Reforming community support services for people with a mental illness

Reform framework for Psychiatric Disability Rehabilitation and Support Services
Reforming community support services for people with a mental illness

Reform framework for Psychiatric Disability Rehabilitation and Support Services
Minister’s foreword

Psychiatric Disability Rehabilitation and Support Services (PDRSS) play a critical role in our service system, supporting people with mental illness to live well in the community.

Clients benefit from the expertise and dedication of the PDRSS workforce, but tell us that the system is complicated and difficult to navigate and service quality is variable.

Providers tell us that the program and funding models are rigid and prevents them responding flexibly to the changing needs of clients.

Carers and families tell us that opportunities for them to participate are limited and their needs aren’t always considered. Opportunities for clients to directly influence their own services are also variable.

Reform of PDRSS will change that while maintaining a strong focus on service quality. This document sets out what will be different, and provides an overview of how we’ll get there, particularly in the context of the roll out of DisabilityCare Australia across Victoria by mid 2019.

There will be a greater focus on achieving outcomes that are meaningful to the client, recognising that people may need a range of different supports to achieve improved mental health.

Providers will have the capacity to adapt the service mix over time as those needs and preferences change.

Area based approaches to intake will make it simpler for people to access services and help ensure those with the greatest needs are prioritised.

Area based approaches to planning and a much greater emphasis on service integration will help give clients more streamlined ‘joined up’ services, in line with broader government reforms such as Services Connect.

These reforms align with the broad directions of DisabilityCare Australia. They represent the first step towards that system for the current PDRSS program. They give all involved the chance to adapt to packaged support and an increased focus on accountability for outcomes.

They will provide an environment in which clients, their carers and families can take a much greater role in shaping the services they need. They will allow participating providers opportunities to implement the kind of changes that will be necessary to support the longer term shift to client directed and funded packages within the DisabilityCare system.

Progressing reforms to the PDRSS program now also ensures that clients get the best possible value from the significant investment we make in this sector and that the kinds of supports delivered are effective, efficient and integrated. While efficiency is important, achieving improvement will not be at the cost of service quality.

It is a time of change: in addition to these reforms and similar reforms to state funded alcohol and drug treatment services, opportunities to drive more streamlined service delivery are being progressed through Services Connect and broader community sector reforms. Close linkages will be maintained between these and broader community sector reform.

The reform also signals a change to the name of the program: it will be renamed the Mental Health Community Support Services (MHCSS) program to better describe the type of services to be provided.
Many people and organisations have contributed to the development of these reforms through participation in consultation forums, written submissions, and a range of advisory and reference groups. VICSERV, The Victorian Mental Illness Awareness Council and The Victorian Mental Health Carers Network have been key participants in these activities.

This input has been critical to shaping the reform agenda and ensuring the reforms are both robust and well grounded. I extend my genuine thanks to all involved.

The Hon Mary Wooldridge MP
Minister for Mental Health
Contents

Overview vii

Part A: Taking action – features of a reformed system 1
Introduction 1
Policy context 2
Features of a reformed system 7

Part B: Service delivery framework 12
Building organisation and system capability 14
Remodelling programs and funding streams 18
Streamlining the configuration of the service delivery system 24

Part C: Implementation plan 26
Overview of 2013–14 recommissioning process 26
Appendix 1: Service catchments 32
Appendix 2: Overview of support packages 33
Appendix 3: Overview of key developmental projects and reviews 35
Overview

Helping adults with a psychiatric disability to live independently, maintain the best possible social and emotional wellbeing and live satisfying lives in the community is central to the reform of the Psychiatric Disability Rehabilitation and Support Services (PDRSS) program.

This document describes the changes we want to achieve for people with a severe mental illness and psychiatric disability and their carers and families and how these changes will be achieved. These are summarised in Table 1 below.

Table 1: Changes to the PDRSS program and delivery system and how these changes will be achieved

