Youth Residential Rehabilitation

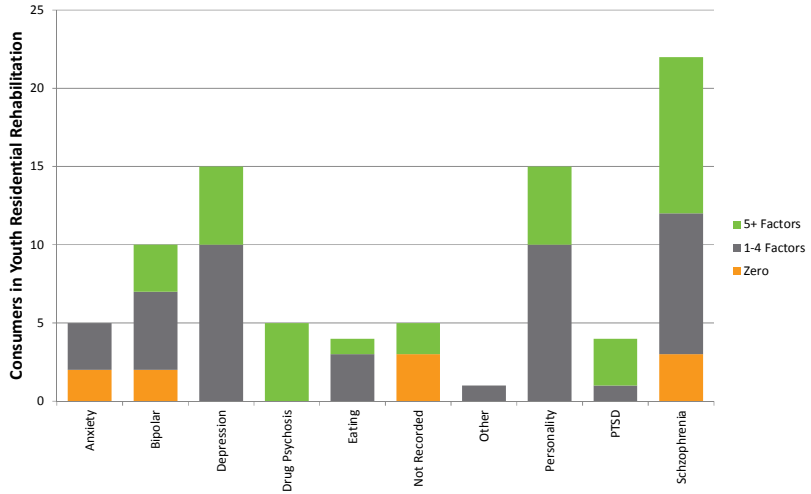
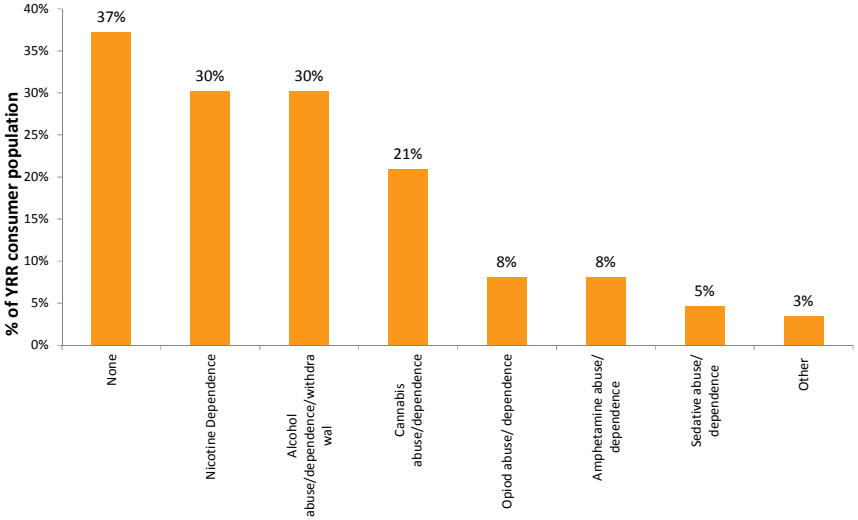


Figure 49: Alcohol and drug dependence profile for consumers in Youth Residential Rehabilitation



There is debate about the desirable age range for a residential rehabilitation service for young people. Initially YRR services targeted young people aged 16 to 24 years but the upper age limit has now been brought into line with broader policy reforms.

There is some debate about the desirable age range for a residential rehabilitation service for young people. For instance, SAMHSA (2009) identifies the key elements of a recovery-oriented system of care for youth with substance use, or co-occurring substance use and mental disorders. Some elements are specific to 12 to 17 year olds such as being family focused; employing a broad definition of family; and ensuring ongoing family involvement.

A different view expressed by local stakeholders is that the breadth of the current age range for YRRS allows flexibility and responsiveness to local need. YRR therefore provides an important alternative for those young people with mental health problems whose rehabilitation has to occur away from their family of origin. SAAP is another accommodation option but it does not include rehabilitation, and early SAAP services had difficulty managing young people with mental health issues. In the 1990s a government-funded program was introduced called 'HARP' which employed psychologists to assist SAAP workers in responding to young people with mental health problems.

The importance of YRR engaging constructively with families is particularly pronounced for the younger cohort of YRR consumers. This entails an understanding of family dynamics, and skill in working with families to resolve tensions and develop ongoing relationships between the consumer and their family. The families of both younger and older YRR cohorts also need to be educated about mental illness, kept informed about their family member's situation, and feel that their contribution is valued.

There are two strategies which could assist YRR staff to manage the different development needs within the 16 to 25 year age range. Firstly, specific training for staff about the differences between the sub-groups and how best to respond. This should include training in engaging families which is a key issue for consumers in the 16 to 17 year age group. The second strategy is to review overnight and weekend staffing arrangements to ensure the ready availability of staff support.

There is compelling research that emphasises the economic advantages of a sustained early intervention for young people with serious mental illness and associated disability.

Two research studies have assessed the economic impact of the 'early intervention in psychosis' approaches. One of these studies had a specific focus on young people.[89] Both studies demonstrated the positive economic outcomes for early intervention.

In 2008 Access Economics found that under an 'incremental cost effectiveness ratio' model that it is cost effective for Government to invest in an early intervention response for young people with a serious mental illness.

Knapp et al (2010) conducted a UK study to assess the economic impact of early intervention services for people with psychosis. The study relied on service use data and also reported on studies which have done more independent follow-ups. It presented convincing evidence for the positive economic outcomes of early intervention. The results included substantially reduced costs of lost employment and lower costs for homicide and suicide.

The authors note, however, that the long-term economic impact of early intervention depends on readmission rates after a patient is discharged from the early intervention team. The study examines the longitudinal results of the OPUS and LEO studies in Denmark and London respectively (see Table 34).

Table 34: Summary of LEO and OPUS studies

Study	Description	Conclusion
OPUS study	A five-year follow-up of the OPUS study in Denmark was performed by Bertelsen et al (2008). The EI intervention lasted for two years and consisted of assertive community treatment, family involvement and social skills training for 275 patients.	At two years there were significant differences in favour of EI for psychotic symptoms and functioning.
LEO study	In a follow-up to the LEO study in south London, Gafoor et al (2010) examined admissions in the period 3.5-5 years after entry to the study.	After controlling for patent characteristics it was found that EI patients spent on average of two more days in hospital than standard care patients. The authors suggest that EI does not have a long-term effect and that when patients are discharged back to standard care they have similar outcomes to others. Knapp et al (2010) make it clear though that the initial savings are not lost.

There is no known financial analysis on the extra expenses incurred in setting up & running a separate service delivery system like the Victorian mental health model. However, the implication for the YRR program is to sustain an early intervention response for young people with serious mental illness and psychiatric disability.

5.5 Outcome orientation and performance

Recommendation (part a): Orient the YRR service models to deliver an agreed set of consumer-focused, mental health recovery outcomes with a greater focus on mental and physical health, economic participation through education and employment, and social participation.

Recommendation (part b): Link YRR consumer outcomes to individual service provider performance, include a performance assessment in funding and service agreements.

Arguments supporting these recommendations:

- The current model for YRR does not adequately deliver on improved mental health outcomes or on other recovery outcomes for consumers
- The Department's current output-focused performance framework for YRR means that providers are not accountable to deliver recovery outcomes for consumers
- YRR providers wish to identify outcomes measures and implement outcome data collection. Three of the nine components of the outcome focus are explored in more detail:
  - *Employment and education* - There is strong evidence to support the importance of an education and employment outcome focus for consumers with a severe and enduring mental illness. However, the majority of YRR consumers are unemployed and providers are mixed in their views about the capacity of their consumers to achieve positive education and employment outcomes
  - *Physical health* - Population health data shows that people with a severe mental illness have higher rates of mortality and physical morbidity than the general population. This is supported by the experience of YRR providers. Though providers do have relationships with health organisations, no YRR data is collected on each consumer's physical health and physical health is a not a direct focus of current YRR programs
  - *Housing* - Stable and affordable housing is critical for people recovering from a severe and enduring mental illness.[90] In YRR, most consumers record their rehabilitation facility as their primary residence. Providers commented that housing for their consumers leaving YRR is one of their biggest issues, and providers have found it traditionally challenging to establish formal partnerships with public housing providers.

YRR providers and consumers commented that the current model for YRR does not adequately deliver improved mental health outcomes or other recovery outcomes for consumers.

Both the SWOT analysis and provider consultations identify that many providers use the language of recovery; however, the articulation of recovery outcomes differs across providers. At a departmental level, long-term success measures and recovery aims are not well articulated. Table 35 outlines a qualitative assessment of the performance of YRR against long-term recovery outcomes identified in program logic models developed for this strategic review. This assessment is based on the literature review, stakeholder consultations and available data such as QDC and the PDRSS census survey.

Table 35: General assessment of recovery outcomes achieved across programs

Programs	Mental Health			Physical Health	Social			Economic		Overall assessment
	Enhanced daily living skills	Psychosocial education attainment	Self-management of illness	Good Physical health and wellbeing	Improved social and family relationships	Stable and affordable long term housing	Family/Carer support and engagement	Educational and vocational achievement and employment	Reduced requirement for intensive clinical support[XI]	
YRR Program									*Unable to make an assessment*	**Medium**
Overall assessment	**Medium**	**Medium**	**Medium**	**Medium**	**Low-medium**	**Low-medium**	**Low-medium**	**Low-medium**	***Unable to make an assessment****	**Medium**

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

The Department's current output-focused performance framework for YRR means that providers are not accountable to deliver recovery outcomes for consumers.

Current data collected for service delivery at a departmental level are output focussed and offer limited insight into the performance of the YRR program. There is a desire from YRR providers to identify outcomes measures and to define what recovery looks like. In comparison to the clinical sector, PDRSS provide little information on service delivery and collect a very limited set of data. The data collected at a departmental level are limited to outputs with no outcome data collected at all. Some organisations are using a variety of wellbeing tools such as CAN-C and BASIS-32 to assess consumers' progress towards recovery. However, it is up to providers to select an assessment tool. Data from assessments are not collected at a departmental level. It should be noted that some providers do attempt to collect some outcome data.

It is a service delivery requirement for all consumers entering YRR to work with their case workers and identify recovery goals for the duration of their support period. The Individual Recovery Plan (IRP) that captures these goals forms the core document to plan services delivered to a consumer. However, Nous observed that the quality of IRPs developed across YRR differ considerably in quality, particularly in the clarity of goals developed for consumers. Nous also observed that IRPs frequently do not articulate goals that will result in recovery outcomes for a consumer.

YRR providers have a strong desire to identify outcomes measures and implement outcome data collection.

All providers are familiar (to varying degrees) with the concept of recovery and what recovery outcomes might look like. A consistent, sector-wide definition of recovery outcomes will assist case workers and consumers alike to better identify recovery goals for consumer's Individual Recovery Plans (IRPs). The providers are in strong agreement about the recovery outcomes that YRR should deliver. The recommended outcomes are provided in Table 36.

Table 36: Recommended outcomes

Mental Health Recovery Outcomes	Components	Rationale
1. **Mental Health**	∘ Daily living skills ∘ Psychosocial education ∘ Self-management of illness and reduced psychological distress.	Consumers achieving outcomes in improved mental health factors remain a key goal of PDRSS services. The sector should still aim to reduce the amount of negative psychosocial episodes and declines in mental health. This can be achieved by ensuring consumers receive psychosocial education, skills for daily living, self-management of illness and reduced psychological distress. Shean (2009) provides a meta-analysis of psychosocial recovery practices that summarises the compelling evidence base for the components of this outcome measure.[91]
2. **Economic**	∘ Educational and vocational achievement and employment ∘ Reduced requirement for intensive clinical support, including acute inpatient admissions.	There is strong evidence on the importance of supported employment or education as one of the primary goals of recovery. Such outcomes have been shown to be critical to an individual's recovery.
3. **Physical Health**	∘ Good mental and physical health and wellbeing.	The sector recognises there should be a renewed emphasis on physical health and family/carer support and engagement; as these elements have not received adequate attention in the past. In comparison with the general population, people with a severe mental illness have higher rates of mortality and physical morbidity.
4. **Social**	∘ Improved social and family relationships ∘ Family/carer support and engagement ∘ Maintain stable and affordable long-term housing.	The key role of families and significant others in consumer recovery is well documented in the Department's policy literature. There is good practice evidence on the specific activities mental health providers can utilise to foster better recognition of families and significant others and achieve more enduring recovery outcomes for consumers. Housing does not fall under the domain of the Department of Health. However there is an explicit acknowledgement that stable and affordable housing is fundamental to recovery, and while the shortage of public housing in Victoria continues, maintaining access to housing options will remain a key outcome for PDRSS programs.

This revised outcome orientation is consistent with the draft outcomes framework originally published in *Because Mental Health Matters*, the Victorian Mental Health Reform Strategy 2009-2019. This framework outlined three levels of outcome broadly based on the National Health Performance Framework: Health and Community Outcomes; Determinants of Mental Health; and Performance of the Service System.

Employment and education **- There is a strong evidence to validate the importance of an education and employment outcome focus for consumers with a severe and enduring mental illness. However, the majority of YRR consumers are unemployed and providers are mixed in their views about the capacity of their consumers to achieve education and employment outcomes.**

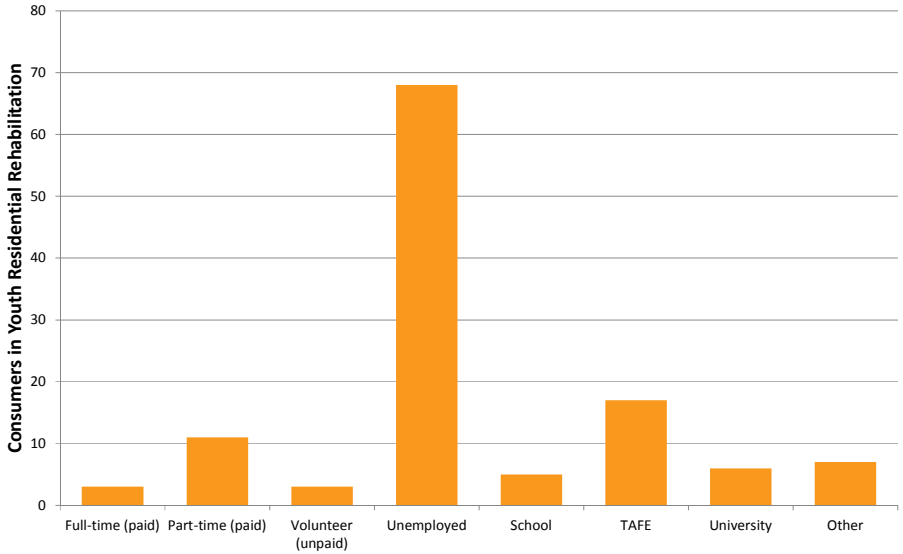
Figure 50 shows that 57% of consumers are unemployed. 23% of consumers are in education and 14% are employed in some capacity.

YRR providers were mixed in their views about the capacity of their consumers to achieve positive education and employment outcomes. Some providers, such as MIF, were quite sophisticated in their approach and were achieving outcomes according to their own records.

Most providers were familiar with the research evidence of the improved consumer outcomes from a clear employment and employment orientation and they acknowledged that new skills would be required.

Appendix C.1 provide the research base to validate an education and employment outcome focus for consumers who have a severe and enduring mental illness.

Figure 50: Overall education and employment participation



***Physical health* - Population health data shows that people with a severe mental illness have higher rates of mortality and physical morbidity than the general population. This is supported by the experience of YRR providers. Though providers do have relationships with health organisations, no YRR data is collected on each consumer's physical health and physical health is a not a direct focus of current YRR programs.**

Though no formal data are collected on each consumer's physical health, Clinicians and YRR providers commented widely that their consumers with a severe mental illness experience more issues with their physical health than the general population. These stakeholder comments are supported by studies that suggest people with a severe mental illness have a lower life expectancy than the general population and have a higher diagnosis rate of diseases such as diabetes and cardiovascular disease.[92]

The seminal study published in Western Australia, *Duty to Care: Physical illness in people with mental illness* (2001) identifies that people with a mental illness are two-and-a-half times more likely to die from the most common causes of death in Western Australia.[93] The Mental Health Council of Australia cites this study to argue that people with a severe mental illness are more likely than the general population to:

- Have a physical illness, and for that illness to go undiagnosed and untreated
- Engage with high-risk behaviours that impact their physical health, such as smoking (the PDRSS Census indicates high rates of smoking and alcohol/drug dependence across consumers in Youth Residential Rehabilitation consumers)
- Overlook health promotion behaviours such as exercise and a healthy diets
- Suffer from high levels of stress, frustration and anger due to their mental illness, and to the stigma they experience.[94]

Program providers do have relationships with health organisations (particularly GPs); however, few providers have productive partnerships with community health services (including dental services, podiatrist, and dieticians). Carers, Clinicians and YRR providers observed that current partnerships with community health services are not sufficient to adequately address physical health issues. These stakeholders noted that even when there is a partnership with a community health service they typically provide in-reach for only a few hours a week (often only one hour per service), which is insufficient time for consumers to receive proper assistance.

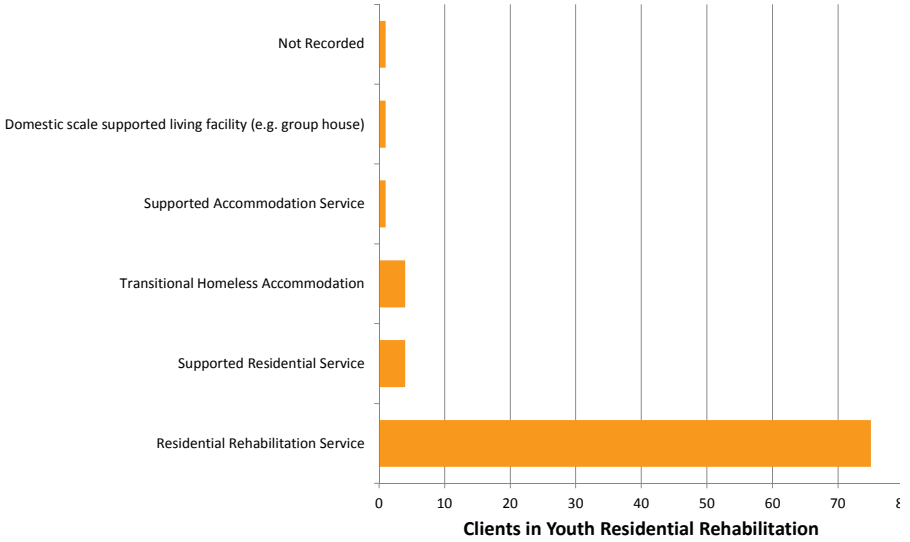
***Housing* - Stable and affordable housing is critical for people recovering from a severe and enduring mental illness.[95] In YRR, most consumers record their rehabilitation facility as their primary residence. Providers commented that housing for their consumers leaving YRR is one of their biggest issues, and providers have found it traditionally challenging to establish formal partnerships with public housing providers.**

YRR providers and consumers strongly identified the shortage of stable housing as a significant barrier to achievement of recovery aims of YRR consumers. Figure 51 highlights that more than 85% of consumers in YRR record their rehabilitation facility as their primary residence.

Providers commented that one of the larger issues for their consumers leaving YRR is housing. Many providers acknowledged that this program was a pseudo housing solution for their consumers and emphasised the difficulty their consumers faced in finding stable and affordable long-term housing.

People recovering from a mental illness identify access to a stable and affordable home as the most critical issue affecting their quality of life and capacity for recovery. It is estimated that over 40% of people with severe mental illness are homeless or housed in tenuous forms of accommodation, often interspersed with periods of hospitalisation and sometimes incarceration.[96]

Figure 51: Housing arrangements



5.6 Service delivery model

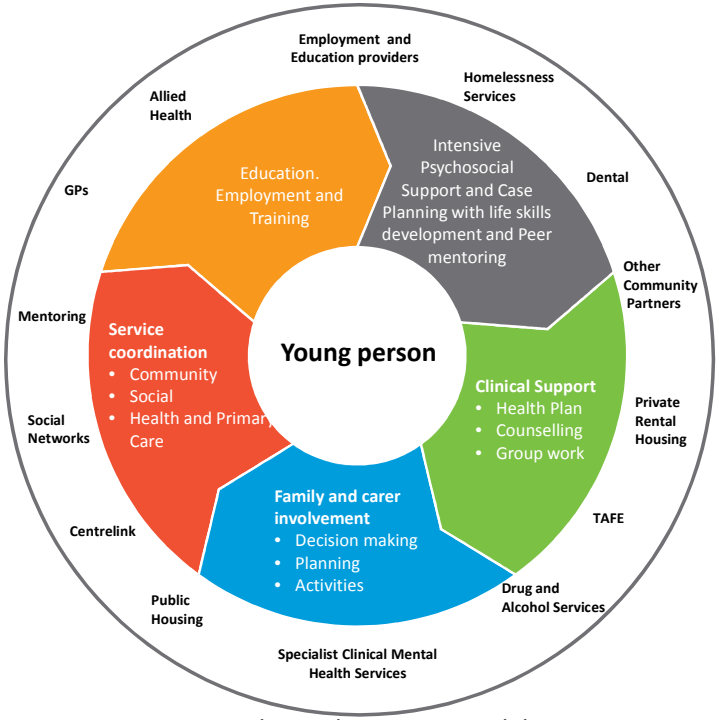
Recommendation: In principle, retain the bed-based residential recovery support with differential access for males and females. Develop strong and active partnerships covering education/ employment, housing, recreation, community services (e.g. youth AOD support programs), and specialist clinical and youth services. Consider other service delivery models as evidence becomes available and opportunities present.

Arguments supporting this recommendation:

- YRR has no clear and consistent service delivery model or outcomes framework from Government to guide service delivery
- There is broad stakeholder consensus for the bed-based approach. Evidence highlights the importance of an individualised program, flexible support sessions and family inclusion
- An alternative residential approach is emerging for homeless young people known as the Foyer Model. This model's activation of partnerships might be applicable to a residential recovery model for young people with a serious mental illness
- An historical attempt to establish end-point housing for young people with a mental illness largely failed due to the service model not meeting the support needs of the young residents
- Gender, age, maturity and sophistication issues are significant in young people's psychosocial recovery and this should inform the service delivery model.