<table>
<thead>
<tr>
<th>Outcomes we want to achieve</th>
<th>What the system will look like</th>
<th>How we will achieve these changes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>People-focused</strong></td>
<td></td>
<td>Building organisational and system capability</td>
</tr>
<tr>
<td>Best health outcomes for people with severe mental illness and psychiatric disability</td>
<td>Easy-to-access services are prioritised to those most in need</td>
<td>• Good governance and quality assurance</td>
</tr>
<tr>
<td>Minimise long-term disability and improved quality-of-life outcomes</td>
<td>An improved client and carer experience, with greater choice and meaningful involvement in decision making</td>
<td></td>
</tr>
<tr>
<td>People are managing their own mental health better</td>
<td>Support will be more person-centred and self-directed</td>
<td>• Capacity for catchment-based planning and cross-sector coordination and collaboration</td>
</tr>
<tr>
<td>People have the best rehabilitation and recovery support possible, tailored to their individual needs and preferences</td>
<td>An enhanced focus on helping clients achieve improved quality of life in respect to their health, social connectedness and economic participation</td>
<td></td>
</tr>
<tr>
<td><strong>System-focused</strong></td>
<td></td>
<td>Remodelling programs and funding streams</td>
</tr>
<tr>
<td>Mental health community support services that are consistent, high quality and readily accessible</td>
<td>Improved carer and family responsiveness, engagement and support for their caring role</td>
<td>• New catchment-based intake mechanism to streamline access and ensure consistent targeting</td>
</tr>
<tr>
<td>Mental health community support services that are highly productive, cost-effective and sustainable</td>
<td>Improved responsiveness to diversity</td>
<td>• Recovery orientated support package tailored to the needs of the individual</td>
</tr>
<tr>
<td>A joined-up response with clinical mental health, primary healthcare and human services to the needs of people with a psychiatric disability and their families</td>
<td>Services are more responsive and accountable to local need</td>
<td>• Strengthened accountability for achieving client outcomes</td>
</tr>
<tr>
<td></td>
<td>Services are an integrated part of the specialist mental health system and are well coordinated with broader health, human services and other social support services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Services are high quality, underpinned by evidence-based practice and decision making</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The workforce is skilled and capable</td>
<td>Streamlining service system configuration</td>
</tr>
<tr>
<td></td>
<td>Resource use is more sustainable and accountable, with ongoing funding based on performance</td>
<td>• Service delivery arrangements configured on a catchment basis and streamlined delivery arrangements</td>
</tr>
<tr>
<td></td>
<td>High-quality services are underpinned by a commitment to continuous improvement</td>
<td>• More equitable distribution of services across the state</td>
</tr>
</tbody>
</table>
This document is primarily targeted to prospective providers of mental health community support services (MHCSS). It should be noted that for the purposes of this document ‘provider’ refers to any agency or group of agencies that seek to provide such services.

The department will not specify a particular form of structure for such arrangements although interested providers will be required to meet governance and accountability requirements.

The framework will be complemented by a more detailed service specification and information for clients and carers. The service specification will be released early in the first quarter of 2013–14.

**Why reform is needed**

Victoria’s current PDRSS sector is vibrant and has many strengths, including its skilled and dedicated workforce. Change however is needed to adapt to the evolving environment and enhance the program’s effectiveness.

The Victorian Government is taking action to make a real difference to the way people are supported to manage their own mental health and achieve improved quality of life.

The Victorian Government is committed to making it easier for people and referring providers to access mental health community support services. The Victorian Government also want to ensure that people who are most disabled by their mental health condition receive the right support when they need it. This is critical to minimise long-term disability.

Providers need to better tailor support to people’s individual needs and preferences. People with a psychiatric disability should have choices that better respond to their needs and receive consistent, high-quality support of the right intensity and duration.

The government’s emphasis is on delivering outcomes that really matter to people and ensuring they can make informed choices about their support needs and better manage their own mental health.

This involves supporting people to meet their goals in relation to independent living, physical health, personal relationships, housing, education, employment and social connectedness.

Families, carers and significant others can be critical supports for people with a mental illness. They can make a significant difference to a person’s recovery. Service delivery must also engage carers and families in ways that take into account the different roles they may play in the individual’s recovery.

People who require support from a range of services want a more coordinated response. Providers of mental health community support services need to work together and in partnership with clinical services to achieve improved mental health outcomes.

Providers also need to work collaboratively with local primary health, human services and other community services to assist people to access and remain engaged with the full range of services they need.

Victoria’s system must also offer effective, evidence-based mental health support of a consistently high quality that delivers value for money.

These reforms will deliver better outcomes for clients, carers and Victoria’s service system. They will also help prepare everyone in the sector for the future shift to DisabilityCare Australia and its client-directed funding approach.

---

1 There is a need to balance a client’s right to privacy with the needs of significant others involved in the person’s informal day to day support for information essential to this role.
What will be different

People who are most disabled by their mental health condition will receive priority support through MHCSS.

Eligibility will be based on a consistent assessment of an individual’s functional ability to undertake activities of daily living and participate in community life.

Under a reformed system:

- services will be easy to access and navigate
- new clients will receive an initial assessment and supported referral to MHCSS as well as other health, human services and social support services they may need
- clients will work in partnership with their service provider and carer(s) to develop a recovery plan
- clients will receive a support package based on their recovery plan that will help them to:
  - improve their daily living, self-care and social and relationship skills, as appropriate
  - achieve their broader quality-of-life needs regarding physical health, social connectedness, housing, education and employment
  - coordinate access to, and engagement with, the range of health and community services they need.
- carers and families will be actively supported in their caring role.

Providers will receive the majority of core service delivery funding to deliver client-directed individualised support packages.

The Department of Human Services, through Services Connect, will be a core partner in how we do business by streamlining access and strengthening the coordination of care of people who need support from mental health and human services systems.

The move to less rigid programs, supported by simplified flexible funding, will make it easier for providers to innovate and respond to people’s needs and preferences, provide support of the right intensity and duration, and better support families in their caring role.

Providers will be accountable for delivering tangible outcomes that really matter for clients and their families, improving the experience of care and ensuring meaningful participation in decision making. Practice and decision making will be informed by the best available evidence.

How service delivery will be organised

MHCSS will be delivered across 16 service catchments, with between one and four catchments in each Department of Health region.

Catchment maps are provided as an appendix to this document2.

Funded service providers will be responsible for delivering services within a clear geographical catchment(s).