An illustration of the proposed service delivery model is provided in Figure 52.

Figure 52: Proposed YRR service delivery model



Bed-Based Recovery model

The YRR has no clear and consistent service delivery model or outcomes framework from Government to guide service delivery. Services are structured as clusters of eight to 10 beds. 14 sites deliver non-24 hour (non-clinical) PDRSS staffed services for 136 beds and three sites deliver 24-hour (non-clinical) PDRSS staffed services for 30 beds. Site visits and consultations indicated that each individual site adopted their own service delivery model.

There are a number of general elements common to most sites. Figure 54 shows that on a given day, 70% of consumers require assistance with work, domestic skills, self-care, social contact or recreation. 61% require assistance with practical issues such as housing or money. YRR consumers also require more assistance with management of risk to self or management of risk to others (combined, 38%).

To facilitate connections with the local community and prepare consumers for the transition from YRR, providers observed that sites have different relationships with clinical services, education and training institutions, employment services and local community services. Providers acknowledge that these relationships are not systematic but are largely based on personal relationships. Figure 53 shows that 5 out of the 10 most used services are health-based. There is no substantial use of education and employment providers even though the research evidence highlights the importance of education and employment in the recovery of young people.[97]

Figure 53: Youth Residential Rehabilitation health and community service use profile – 10 most used services (other than Youth Residential Rehabilitation)

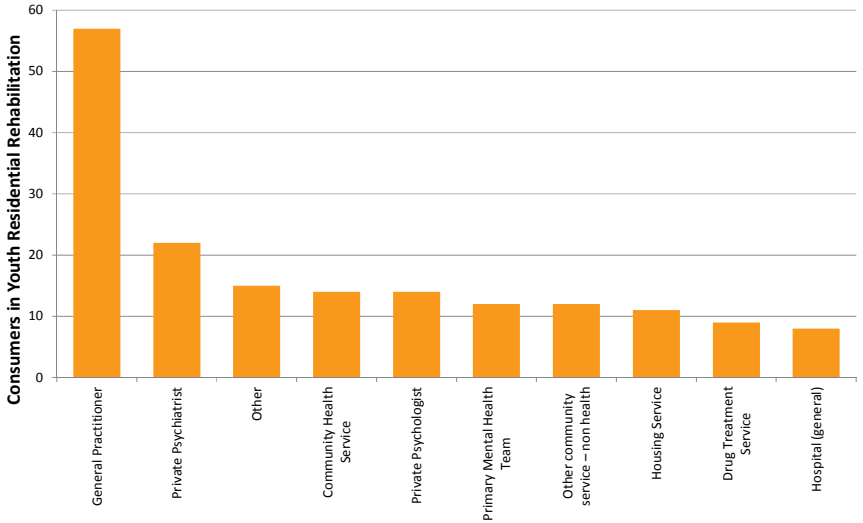
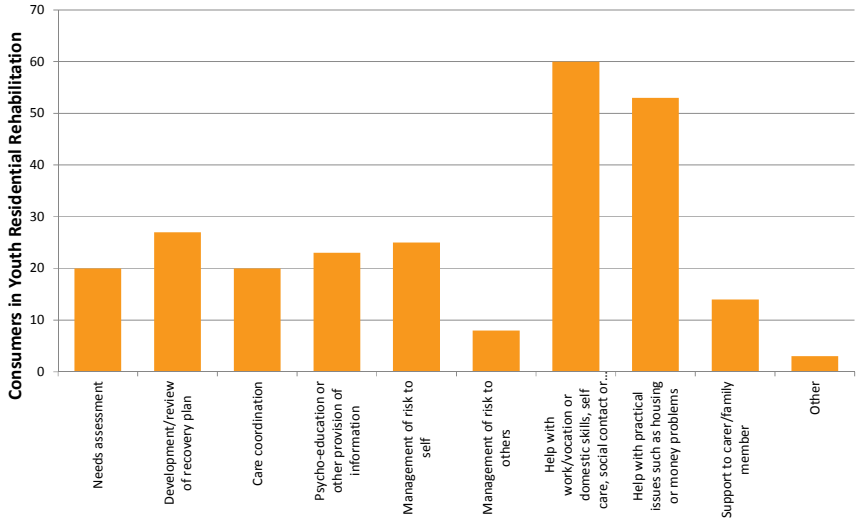


Figure 54: Services provided - Youth Residential Rehabilitation



There is no supporting evidence about Youth Residential Rehabilitation services. However, there is broad stakeholder consensus for the bed-based approach. The evidence that does exist supports the importance of an individualised program, flexible support sessions and family inclusion.

In consultations with YRR stakeholders, there was broad agreement for the retention of a bed-based approach for young people. The general view was that the bed-based approach is necessary given the critical development stage of young people. This approach gives stability, peer support and relative safety.

The only published article on Victorian Youth Residential Rehabilitation programs describes the setting up a new service in a rural setting in Victoria. Johnstone and Thorne (2001) evaluated a new Youth Residential Rehabilitation Service in Ballarat. They highlight some of the challenges faced by staff and describe an innovative approach to involving families.[98] Over the period of the evaluation, twenty young people had participated in the service, with the average stay being six to eight months (p.24).[99] An initial major issue was the unexpectedly high level of substance abuse (90 percent) amongst the young people referred to the service. Table 37 shows the components that the authors reported as producing positive outcomes.

Table 37: Components for positive outcomes

Component	Explanation
Individualised programs	Individual program plans established to identify life skills needing development.
Flexible support sessions	Flexible use made of one-to-one sessions with their key worker, group work, peer support and unstructured time.[100]
Family inclusion	An inclusive approach with families, inviting their involvement in decision-making and encouraging their participation in meals and activities. This included providing overnight accommodation for relatives from outlying rural hamlets.[101]

Apart from residential rehabilitation services for young people in Victoria, there are comparable services in other jurisdictions. An example is the Young People's Program (YPP) set up in Western Sydney by the NSW Richmond Fellowship in 1997. The YPP is a transitional residential service for young people with mental illness and co-occurring substance use problems aged 17 to 25 years. It operates on a core and cluster model, with a staffed, ten-bedded house, a transitional house with medium level support, and satellite housing with outreach support. Since 2002, the core house has only taken males, although the service was initially intended for young women as well. An evaluation by the University of Western Sydney is currently underway. There are no other known published evaluations of residential rehabilitation services for young people.

An alternative residential approach is emerging for homeless young people known as the Foyer Model. This model's activation of partnerships might be applicable to a residential recovery model for young people with a serious mental illness.

The Foyer model for young people who are homeless or at risk of homelessness is gaining support in Victoria.[102] The Foyer model was established in France and has been trialled successfully in Britain in the 1990s. There are now well-established examples of Foyer services in England and Scotland. The Foyer model places the young person in accommodation, connects them to education and/or employment services, assists them with basic skills and independent living skills, and helps them find permanent accommodation and ongoing support after the person has left the Foyer. Length of stay can be up to 2 years and exit planning takes place well in advance of the young person leaving the program. Formal partnerships with education/employment, housing, recreation, community services (e.g. youth AOD support programs), and other youth services are standard with this model.

Stakeholders who have seen the Foyer model in action commented that the success of the program can be attributed to the service model framework of six components as shown in Table 38.

Table 38: Service model framework

Service model frame		
• Sense of ownership	• Participation	• Support
• Choice	• Leadership	• Health and wellbeing

It is not clear whether Foyer services cater for young people with serious mental illness.

An historical attempt to establish end-point housing for young people with a mental illness largely failed due to the service model not meeting the support needs of the young residents.

An attempt to establish end-point housing for young people in 1994-95 largely failed due to the service model not meeting the support needs of the young residents. In the mid-1990s, Victoria's Housing and Support program provided four purpose-built units in Evans Street, East Brunswick for the Early Psychosis and Prevention Centre (EPPIC). The Schizophrenia Fellowship (now known as the Mental Illness Fellowship, or MIF) was funded for two support workers (equivalent of 0.5EFT) to support these residents. However, difficulty in providing an adequate level of support to the young people, and the complexity of their developmental needs resulted in two units being re-categorised as transitional housing, with only two units continuing to house long term tenants.

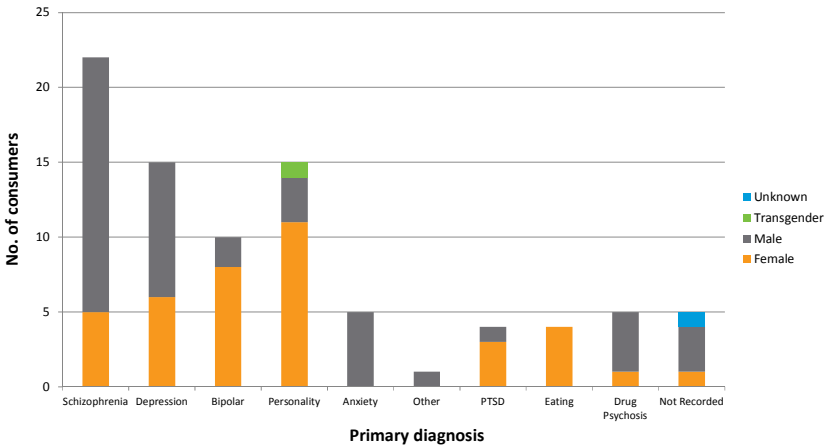
Gender, age and maturity issues are significant in young people's psychosocial recovery and should inform the service delivery model.

Providers and Nous's expert panel expressed the view that gender, age and maturity issues are significant in young people's psychosocial recovery and should inform the service delivery model.

- Gender – Figure 55 shows a difference between male and female primary diagnosis in YRR. Females are dominant in Bipolar and Personality disorders. Males are dominant in Schizophrenia. Providers and Nous's expert panel noted that sexual abuse is often a cause of female mental health issues and therefore these consumers have a need to feel safe. Morton et al (1999) found evidence to separate young males and females in residence based on underlying diagnosis issues[103]
- Age and maturity – The broad stakeholder view is that younger consumers enter the program during a critical developmental stage in their lives. Services need to provide support for consumers to develop basic living and socialisation skills that are developmentally consistent for young people. This view is supported by the research of Birleson and Vance (2008) who found that younger teenagers aged between 12 and 17 years have different developmental needs to their older peers aged 18 to 25. Birleson and Vance argue that services should reflect this difference in the age group targeted.[104] They claim that mixing the two groups can lead to an unfortunate 'adultification' of the younger group (p.25).

Implications for YRR service design include younger consumers benefiting from more 24-hour staffed services, especially where younger consumers (e.g. 16 or 17 year olds) are living in services with older consumers (e.g. 21+ year olds). There may also be potential for more formal separation of residential spaces for males and female.

Figure 55: Male and Female Primary Diagnosis in YRR



5.7 Support period

Recommendation: Consumers should have access to this program for 12 months and be provided with an average of 6 hours of contact per week.

Arguments supporting this recommendation:

- Young adult mental health experts and service provider opinion is that 12 months is the appropriate period for a youth residential recovery program. There is no research evidence, however, for a definitive support period recommendation
- Youth Residential Rehabilitation consumers currently receive 3.5 to 4 hours per week of direct contact hours with staff. However, this level of direct contact does not reflect an intensive residential support setting.

Young adult mental health experts and service provider opinion is that 12 months is the appropriate period for a youth residential recovery program. There is no research evidence, however, for a definitive support period recommendation.

Young adult mental health experts and service provider opinion is that 12 months is the appropriate period for a youth residential recovery program. The rationale for this opinion is based on:

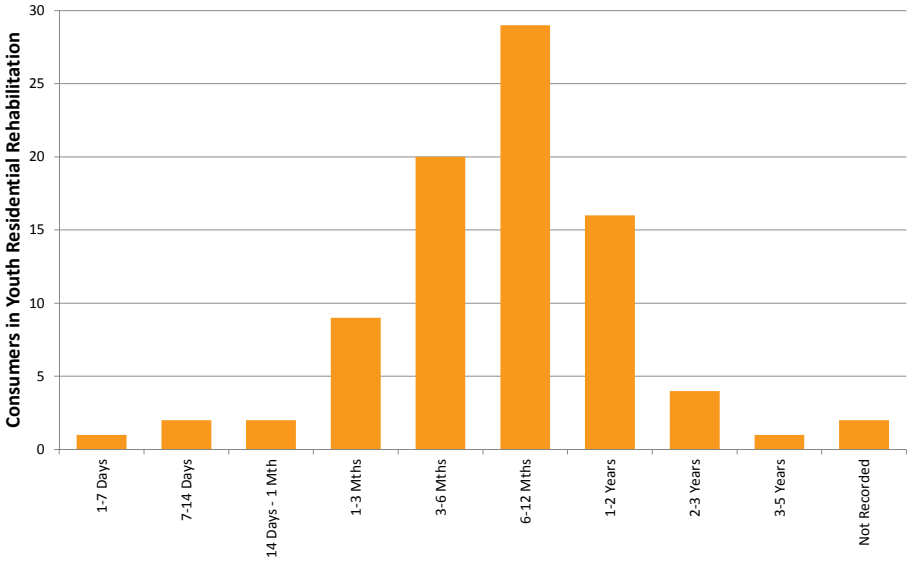
- The historical support period trends for consumers in YRR
- Practice observations regarding younger consumer capacity to stay in residential rehabilitation for extended periods of time and the associated risk of institutionalisation.

These opinions are practice informed as there is no research evidence on optimal time periods for young people in mental health residential rehabilitation.

According to the PDRSS Census 2010 34%of YRR consumers, at the time of the survey, were being supported for 6-12 months (see Figure 56). YRR providers were unable to pinpoint why consumers left before the recommended support period of 18-24 months.

As reference points, Foyer models operate for up to 2 years and the YSAS AoD youth residential model operates for 6 months.

Figure 56: Profile of the support period for current consumers in Youth Residential Rehabilitation



Youth Residential Rehabilitation consumers currently receive 3.5 to 4 hours per week of direct contact hours with staff. However, this level of direct contact does not reflect an intensive residential support setting.

Figure 57 shows that 83% of consumers receive a service at least once a day which is the highest rate of service frequency across PDRSS. Although YRR consumers have frequent service contact, Figure 58 shows that the length of time per contact for 65% of consumers averages 1 hour or less. Provider consultations indicate that this time is a mix between group and individual time with staff.

The challenge for the existing YRR model is that the average amount of contact time per week equates to between 3.5 to 4 hours which is similar to ARR and Moderate HBOS.

Figure 57: Service frequency for consumers

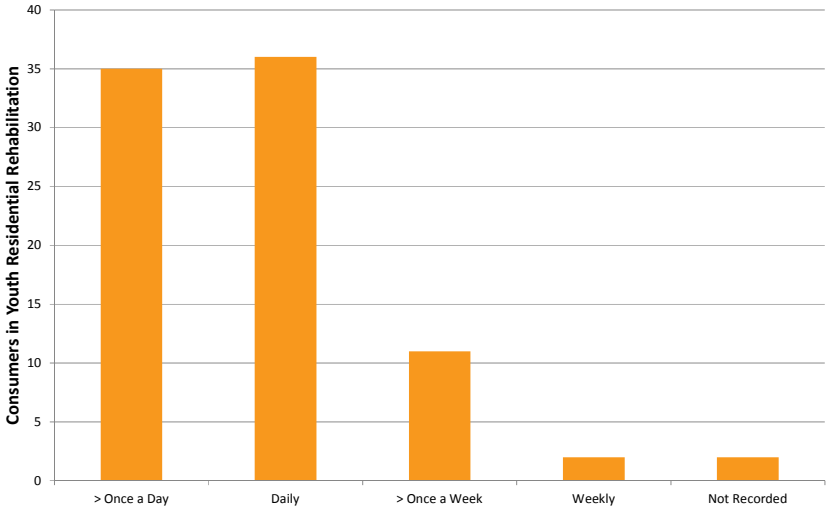
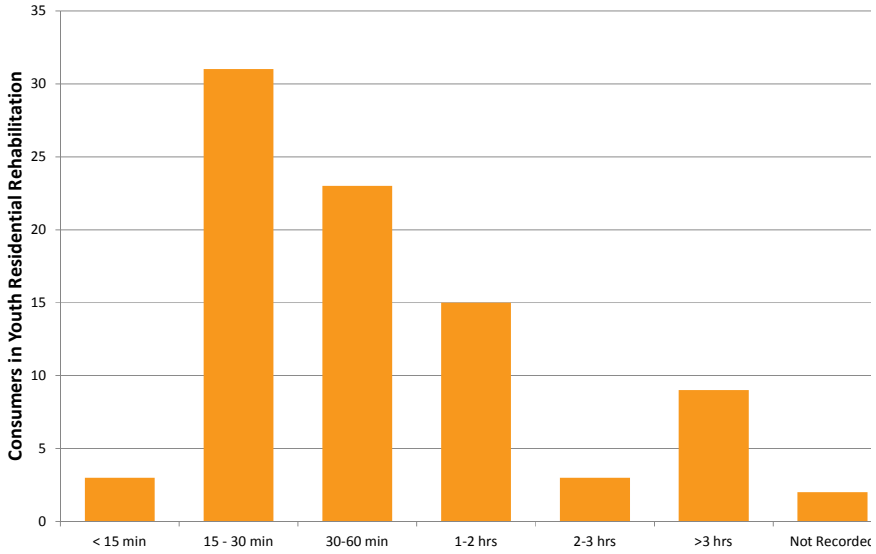


Figure 58: Time contact profile for consumers



5.8 Geographic distribution

Recommendation: Conduct a detailed geographic demand study to determine distribution requirements for the YRR model across Victoria.

Stakeholder conversations and policy documentation indicate that the geographic distribution of YRR across the state was determined more by opportunity than design. As a consequence there is an uneven distribution of programs. There is no available data that accurately determines service demand. Waiting lists are not maintained by providers though providers indicate close to 100% utilisation of their services.

Current service distribution across Victoria indicates that the volume of YRR beds is located within the North and Western Metropolitan region. Barwon South West and Hume have the highest per capita representational of beds. YRR has 50% more beds per capita than ARR. Table 39 outlines the distribution of YRR in Victoria.

Table 39: Distribution of programs

Catchment	Population	Estimated population with severe mental illness (3% of the total population)	Estimated population with current severe mental illness (30% of the severely mentally ill population)	YRR (beds)	YRR beds per capita (by population with a current severe mental illness)
North and Western Metro Region	1,848,643	55,459	16,638	40	0.24%
Southern Metro Region	1,361,175	40,835	12,251	28	0.23%
Eastern Metro Region	1,053,316	31,599	9,480	28	0.30%
Barwon South West	383,857	11,516	3,455	20	0.58%
Loddon Mallee	318,162	9,545	2,863	10	0.35%
Hume	275,004	8,250	2,475	20	0.81%
Gippsland	259,182	7,775	2,333	10	0.43%
Grampians	213,826	6,415	1,924	10	0.52%
TOTAL	**5,713,165**	**474,917**	**51,418**	**166**	**0.32%**

Appendix D.2 provides a spatial map of the distribution of YRR across Victoria.

5.9 Coordinated services and partnerships

Recommendation: Formalise service coordination mechanisms with specialist clinical mental health, community, social, health and primary care services to scale the treatment and support response to each consumer's need. Establish entry and exit pathways on an area mental health service basis. Some flexibility is necessary with the entry criteria due to the complexity of clients coming though the child protection, alcohol and drug, and homeless systems with a serious mental illness.

There is no formal mechanism to coordinate service activity for YRR consumers. Whilst there are examples of productive partnerships, there is scope to substantially improve partnerships to achieve recovery aims for consumers.

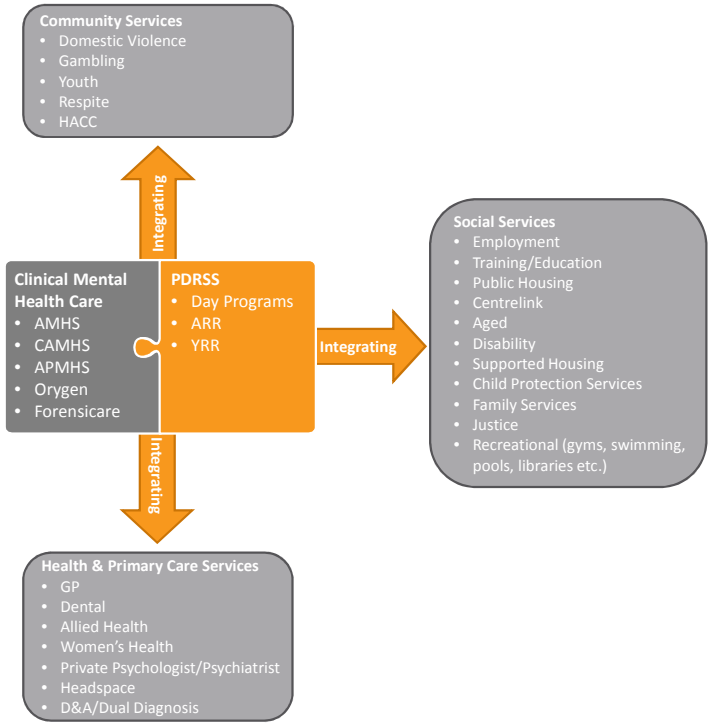
As shown in Figure 59, the treatment and support response by YRR should be provided through a flexible process to scale its service to each consumer according to need:

- Scale up - to enable referral to specialist clinical mental health services for a swift and targeted response when a consumer's clinical state worsens. Swift referrals may avoid potentially more traumatic admissions to clinical services due to further deterioration
- Scale down – includes a range of transition services (outside of hospital) where consumers can receive varying levels of support to recover and transition back into the community. This is similar to rehabilitation options available for other physical illnesses.

This scale up/scale down response should also acknowledge new service options such as YPARCs that form part of the broader youth reforms.