---

2 These catchments have a high level of alignment with the 17 Department of Human Services catchment areas. Minor differences reflect differing relationships between health and human services delivery.
Catchments will be used to organise service delivery and the allocation of resources. **They will not be used to restrict client access and choice in service provider.**

In metropolitan Melbourne, there will be a total of nine catchments. The non-metropolitan area will be divided into a total of seven catchments.

A provider can apply to deliver MHCSS in one or more catchments.

Providers in each catchment area will work collaboratively with one catchment-based intake point and with a common plan which will identify critical services gaps within the catchment.

These structural changes will drive innovation, strengthen accountability, improved service quality and deliver value for money for services users and the Victorian community.

Funded providers will actively plan for, and respond effectively to, the diverse range of people who need support, recognising that social, cultural, economic and environmental factors impact on a person’s experience of mental illness and the prevalence of psychiatric disability.

Particular attention will be placed on the needs of people who face the greatest disadvantage and discrimination.

**How reform will be achieved**

In order to achieve these person-focused objectives we will implement a change program that will:

- streamline current service delivery arrangements and responsibilities on a catchment(s) basis
- remodel existing programs, with the majority of program funding used to deliver flexible, individualised support packages
- increase accountability and transparency, with a more explicit focus on achieving client outcomes
- support the development of a stronger, more capable and more sustainable workforce.

The streamlining of current service delivery arrangements and responsibilities will be undertaken through an open recommissioning process that will commence in mid-2013.

Selected programs (including standard, moderate and intensive home-based outreach support (HBOS), day programs, care coordination, aged intensive and special client packages) will be discontinued as separate funding streams and replaced by individualised client support packages.

The volume of services to be delivered by individual providers will be determined through the 2013–14 recommissioning process. Contracted providers will have a level of service provision that supports cost-effective service provision and gives them the capacity to respond to diversity of client need.

An intake assessment function will be established to create a single entry point in each catchment. All referrals to MHCSS will be through this initial assessment and referral ‘portal’. This function will be undertaken by a MHCSS provider on behalf of other providers in the catchment.
A new area-based planning function will be created to assist MHCSS providers to better understand and respond to population need and plan collaboratively with clinical mental health, primary healthcare and human services.

The reforms described in the framework will require the workforce to conduct its professional activities in new ways and may require new or enhanced skill sets. We will work closely with service providers to prepare the workforce for this change.

These reforms, coupled to an outcome-focused performance management framework, will promote efficient, high-quality and sustainable service delivery.

They are being informed by a range of development projects, including the pilot of intake and assessment models.

More details on how reform will be achieved are provided in Part B (page 12) of this document.

Overview of the main recommissioning process

The process for recommissioning service delivery arrangements will be open to all interested providers, including non-government organisations, public and private providers.

Submitting providers will need to satisfy a range of requirements in areas such as: expertise in high-quality service provision; understanding of roles and responsibilities in a reformed system; capability to work collaboratively in a local delivery environment; client and carer participation; governance and accountability; and operational capability.

The 2013–14 recommissioning program for core service delivery will involve the following phases:

- **Selection of ‘preferred’ providers** through an open process. This process is expected to take up to six months.
- **Determination of service delivery responsibilities.** This process is expected to be completed by the end of the third quarter of 2013–2014.
- **Preparation for transition to new service delivery arrangements.** Service providers will prepare to transition to the new delivery arrangements in the fourth quarter of 2013–2014.

New service delivery arrangements will commence on 1 July 2014. Figure 1 depicts this process.

Selected programs will not be included in the 2013–14 recommissioning process as they are subject to further review processes. These include the mutual support and self-help (MSSH), planned respite, supported accommodation services, adult residential rehabilitation services and Aboriginal mental health support program streams.

PDRSS programs operating in Barwon will also be exempt from this process on the basis that Barwon is a launch site for DisabilityCare Australia.

We will work closely with all service providers, consumer and carer peak bodies and other mechanisms throughout this process to support the smooth transition of clients to new service delivery arrangements.

More details on how reform will be implemented are provided in Part C (page 26) of this document.

The fourth phase will be the next stage of reform that will involve the consolidation of the 2013–14 reform and implementation of the outcomes of the program reviews.

Appendix 2 provides an overview of program reviews and key developmental projects that relate to this phase.
Eligibility

People eligible for state-funded mental health community support services will:

• be 16–64 years of age
• have a disability that is attributable to a psychiatric condition and
• have impairment or impairments that are permanent, or are likely to be permanent\(^3\) and
• impairment or impairments that result in substantially reduced psychosocial functioning in undertaking, one or more of the following activities:
  – communication
  – social interaction
  – learning
  – self-care
  – self-management; and
• The impairment or impairments that affect the person's capacity for social and economic participation.

Priority will be given to people who are most disabled by their psychiatric condition.

MHCSS will not be extended to new clients aged 65 years or older. This is consistent with age eligibility for DisabilityCare Australia.

An overview of the client pathway in a reformed system is described in Figure 2 (page 6). Note that younger people are outside the scope of this system, as child and youth mental health and other services are already designed to meet the specific needs of that age group.