There are also no clear entry and exit pathways for YRR consumers. Hence the proposed YRR service delivery model will need entry and exit criteria and pathways on an area mental health service basis to ensure better targeting and throughput. Some flexibility is necessary with the entry criteria due to the complexity of clients coming though the child protection, alcohol and drug, and homeless systems with a serious mental illness.

Figure 59: New PDRSS transition arrangements



The most common referral pathways into YRR are through public clinical specialist mental health services. However there is no formal entry coordination mechanism and the selection method of consumers into YRR services is not transparent. Concern was expressed about the unknown exit pathways for consumers.

Figure 60 shows that most common referral pathway into Youth Residential Rehabilitation is through public clinical specialist mental health services (53%). The next largest sources of referrals are homelessness services (10%), acute in-patient (hospital) (6%) and family, friends or self (6%).[105]

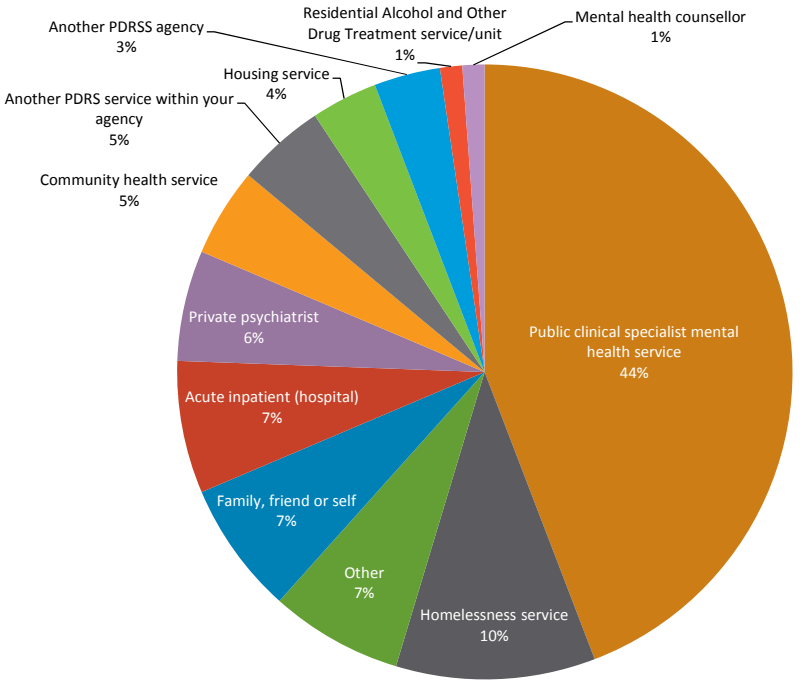
There is a view by PDRSS providers that clinical services and PDRSS operate in silos, and rarely share information with other providers and other services within the PDRSS sector. Clinicians, providers and the Department believe that closer coordination with the clinical sector will assist YRR consumers in their recovery. However, there may also be significant ideological and cultural barriers that prevent better collaboration with the clinical sector. These findings are consistent with the findings from the Department's 2007 Report which noted:

"Clinical and PDRSS service sectors appear to operate relatively independently with few structural points of cross-over and integration resulting in a non-strategic, ad hoc approach to resource allocation."[106]

Clinicians also expressed the view that the method for selection of consumers into YRR is unclear, and that individual sites have different selection criteria. Clinicians observed that the definition for target consumers (diagnosis, requirements etc.) is not specific enough and does not provide sufficient guidance for clinicians to identify the type of consumers who would benefit from YRR, nor does it provide guidance for how consumers should be selected into services.

Clinicians and carers also note that organisations and service types are not well known enough, and it is difficult to know what services are available for a consumer.

Figure 60: Profile of referral pathways for consumers in Youth Residential Rehabilitation



Current partnerships arrangements with other service providers are underdeveloped and are largely driven by individual YRR sites.

Partnerships with employment and education, community health, housing, clinical and recreational services assist consumers to connect with services that will enable recovery and social inclusion through sustainable re-connection with the mainstream community. Providers observed that, while there are examples of productive partnerships, overall there is scope to substantially improve partnerships to achieve recovery aims for consumers.

Table 40 provides a general assessment of partnership arrangements between YRR and key services together with examples of productive partnership arrangements.

Table 40: YRR partnership arrangements

Service	General assessment of YRR partnership arrangements	Example(s) of partnership arrangement
Employment and education	• Mostly referral arrangements with local employment services or specialist employment consultant in-reach • Some partnerships with job agencies, however little evidence in employment figures that this is producing positive results • Some arrangements with education institutions (especially TAFEs), but little evidence of outcomes.	Mental Illness Fellowship (MIF) has successfully co-located specialist employment consultants within a clinical service. To facilitate this partnership, MIF have received funding from DEEWR.
Housing	• Some relationships with housing associations, however with limited benefits due to significant barriers.	
Clinical sector	• Some contact with the specialist clinical mental health sector – but mostly for incidents requiring CATT and for ongoing clinical case management.	Opening Doors (MIF and Alfred) have joint service delivery, joint protocols, and shared decision-making around access and resource allocation.
Community health services	• Mostly time limited contact, on 'as needs' basis.	
Community recreation services	• Poor arrangements with community recreation services • Contact with recreation services is mostly through excursions.	MIND self-funds access to gyms/libraries for residential rehabilitation consumers.
Community services (e.g. homeless, youth, or family services)	• Referral arrangements as required • However, limited contact with these services.	MIND has recently established a partnership with the Youth Substance Abuse Service (YSAS) and has set up a Family and Carer Reference Group. MIND is leading a three year demonstration program funded by the Department of Families, Communities, Housing and Indigenous Affairs called Mind Building Family Skills Together.

An example of where a partnership should exist with YRR is youth mentoring. Beyond the adoption of peer mentoring by providers, the YRR service design model does not include formal youth mentoring.

Formal mentoring provides young people with support and guidance through planned relationships with positive adult and peer role models; it does so within a framework that includes experienced and qualified staff and trained volunteers. Mentoring should not be considered a replacement for a parent, nor are they a counselor or teacher. They are a sounding board and confidant to the young person.

The available evidence is that well planned and organised formal mentoring programs provides strong individual support, advice and guidance for young people and help in practical ways at important 'transitions' points in their lives[107]. Social isolation and economic disadvantage, physical, emotional or sexual abuse are common characteristics for young people who would benefit from mentoring[108]. These characteristics correlate well to the characteristics for YRR consumers. Dubois (2002) has shown that the benefits of mentoring for young people include:

- Less likely to become involved in criminal activity
- Less likely to become involved in drug taking and alcohol abuse
- Less likely to leave school early
- More likely to have improved academic performance
- Have better relationships with their teachers and family compared to their peers who are not mentored.[109]

The types of mentoring are varied and include community-based, school-based and peer mentoring. Peer mentoring is currently being adopted by a number of YRR providers.

The Commonwealth Government has directly invested in mentoring in the mental health sector through its $284.8 m PHaMS program. This program has been adopted by a number of YRR providers such as MIND and MIF but it not embedded within the YRR program service model. The Commonwealth and State Governments have also funded and supported youth specific mentoring programs. The Commonwealth Government supports the Australian Youth Mentoring Network through the Department of Education, Employment and Workplace Relations (DEEWR). The State Government funds youth mentoring through the Office of Youth and its Mentoring and Capacity Building Initiative ($3.9m over 4 years).

Part of the proposed YRR service model should include a mentoring component (and not just peer mentoring). Providers should create formal links with the youth mentoring State and Commonwealth initiatives and possibly the Victorian Youth Mentoring Alliance (Victoria's peak body).

5.10 Workforce capability

Recommendation: Invest in workforce skills (including the pilot of peer support workers) based on an agreed set of core competencies, and agree a multi-level award structure (consistent with the Fair Work Australia award rationalisation initiative) that reflects the range of professional and non-professional skill requirements.

Arguments to support this recommendation:

- The proposed YRR program changes will be stymied without workforce skills development and a multi-level award structure
- The current YRR workforce capacity and capability are inadequate to support the recovery goals of increased numbers of consumers with increasingly complex issues. There are limited staff development opportunities and no established core competencies
- The lack of a structured career pathway and remuneration contributes to low staff retention and disrupts consumers' continuum of care. The YRR workforce is undervalued and lacks recognition
- The most prevalent difficulty for YRR consumers is unresolved trauma resulting for example, from sexual abuse and associated grief. Research evidence shows that peer support is beneficial for young people with a health condition. However, it must be delivered in conjunction with clinical support and other strong outcomes-based recovery interventions
- In Australia and overseas, people with experience of mental illness are increasingly being employed in peer support roles. The emerging research evidence is positive about regaining self-confidence, reducing hospital readmissions and sustained competitive employment.

The proposed YRR program changes will be stymied without workforce skills development and a multi-level award structure.

The proposed approach to YRR will require a changed workforce mix of professional, certificate, and specialist skills in employment, education, and housing. As shown in Figure 61, managing collaborative service delivery arrangements with other providers will require new skills for the workforce and higher skilled roles. Workforce recommendations include:

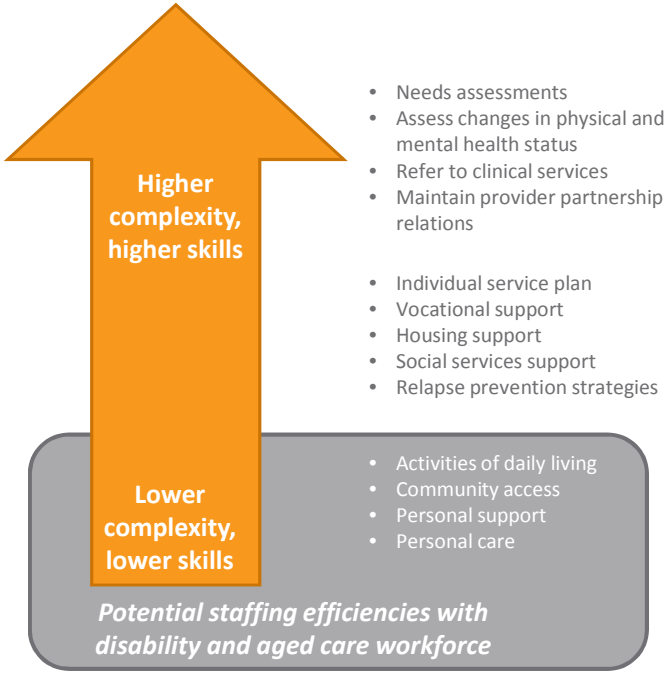
- **Skill development** - Investment in workforce development is required to increase the skill levels of the workforce.

  Significant concerns were expressed by the clinical sector, PDRSS sector, consumers and carers about the capacity of the YRR workforce to effectively meet consumer needs, or deliver new YRR models. The new service models will require a mix of professional and non-professional workforce. Providers who have attempted shifting to new service formats found that the lower skill levels and resistance to change of the current workforce are barriers to implementing new models

- Multi-level **award structure** - PDRSS must develop a multi-level award structure to reflect the different skills levels, consistent with the Fair Work Australia award rationalisation initiative. The award must create opportunities for advancement if the sector is to retain & grow a skilled workforce.

Restructuring the award levels could enable potential staffing efficiencies with disability or aged care support workers. Some providers are already considering stratifying tasks into professional vs. less skilled roles - the less complex tasks being undertaken by a TAFE-trained worker & the more complex by those with a professional qualification.

Figure 61: Skill development



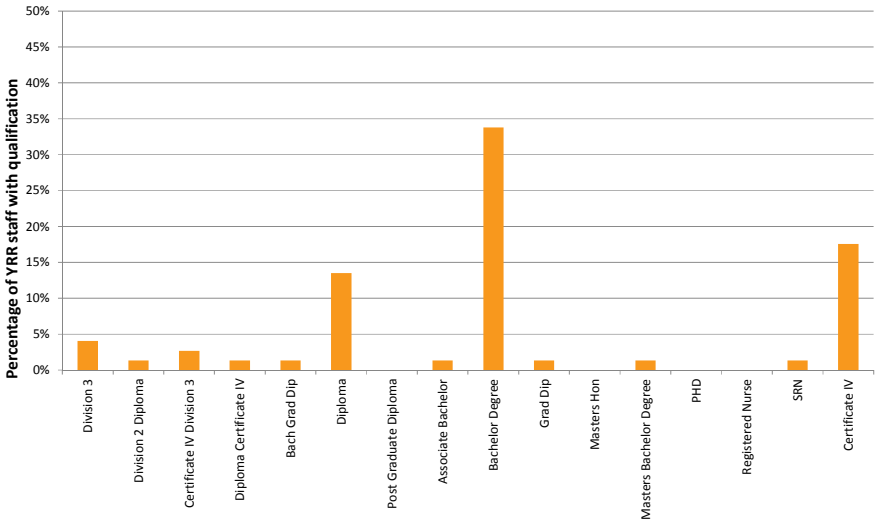
The current YRR workforce capacity and capability are inadequate to support the recovery goals of increased numbers of consumers with increasingly complex issues. There are limited staff development opportunities and no established core competencies.

The SWOT analysis identifies inadequate workforce capacity and capability to deliver required services as a key threat to the sector.[110] Providers noted that the increasing complexity of consumers (especially the increasing prevalence of dual diagnosis consumers) requires a more highly skilled and qualified YRR workforce. The SWOT analysis also acknowledges the particular difficulty rural providers experience in attracting adequately skilled staff.

YRR providers have recognised these skills concerns and have implemented a minimum of a bachelor's degree as a prerequisite for employment. Figure 62 highlights the qualifications of YRR staff at MIND. It shows that 34% of staff have Bachelor degrees, 17% have a Certificate IV and 13% have a diploma-level qualification. Providers and the SWOT also identified the PDRSS specific certificate III qualification as an important skills baseline for YRR workers.[111]

Even with the contribution of VICSERV, it is widely acknowledged that there has been limited investment in staff development. Providers observe that this affects the ability of staff to develop and keep their knowledge up-to-date and relevant to consumers' needs. The SWOT analysis identifies opportunities for training in humanistic approaches and person-centred service delivery, understanding evidence-based practices and an outcomes focus, family inclusion and working with people with complex issues.[112] Providers also identified a training need for working with consumers with alcohol and other drug dependence, how to connect with housing and employment services and recovery planning. The SWOT analysis framed this as an opportunity to identify and develop a set of core competencies that are shared across clinical and PDRSS workforces.[113] The establishment of core competencies is a foundation block for a productive workforce.

Figure 62: Qualifications of MIND YRR staff



The lack of a structured career pathway and remuneration contributes to low staff retention and disrupts consumers' continuum of care. The YRR workforce is undervalued and lacks recognition.

Consumers and carers noted a high turnover in staff across the three programs. These stakeholders acknowledged that YRR staff are generally hard working and often encounter difficult situations that may lead to stress and 'burn out' – particularly in those staff working in the residential rehabilitation services. The SWOT analysis also identifies the lack of career structures and development opportunities as key factors in poor staff retention.

Providers observe that the lack of career structures is compounded by a perception that there is inequity in pay between PDRSS and clinical staff. It is generally perceived by YRR providers that clinical staff are paid 30% more than YRR staff for similar positions. The exodus of many YRR staff into the clinical sector is attributed by YRR providers to this pay differential – a fact also identified in the SWOT analysis. This perception is not shared by clinical stakeholders.

The SWOT analysis also identifies that the PDRSS workforce is perceived to be undervalued and lacking recognition of the skills, competence and contribution of the workforce. This observation is supported by the views of YRR providers who identify low morale of staff as a key factor in high staff turnover and a resistance to change service delivery practices.

Consumers and carers observed that high staff turnover results in low continuity of care which impacts on their recovery. Consumers find that they must re-tell their stories, re-form relationships of trust and make new connections with each new staff member. This is particularly difficult for a population that already struggles to make connections. Staff turnover was cited as disruptive to a consumer's sense of stability and trust.

The most prevalent difficulty for YRR consumers is unresolved trauma resulting for example, from sexual abuse and associated grief. Research evidence shows that peer support is beneficial for young people with a health condition. However, it must be delivered in conjunction with clinical support and other strong outcomes-based recovery interventions.

PDRSS census data shows that the most prevalent difficulty is unresolved trauma (e.g. sexual abuse, grief), which is experienced by 47% of consumers. Peer support for young people with a health condition (such as mental illness) helps to maintain or re-gain social confidence.[114] Consumers in YRR in particular identify the importance of having peers who have had a mental illness as role models. This view is supported by research evidence that suggests that role models promote aspirations and provide positive reinforcement.[115]

Providers, carers and consumers identified that peer support and mentoring is beneficial to recovery for people with a severe mental illness. However, it must be delivered in conjunction with clinical support and other strong outcomes-based recovery interventions such as education and employment, housing and community health services. Some providers have employed dedicated peer support workers, some of whom have experience of mental illness. However, the role of peer support and mentoring is not well articulated for PDRSS. Evidence suggests that peer support should be structured and delivered with a goal in mind.[116]

The SWOT analysis identified peer support activities as both a strength and a weakness of PDRSS sector. The report acknowledged that peer support activities had great potential to support the recovery aims of consumers. However, the report also identifies that despite the evidence regarding the effectiveness of peer support workers, many providers are yet to adopt it as standard practice.[117]

Providers identified the importance of peer support networks in assisting consumers to transition out of YRR. Peer support can provide consumers with confidence to make the change, and continued support enables consumers to maintain independent living in the community. For this reason, peer support was identified as particularly important for consumers in residential rehabilitation services who find it difficult to leave familiar services and live independently in the community. The SWOT analysis regards the fact that some of the workforce has experience of mental illness as a positive feature.[118] This observation is supported by provider views that peer delivered services provide role models for residents and that shared experience is critical to forming confidence and ongoing support networks.

The Community Services and Health Industry Council (CS&HIC) has published a background paper on the need for peer support training. The CS&HIC is now developing a set of competencies for the introduction of a Certificate IV in Mental Health Peer Work. The proposed qualification is for consumer and carers who are employed in roles to support consumer or carer peers. It is noted that titles for these roles might include consumer consultant, consumer representative, peer support worker, peer specialist, carer consultant or carer representative.[119]

In Australia and overseas, people with experience of mental illness are increasingly being employed in peer support roles. The emerging research evidence is positive about regaining self-confidence, reducing hospital readmissions and sustained competitive employment.

Table 41 highlights examples and research evidence with peer support roles in Australia and overseas

Table 41: Examples and research evidence with peer support roles

Location	Examples and research evidence
South Australia	Lawn et al (2008) describe a three-month successful program of peer support in South Australia which aimed to assist consumers avoid unnecessary hospital admission and/or achieve early discharge from a hospital.[120]
Australia	The Personal Helpers and Mentors (PhaMs) program is a Commonwealth funded program introduced as a 2006 COAG Mental Health Initiative. It has many parallels to UK STR workers, and the Home-Based Outreach provided by Victorian PDRSS. There are several unique features to the PhaMs model: • People using PhaMS do not require a formal clinical diagnosis of severe mental illness to access the service. Instead, applicants have to complete a functional assessment • Each PhaMS team of five workers has to have a Peer Support Worker • PHaMs is intended to provide long term support to people with diverse and complex needs: "There is no time limit on how long a participant can stay in PhaMs."[121] The program has been evaluated but the results are not yet publicly available. It is not known how many consumers have been employed in the Peer Support Worker role.
UK	Employment of a new type of mental health support worker began in 2003. The new role is called 'Support Time and Recovery' to convey that the workers are employed to provide support for consumers, to spend time with them and to assist with their recovery. In 2003, 3,000 STR workers were recruited. Whilst people with direct experience of mental illness were not specifically targeted for the positions, a number applied and were successful. An evaluation of STR workers was published in 2006 by Huxley et al. Findings show that the aims of improving social inclusion and quality of life for participants were being met. The proportion of STR workers with personal experience of mental illness was not identified, but those with this background were found to be effective in the role, despite initial reservations from co-workers.[122]
USA	Specific peer support roles are being explored in the USA. As reported by Fukui et al. (2010), six consumer-run organisations have successfully trialled the use of peer-led groups in assisting consumers to identify and pursue life goals.[123]

5.11 Families and other carers

Recommendation: Reconnect and engage families and other carers in a consumer's recovery process, including decision-making, planning and activities.

Carers commented positively about the contribution YRR and the clinical team made to help consumers learn basic living skills and improve their coping skills. They also noted YRR offers valuable socialising opportunities for consumers.

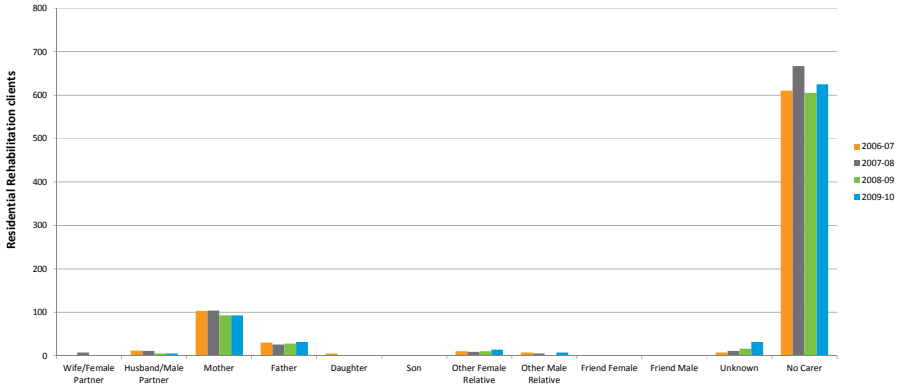
Carers also commented that they were usually not consulted about matters of planning and decision-making about their family member's progress. YRR staff often justified this exclusion on the grounds of confidentiality. Carers noted that whilst YRR staff might be involved with a consumer for a few years, families were in for the long haul. YRR providers interviewed as part of this project acknowledge that family involvement should be more actively sought and fostered.

The key role of families and other carers in consumer recovery is well documented in the Department's policy literature. (See Appendix C.7) There is also good research evidence on the specific activities mental health providers can utilise to foster better recognition of families and carers including staff training, family interventions and carer engagement protocols. (See Appendix C.8).