Figure 1: Overview of the 2013–14 recommissioning process and indicative timeline

3 Note: A psychiatric impairment that varies in intensity is also considered permanent if it is likely the person requires ongoing specialist support.
Part A: Taking action – features of a reformed system

Victoria’s reformed mental health community support services system will ensure adults with enduring psychiatric disability receive personalised support that delivers outcomes that really matter to them.

The reform will also ensure that carers and families are better supported in their caring role.

Support will be coordinated with clinical mental health treatment and primary healthcare and with the broader human services system (through Services Connect) to effectively address the health, social and economic impacts of mental illness and psychiatric disability.

The reformed system will offer high-quality, consistent, evidence-based services through a capable and engaged workforce.

The reform will prepare MHCSS providers for the transition to client directed support under Disability Care Australia.

Introduction

Current program overview

Victoria’s state-funded mental health community support services are an integral part of our system of public and private mental health treatment and care. They play an increasingly central role in supporting people with an enduring psychiatric disability on their recovery journey and families in their caring role.

Since the early 1990s the Victorian Government has progressively grown its investment in community mental health services in recognition of the need to address the impact of mental illness on people’s capacity for day-to-day living and the social and economic disadvantage resulting from the illness itself.

The current PDRSS program is delivered through an annual State Government Budget allocation of around $117 million per annum. This constitutes the largest funding input into community mental health support services in Victoria.

These services are currently delivered through 105 community-managed providers, many of whom have a long history in working with, and advocating for, people with a mental illness. In 2012–13, an estimated 12,600 people received support.

Background to the reform

In April 2012 the Victorian Government released a consultation paper to seek stakeholders’ views and input on the government’s proposed directions for the reform and development of the PDRSS program.

The paper was based on analysis of client data and information gathered through consultation with key stakeholders, independent reviews and advice from a sector-based partnership group. It identified the key issues driving the need for reform and proposed a framework to guide a staged program of change.

The proposed framework comprised three key inter-related elements: building organisational and system capability; remodelling programs and funding streams; and streamlining service system configuration around catchment-based responsibilities.
The consultation process involved regional and statewide forums, meetings with peaks and 69 written submissions. It confirmed the readiness of service providers and key stakeholders to embrace reform and take the next steps for effectiveness and sustainability.

The consultation paper and an overview of the key findings of the consultation process are available on the PDRSS reform webpage at <www.health.vic.gov/mentalhealth/pdrss-reform>

Policy context

Improving the mental health of all Victorians and delivering timely, effective treatment and support to those affected by mental illness is a clear priority of the Victorian Government.

The government’s key commitments in this area were outlined in its 2010 election platform, the Coalition Plan for Mental Health, which signalled the need to reinvigorate and rebalance the reform program.

The Coalition Plan for Mental Health has been progressed through an additional $273 million over five years committed from 2011–12 through progressive State Budgets. The Victorian Government currently invests over $1.2 billion in specialist mental health services each year, which includes the MHCSS program.

The soon to be released Victorian Government’s Priorities for Mental Health Reform 2013–2015 details reforms that will drive effective and efficient delivery across public clinical mental health services and mental health community support services. PDRSS reform is an integral element of this overarching reform agenda.

The national mental health policy context has also placed an increasing focus on the role of non-government organisations and non-clinical services in the delivery of mental health services.

National mental health policy includes a focus on supporting people with a mental illness to achieve social and economic participation outcomes through whole-of-government effort and performance management.

We are keen to see Victoria benefit fully from the national mental health reform program. This includes the Council of Australian Governments (COAG) Roadmap for National Mental Health Reform 2012–2022 and additional Commonwealth investment in mental health.

The framework also takes into consideration a number of key reforms, as outlined below.

Introduction of a national disability insurance scheme, DisabilityCare Australia

DisabilityCare Australia is a groundbreaking reform to the way people with a disability, including those with a psychiatric disability, will access the supports they need. A cornerstone of DisabilityCare Australia is client-directed funding.

The Victorian Government is taking a lead role in driving the establishment of DisabilityCare Australia to ensure that eligible people with disability, their families and carers have the lifetime support they need.

The Victorian Government is working with DisabilityCare Australia to support the scheme’s launch in Barwon.

The Victorian Government has committed $2.5 billion per annum to the full rollout of DisabilityCare Australia in Victoria by mid 2019. It is anticipated the majority of MHCSS clients will transition to DisabilityCare Australia as it is rolled out across Victoria.
Preparing for the introduction of DisabilityCare Australia is a key driver for the reform of the current PDRSS program. The move to client-directed, flexible support packages, developed in partnership with clients and their carer(s), is a key step towards client-directed funding as envisaged by DisabilityCare Australia.

The strong focus on helping people and their carers to develop the knowledge and confidence they need to make choices about their support needs will also help people ready themselves for DisabilityCare Australia.

These reforms, combined with action to improve service quality, strengthen accountability for achieving client-directed outcomes and build workforce capability, will position Victoria’s system to respond proactively to the opportunities DisabilityCare Australia will bring.

For more information on these reforms go to: <http://www.disabilitycareaustralia.gov.au/>

Health reform

Key developments in mental health will be guided by Victorian health and wellbeing plans and frameworks such as the Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan and Rural and the Regional Health Plan.

These plans focus on strengthening the integration of mental health within the broader health system and aim to ensure mental and physical health are closely coordinated at both the provider and the individual care levels.