Figure 63 illustrates that many consumers have no identified carer. This highlights the need for YRR providers to work with their consumers and aid them with reconnecting with their family or significant others.

The challenges carers experience in YRR is consistent with their experience of other parts of the mental service system in Australia. (See Appendix C.6).

Figure 63: Consumers and carers



Note: CDS data combines ARR and YRR carer data.

5.12 Funding model

Recommendation: Establish a service-based funding model with financial incentives for the achievement of individual consumer recovery outcomes.

YRR services are funded on an output basis, based on bed-days. The State Government provides $8.02 million of recurrent funding for YRR services. This includes $865,450 of additional funding for some sites to provide dual diagnosis and outreach services. Both providers and the SWOT analysis identify that a strength of the sector is that it provides 'value for money' services. Appendix E demonstrates the cost difference between PDRSS clinical beds and residential rehabilitation beds. However, it must also be acknowledged that those using clinical bed-based services have more complex clinical needs.

The challenge for the existing YRR model is the cost implications of its service profile:

- YRR costs approximately $53,500 per consumer per annum
- Moderate HBOS, for a similar number of contact hours per week, costs $14,500 per consumer per annum.

It should be noted that recent funding per consumer for the Ballarat Foyer model from the Office of Housing is comparable to YRR service funding.

The Government should also consider provider incentives for the achievement of individual consumer recovery outcomes. This model ensures a consumer–orientation to funding and an incentive for providers to achieve recovery outcomes with the consumers.

5.13 Structural design

Recommendation: Establish a competitive market to optimise the role of the YRR program within the broader psychosocial recovery system.

Arguments supporting this recommendation:

- The YRR service system set up by the Department through competitive tendering poses risks for the Government
- Optimal market design is a significant decision by Government. Selective tendering or accreditation appear the most viable design options. However, more detailed analysis is required before a final market design option can be recommended.

The YRR service system set up by the Department through competitive tendering poses risks for the Government.

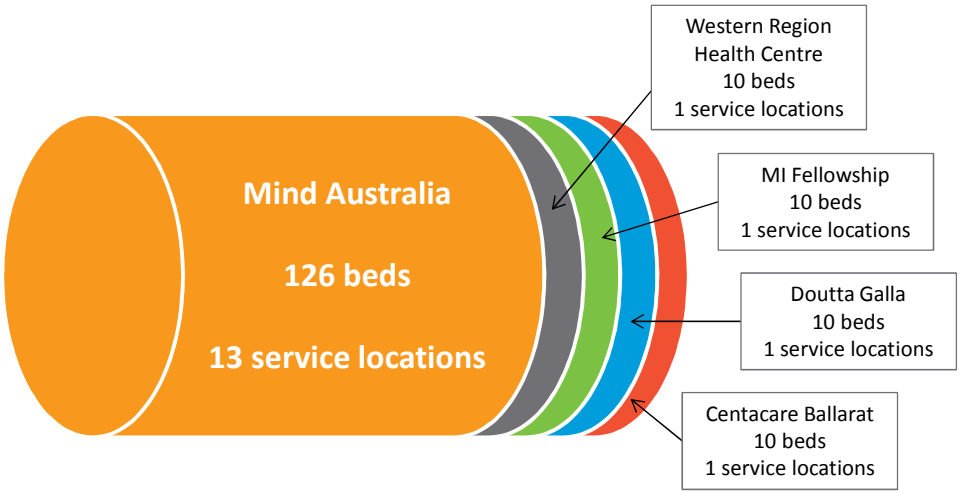
Figure 64 shows that there are five organisations providing services in Youth Residential Rehabilitation. However, one organisation provides services for 76% of the beds resulting in a market that is effectively a monopoly. A continued monopoly in YRR services poses risks for the Government including:

- Inflated service delivery prices resulting in less efficiency of the Government's funding dollar
- Poor response to consumer demands resulting in lack of choice and range of services
- Anti-competitive behaviour, including potential for larger providers to coerce smaller providers
- Referral of disproportionate level of authority to a single provider resulting in undue influence over the rest of the sector and any strategic direction set by the Department.

Providers also identified situations of consortium where the larger provider sub-contracts smaller providers to deliver services for which the larger provider receives the funding. This situation reduces the efficiency of the funding dollar by diverting funds away from delivering services for consumers towards operational expenditure across two organisations.

The Commonwealth Government's experience with aged care highlights a further risk. The Government initiated a tender process for a range of services into the oligopoly aged care market. The two major providers for the majority of aged care services chose not to tender. This meant that the Commonwealth Government must re-think its strategy and terms of reference for the tender as it is reliant on these two providers participating.

Figure 64: Distribution of YRR beds across provider organisations



Optimal market design is a significant decision by Government. Selective tendering or accreditation appear the most viable design options, however more detailed analysis is required before a final market design option can be agreed.

Market design is an increasingly critical responsibility of Government. The Victorian Government has partly outsourced the provision of services for people with a mental illness to the community sector. This has created a new market for the delivery of psychosocial recovery services. Mental health consumers benefit from market design through:

- Development of new service options or access to previously rationed Government services
- Incentives for innovative PDRSS providers to increase quality and reduce costs.

Analysis of market design for each of the three PDRSS programs has highlighted that the current market is not achieving these benefits. Government needs to rethink its 'rules of the game' by aligning its policy goals with sustainable business practice of PDRSS providers. In developing these rules, Government needs to consider the population profile, regional and metro geography, workforce capability, service pricing, performance incentives and the interconnections between various programs.

Table 42 outlines market design options for YRR:

Table 42: Market design options

Market mechanism	Explanation	Assessment
Retendering	Publically retender all current contracts with sunset clauses.	*Traditional* – Current process and has created skewed markets.
Selective tendering	Select a small number of providers and run a closed tendering process, again with sunset clauses.	*Better control* – Allows Government to maintain better control of provider size and quality.
Accreditation	Establish an accreditation scheme with providers required to meet a series of minimum standards e.g. AusAID, Australian Aged Care.	*Quality assurance* – Provides Government with a safeguard of minimum provider standards.
Social Impact Bonds	Issue individual bonds to providers and pay a premium (i.e. interest) upon expiration for recovery outcomes achieves. NSW Government – Juvenile Justice and Mental Health.	*Radical* – This is only being trialled but is aimed at 'wicked' social problems in complex service systems such as mental health. It operates more like a public/private partnership.

6 PDRSS-wide service design recommendations

Three service design recommendations were identified that apply to all PDRSS. They address the sector's role, alignment with clinical services, and the promotion and sharing of service innovations.

The recommendations that apply to the whole PDRSS sector are summarised in Table 43.

Table 43: PDRSS-wide recommendations

Component	Summary recommendation
1. **Sector role and name**	Position the PDRSS sector as a core component of the specialist mental health system continuum of care. This will help consumers more successfully access the full range of community, health and social services they need to continue/resume living in the community. Re-name PDRSS to Community Mental Health Recovery Services (CMHRS).
2. **Alignment with clinical services**	Better align the specialist mental health continuum of care between PDRSS programs and clinical services. This will require shared program outcomes, shared planning and coordination tools, and more formal regional coordination arrangements.
3. **Service innovations**	Share and promote evidence-based service innovations from providers that align to the proposed recovery role and outcome-focus of the sector.

6.1 Sector role and name

Recommendation: Position the PDRSS sector as a core component of the specialist mental health system continuum of care. This will assist consumers to access the full range of community, health and social services they need to continue or resume living at home or in the community. Re-name PDRSS to Community Mental Health Recovery Services (CMHRS).

A change in the PDRSS sector's role will further enhance the capacity of each program to support the recovery of consumers to continue or resume living at home or in the community. The change of name for the sector from PDRSS to CMHRS will better reflect its service orientation.

Recovery provides the direction for the development of rehabilitation services. It provides a framework that goes beyond offering people somewhere to go during the day. A framework of recovery ensures that hope, respect and pathways to community participation are incorporated into the day-to-day activities of rehabilitation programs[124]. However, rehabilitation services should not be considered the only vehicle for recovery. Instead rehabilitation services are one component of a comprehensive service system that collectively works towards the goal of recovery.

There has been debate in recent years regarding the distinction between recovery and rehabilitation. The difference between these two concepts is probably best articulated by Deegan:

"Rehabilitation refers to the services and technologies that are made available to disabled persons so that they may learn to adapt to their world. Recovery refers to the lived or real life experience of persons as they accept and overcome the challenge of the disability"[125].

Providers were supportive of this role shift and the change in sector name from Psychiatric Disability Rehabilitation and Support Services (PDRSS) to Community Mental Health Recovery Services (CMHRS).

6.2 Alignment with clinical services

Recommendation: Align the specialist mental health continuum of care between PDRSS programs and clinical services. This will require shared program outcomes, shared planning and coordination tools, and more formal regional coordination arrangements.

There is a strong view that closer alignment with the clinical sector will facilitate better recovery outcomes for consumers across the three programs.

The SWOT analysis identifies the increased collaboration between PDRSS and clinical services as a strength of the sector. However, clinicians and providers noted that there was still a vast amount of work required to improve partnerships between the three programs and the clinical sector to a productive standard. Strong partnerships with the clinical sector are critical for the three programs considered in this review, particularly in view of the high proportion of consumers with low-prevalence disorders who may require regular clinical assistance.

Clinicians and providers acknowledge that there is a perceived 'us' and 'them' divide between PDRSS and clinical services that is a significant barrier to the formation of effective partnerships between the two sectors. The SWOT analysis identifies a sense of competition between the two sectors, due partly to the fact that the majority of mental health funding is directed to clinical services, and also to the prevailing belief that "clinical expertise is paramount."[126] There is also a perception that clinical services do not value the benefit and contribution of PDRSS. Clinicians also expressed concern that once consumers leave the clinical system into one of the three programs, PDRSS staff may not necessarily support them to access the clinical sector when they need to.

Clinicians and providers also cite examples of other barriers, including a lack of shared clinical/PDRSS consumer information and the absence of an agreed, coordinated clinical/PDRSS service delivery framework. The lack of shared information, database and framework affects the transition of consumers through the mental health system. Consumers cite examples where lack of shared information and data means that they are regularly providing the same information across the range of services they access. Clinicians and providers also note that shared information will result in a better evidence base to assess program outcomes.

Although clinicians and providers identified that stronger partnerships and alignment with the clinical sector will benefit consumers, both PDRSS stakeholders and the SWOT analysis argues for maintenance of a clear separation of PDRSS and clinical services to maintain the culture, history and values of the sector.[127] PDRSS stakeholders also expressed a fear that if integration of clinical services and PDRSS occurred, the unique non-clinical and humanistic perspective offered by PDRSS would be lost.

Table 44 contains the recommendations to coordinate PDRSS programs with clinical services.

Table 44: Recommendations for alignment with clinical services

Component	Recommendations for clinical alignment
Shared program outcomes	• PDRSS programs and clinical services have shared recovery outcomes • Encourage early engagement of PDRSS services with potential in-reach into clinical emergency and bed-based services • Improve coordination and collaboration around targeted consumer outcomes.
Coordination through area mental health services	• Plan and allocate bed-based resources according to regional population-based needs • Formalise regional partnering arrangements between clinical services and PDRSS based on shared management structures, transparent funding and staffing arrangements, and agreed joint outcomes (e.g. Melbourne Health HARP MH program) • Joint decision-making between clinical services and PDRSS regarding access and flexible use of scarce bed-based resources within the region (e.g. the Opening Doors Model) • PDRSS targeting more closely aligned to the clinical system but recognising that PDRSS consumers do not have to be consumers of the specialist clinical public health system.
Care coordination	• Comprehensive and shared clinical and psychosocial assessment • Coordinated treatment plan between the various providers in the form of a shared recovery plan • Shared referral and operational protocols • Care coordination to assist people to receive appropriate care in the community and avoid acute in-patient hospitalisations.

6.3 Service innovations

Recommendation: Share and promote evidence-based service innovations from providers that align to the proposed recovery role and outcome-focus of the sector.

Arguments supporting this recommendation:

- There is a growing recognition by the PDRSS sector that they must adopt more structured, consumer-orientated processes using evidence-based approaches and social participation to deliver recovery outcomes
- The need for change is well understood within the PDRSS sector. However for many providers, this will mean significant changes to service delivery. The more innovative providers are already introducing new service approaches that aim to achieve these outcomes. These approaches include:
  - Individually tailored services delivered in the community
  - Sharpened focus on employment and education
  - Coordination with broader support services
  - Flexible and responsive service delivery for under-represented population groups
  - Flexible service delivery structures and partnerships.

There is a growing recognition by the PDRSS sector that they must adopt more structured, consumer-orientated processes using evidence-based approaches and social participation to deliver recovery outcomes.

Table 45 shows how emerging service trends are driving providers to change how their services are configured.

Table 45: Emerging service approaches

Service trends	Moving away from . . .	…Moving towards	…Driving changes to service configurations
Recovery philosophy	Unstructured time with unlimited approaches.	Identifying and achieving recovery goals.	• New service delivery formats • New collaborative partnerships to deliver services • New workforce capabilities and key roles • Demand for new funding models
Meaningful program structures	Ongoing, 'one size fits all', group based program offerings. Loosely structured. Non-throughput models. Services structured around a standard length of access.	Individually tailored, goal oriented programs. A sharpened focus on delivering social participation and employment/education. Transition to optimal recovery status for the individual. Flexible program structures enabling consumers to dip in and out of service access when they require varying levels of support, including beyond business hours.	
Consumer-centred support	Doing for the consumer. Institutional relationship to consumer. Insular service delivery.	Empowering/doing with the consumer. Self-directed support (consumer shares responsibility for achieving outcomes). Facilitate linking the consumer to services which enable recovery. Individualised packages.	
Social participation	Segregated from community Centre-based.	Support consumers to access mainstream services/activities. Deliver services in the community.	

The need for change is well understood within the PDRSS sector. However, for many providers this will mean significant changes to service delivery. The more innovative providers are already introducing new service approaches that aim to achieve these outcomes.

Table 46 shows how the more innovative providers such as NEAMI, Snap, EACH and MIF are already introducing new approaches to service delivery. Most of these innovations should be accomplished in a cost-neutral manner. However, investment will be needed to improve staff capability associated with new service delivery models and the staff costs associated with Day Program extended hours and weekend access.

Table 46: Service innovations

Service innovation	Recommendations for service structure
Individually tailored services delivered in the community	• No longer deliver centre-based Day Program, all services delivered in the community (Neighbourhood Houses, gyms, TAFEs). • More individual support and individually tailored program instead of a generic program • Partnering with other local service providers such as TAFEs/universities to deliver tailored services that meet the needs of mental health consumers • Support consumers to access mainstream services, AND support the main stream service providers to service mental health consumers.
Sharpened focus on employment/ education	• A strong focus on employment / vocational education opportunities, often with in-house employment or vocational expertise • An active intervention model – getting consumers into employment/ education and providing the supports to enable them to stay, rather than waiting until the consumer is 'work ready'.
Coordination with broader support services	• Wrap services around the consumer which requires coordination between a range of community, social, health and primary care services to meet the broader support needs for the individual • This requires a broader system-wide outlook. It also requires the ability to communicate and partner with a range of local service providers • Larger, more diversified providers are more successful than those organisations that retain a narrow PDRSS service focus.
Flexible and responsive service delivery for under-represented population groups	• Develop individualised programs that focus on early intervention in the course of disability and include 'marginalised' groups such as CALD who otherwise find it difficult to access programs in their current format • Provide in-reach expertise and support services to mainstream services that these consumers currently access.
Flexible service delivery structures and partnerships	• Extended hours/weekend access • Innovative and collaborative partnerships (e.g. with clinical or housing associations) to make joint decisions on flexible/best use of a range of local bed-based or supported accommodation resources.

7 Transition towards major change

The recommendations provided in this strategic review present a major change in each of the three PDRSS programs towards focusing on goal-orientated, recovery-based delivery with stronger accountability and oversight by the State Government.

Figure 65 and Figure 66 highlights the effect the Day Program, ARR and YRR programs will have on PDRSS program composition; Day Programs are reconfigured; ARR is incorporated into HBOS; YRR is reconstituted though it retains its bed-based residential facilities.

Figure 65: Current activities and service types of the PDRSS sector

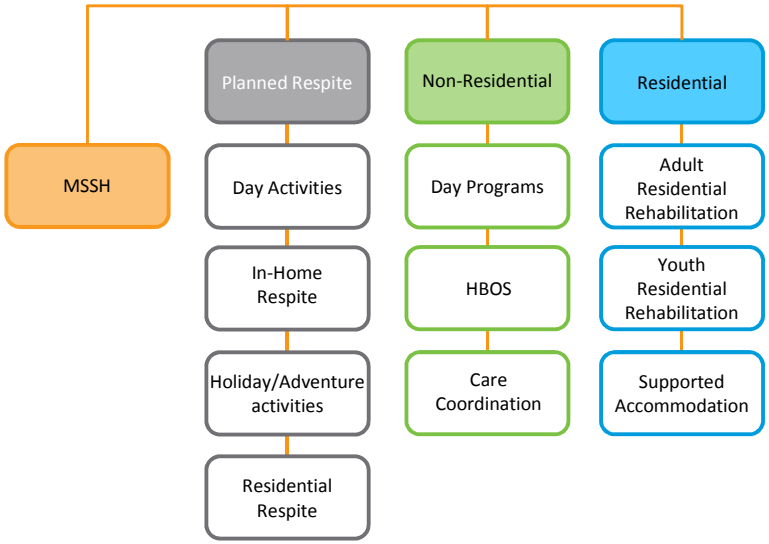
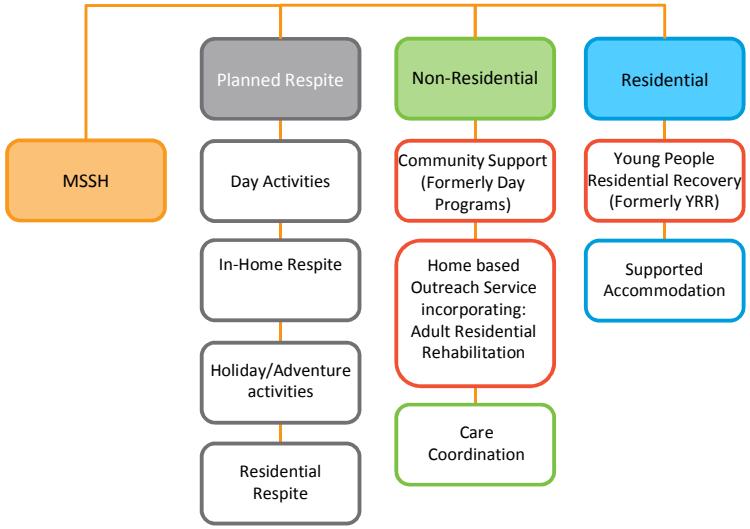


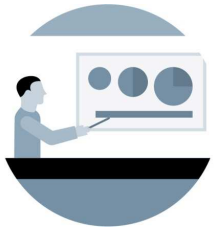
Figure 66: Proposed activities and service types of the PDRSS sector



Government will need to engage the PDRSS sector on a mass scale to unlock service design challenges and improve the performance results of the ARR, YRR and Day Programs. Participation of the whole sector is necessary.

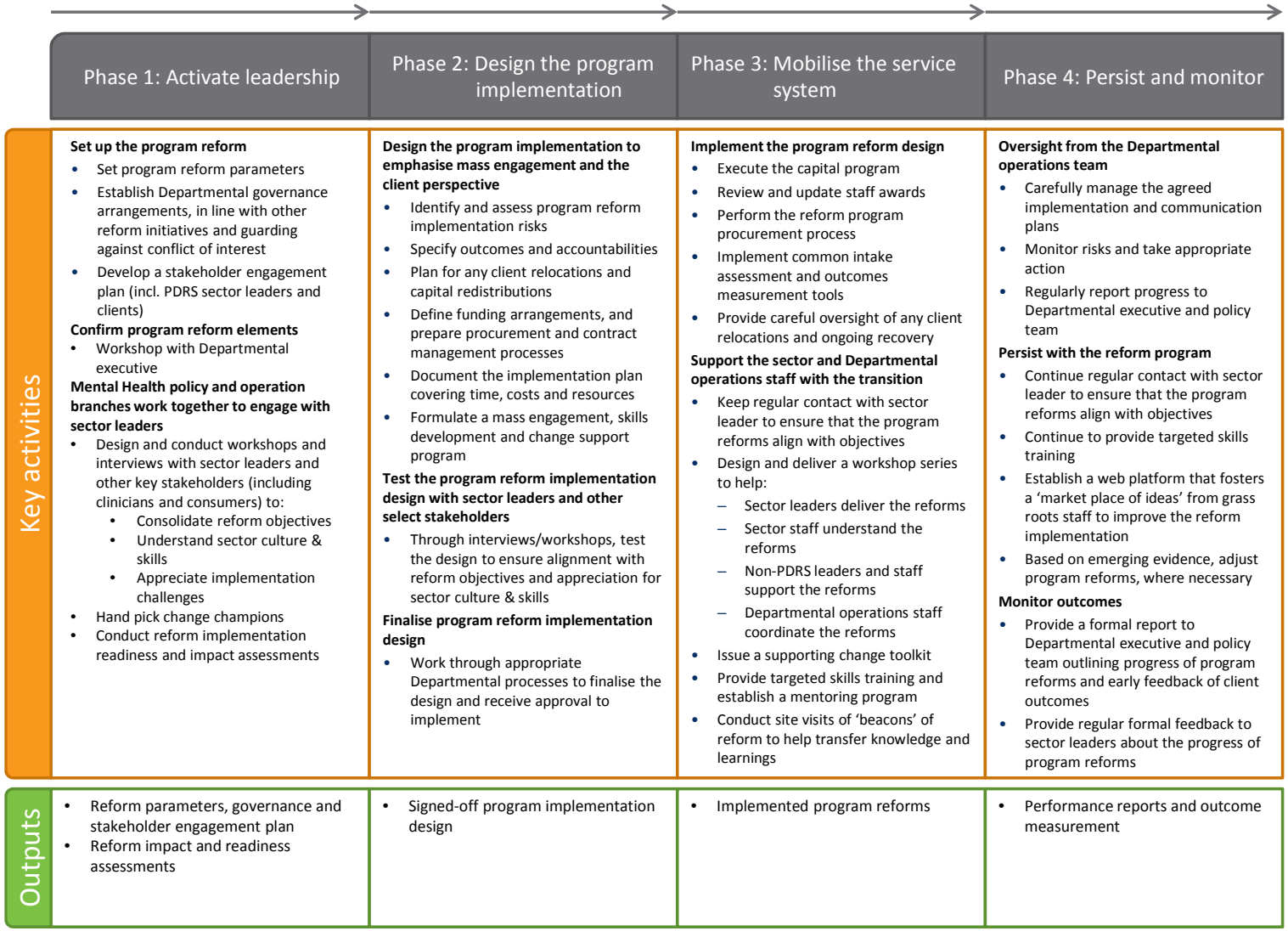
Figure 67 outlines the conceptual underpinning to implement the proposed changes.