This reform framework aligns with the directions articulated in these plans. The new MHCSS program will have an important role to play in contributing to overall community health and wellbeing.

For more information on these reforms go to: <http://www.health.vic.gov.au/healthplan2022/>

Reform to the Victorian Mental Health Act

Proposed reforms to Victoria’s mental health legislation are highly relevant to all services supporting people living with mental illness.

These reforms will seek to improve consumer experience and outcomes by:

- introducing a supported decision-making model that gives all patients a voice in their assessment, treatment and recovery
- focusing on minimising the duration of compulsory treatment and ensuring that treatment is provided in the least restrictive and least intrusive manner possible
- increasing safeguards to protect patient rights and dignity including establishing a new mental health tribunal and a mental health complaints commissioner.

Although primarily concerned with individuals requiring compulsory treatment, the new legislation and the practice and culture changes being promoted as part of its implementation will be important for all mental health service providers. MHCSS will need to be familiar with the provisions of the new legislation as they apply to consumers they work with and the services they deliver.

MHCSS will support many people on community treatment orders as well as those who may require compulsory inpatient treatment. These services are an integral part of care planning for people on treatment orders, even though primary responsibility for this lies with area mental health services.
MHCSS will be expected to continue to work closely with clinical services in these cases and to be alert to the particular issues that might arise for clients as a result of current or prior compulsory treatment.

A number of proposed elements of the new legislation designed to promote supported decision making and working in partnership with consumers, carers and families – including advance statements and nominated persons – will also be particularly relevant to MHCSS as part of their longer term care and support for consumers.

Up-to-date information about the legislative proposals can be found at <www.health.vic.gov.au/mentalhealth/mhactreform>

Reforms to Victoria’s human services
Through Services Connect – the new model for integrated services for vulnerable people – the Victorian Government is changing the way human services are delivered to achieve a more coordinated, person-centred response no matter how complex a person’s needs.

The basis of this reform agenda lies in improving the coordination of human services, taking a holistic approach to the needs of individuals and families, and streamlining client pathways. Psychosocial rehabilitation services are within scope in Services Connect lead sites which have been operating since early 2012. The on-the-ground experience of these locations will provide insight into how to achieve greater integration between PDRSS and state funded human services at a broader scale.

The PDRSS reform framework facilitates linkages with this system reform by: streamlining client pathways to an integrated set of functions; strengthening the coordination of care for people who need support from both systems; and promoting cross-sector collaboration, service coordination and planning to achieve a more joined-up response to the needs of shared clients.

For more information on these reforms go to <http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/services-connect>

Reform of the community services system sector
To achieve a genuinely integrated human services system, which is the goal of Services Connect, it is essential for government and non-government providers to work together. The relationship between government and the human services sector is crucial in this regard.

In response to this imperative, the Victorian Government, led by the Department of Human Services, has joined with the Victorian Council of Social Services (VCOSS) and independent project leader Professor Peter Shergold to run a consultation process on how the community-based human service system in Victoria can be reformed to be more effective, accessible and sustainable.

Key themes being addressed include how the community services can deliver greater support to people who are most vulnerable; respond to rising expectations and cost pressures; and work more collaboratively together. This process is designed to run in parallel with existing sector or program-specific reforms.

The PDRSS reform strongly aligns with many of the directions contained in the interim paper on community services system reform. The PDRSS reform will provide a ‘live’ opportunity to translate many of these into the Victorian service delivery context.
**Strengthening our response to vulnerable children**

Another vital government priority in which mental health is being strongly incorporated is the strategy for vulnerable children and families developed in response to the *Protecting Victoria’s Vulnerable Children Inquiry*.

An explicit focus of the PDRSS reform is to strengthen the role of mental health community support services in identifying dependent children and ensuring that parents with a psychiatric disability are better supported in their parenting role.

Arrangements for MHCSS will enable these services to form part of local networks established under that strategy.


**Reforms to the alcohol and other drug treatment (AOD) system**

The Victorian Government is reforming the state funded alcohol and drug treatment system in parallel with PDRSS reform. AOD reform will deliver more consistent, high-quality and coordinated treatment services for Victorians with substance misuse problems.

Given the complex links between mental illness and substance misuse, improved collaboration and service coordination will be required between providers of mental health community support and alcohol and drug treatment services.

For more information on these reforms go to <http://www.health.vic.gov.au/aod/sectorreform.htm>

**Commonwealth investment in mental health support services**

The Commonwealth Government has progressively invested in community mental health programs across the nation, such as Personal Helpers and Mentors, Mental Health Respite, Support for Day to Day Living in the Community and more recently Partners in Recovery. Many of these services are delivered by providers currently funded to provide PDRSS.