Figure 67: Conceptual approach to PDRSS change

1. Activate leadership	2. Design the program implementation	3. Mobilise the service system	4. Persist and monitor
			
The Department's executive to work with PDRSS sector leaders and Departmental operations staff to crystallise ARR, YRR and Day Program design. Activated leadership is the engine that starts the major reforms mooted for the PDRSS sector, and maintains the momentum. Leadership (and not just by "leaders") is the only way to generate the energy and focus needed to initiate lasting reform.	**Design and implement a process to motivate the PDRSS sector to support the new design.** Many program initiatives do not deliver to expectation because they rely too much on rational data gathering, analysis, report writing and presentations. A more creative and successful approach aims to grab the 'feelings that motivate useful action'. Hence, planning the program reform implementation is largely about how best to motivate the PDRSS sector to support the new program designs.	**Deliver an implementation program that mobilises mass change and renewal.** Mass engagement is not about relying on traditional approaches that cascade change down from the Department to the PDRSS sector. Implementation of service reform is an important skill for all PDRSS staff; up and down hierarchies. In the most successful program reform initiatives, everyone plays a crucial role in reorientating programs and their consumers to a changing world.	**Measure the results to signpost the reform journey.** Highly effective program reform requires clarity on the Return on Investment (ROI) behavioural outcomes. This requires measurement at specific stages in the change journey. Measurement outcomes are critical to inform highly effective program decisions.

The physical phases to implement the changes are outlined in Figure 68 and described in more detail in the following section.

Figure 68: Program reform phases



7.1 Program reform phases

The goal in this phase is to develop an understanding of the PDRSS sector's environment which includes the potential impact of the reforms and the readiness of PDRSS providers to adopt these reforms. Leadership from both the Department and the PDRSS sector is essential.

7.1.1 Set up the program reform

The Department needs to specify the program reform parameters, establish Departmental governance arrangements, and develop a stakeholder engagement plan. This process will ensure there is a clear and shared understanding within the Department. Governance arrangements should be in line with other reform initiatives and guard against any potential conflicts of interest. The stakeholder engagement plan should include approaches for PDRSS sector leaders all the way through to PDRSS consumers.

7.1.2 Confirm program reform elements

The ARR, YRR and Day Program reforms are part of the Department's Psychosocial Rehabilitation and Recovery Plan. As such, the detailed program reforms should naturally cascade from this broader plan. A workshop with Departmental executives is essential to ensure the detailed program reform elements align with this plan.

7.1.3 Engage with sector leaders

Early engagement with the PDRSS sector and its peer body, Vicserv, is essential for buy-in of the reforms. This may help some providers to opt out, particularly with Day Programs. The Department's Policy and Operations teams should work together to design and conduct workshops and interviews with PDRSS sector leaders, Vicserv and other key stakeholders including consumers and clinicians to:

- Consolidate reform objectives
- Understand sector culture and skills
- Appreciate implementation challenges
- Identify and hand-pick change champions.

To understand the likely impacts the reforms may have on the PDRSS sector, the Department should conduct two sector-wide diagnostics:

- Change impact assessment: enables the Department to understand the impact of the planned reform on the PDRSS sector in terms of process, tools, behaviours, skills and knowledge, culture etc. Awareness of the specific and likely impacts on different parts of the PDRSS sector is critical to preparation for the reform
- Change readiness assessment: identifies the change readiness of the PDRSS sector and provides a baseline to track the effectiveness and success of the reform program over time and provides a context for the development of the reform implementation plan.

7.2 Phase 2: Design the program implementation

The goal in this phase is to design the implementation of the reform program emphasising mass engagement and the consumers' perspective, and alignment with other activities being undertaken as part of the Department's Psychosocial Rehabilitation and Recovery Plan

7.2.1 Design the program implementation to emphasise mass engagement and the consumers' perspective

The Department will need to develop a detailed implementation plan that will support the delivery of the reforms whilst building capability within the PDRSS sector to sustain the reforms. The implementation plan should contain the core components outlined in Table 47 below.

Table 47: Implementation plan components

Implementation plan core components	
1. Identified program reform implementation risks and their controls	6. Defined budget and funding arrangements
2. Reform program outcomes	7. Approach for procurement and contract management processes
3. Detailed roles and accountabilities for all significant players (including plans for updated staff award structures)	8. Formulated approach for mass engagement within the PDRSS sector
4. A deployment plan for any consumer relocations	9. Plans for specific skills development
5. Execution details for any capital redistributions	10. Details for a change support program
	11. A high-level implementation plan covering time, costs and resources

7.2.2 Test and finalise strategy

The Department should conduct workshops (and potentially some interviews) with sector leaders, Vicserv and other selected stakeholders to test and validate the detailed implementation plan. This process will help to re-enforce alignment with reform objectives and assist the Department to gain further appreciation for the sector's culture, skills and change readiness.

The Department will then need to work through its own internal processes to finalise the design and receive approval to implement the reforms.

7.3 Phase 3: Mobilise the service system

The goal in this phase is to implement the activities required to ensure successful program reforms across the PDRSS sector.

7.3.1 Implement the reform program design

Based on the agreed reform program implementation plan, the Department needs to mobilise the PDRSS sector and implement the reforms. Although the exact activities will be determined by the implementation plan, they are likely to include:

- Execution of the capital program
- Performance of the reform program procurement process through open tender
- Implementation of common intake assessment and outcomes measurement tools.

7.3.2 Careful oversight of any consumer relocations and ongoing recovery

The intended reforms are substantial and will require the Department to support the sector during its transition. Actions should include:

- **Feedback loops** - Regular contact with sector leaders to ensure that the program reforms align with objectives
- **Change workshops** - Design and deliver a workshop series to help:
  - Sector leaders deliver the reforms
  - Sector staff understand the reforms
  - Non-PDRSS leaders and staff support the reforms
  - Departmental operations staff coordinate the reforms
- **Change toolkit** - Issue a change toolkit that may include a practical guide for executives and managers who lead and implement the reforms. This may include specific initiatives such as checklists and templates as well as readings and guidelines to help build their skills over time
- **Technical skills training** - Targeted skills training including the use of common intake and assessment tools, and development and use of Individual Recovery Plans. This training could be provided by Vicserv
- **'Beacon' site visits -** Organise and conduct site visits with service deliverers who are identified as 'beacons' of reform to help transfer knowledge and learning.

7.4 Phase 4: Persist and monitor

The goal in this phase is to provide support and guidance to enable sustained reform across the PDRSS sector

7.4.1 Oversight from the Departmental operations team

Throughout the reform implementation the Department's operations team will play an important oversight role. Their key responsibilities should include management of the agreed implementation and communication plans; monitoring of risks and taking appropriate action (including escalating where required); and regularly reporting progress to Departmental executive and policy team (as outlined below).

7.4.2 Persist with the reform program

The Department should continue to work with the program providers throughout the delivery of the reform programs to provide support, guidance and resources to enable sustained change across the sector. The exact nature of the activities required will be outlined in the implementation plan. However, they should include:

- Regular contact with sector leaders to ensure that the program reforms are aligned with objectives
- Targeted skills training
- Establishment of a web platform that fosters a 'market place of ideas' from grass roots staff to improve the reform implementation.

Based on any emerging evidence, the Department may also need to adjust program reforms. This will require separate planning and implementation.

7.4.3 Monitor outcomes

The Department's executive, policy team and PDRSS sector should be provided with regular progress reports throughout the implementation, monitoring progress of program reforms and feedback of consumer outcomes. This might include:

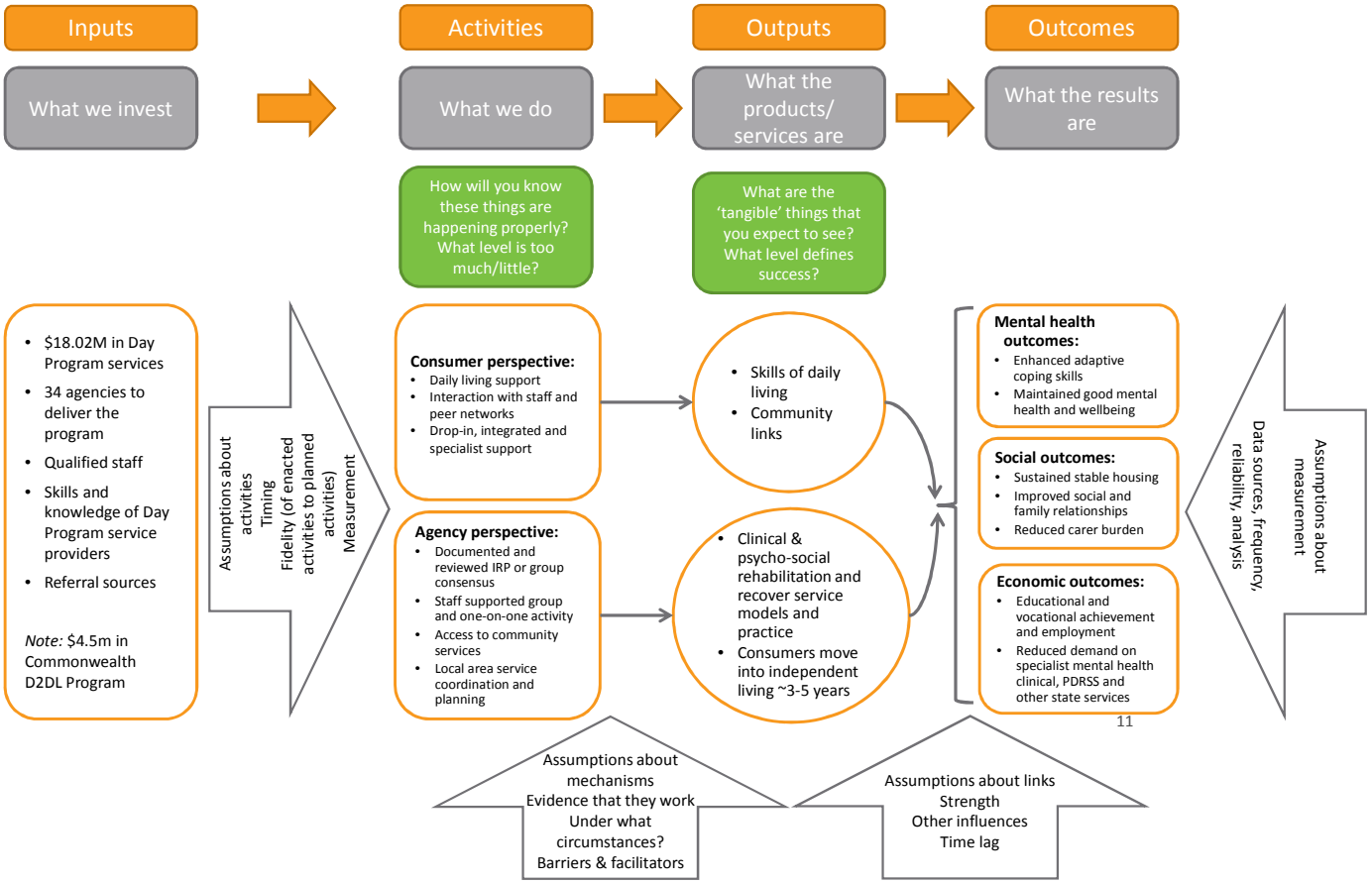
- **Quarterly reporting** – The policy team and PDRSS sector leaders should receive a quarterly performance report
- **Half-yearly reporting** – The Department's executive should receive progress reports and presentations every six months
- **Annual reporting** – The Department's executive and policy team should receive an annual report outlining progress for the previous 12 months.

Monitoring the progress of program outcomes will require the development and implementation of effective outcome measurement tools. This will also require ability from within the Department to effectively analyse and communicate key insights from the outcome data collected.

Appendix A Program logic models

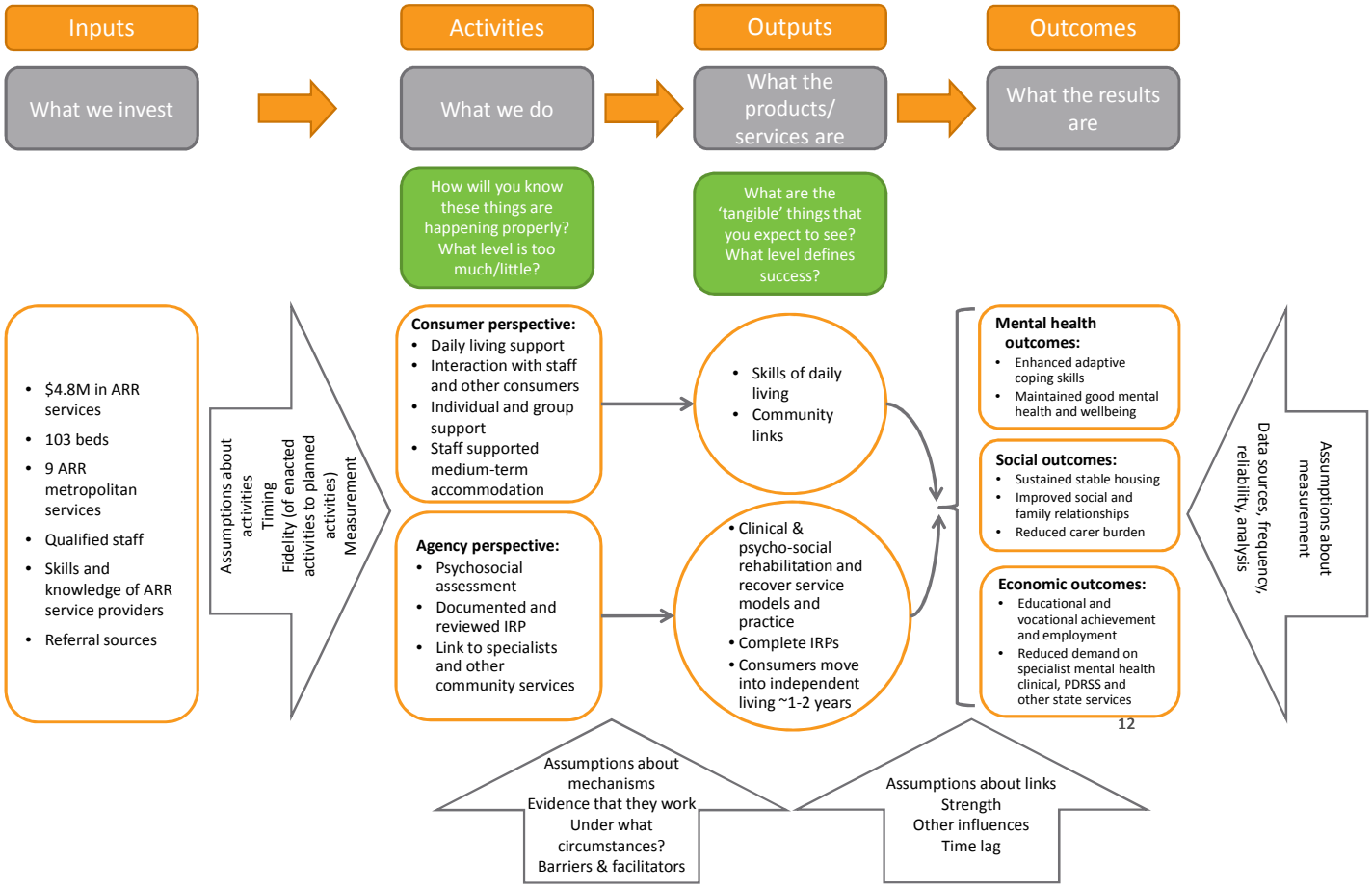
A.1 Day Program

Figure 69: Program logic model for Day Program



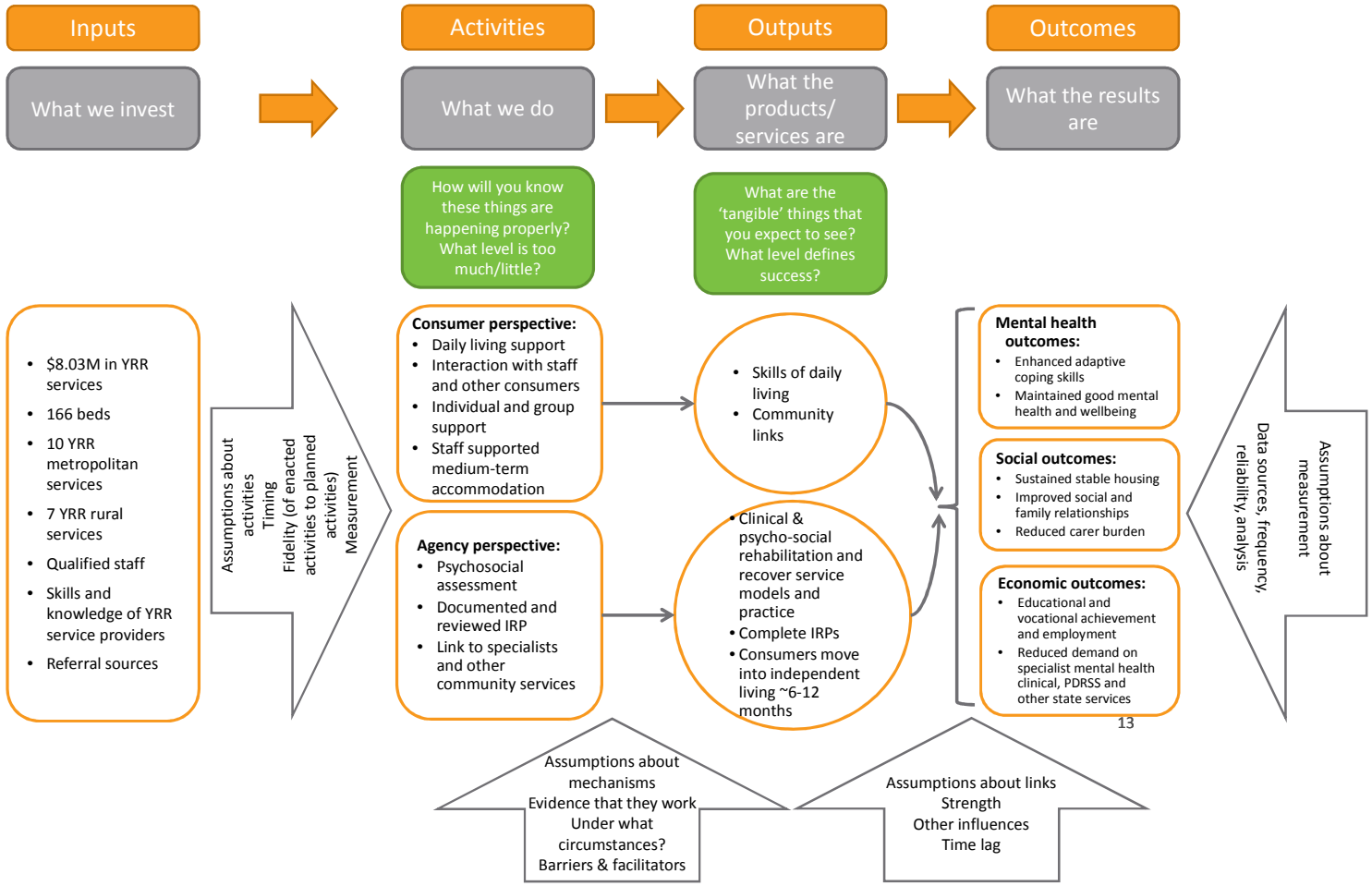
A.2 Adult Residential Rehabilitation

Figure 70: Program logic model for Adult Residential Rehabilitation



A.3 Youth Residential Rehabilitation

Figure 71: Program logic model for Youth Residential Rehabilitation



Appendix B Stakeholders consulted

Agency	Name and Role
Argos, Preston (MIND)	Judy Hamann, GM Victorian Services Shane Elsley, Program Manager
Bromham Place Richmond (MIF)	Tracey Swadling, Regional Manager Philip Watson, Rehabilitation Manager
Carers Victoria	Ben Isley, Policy Advisor
Centacare Ballarat Inc	David Beaver, Director Deanne Davis, Program Manager
Department of Health	Bill McDonald, Manager Child & Youth Mental Health, MH&D Div
Department of Health	Robyn Fisher, Manager D&A Service Delivery
Department of Health	Francene McCartin, Asst Director, Statewide Initiatives, Disability Services
Department of Human Services	Sally Elizabeth, Project Leader, Housing Sector Development, Housing and Community Building Division
Doutta Galla Community Health Service	Caz Healy, CEO Gerard Reid, GM Mental Health & Complex Needs
EACH	Peter Ruzyla, CEO
FaHCSIA	Evan Lewis, Group Manager of Community Engagement and Development
Grampians Area Mental Health Service	Dr Abdul Khalid, Clinical Director, Psychiatric Services, Ballarat Health Services Tamara Irish, Executive Director - Psychiatric Services, Ballarat Health Services