The reformed MHCSS sector will seek to ensure Victorian Government effort is complementary and the continuum of support available to adult Victorians with a psychiatric disability is strengthened.
Figure 2: An overview of the client pathway in a reformed system

How will I experience a mental health community support service

Access and identify

Access to services
- Easy to find and access
- Initial need identified and assessed
- Improved service at first contact
- Appropriate, meaningful referral
- Engagement while waiting for mental health support service (if required)

Assess and plan

Comprehensive needs assessment and Recovery Plan developed
- Person – centered assessment
- One record for each person
- Brief screening for significant others in their caring role
- Level and intensity of support identified based on need
- Recovery plan developed with the person and their family

Service response

Provision of service to help the person improve their quality of life
- Individualised support
- Focus on improving daily living skills, capacity for mental health self – management and social connectedness
- Support to access health and human services required

I have an urgent need
I will immediately be put in touch with an emergency service

I have a psychiatric disability
I will be put in touch with a mental health community support service

I do not have a psychiatric disability but I have other support needs
I will be put in touch with someone who can assist me e.g. through Services Connect

Comprehensive needs assessment and Recovery Plan developed
I have discussed my needs and aspirations
I have discussed my needs and aspirations in partnership with a mental health professional
I have directed decisions related to my needs
My carers/family have been actively involved in the assessment of my needs

I receive individualised support based on my needs
I work in partnership with my key worker who provides support and helps me coordinate access to other health and human services I need
I work with my key worker to monitor my needs and adjust the support I need if my needs change
My carers/family are supported in their caring role

I do not need support anymore but I know I can re-engage if I need to
Features of a reformed system

The reformed system will have the following 10 features.

1. **Easy to access services and a focus on those most in need**

   **What will be different**
   Mental health community support services will be easier to find and access as entry points and referral pathways are simplified.

   The right services will be provided to the right people, with priority given to those who are most disabled by their mental health condition.

   At the same time, there will also be options for people who only want or need a shorter-term intervention with a strong focus on self-management.

   **How this will be achieved**
   Access will be streamlined through the introduction of a new catchment-based community intake assessment mechanism and standardised processes.

   Providers will be required to accept all referrals via this mechanism, which will replace intake assessment undertaken at the provider level.

   Anyone can make a referral to MHCSS via this entry point including a person with a psychiatric disability, a carer, family member and significant other, as well as health and community services.

   The capacity for service providers to support new clients will also be improved through the use of consistent discharge criteria. This will reduce long-term dependency when this is not in the best interests of the client.

2. **Client-directed and person-centred support with a focus on improving health, social connectedness and economic participation**

   **What will be different**
   Clients will receive an individually tailored service response designed according to, and directed by, their preferences and changing needs.

   Services will be provided in a way that respects the decision-making capacity of the client.

   In line with this, clients will be actively involved in the planning, coordination and decision making related to their support. Support will focus on achieving quality of life outcomes that are meaningful to them. Clients will be able to better manage their own mental health.

   Clients will be able to make informed choices about their mental health and other support needs and be active partners with their service provider in ensuring their needs are met.

   Clients will access and remain engaged with the range of other health, human services and social support services they need.

   **How this will be achieved**
   The majority of available program funding will be collapsed into one program stream to create individualised client support packages. This will give service providers the flexibility they need to respond to the needs and aspirations of individual clients.
Every aspect of service provision – including initial intake, comprehensive needs assessment, the development of an individually tailored recovery plan and delivery of the support package – will be client-directed and focused.

As part of a person’s individual recovery plan, service providers will help them to improve their daily living skills and achieve improved quality of life with respect to physical health (including substance misuse), relationships, social connectedness, housing, education and employment.

Service providers will also routinely offer evidence-based self-management programs to support people to better cope with, and manage, their mental illness.

Service providers will actively support and promote attitudes and cultures within their workforce that promote and support person-centred and client-directed practice. This will require leadership and workforce development to ensure workers have the skills, competency and culture to deliver person-centred services.

3 Family-inclusive support

What will be different

Carers and family members will be an integral part of support, recognising the important role carers and family can play in an individual’s recovery.

Carer and family support needs will be identified. People will be provided with information and advice, as well as supported referral, to support them in their caring role.

How this will be achieved

All service providers will adopt a family-inclusive approach, ensuring their workforce has the skills and competency to work in a family-inclusive manner.

Service providers will be required to undertake a brief assessment to identify the needs of carers in their caring role, and provide relevant information and advice, as well as supported referral, as appropriate.

Service providers will also identify dependent children and any existing or emerging risk, and facilitate appropriate referral, as well as provide opportunities for clients to tailor their individual recovery plan to be inclusive of their role as a parent.

4 Responsive to client diversity

What will be different

Service providers will be responsive to the diverse characteristics and needs of people with a psychiatric disability.

Meeting the needs of these groups will be seen as core business of MHCSS providers and not an ‘add-on’ component.

Priority attention will be given to cohorts of people who face the greatest vulnerability.

How this will be achieved

The needs of these groups will be identified through catchment-based planning and cross-sector collaboration. Population subgroups will be reflected in provider-level service targets and be informed by demand modelling.
Service providers will develop effective partnerships with a range of providers and community groups, such as Aboriginal community-controlled health organisations, homelessness providers and refugee organisations and communities, to ensure people requiring MHCSS are identified and supported.

Service providers will also ensure practice and service culture is responsive to the diverse needs of these and other identified groups.

5 Community-focused and accountable to local needs

What will be different
Service providers will be accountable and responsive to the needs of a defined local community, and transparent in their achievement of client outcomes and targets.

How this will be achieved
A catchment-level plan will be developed in partnership with key health and human services, and will identify the needs of people with a psychiatric disability living in the service catchment.