Agency	Name and Role
Jacaranda, Shepparton (MIND)	Sharon Collins, Acting Manager Jacaranda
Mallee Family Care	Cath Murphy, CEO
McAuley Community Services for Women	Jocelyn Bignold, CEO Robyn Davies, Regina Coeli, Program Coordinator
Mental Illness Fellowship	Laura Collister, General Manager, Rehabilitation
MIND Australia	Dr Gerry Naughtin, CEO Ray Judd, GM Corporate Development & Support Services Judy Hamann, GM Victoria Operations
NEAMI	Glen Tobias, Victorian Manager
Opening Doors 94 Alma Rd	Melanie Purkiss, Residential Rehabilitation Manager Southern Metropolitan & Gippsland Sean Hegarty, Senior Coordinator
ORYGEN Health	Eoin Killacky, Associate Professor
Pathways, Rehabilitation And Support Services Inc, Geelong	Paul Napper, Director Andre Cristoffelsz, Regional Manager, Barwon Mark Rosser, Program Development Manager
Peninsula headspace	Rose-Mary Dowling, Program Manager
Prahran Mission	Quinn Pawson, CEO Mark Smith, General Manager Services
Rocket Youth Residential Services	Cheryl McDonald, Program Manager Vivienne Archdall, Project Officer, MindMatters

Agency	Name and Role
SNAP Gippsland	Chris McNamara, CEO
St Luke's Anglicare, Bendigo	Margaret Brooks, Director
SWOT Analysis	Kris Honey, Author
Uniting Care, 101 Carlisle St, St Kilda	Shane Lawlor, Executive Officer
Vicserv	Kim Koop, CEO
VMIAC	Lei Ning, Deputy Director
Western Region Health Centre	Lyn Morgain, CEO
YSAS	David Murray, Executive Officer
Argos, Preston (MIND)	Judy Hamann, GM Victorian Services Shane Elsley, Program Manager
Bromham Place Richmond (MIF)	Tracey Swadling, Regional Manager Philip Watson, Rehabilitation Manager

B.1 Review reference groups

B.1.1 Adult and Youth Residential Rehabilitation

Name	Organisation
Rosemary Dowling	Director, Peninsula Headspace
Dr Paul Denborough	Alfred CAMHS
Lisa Brophy	Chief Social Worker, North West Area Mental Health Service
Dr Richard Harvey	Deputy Clinical Director, Barwon Health
Grant Burkitt	Forensicare
Dr Gerry Naughtin	MIND Australia
Liz Crowther	Mental Illness Fellowship
Caz Healy	Doutta Galla Community Health Service
Chris McNamara	SNAP Gippsland Inc
Vittoria Tonin	ORYGEN Youth Platform Group
Lei Ning	Deputy Director, Victorian Mental Illness Awareness Council
Anne Casey	Carer and Family Consultant, Alfred Health
Ben Isley	Carers Victoria
Dr Stefan Gruenert	Odyssey House
Michael Perusco	Sacred Heart Mission

B.1.2 Day Programs

Name	Organisation
Rod Fithall	Northern Area Mental Health Service
Dr Richard Harvey	Deputy Clinical Director, Barwon Health
Cayte Hoppner	Director of Mental Health, Senior Psychiatric Nurse, Mid West Area Mental Health Service
Lisa Wright	Clinical Coordinator, NCSO Consultation Liaison Program, A/Chief Social Worker Forensicare
Associate Professor Eoin Killacky	ORYGEN Health
Laura Collister	Mental Illness Fellowship
Peter Ruzyla	EACH
Quinn Pawson	Prahran Mission
Glen Tobias	NEAMI
Chris McNamara	SNAP Gippsland
Neil Thurton	Western Region Health Centre
Penny Lewisohn	Chair, Alfred Parents and Friends Association
Simon Crawford	Access for all Abilities, City of Melbourne and City of Wyndham, YMCA Victoria

B.2 Other workshop stakeholders

Name
Clinical Providers
Consumers
Carers
Rural consumers and carers

Appendix C Background research

C.1 Approaches to employment

There are three approaches to employment for people with psychiatric disability: The 'individual placement and support' program; the 'social enterprise' approach; and the 'transitional employment' approach. The first approach has the strongest proponents.

The individual placement and support program is often referred to as the 'supported employment' approach and started in New Hampshire in the early 1990s. The second 'social enterprise' approach was pioneered in Trieste in the early 70s and introduced into Victoria in 2004. The third approach 'transitional employment' that underpins the Clubhouse model began in New York in the 1950s. It was introduced in Victoria in the 2000s by the Prahran Mission and the Schizophrenia Fellowship (now the Mental Illness Fellowship).

Leff and Warner (2006) have reviewed evidence on the effectiveness of different approaches to employment in securing ongoing jobs in a competitive employment market for people with a mental illness.[128] Their key points are provided in Table 48.

Table 48: Employment models

Employment approach	Leff and Warner (2006) conclusions	Further research evidence
Individual placement and support	Individual placement and support is the form of supported employment found to be the most successful in people with a mental illness gaining permanent paid work in the open employment market. Enhanced results can be obtained if employment staff are a coordinated part of a mental health service, rather than a separate entity (pp.129-132).	A study by King et al. (2006) found evidence that showed optimal results were achieved through integration of clinical and employment services, usually through co-locating an employment specialist in a specialist public clinical mental health service. Bond (2004) also provides evidence of the success of this approach in enabling consumers to secure competitive employment, compared to those not involved in supported employment programs.[129] Bond is one of the US proponents of supported employment. In Australia, Collister (2009/10) outlined an analysis of the key components of the individual placement and support employment model, and evidence of its success in achieving jobs in the open employment market for people with low prevalence disorders such as schizophrenia.[130] Killackey el at (2008) conducted a six-month randomised trial in Melbourne with 41 young people with first-episode psychosis to test the effectiveness across a range of measures of the individual placement and support (IPS) approach compared to 'treatment as usual' (TAU).[131] The IPS group showed statistically significant better outcomes than the TAU group in terms of employment, hours worked, jobs obtained and length of employment.

Employment approach	Leff and Warner (2006) conclusions	Further research evidence
Social enterprise	Some consumers may not be able to take on or sustain jobs in competitive employment, due to the nature and length of their disability. Social enterprises may be a viable alternative for this group. This includes consumer-run enterprises (pp.132-134; 136-146).	Crosse (2004) describes how a social enterprise operates and the nature of its benefits for people with psychiatric disabilities who want paid employment.[132] Crosse set up Social Firms of Australia (SoFA) in 2004. SoFA is an umbrella organisation which assists development of not-for-profit business enterprises whose purpose is to create accessible employment for people with psychiatric and/or other disabilities. By late 2008, SoFA had helped set up six enterprises with 218 employees, 113 of whom have disabilities. SoFA organisations typically employ 25-50% of its workforce from disadvantaged groups. According to SoFA, preliminary evaluation undertaken by the Psychosocial Research Centre of the Department of Psychiatry at the University of Melbourne indicates that employees have improved mental health, social connectedness and self-esteem. The UK Social Enterprise Coalition describes the importance of social enterprises to help marginalised members of society to access employment, particularly those people who many mainstream employers are reluctant to employ. The Coalition cites a survey conducted by the Chartered Institute of Personnel and Development which found that 60% of employees would not employ someone who had a history of mental health problems. The Coalition makes it clear that a primary benefit of social enterprise is the training and employment experience which enables marginalised employees to take the next step and access mainstream employment. In this way, 'social enterprise' can often act as the intermediate step for some people disadvantaged in the work place on their way to open employment.'[133]
Transitional employment	The transitional employment approach used by US clubhouses seeks to give members job skills by placing them in time-limited contract work. Members move through different contract jobs. However, this is problematic for people with a mental illness, who typically find change stressful (pp.127-128; 159-162). This approach has not been demonstrably successful in securing ongoing jobs and the clubhouse model itself has a weak evidence base (p.161).	Bromham Place, run by the Mental Illness Fellowship, was an example of a Clubhouse in Victoria, although this service no longer follows the Clubhouse model.
Vocational rehabilitation	The traditional vocational rehabilitation approach of 'train and place' has had limited success as it was designed for people with physical not psychiatric disability (pp.126-127).	

C.2 Supported education

Supported education programs in Australia, the US, the UK and New Zealand are expanding.[134] People with a mental illness utilising these programs have achieved completion rates comparable to the mainstream population. There is emerging evidence to support an IPS-like model for young people with a mental illness.

Supported education seeks to improve the access and participation rates of people with a psychiatric disability in post-secondary education by providing the necessary supports to enable them to do so.[135] There are three main types of supported education:[136]

- **Self contained classroom** model where people with a mental illness attend classes separate to the mainstream classes at a mainstream educational campus. Support is provided by staff from the educational institution or mental health services
- **Onsite support model** where people with mental illness attend mainstream classes at the educational institution and are supported by disability services or counselling staff
- **Mobile support model** where students attend mainstream classes and receive support onsite by community mental health staff.

Lachlan Best provides one successful example of a self contained classroom model for students with severe mental illness. The partnership between TAFE New South Wales and the Therapy and Recovery Service of the Division of Mental Health, Liverpool demonstrated a high rate of course completion of 72%, compared to a rate of 77% for the general population. Of the 61 completions, 9 commenced open employment, 11 participated in mainstream education, 12 in sheltered employment, 15 were job seeking for further employment, 2 in volunteer work and 8 did not pursue vocational or educational goals.

The Mental Illness Fellowship (MIF) in Melbourne started a self contained classroom model in 2004 to enable people with psychiatric disability to re-engage with education. MIF is a Registered Training Provider, and offers the General Education for Adults (GEA) Certificate, which focuses on literacy and numeracy and other employment-related skills. The course enrols 15 to 20 students annually, with students taking classes two days per week, four hours per day. It is now offered at three sites. In partnership with MIF, La Trobe University is evaluating course outcomes.

Robson et al (2010) report preliminary positive outcomes from the implementation of a supported education program in a NSW community mental health service.[137] The program was modelled on the individual placement and support approach to supported employment and was run in conjunction with a support employment program for young consumers of the CMHS. To date, 70% of participants were either continuing or completing their chosen formal study.[138]

Killackey (2008) argues that an expanded version of the IPS to include educational goals for young people would be most appropriate for young people with first episode psychosis.[139] This view is reiterated by Rinaldi (2010) who found that an adapted IPS model which included educational goals produced significant education and employment outcomes for a mean of 69% of young people with first episode psychosis, compared to 35% of a control group.[140]

C.3 Victoria's public housing shortage

The capacity to support people with a serious mental illness to live independently in the community is affected by Victoria's public housing shortage.

As at 30 June 2009, 62,561 households were accommodated in public housing dwellings and there were 39,940 applications on the waiting list.[141] Private housing demand is also under stress due to population growth and high employment. At 30 June 2009, private rental vacancy rates were 1.3% in metropolitan Melbourne.[142]

Employment participation improves housing choice for people with a mental illness as they have greater income to pay for private housing options. People with a mental illness have some of the lowest employment participation rates of any group with a disability. Only 25% of working-age people with a mental illness are in the workforce.[143]

All stakeholders observe that for many consumers, recovery is non-linear which makes securing and maintaining stable housing difficult – regardless of whether it is public or private. There is recognition that consumers require assistance to secure housing, but also, to maintain housing, consumers require flexible support that addresses their needs according to the stage in their recovery.

PDRSS providers note that services spend a significant amount of time assisting consumers to find and maintain stable housing. The difficulty lies in partnering with housing associations to find suitable *and sustainable* housing for consumers; as identified by many providers, the difficulty in working with housing associations is mainly due to the lack transparency of the housing allocation process. As several PDRSS providers identified, housing associations seem to consider consumers with mental illness too difficult to deal with.

This observation is supported by the recent Victorian parliamentary inquiry into public housing which found that people with a mental illness find it difficult to qualify for public housing through the segmented waiting list.[144] The inquiry also identifies that people with mental illness are under-represented on public housing waiting lists.[145] It should be noted that the inquiry recommends a new waiting list segmentation model that reallocates Department of Health consumers in 'mental health residential facilities' and consumers who are homeless into the '1st priority group' segment.[146]

C.4 Recent approaches to guide psychosocial service delivery

Day Program providers are increasingly drawing on the social inclusion and recovery approaches to guide their psychosocial service delivery.

Day Program providers have recently included the approaches of social inclusion and community integration, and recovery to guide their psychosocial service delivery. These approaches have begun to replace the notion of rehabilitation. Table 49 details these approaches and the research evidence to support them.

Table 49: Recent philosophies to guide psychosocial service delivery

Theme	Commentary	Research evidence
Social Inclusion and Community Integration	Social inclusion and community integration are prominent themes in recent literature on day programs.	Core components include working with communities to enhance acceptance, as well as with individuals to become part of their local community (Bates 2002). More specifically, this philosophy involves workers encouraging individual consumers to identify their aspirations across domains such as employment, education, arts and leisure, then supporting them to make use of related activities in normal community settings (Howat 2004, p.276).
Recovery	The commitment to a recovery approach is now seen as a core component of work with individual consumers and of service design across the mental health sector.	The recovery approach has been endorsed nationally by the revised National Standards for Mental Health Services 2010, which includes a statement of 'Principles of recovery oriented mental health practice' (pp.42-43). In this document, Standard 10.1 is called 'Supporting Recovery' and states '*The MHS incorporates recovery principles into service delivery culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery*' (2010, pp.21-22). There are 10 specific criteria to assist the application of these principles in practice. A recovery approach is as much a philosophical stance as a set of evidence-based practices. A summary of key research evidence is provided below: • **Recovery approach for people with serious mental illness** - Championed by Dr William Anthony of the Boston University Center for Psychiatric Rehabilitation, Anthony's (1993) publication was an early influence on the spread of the recovery approach for people with serious mental illness.[147] • **Individual nature of the recovery path** - Davison (2003) has corroborated these early recovery studies. He found from consumer accounts of their experience of recovery, the individual nature of the paths followed.[148] Davidson also draws out common ingredients for success, such as the importance of self-determination and hope.[149] • **Recovery in a local context** - O'Hagan (2004), a member of New Zealand's Mental Health Commission, discusses how NZ re-defined the largely American concept of recovery to make it applicable to the local context e.g. the NZ version portrays recovery as a social as well as individual responsibility.[150] • **Application of recovery models to improve consumer participation in society** - A detailed practice guide from the UK showing how a recovery approach can and should be used with consumers to ensure they are more able to participate in society.[151] • **Application of recovery concepts to improve service delivery** - A UK report which focuses on recovery as an organising concept and guide for improving services and assessing their relevance to people with a mental illness.[152]

C.5 Emerging Service delivery models

Day Program providers are drawing on emerging service delivery models; the Collaborative Recovery Model and the Strengths-Based Approach. These models are replacing the Boston Rehabilitation Model and the Clubhouse Model.

In the mid-1990s, several Victorian PDRSS such as Prahran Mission and Aspire in Warrnambool adopted the Boston Rehabilitation Model. The Boston model was originally developed by the Boston Centre for Psychiatric Rehabilitation. This model (and the Clubhouse Model) were initially influential but had fidelity requirements which some agencies found onerous and/or inappropriate. Providers are now drawing on new service delivery models; namely the Collaborative Recovery Model and the Strengths-Based Approach. Table 50 details the application service delivery models and the research evidence to support them.

Table 50: New service delivery models

Service delivery models	Application	Evidence
Collaborative Recovery Model	This model is gaining currency in Victoria through being adopted by Victorian psychosocial rehabilitation programs (SNAP, Neami) as well as by services in other states such as NSW. Based on the recovery philosophy, it was initiated by mental health professionals working in the NSW Illawarra AMHS. SNAP and Neami are two sites included in a five-year multi-site evaluation by the University of Wollongong, funded by the NH&MRC. The Collaborative Recovery Model (CRM) has a clear practice framework.[153] This comprises two guiding principles, and four components which are implemented in collaboration with the individual consumer. The four components are change enhancement (motivational interviewing), collaborative needs identification (using the Camberwell Assessment of Need Short Appraisal Schedule: CANSAS), collaborative goal setting and striving, and collaborative task assignment and monitoring. All staff undergo training as part of the introduction of CRM to an agency.	First published by Oades et al in 2005.[154] They argue that it combines evidence-based practices and relevant competencies, and incorporates consumers' subjective experiences.
Strengths Model	This model was developed in the US in the 1980s and 1990s. The model incorporates a recovery approach, and is used in both PDRSS day programs and clinical mental health services in Victoria (an example of its use in a clinical model is provided by Chopra et al 2009).[155] The model focuses on identifying and working with a person's skills and abilities, rather than focusing on their deficits. Use of the model requires undertaking five functions with the consumer. These are engagement, strengths assessment, person-centred planning, and resource acquisition. A final function is collaborative monitoring of progress with the consumer, and making adjustments as necessary. Strengths assessment covers seven life domains directly related to successful community tenure, including the person's living situation, financial resources, employment and education, social supports, health, recreation and culture. The focus is on what works for the person and what they want to change. Resource acquisition involves identifying resources in the person's community which can be harnessed in achieving their recovery goals.	Rapp and Goscha (2006), the originators of the strengths model, claim evaluation shows the effectiveness of the model (pp.68-71). They also provide a fidelity scale (pp.264-265) to test adherence to the core tenets of the model.

C.6 Carer satisfaction

The challenges carers experience in the three PDRSS programs is consistent with their experience of other parts of the mental service system in Australia.

In 1996, consumer and carer satisfaction surveys were piloted in Victorian clinical services, and administered on an annual basis from 1997-2000. After being redeveloped in 2001-02, the surveys were implemented across PDRSS as well as clinical services from 2003-04 (MHB 2004, p.28). Results from the 2003-04 carer survey showed that less than 50% of carers knew how to access information and resources about clinical services which were relevant to their role as carers (MHB 2004, p.30).

This experience is common across mental health services, although research has largely focused on clinical services. An example is a Queensland study by Hodgson et al. (2002), which concluded that:[156]

'despite clear policy guidelines that favour communication and partnership with carers, mental health professionals have yet to develop skills and attitudes consistent with genuine involvement with carers in core clinical processes' (p.2).

In 2009, the Mental Health Council of Australia (MHCA) undertook the first national survey of carers of people with a mental illness.[157] 15 issues were identified for attention and are listed in the report (p.6). With a couple of exceptions, most are sufficiently general to apply across PDRSS as well as clinical services. The MHCA intends to use the list as a report card against which to assess service performance in repeated surveys. The issues are provided in Table 51.

Table 51: Carer issues

Issues identified by carers for attention	
∘ Listen to and respect carers ∘ Integrated recovery-based care for the consumer ∘ More and better trained staff at all levels ∘ Knowledge and information for carers ∘ Carer and consumer education for all professional groups and agencies ∘ Support systems, services and processes established for carers ∘ Early intervention at each episode of care	∘ Acute care to be therapeutic and accessible ∘ Stigma, discrimination and isolation for carers and consumers ∘ Accommodation options for consumers at all levels of care ∘ Financial costs to carers ∘ Physical and mental health of carers ∘ Flexible respite options for carers ∘ Privacy and confidentiality issues ∘ Employment options for carers

The report includes carers' experience of PDRSS-type services, with comments made on the lack of training and career structure in this sector, which meant workers lacked relevant skills and turnover was high. For example: *'Carers noted a lack of care workers who were knowledgeable about or able to care for those with a mental illness, particularly in the area of respite (p.31).'*

C.7 The key roles of carers

The key role of families and other carers in consumer recovery is well documented in the Department's policy literature.

Victoria's approach to families and other carers is set out in the 2004 document *Caring Together: An action plan for carer involvement in Victorian public mental health services.* This document applies to PDRSS as well as clinical services, and aims to encourage greater attention and responsiveness to the needs of families and other carers, and to support their role. To date, implementation of the action plan has not been evaluated.

A 2005 circular from Victoria's Chief Psychiatrist affirms the key role of families and carers:[158]

'Increasing evidence demonstrates that well-being and outcome for both consumers and carers are improved by involving families and carers. As we begin to understand the contribution that carers make in the process of recovery and relapse prevention there is a need to optimize genuine carer involvement in treatment and care.'

In 2008, the Victorian Mental Health Branch published a review of the mental health carer support and resource program.[159] This focused on the state-funded mental health carer support program, comprising a carer support brokerage fund and employment of carer consultants, and carer support and resource workers (a joint Commonwealth/State funded initiative). However, the mental health support program largely operates through clinical services, although it is acknowledged that some PDRSS are employing carer consultants using other funding sources.

C.8 Evidence of carer activities

There is substantial research evidence on the specific activities mental health providers can utilise to foster better recognition of families and carers including staff training, family interventions and carer engagement protocols.

In 1997, the Victorian Mental Health Branch funded the Bouverie Family Centre to develop and implement training for staff of clinical services in working with families. Called the Family Sensitive Training (FaST) program, this was run for staff in all clinical services from 1997 to 1999. The training program for adult mental health services also included PDRSS workers (160 participated), and carers and consumers also took part. The program was evaluated and was found to be successful in raising staff awareness about the needs of carers and how to provide better support.[160]

Dixon et al (2000)[161], McFarlane etc. (1995)[162] and Mihalopoulos et al (2004)[163] demonstrate that there are a number of different approaches to working therapeutically with families. For instance, there is now substantial evidence on the effectiveness of psychoeducational approaches, including the use of multiple family groups, to assist carers manage the challenge of having a family member with a mental illness. However, these studies focus on interventions used in clinical services. There is little research available on how best to work with families in PDRSS-type services such as residential rehabilitation or day programs.