Service providers will be accountable for responding to the needs of their local community through targets and other performance measures that are informed by the plan.

6 Integrated part of the specialist mental health and broader health and community service systems

What will be different
An individual’s support will complement their clinical treatment and continuity of care will be improved for clients as they move between mental health community support services and other health and community services.

How this will be achieved
Providers of MHCSS will be required to work collaboratively with area mental health services and key health and human services in their service delivery catchment to support effective service coordination and clearly defined referral pathways.

The Services Connect model aims to provide a much simpler and more effective way of connecting across mental health and human services. The Victorian Government is continuing and expanding testing of Services Connect in a range of sites across the state in 2013–14. A major focus will be on how MHCSS providers and human services providers in these sites can work in an integrated way, so that the lessons from these sites can be applied on a broader scale.

The Victorian Government will work with the Commonwealth Government and funded providers of mental health support services to reduce duplication of effort and strengthen the continuum of care for clients.

Communication, coordination and continuity of care will be further supported by ensuring client information can be easily transferred across services.
7  Sustainability through efficiency and effectiveness

What will be different
Service delivery arrangements will be structured in ways that deliver acceptable standards of quality and higher levels of access to those most in need, and maximises the efficient and effective use of current government investment.

How this will be achieved
Service delivery will be streamlined on a catchment basis. Catchments will be used for planning and resource distribution – they will not restrict client access and choice in service provider.

Service delivery will be underpinned by a funding model that supports sustainability and gives providers the flexibility to organise service delivery to ensure the best possible outcomes for clients. Providers will have the scale of service provision needed to deliver services efficiently within acceptable standards of quality.

8  High-quality evidence-based services

What will be different
The quality of MHCSS will be consistent from program to program, provider to provider, and catchment to catchment.

Provider-level planning and service design and delivery will be informed by clients’ and carers’ knowledge and understanding of what works well and what can be improved.

How this will be achieved
Service providers will meet clearly defined service standards to ensure consistency of quality.

Service design, practice and decision making will be based on the best available evidence and informed by client and carer experience.

Service providers will have governance structures and processes that support client and carer participation in provider-level policy, strategy and service design.

9  Highly skilled and capable workforce

What will be different
The workforce will have the skills and competencies to support clients, including those with high-level psychiatric disability and multiple and complex needs.

New or enhanced workforce skill sets will deliver new functions and approaches, such as evidence-based models of care, client-directed decision making and family-inclusive practice.

How this will be achieved
As part of the government’s workforce development strategy, we will work with providers to:

- develop a competency framework, setting out the optimal attitudes, values and skills of the MHCSS workforce
- better respond to the needs of high-need clients
- strengthen practice governance
- build a workforce that is trauma-informed, family-sensitive, culturally responsive and adopts a person-centred and family-inclusive approach.
10 Strengthened accountability and transparency for achieving client outcomes

What will be different
Service providers will be accountable for achieving outcomes that are meaningful to clients, carers, family members and significant others.

How this will be achieved
A new outcomes focused performance management framework will be implemented and monitored by the Department of Health. This framework will be developed with input from consumers, carers and funded service providers.

Ongoing funding will be linked to an assessment of the service providers’ performance by measuring client outcomes, processes or key outputs that are known to relate to positive client outcomes as well as achievement of targets.
Part B: Service delivery framework

Achieving reform will involve remodelling existing programs, introducing new functions and streamlining current service delivery arrangements and responsibilities on a catchment basis. A key change will be the move to recovery-oriented individualised support packages and a single entry point in each service catchment.

Achieving reform will involve action across the following interrelated areas.

1. **Building organisational and system capability** – a stronger, more sustainable system of catchment-based service providers delivering high-quality, well-governed, efficient and effective services.

2. **Remodelling programs and funding streams** – streamlined and flexible programs/functions and funding models to deliver person-centred, individualised support.

3. **Streamlining the configuration of the service delivery system** – high-quality providers delivering a flexible set of services on a catchment basis to acceptable standards of access, quality and efficiency.

This section details the specific actions that will be undertaken under each of these ‘building blocks’ for change, with a summary provided as Table 2.