In the UK, the 'Triangle of Care' has been developed to foster better recognition of carers in acute mental health care.[164] The approach has six key components which could be adapted for use in other service settings, such as PDRSS. They are:

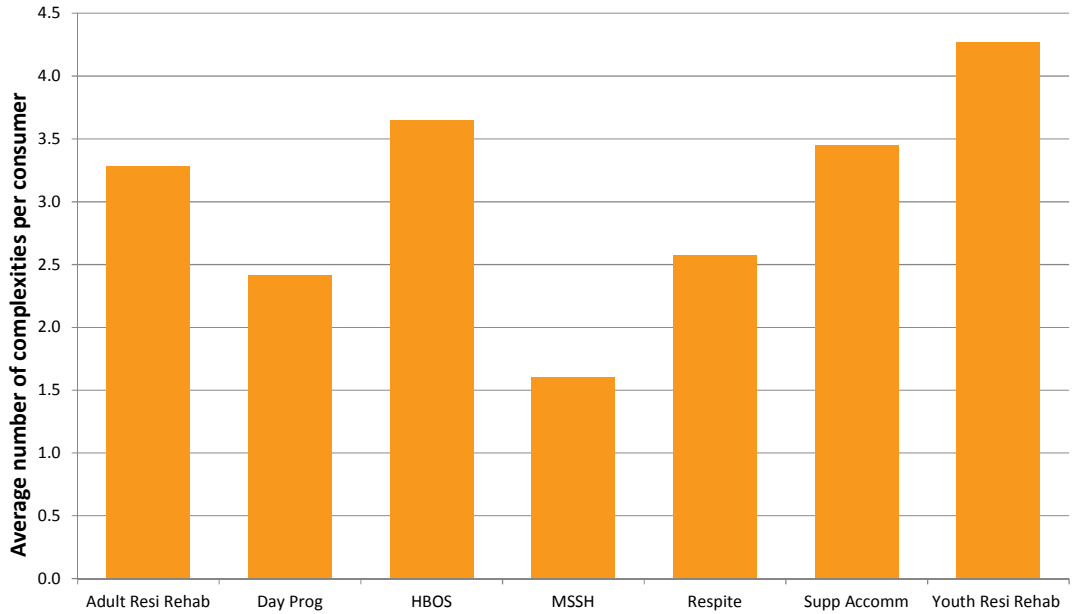
1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter
2. Staff are ‘carer aware’ and trained in carer engagement strategies
3. Policy and practice protocols re confidentiality and sharing information are in place
4. Defined post(s) responsible for carers are in place
5. A carer introduction to the service and staff is available, with a relevant range of information across the acute care pathway
6. A range of carer support services is available.

Appendix D Additional data

D.1 Profile of complexities associated with mental illness across PDRSS programs

The average number of complexities per consumer for PDRSS is provided in Figure 72. Youth Residential Rehabilitation has the highest average number of complexities per consumer (4.3). Mutual Support and Self-Help (MSSH) has the lowest average number of complexities per consumer (1.6).[165]

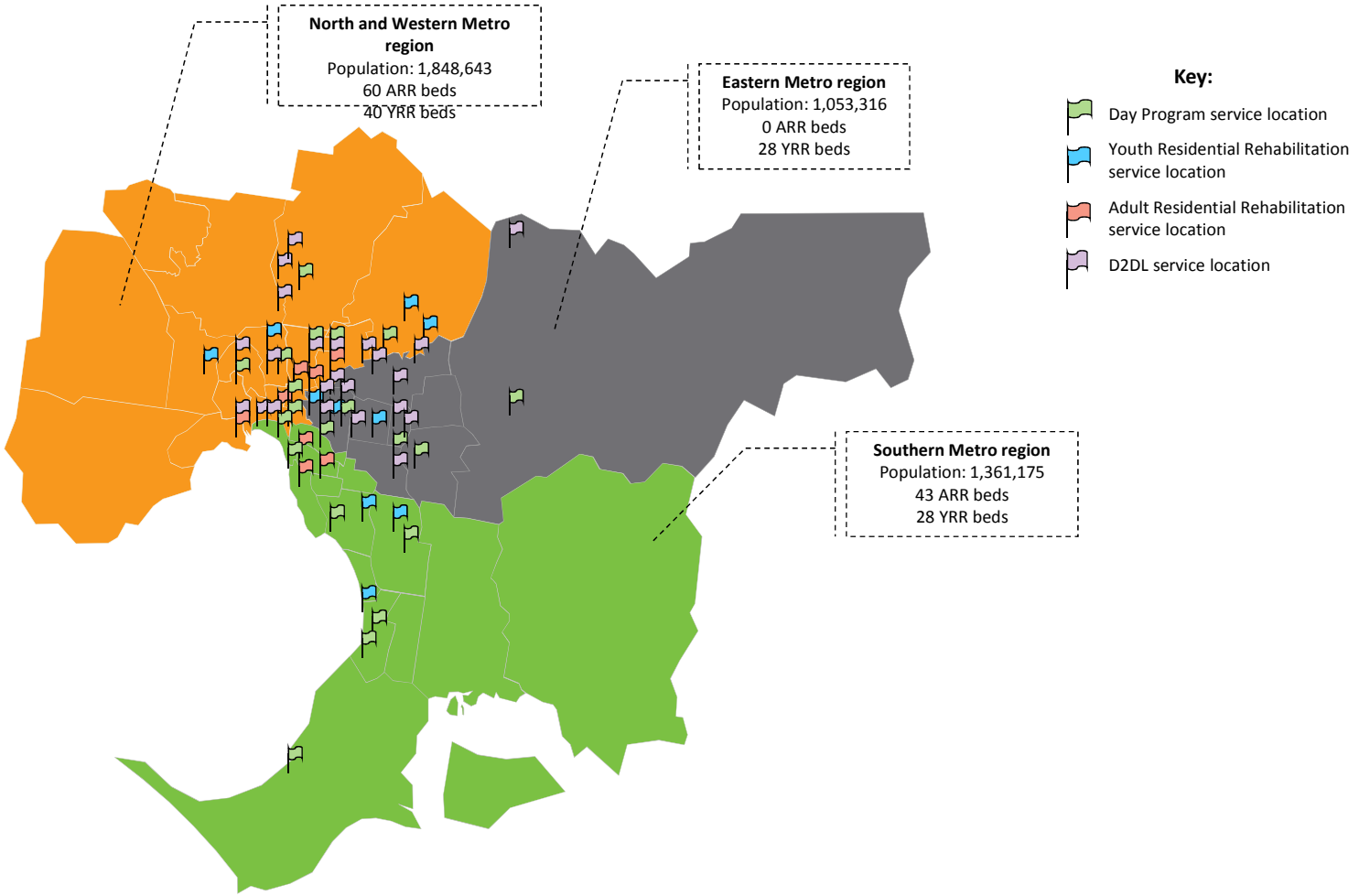
Figure 72: Average number of complexities per consumer across PDRSS[166]



D.2 Distribution of programs in Victoria

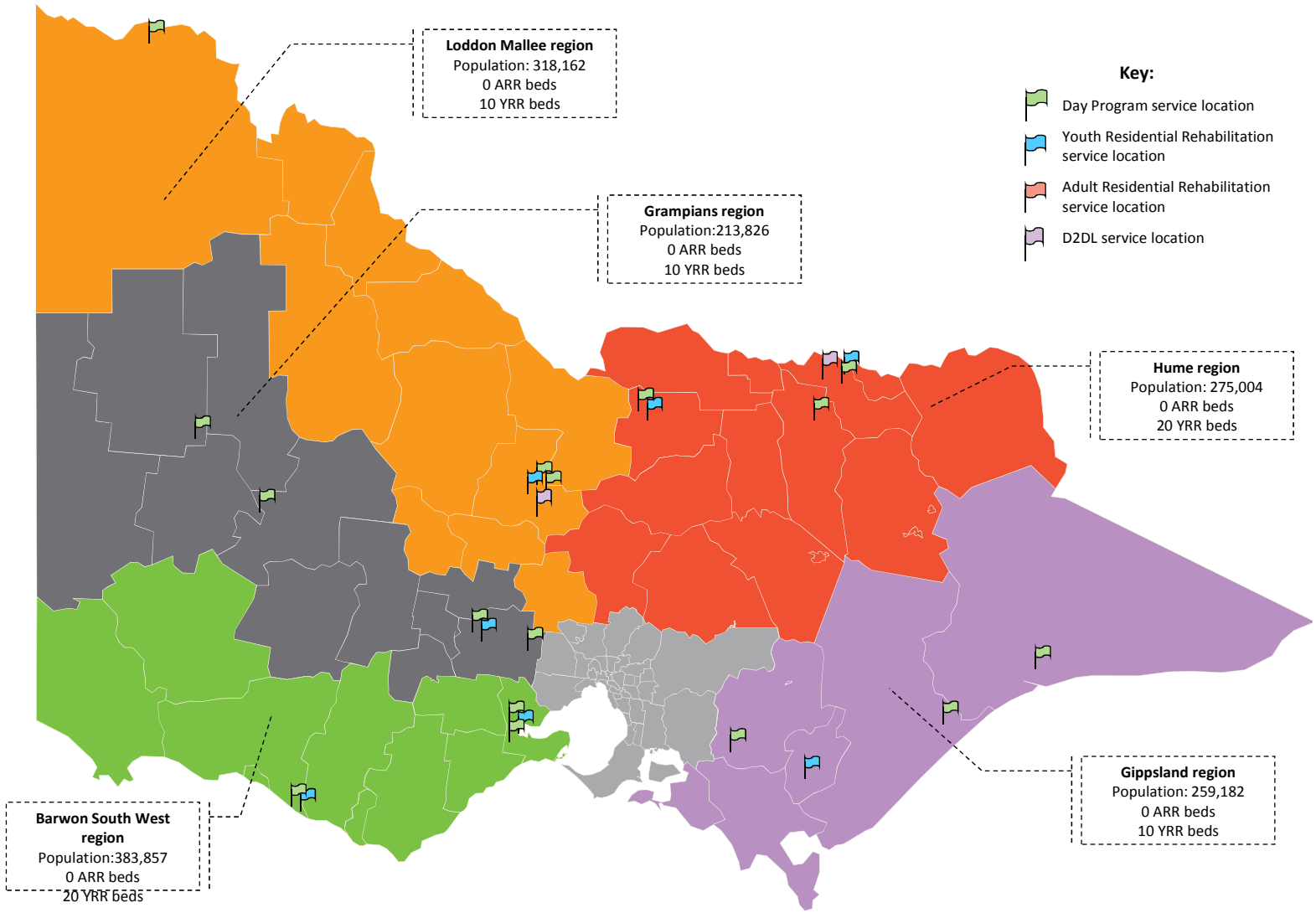
D.2.1 Metropolitan regions

Figure 73: Geographic distribution of programs across metropolitan regions



D.2.2 Rural regions

Figure 74: Geographic distribution of programs across rural regions



D.3 Modelling for Day Program hours delivered

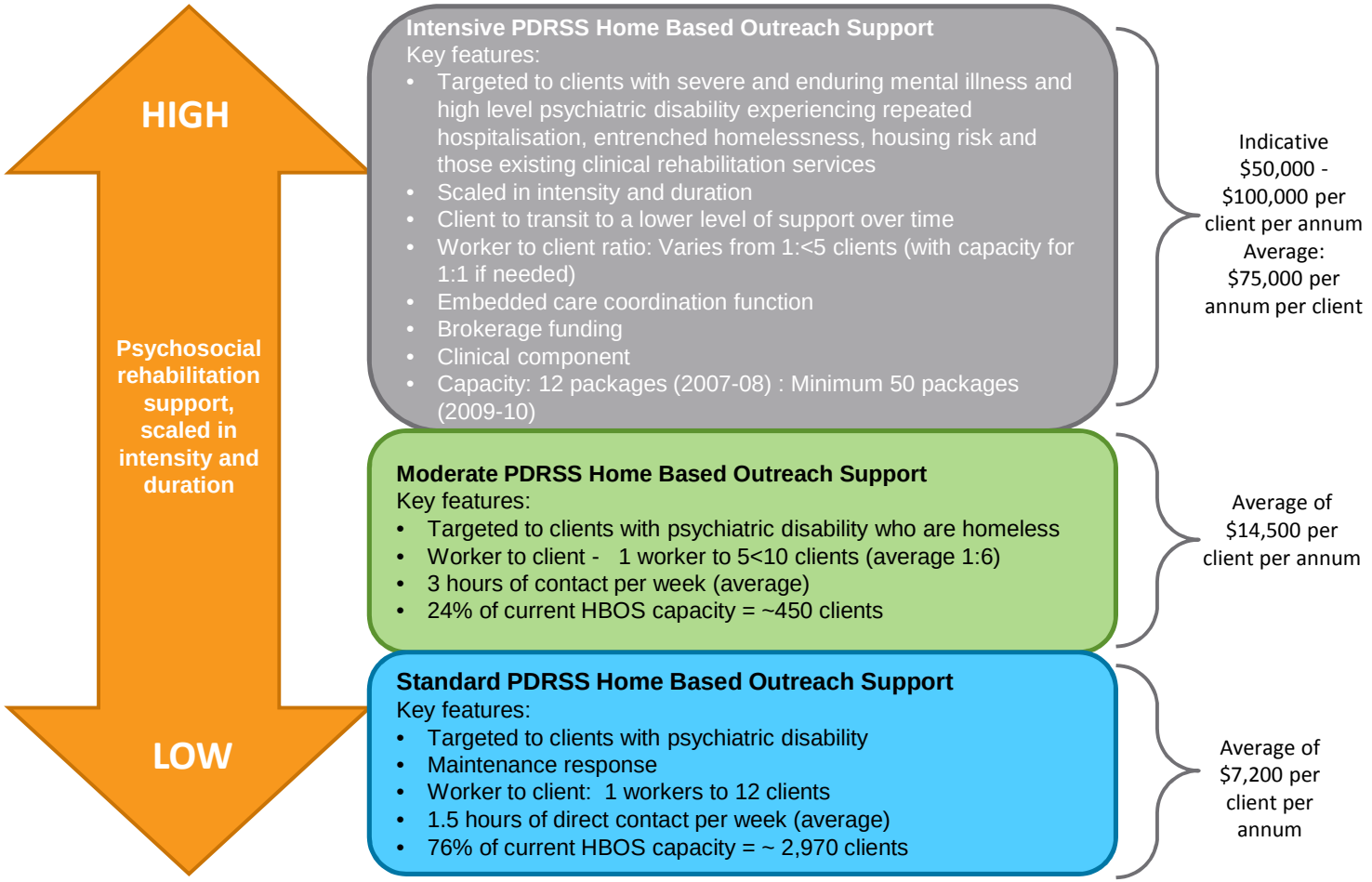
Day Program hours delivered across Victoria *	Average number of hours per consumer per year #	Average number of hours per consumer per week +
474,917 hours	70 hours	1.34 hours

* Day Program hours for each region delivered is calculated by dividing the funding provided to each organisation by the standard cost per activity hour for each service stream for which they are funded (drop-in, standard, high cost or specialist Day Program) . The total number of hours delivered in each region is a sum of all service stream hours delivered within the region.

The total number of consumers in Day Program 2009-10 is assumed to be 6,803 as captured by the QDC.

+ Assumes 52 weeks in a year and does not take Christmas holiday closures and other long periods of closure that may happen across some providers.

Appendix E Overview of PDRSS HBOS



Appendix F Current bed-based services and housing models

F.1 Bed based services

Victoria has both clinical and non-clinical bed-based services in the community. These two categories are differentiated by:

- The level of complexity of the residents' psychiatric condition and the clinical care needed
- Whether on-site staffing comprises clinical or PDRSS staff
- Whether beds are gazetted or not (for involuntary treatment)
- The level of government payment per bed
- Whether clinical care and disability support is provided in-house or on an in-reach basis.

F.1.1 Community-based Clinical Bed-based Services (excluding SECUs)

Community Care Units (CCUs): Community-based clinical beds with 24hr clinical staffing ($337 per bed day metro, $340 rural). Some individual CCU consumers have PDRSS in-reach (e.g. through IRRCS care packages). Some CCUs are gazetted to take consumers for involuntary treatment e.g. Maroondah CCH. Note: a new 22 bed CCU for Austin Health (North-East AMHS) was funded in 2010/11 budget.

Prevention and Recovery Care Services (PARCS): Community-based short stay, step-up/step-down units ($399 bed day metro & rural). PDRSS provide 24hr staffing, managed by local AMHS which provides clinical in-reach. Currently there are 10 units for adults, with two units for youth coming on stream in Jan 2011 in Frankston and Bendigo ($480 bed day metro and rural).

F.1.2 Non-Clinical Bed-based Services

Adult Residential Rehabilitation Services (ARRS): PDRSS staffed and managed ($148.35 per bed day 24 hour staffed; $118.59 non-24 hour). Transitional. Clinical input from local AMHS.

Note: A hybrid ARRS/CCU model has 24hr PDRSS staffing with clinical in-reach (MIF Shepparton Specialist Adult Residential Rehabilitation Services).

Youth Residential Rehabilitation Services (YRRS): PDRSS staffed and managed. Some with 24hr staffing. Transitional.

Supported Accommodation Services (SAS): PDRSS staffed and managed (bed day price $40.29 for 11+ beds, $115.10 for 0-11 beds, 24 hour staffed; $55.85 for 11+ beds, $75.11 for 0-11 beds, non-24 hour staffed) for slow-stream rehabilitation.

Name	Type	Clinical state	Onsite staff	Clinical in-reach	PDRSS in- reach	Bed day price metro	Bed day price rural	Bed day price 24hr staff	Bed price non 24hr staff
CCU	Clinical	Complex	Yes, clinical		Some consumers	$337	$340		
PARC adult	Clinical	Sub-acute	Yes, PDRRS	Yes		$399	$399		
PARC youth	Clinical	Sub-acute	Yes, PDRRS	Yes		$480	$480		
ARRS	PDRSS		Yes, PDRSS	No				$115.10 0-11 consumers $40.29 11+	$75.11 0-11 consumers $55.85 11+
YRRS	PDRSS		Yes, PDRRS	No				$115.10 0-11 consumers $40.29 11+	$75.11 0-11 consumers $55.85 11+
SAS	PDRSS		Yes, PDRRS	No				$115.10 0-11 consumers $40.29 11+	$75.11 0-11 consumers $55.85 11+

F.2 Housing models

There are several models of housing and support differentiated by:

- Whether the housing is a public housing or NGO property, or privately owned or rented
- Whether the landlord is the Office of Housing, a PDRSS, an NGO Housing Association or a real estate agent
- Whether support services are on-site or provided on an in-reach basis
- Whether all residents have psychiatric disabilities and/or have other problems e.g. drug abuse.

F.2.1 Mental health specific housing

Housing and Support (HASP): Office of Housing allocates properties (spot-purchased or purpose-built), consumer has secure tenure, and PDRSS provides flexible support on an in-reach basis. Landlord may be NGO Housing Association or Office of Housing.

Supported Housing: Properties owned or leased by PDRSS, which may cover landlord function as well as provide flexible in-reach support, or use of a Housing Association to manage tenancies. Alternatively, properties are rented on the private market, PDRSS provides flexible in-reach support and landlord is private real estate agent.

Private Supported Housing: Groups of parents set up an association and have bought or leased properties. Support may be provided on an in-reach basis by a PDRSS or privately purchased. Examples are the Haven in Prahran (to open shortly), and Jeshimon House in Camberwell.

NOTE: MIF has received support from the incoming Government for **a new housing and support demonstration project** that comprises:

- 50 one bedroom units in the private rental sector across various locations throughout Melbourne
- Rent subsidies of $8,200 per person participating in the project per year so that tenants no longer have to choose between paying their rent and buying their medication
- An extra $127,000 a year to provide 50 community support packages to people participating in the demonstration project.

F.2.2 Homeless Housing Projects

Note - none 'reserve' a set number of places for people with psychiatric disabilities.

Rooming Housing Plus: Large government-owned property on Queens Rd (former Ambulance Training College). Residents have permanent tenure. Mixed population in terms of disability and level of support required - many were formerly residents in Scottsdale, an SRS which closed down. Managed by NGO Sacred Heart.

Elizabeth Street Common Ground: New multi-story apartment building on Elizabeth Street based on New York Common Ground model. Joint project between Commonwealth (housing) and State (housing and recurrent funding for the support services). Building has 135 apartments, 61 for people who have been homeless, some of whom have psychiatric disabilities, and 60 for people on low incomes, and 14 for students. Secure tenancies. Support services provided on-site by HomeGround, an NGO, with Yarra Community Housing managing the tenancies.

Journey to Social Inclusion (J2SI): Sacred Heart Supported Housing three year demonstration project in St Kilda (Michael Perusco is CEO). Project began in 2009 and will run for 3 years. Commonwealth funded housing through Social Housing program, and Victorian State Government funded through Sacred Heart provide support, including funding for external psychological counselling. Total of 40 participants with extensive histories of homelessness and related problems, including mental illness.

A.1.1 Private For-Profit Sector

Supported Residential Services (SRS): Commercial residential care services located in metropolitan Melbourne and some rural towns. Provide bed and board for people unable to live independently.

Around one-third of SRS residents have psychiatric disabilities; others have mixed disabilities or are elderly. Charges at some SRS are pensioner-level, others more. Through the SAVVI program, the State Government has funded HACC services to provide support to residents of some pensioner-level SRS.

Boarding Houses & Rooming Houses: Commercial properties with a range of charges but mostly low cost. Some provide on-site cooking facilities; others provide one or more meals. Usually a manager on site or on call but minimal support services.

Appendix G End notes

[1] Victorian Government Department of Human Services (1997). *Suicide Prevention Taskforce Report*. Melbourne, Government of Victoria.

[2] Success Works (1999). *Evaluation of suicide prevention initiatives - Consultants Report*. Melbourne, Government of Victoria.

[3] Mental Health and Drugs Division, Department of Human Services, February 2009. *Because mental health matters: Victorian mental health reform strategy 2009-2019,* pp. 59-60.

[4] Australian Government Social Inclusion Board. www.socialinclusion.gov.au, accessed 3 November 2010.

[5] Data source: 2009-10 data set, Quarterly Data Collection, Department of Health.

[6] Data source: March 2010 PDRSS Census, Department of Health.

[7] Data source: March 2010 PDRSS Census, Department of Health.

[8] Data source: March 2010 PDRSS Census, Department of Health.

[9] Spink, Janet (2000). *Gender & Psychosocial Rehabilitation: A study of the different perspectives of service users, service providers and policy makers.* Melbourne, VICSERV.

[10] ibid, p. 27.

[11] Data source: March 2010 PDRSS Census, Department of Health.

[12] Data source: March 2010 PDRSS Census, Department of Health.

[13] Department of Health and Ageing (1999). *National Survey of Mental Health and Welling Report 4. People Living with a Psychotic Illness* (p.9).

[14] Data source: March 2010 PDRSS Census, Department of Health.

[15] Shean G (2009). *Evidence-Based Psychosocial Practices and Recovery from Schizophrenia*. Psychiatry 72(4).

[16] Martin, A. (2009). *Preventing diet-related chronic disease in people with severe mental illness: Embedding coordinated care pathways into a local community mental health service.* Project Report: 1st January 2008 - 30th June, 2009. Flinders Human Behaviour and Health Research Unit, Flinders University of South Australia. p.18.

[17] Coghlan R, Lawrence D, Holman CDJ, Jablensky AV (2001). *Duty to Care: Physical illness in people with mental illness*. Perth: The University of Western Australia. p.5.

[18] Mental Health Council of Australia (2004). *Access to Health Services by People with Mental Illness*, accessed from http://www.hreoc.gov.au/disability_rights/health/mhca.doc.

[19] Mental Health and Drugs Division (2009*). Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019.* Melbourne, Department of Human Services. Reform Area 2: Early in Life: p. 106.

[20] Mental Health and Drugs Division (2009*). Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019.* Melbourne, Department of Human Services. Reform Area 2: Early in Life: p. 106.

[21] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p.12.

[22] Weir W. & Rosen A. (1989). Living Skills Centres for People with Serious Psychiatric Disorders. Australian Occupational Therapy Journal, 36, 2.

[23] Ibid.

[24] Ibid

[25] Ibid.

[26] Ibid.

[27] Huxley N, Rendall M, Sederer L, (2000). *Psychosocial Treatments in Schizophrenia: A Review of the Past 20 Years*. The Journal of Nervous and Mental Disease, 188(4):187-201.

[28] Kurtz M, Mueser K (2008). *A Meta-Analysis of Controlled Research on Social Skills Training for Schizophrenia*. Journal of Consulting and Clinical Psychology. Vol. 76, No. 3, 491–504.

[29] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 14.

[30] VICSERV (2006). *Into Community: Day Program past, present and future*; Melbourne, New Paradigm Press.

[31] Department of Health (2003). *Victoria's Mental Health Services Psychiatric Disability Rehabilitation and Support Services Guidelines for Service Delivery*, p. 25.

[32] Department of Health (2003). *Victoria's Mental Health Services Psychiatric Disability Rehabilitation and Support Services Guidelines for Service Delivery*, p. 25.

[33] 2009-10 data set, Quarterly Data Collection, Department of Health; Department of Health Day Program funding allocation according to program type. Modelling assumptions: Number of consumers in Day Program is 6,803 (2009-10 Quarterly Data Collection). Number of Day Program hours delivered is estimated at 474,917 hours for 2009-10. Average hours per consumers are 70 hours for 2009-10.

[34] Data source: March 2010 PDRSS Census, Department of Health.

[35] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 7.

[36] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 40.

[37] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 9-10.

[38] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 21.

[39] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 25.

[40] Australian Government 2010-11 Health and Ageing Portfolio Budget Statements p.319). Accessed at http://www.health.gov.au/internet/budget/publishing.nsf/Content/2010-2011_Health_PBS.

[41] Department of Health (2010). *Paths to Personalisation in Mental Health: a whole system, whole life framework*. London, National Mental Health Development Unit.

[42] Department of Health (2006). *Direct payments to people with mental health problems: a guide to action*. London, National Mental Health Development Unit.

[43] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 20.

[44] Data source: March 2010 PDRSS Census, Department of Health.

[45] Data source: March 2010 PDRSS Census, Department of Health.

[46] Data source: 2009-10 data set, Quarterly Data Collection, Department of Health.

[47] Data source: March 2010 PDRSS Census, Department of Health.

[48] Mental Health and Drugs Division (2009*). Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019.* Melbourne, Department of Human Services. Reform Area 2: Early in Life: p. 106.

[49] Shean G (2009). *Evidence-Based Psychosocial Practices and Recovery from Schizophrenia*. Psychiatry 72(4).

[50] Martin, A. (2009). *Preventing diet-related chronic disease in people with severe mental illness: Embedding coordinated care pathways into a local community mental health service.* Project Report: 1st January 2008 - 30th June, 2009. Flinders Human Behaviour and Health Research Unit, Flinders University of South Australia. p.18.

[51] Coghlan R, Lawrence D, Holman CDJ, Jablensky AV (2001). *Duty to Care: Physical illness in people with mental illness*. Perth: The University of Western Australia. p.5.

[52] Mental Health Council of Australia (2004) *Access to Health Services by People with Mental Illness*, accessed from http://www.hreoc.gov.au/disability_rights/health/mhca.doc.

[53] Mental Health and Drugs Division (2009*). Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019.* Melbourne, Department of Human Services. Reform Area 2: Early in Life: p. 106.

[54] Mental Health and Drugs Division (2009*). Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019.* Melbourne, Department of Human Services. Reform Area 2: Early in Life: p. 106.

[55] MI fellowship, Mind Neami (2010). *Housing needs Survey*. Independent study.

[56] Macpherson Rob, Shepherd Geoff & Edwards Tom (2004). *Supported accommodation for people with severe mental illness: a review.* Advances in Psychiatric Treatment, 10, pp. 180-188.

[57] Tanzman, Beth (1993). *An Overview of Surveys of Mental Health Consumers' Preferences for Housing and Support Services.* Hospital and Community Psychiatry, 44, 5, pp. 450-455.

[58] Chopra, Prem & Herrman, Helen (2010). *The Long-term Outcomes and Unmet Needs of a Cohort of Former Long-Stay Patients in Melbourne*, Australia. Community Mental Health Journal, 8 October, 1-11.

[59] Vandevooren J, Miller L & O'Reilly R (2007). O*utcomes in community-based residential treatment and rehabilitation for people with psychiatric disabilities: A retrospective study.* Psychiatric Rehabilitation Journal, 30, 3, 215-217.

[60] Howat, John (2004). Rehabilitation and continuing care. Chap 26 in Campling, Penelope, Davies, Steffan & Farquarson, Graeme (Eds.), *From Toxic Institutions to Therapeutic Environments: Residential Settings in Mental Health Services*. London, Gaskell; pp.267-277.

[61] Thornicroft, G. & Tansella, M. (2004). *The Components of a Modern Mental Health Service.* British Journal of Psychiatry, 185, 4, 283-290.

[62] Vandevooren J, Miller L & O'Reilly R (2007). Outcomes *in community-based residential treatment and rehabilitation for people with psychiatric disabilities: A retrospective study.* Psychiatric Rehabilitation Journal, 30, 3, 215-217.

[63] Carling, Paul J. (1993). *Housing and Supports for Persons with Mental Illness: Emerging Approaches to Research and Practice.* Hospital and Community Psychiatry, 44, 5, 439-449.

[64] Carling, Paul J. (1995). *Return to Community: Building Support Systems for People with Psychiatric Disabilities.* New York, The Guildford Press.

[65] Ibid.

[66] Ibid.

[67] Gulcur Leyla, Tsemberis Sam, Stefancic Ana & Greenwood Ronni M (2007). *Community Integration of Adults with Psychiatric Disabilities and Histories of Homelessness.* Community Mental Health Journal, 43, 3, pp. 211-228.

[68] Stefancic, Ana & Tsemberis, Sam (2007). *Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: Four-Year Study of Housing Access and Retention*. Journal of Primary Prevention, 28, 3-4, pp. 265-279.

[69] Robson, Belinda (1995). *Can I Call This Home? An evaluation of the Victorian Housing and Support Program for people with psychiatric disabilities*. Melbourne, VICSERV.

[70] Ibid.

[71] Ibid.

[72] O'Brien A, Inglis S & Reynolds A (2002). Effective *Program Linkages: an examination of current knowledge with particular emphasis on people with a mental illness*. Melbourne, Australian Housing Urban Research Institute (AHURI).

[73] Chester, Janice, Fletcher, Meredith & Jones, Rebecca (2005). *Mental illness recovery and place*. Australian e-Journal for the Advancement of Mental Health, 4, 2.

[74] Carter, Meg (2008). *From Psychiatric Hospital to Supported Housing: The Neami Community Housing Program, Melbourne, Australia 1995-2008*. Hawthorn, Institute for Social Research, Swinburne University. Accessed at http://www.sisr.net/publications/0808carter.pdf.

[75] Meehan, Tom, Stedman, Terry & Robertson, Samantha (2007). *The Importance of Housing for People with Serious Mental Illness.* New Paradigm, The Australian Journal on Psychosocial Rehabilitation, September, pp. 54-56.

[76] Department of Health, IRRC Pilot Evaluation Report.

[77] Data source: March 2010 PDRSS Census, Department of Health.

[78] Mental Health and Drugs Division, Department of Human Services, February 2007. *An analysis of the Victorian rehabilitation and recovery care service system for people with severe mental illness and associated disability*, pp 37-39.

[79] Family and Community Development Committee (September 2010). *Inquiry into the Adequacy and Future Directions of Public Housing in Victoria*, p.105.

[80] Family and Community Development Committee (September 2010). *Inquiry into the Adequacy and Future Directions of Public Housing in Victoria*, p.106.

[81] Family and Community Development Committee (September 2010). *Inquiry into the Adequacy and Future Directions of Public Housing in Victoria*, p.113.

[82] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 40.

[83] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 9-10.

[84] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 21.

[85] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 25.

[86] Data source: March 2010 PDRSS Census, Department of Health.

[87] Data source: March 2010 PDRSS Census, Department of Health.

[88] Data source: March 2010 PDRSS Census, Department of Health.

[89] Access Economics (2008). *Staying Connected: A Cost Benefit Analysis of Early Intervention*. Accessed from http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=184.

[90] Mental Health and Drugs Division (2009*). Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019.* Melbourne, Department of Human Services. Reform Area 2: Early in Life: p. 106.

[91] Shean G (2009). *Evidence-Based Psychosocial Practices and Recovery from Schizophrenia*. Psychiatry 72(4).

[92] Martin, A. (2009). *Preventing diet-related chronic disease in people with severe mental illness: Embedding coordinated care pathways into a local community mental health service.* Project Report: 1st January 2008 - 30th June, 2009. Flinders Human Behaviour and Health Research Unit, Flinders University of South Australia. p.18.

[93] Coghlan R, Lawrence D, Holman CDJ, Jablensky AV (2001) *Duty to Care: Physical illness in people with mental illness*. Perth: The University of Western Australia. p. 5.

[94] Mental Health Council of Australia (2004). *Access to Health Services by People with Mental Illness*, accessed from http://www.hreoc.gov.au/disability_rights/health/mhca.doc.

[95] Mental Health and Drugs Division (2009*). Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019.* Melbourne, Department of Human Services. Reform Area 2: Early in Life: p. 106.

[96] Mental Health and Drugs Division (2009*). Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019.* Melbourne, Department of Human Services. Reform Area 2: Early in Life: p. 106.

[97] Killackey Eoin, Jackson Henry J & McGorry, Patrick D (2008). *Vocational intervention in first-episode psychosis: individual placement and support v. treatment as usual.* British Journal of Psychiatry, 193,114-120.

[98] Johnston, Carmel & Thorne, Ivan (2001). *Making a significant change: a rural residential rehabilitation service*, New Paradigm, The Australian Journal on Psychosocial Rehabilitation, Dec, pp. 9-25.

[99] Ibid.

[100] ibid. p. 22.

[101] ibid. p. 23.

[102] Victorian Government Department of Human Services (2010). *Enhanced Accommodation and Support Models for Young People - with an emphasis on participation in employment, education and training. Discussion Paper* - April 2010.

[103] Morton, J, Clark, R, and Pead, J. (1999). *When care is not enough.* Department of Human Services, Victoria.

[104] Birleson P, Vance A. (2008). *Developing the 'youth model' in mental health services.* Australian Psychiatry. 2008 Apr;16(2):136-7.

[105] Data source: March 2010 PDRSS Census, Department of Health.

[106] Mental Health and Drugs Division, Department of Human Services, February 2007. *An analysis of the Victorian rehabilitation and recovery care service system for people with severe mental illness and associated disability*, pp 37-39.

[107] Robyn Hartley (2004) *Young People and Mentoring: towards a national strategy.* Accessed at http://www.youthmentoring.org.au/aust_research.html.

[108] Tierney J, Grossman J. Grossman L and Resch N.(1995) *Making a Difference An Impact Study of Big Brothers/Big Sisters*. Public/Private Ventures, Philadelphia.

[109] DuBois D L, Holloway B E, Valentine J C and Cooper H (2002) *Effectiveness of mentoring programs for youth: A meta-analytic review*. American Journal of Community Psychology, 30(2), 157-197.

[110] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 40.

[111] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 9-10.

[112] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 21.

[113] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 25.

[114] Edwards et al (February 2010). *Young people with health conditions – staying engaged during the senior years of education*, The Royal Children's Hospital Education Institute; Researching Futures, Melbourne. p.7.

[115] University of Wisconsin (December 2002). *Youth to Youth: A review of peer program theoretical underpinnings, forms, functions, and process- and outcome-related findings*, Wisconsin Department of Public Instruction, Madison, Wisconsin, p. 9.

[116] University of Wisconsin (December 2002). *Youth to Youth: A review of peer program theoretical underpinnings, forms, functions, and process- and outcome-related findings*, Wisconsin Department of Public Instruction, Madison, Wisconsin, p. 8.

[117] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 11.

[118] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 11.

[119] Community Services and Health Industry Skills Council (2010), *Mental Health Peer Workforce Competency Development Draft Scoping Report*. Accessed at http://www.mhccact.org.au/cms/media/user_uploads/peer_workforce_consultation/PeerWorkForceScopingReport.pdf.

[120] Lawn, Sharon, Smith Ann & Hueter, Kelly (2008). *Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service. Journal of Mental Health*, 17, 5, pp. 498-508.

[121] Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), *PHaMs Operational Guidelines*. Accessed 15 December 2010 at www.fahcsia.gov.au/sa/mentalhealth/pubs/operational_guidelines/Pages/2recovery.aspx.

[122] Huxley, Peter, King, Sarah, Evans, Sherrill, Davidson, Bill & Beresford, Peter (2006). *No Recovery without Time and Support: Evaluation of the Introduction of Support, Time and Recovery Workers in three pilot sites,* pp. 5-6. Accessed at http://www.recoverydevon.co.uk/download/Support_Time_Recovery/STR_Worker_Pilot_Evaluation_Final_Report.pdf.

[123] Fukui S, Davidson LJ, Holter MC & Rapp CA (2010). Pathways to Recovery (PTR): *Impact of Peer-Led Group Participation on Mental Health Recovery Outcomes.* Psychiatric Rehabilitation Journal, Summer, 34, 1, pp. 42-48.

[124] SANE Australia. (2001). *The Blueprint Guide to Psychosocial Rehabilitation*. SANE Australia, Melbourne.

[125] Deegan, P. (1988). *Best Practice (online)*, http://www.senseinternet.com.au/fintry/bestpractice.htm.

[126] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 19.

[127] KNH Consulting (May 2010). *SWOT Analysis Report: Psychosocial Rehabilitation and Recovery Services Reform and Development Project*, p. 26.

[128] Leff, Julian & Warner, Richard (2006). *The spectrum of work programmes*. Chap 11 in Social Inclusion of People with Mental Illness. Cambridge, Cambridge University Press, pp.125-134.

[129] Bond, Gary R. (2004). Supported employment: Evidence for an evidence-based practice. Psychiatric Rehabilitation Journal, 27, 4, spring, 345-359.

[130] Collister, Laura (2009/10) *Unfinished Business: participation in employment and education.* New Paradigm, The Australian Journal on Psychosocial Rehabilitation, Summer, 28-30.

[131] Killackey Eoin, Jackson Henry J & McGorry, Patrick D (2008). *Vocational intervention in first-episode psychosis: individual placement and support v. treatment as usual.* British Journal of Psychiatry, 193,114-120.

[132] Crosse, Caroline (2004). *The social firm: employment as an integral part of rehabilitation.* New Paradigm, The Australian Journal on Psychosocial Rehabilitation, March, 39-45.

[133] Social Enterprise Coalition (2007). *In work better off: next steps to full employment: Consultation Response*, London. Available at www.socialenterprise.org.uk/data/files/Policy/dwp_consultation_response_oct_07.pdf.

[134] Ennals, Priscilla, Cartwright, Emma, & Rinaudo, Ben (2010). *Supported education: one pathway to social inclusion for people with interrupted educational trajectories*. New Paradigm, The Australian Journal on Psychosocial Rehabilitation, Winter, 12-16.

[135] Murphy A.A., Mullen M. and Spagnolo A. (2005). *Enhancing individual placement and support: Promoting job tenure by integrating natural supports and supported education.* American Journal of Psychiatric Rehabilitation, 8, 37-61.

[136] Unger K, (1990) *Supported postsecondary education for people with mental illness.* American Rehabilitation,16,10-14.

[137] Robson, Emma, Waghorn, Geoff, Sherring, Joanne & Morris, Adrienne (2010). *Preliminary outcomes from an individualised supported education program delivered by a community mental health service.* British Journal of Occupational Therapy, 10, 481-486.

[138] Ibid.

[139] Killackey E., Jackson H.J., and McGorry .D. (2008). *Vocational intervention in first episode psychosis: individual placement and support v. treatment as usual*. The British Journal of Psychiatry,193, 114-120.

[140] Rinaldi M., Smith J., Shepherd G., Singh S., and Craig T., (2010). *First episode psychosis and employment: a review*, International Review of Psychiatry, v 22, 2, 148-162.

[141] Housing and Community Building Division, (2010). *Summary of housing assistance programs 2008–2009*, Department of Human Services. p. 3.

[142] Family and Community Development Committee (September 2010). *Inquiry into the Adequacy and Future Directions of Public Housing in Victoria*, p. 120.

[143] Mental Health and Drugs Division (2009*). Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019.* Melbourne, Department of Human Services. Reform Area 2: Early in Life: p. 31.

[144] Family and Community Development Committee (September 2010). *Inquiry into the Adequacy and Future Directions of Public Housing in Victoria*, p. 105.

[145] Family and Community Development Committee (September 2010). *Inquiry into the Adequacy and Future Directions of Public Housing in Victoria*, p. 106.

[146] Family and Community Development Committee (September 2010). *Inquiry into the Adequacy and Future Directions of Public Housing in Victoria*, p. 113.

[147] Anthony, W. A. (1993). *Recovery from mental illness: The guiding vision of mental health service system in the 1990s.* Psychosocial Rehabilitation Journal, 16 (4), 11-23.

[148] Davidson, Larry (2003). *Living Outside Mental Illness: Qualitative Studies of Recovery in Schizophrenia.* New York, New York University Press.

[149] Ibid.

[150] O'Hagan, Mary (2004). Recovery in New Zealand: Lessons for Australia? Guest Editorial in Australian e-Journal for the Advancement of Mental Health, 3, 1.

[151] Repper, Julie & Perkins, Rachel (2003). *Social Inclusion and Recovery: A Model for Mental Health Practice*. London, Balliere Tindall.

[152] Shepherd, G., Boardman, J. & Slade, M. (2008). *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health.

[153] Oades, Lindsay, Crowe, Trevor & Deane, Frank (2007). *The Collaborative Recovery Model: moving beyond 'us and them' in mental health.* New Paradigm, The Australian Journal on Psychosocial Rehabilitation, June, 32-37.

[154] Oades, L, Deane, F, Crowe, T, Lambert, W G, Kavanagh, D & Lloyd, C (2005). *Collaborative recovery: an integrative model for working with individuals who experience chronic and recurring mental illness*. Australasian Psychiatry, 13 (3), 279-284.

[155] Chopra, P, Hamilton, B, Castle, D, Smith, J, Mileshkin, C, Deans, M, Wynne, B, Prigg, G, Toomey, N & Wilson, M (2009). *Implementation of the Strengths Model at an area mental health service.* Australasian Psychiatry, 17 (3), 202-206.

[156] Hodgson, O., King, R. & Leggatt, M. (2002). *Carers of mentally ill people in Queensland: Their perceived relationships with professional mental health service providers: Report on a survey*. Australian e-Journal for the Advancement of Mental Health 1(3).

[157] Mental Health Council of Australia (2009). *From Adversity to Advocacy: The Lives and Hopes of Mental Health Carers*. Canberra, MHCA.

[158] Mental Health Branch, Metropolitan Health and Aged Care Services Division (2005). Chief Psychiatrist *Guideline: Working together with families and carers*. Melbourne, Victorian Department of Human Services. p.1.

[159] Mental Health and Drugs Division (2008). *Review of the Mental Health Carer Support Program and carer support and resource workers (mental health) - Final Report.* Melbourne, Victorian Department of Human Services.

[160] http://www.bouverie.org.au/programs/mental-health-team/family-sensitive-practive-family-sensitive-training/get-together.

[161] Dixon L, Adams C & Lucksted A (2000). *Update on Family Psychoeducation for Schizophreni*a, Schizophrenia Bulletin, 26 (1), 5 - 20.

[162] McFarlane WR, Link B, Dushay R, Marchal J & Crilly J (1995). Psychoeducational Multiple Family Groups: Four Year Relapse Outcome in Schizophrenia. Family Process, 34, 127-144.

[163] Mihalopoulos C, Magnus A, Carter R and Vos T (2004). *Assessing cost effectiveness in mental health: family interventions for schizophrenia and related conditions.* ANZ Journal of Psychiatry, 38, 511-519.

[164] National Mental Health Development Unit (2009). *The Triangle of Care. Carers Included: A Guide to Best Practice in Acute Mental Health Care*. London, NMHDU.

[165] Data source: March 2010 PDRSS Census, Department of Health.

[166] Data source: March 2010 PDRSS Census, Department of Health.