**Table 2: A summary of the service system improvements under each reform building block**

<table>
<thead>
<tr>
<th>Building block for change</th>
<th>Intended service system improvements</th>
</tr>
</thead>
</table>
| Building organisational and system capability         | Strengthened organisational capability to provide good governance and quality assurance, including complaint mechanisms.  
New or enhanced capacity to:  
• undertake **catchment-based service planning** to better identify and respond to population need  
• strengthen cross-sector collaboration to achieve a more joined-up response to clients.  
Greater accountability and transparency for achieving client outcomes through a **new performance management framework**.  
Service delivery underpinned by **evidence-based practice** and strengthened practice governance.  
A **sustainable workforce** with the skills, competency, knowledge, values and attitudes to deliver high-quality, person-centred, family-inclusive and culturally safe services.  
Improved monitoring of and accountability for client outcomes through **better client information management systems**. |
<table>
<thead>
<tr>
<th>Building block for change</th>
<th>Intended service system improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remodelling programs and funding streams</td>
<td>A new catchment based intake assessment function to facilitate consistent and more streamlined service access. Streamlined, flexible programs and funding models to make it easier for service providers to innovate and respond with agility to the changing needs of clients, with the majority of funding used to deliver individual client support packages. Remodelling and refocused bed-based services to produce optimal outcomes for clients, ensure alignment with best practice and better connect clients to local health and community services to support their smooth transition to independent living. Strengthened accountability and transparency for achieving service benchmarks and targets and delivering client-directed mental health, social connectedness, physical health, employment and education outcomes across all programs. A collaborative, coordinated response with clinical mental health treatment services and local primary healthcare, human services and other social support services for people who need support from multiple service systems.</td>
</tr>
<tr>
<td>Streamlining the configuration of the service delivery system</td>
<td>Catchment-based delivery structures with streamlined delivery responsibilities to: • minimise overlap in service responsibilities in a given catchment • improve overall service access and continuity of care for clients and their carers • deliver acceptable standards of quality, efficiency and sustainability • maximise the efficient and effective use of current government and other investment. Services more equitably distributed across the state.</td>
</tr>
</tbody>
</table>
1. Building organisation and system capability

The reconfiguration of service delivery arrangements and responsibilities will provide structural reform to support efficient, sustainable delivery.

Funded providers will be required to actively involve clients and carers in their decision-making structures and processes to ensure their views inform strategy, planning and service design at the provider level.

They will also be required to work collaboratively with key services that have a shared responsibility for people with a psychiatric disability, such as specialist clinical mental health, primary healthcare, child, youth and family services, employment, housing and homelessness services.

Governance and accountability

Providers need to demonstrate how their structures, capability, planning and decision-making processes and related policies and practices, will ensure safe, appropriate service delivery. This will include areas such as risk management, client privacy and complaint management processes.

Submitting providers will also be required to show how they facilitate client and carer participation in service planning and design, program evaluation and research activities where appropriate.

Funding model and pricing

The delivery of MHCSS will be underpinned by a new funding model, which will be largely activity-based. The new funding model will enable flexibility in the development and delivery of individual recovery plans, enabling providers to package support for clients according to the totality of their support needs.

This represents a step towards the DisabilityCare model in that it will provide flexibility in service delivery while providing certainty to the provider sector during the coming transition.

The Department of Health will stipulate the prices for each program/function in the service specification for the recommissioning process.

The pricing for each program and function will take into account the total efficient cost of service provision (direct costs, fixed costs and overheads) to ensure sustainability of service delivery. The new funding model for recommissioned services will come into effect on 1 July 2014.

Pricing is not negotiable. The department will not invite competition on price through the recommissioning process.

The expected funding model for each program and function to be tendered through the 2013–14 recommissioning process is detailed in Table 3.

Table 3: Funding model for selected MHCSS programs and functions

<table>
<thead>
<tr>
<th>Program/function</th>
<th>Funding model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individualised client support packages</td>
<td>Activity-based (hour of support)</td>
</tr>
<tr>
<td>Youth residential rehabilitation</td>
<td>Bed day rate</td>
</tr>
<tr>
<td>Community intake assessment function (maximum one function per catchment)</td>
<td>Block funded</td>
</tr>
<tr>
<td>Catchment-based planning function (0.5 FTE per catchment)</td>
<td>Block funded</td>
</tr>
</tbody>
</table>
New functions

The reform aims to ensure more consistent access to MHCSS across the state and well planned services. This will be achieved by investing in new catchment-based planning and intake assessment functions.

Catchment-based planning

The new area-based planning function will better equip all MHCSS providers operating in a given catchment to understand and respond to population need. This new planning capacity will also assist MHCSS providers to work collaboratively with clinical mental health, primary healthcare and human services to identify and address cross-sector issues.

All funded MHCSS providers in a given catchment will be required to actively participate in the development of the catchment-wide plan.

This catchment plan will identify critical service gaps and pressures and strategies to improve responsiveness to client and community need and population diversity, including vulnerable population groups.

This analysis will be linked to an increased understanding of met and unmet demand.

Each plan will provide the basis for improved service coordination and, by doing this, achieve a more joined-up approach to the needs of individual clients.

Service enhancement

Other service enhancements will also be implemented to improve service quality, consistency and accountability.

This will include:

- improved consistency in access and targeting through:
  - standardisation of comprehensive assessment processes
  - standardisation of exit/discharge criteria.
- improved service quality and consistency through:
  - systematic use of evidence-based service models and practice
  - stronger focus on building the individual’s capacity for self-management and the skills and confidence needed to be actively involved in decisions related to their support
  - development and systematic use of risk management frameworks to better identify and manage risk.

Service enhancements will be supported by a comprehensive workforce development program.

---

4 Note: The Department of Health will set requirements for these functions and processes in service delivery guidelines.
New performance management framework

As part of the implementation of the reform program there will be clear standards, quality assurance framework(s) and reporting requirements set by the department.

A new performance management framework will measure individual client outcomes and those processes that are central to safety, quality and positive client experience.

The framework will:

- drive improved outcomes for clients, carers and their families
- hold funded providers accountable to achieving these outcomes and quality standards through the efficient and effective use of government funding
- set out the accountability and reporting requirements for funded providers, including how performance will be measured and monitored and the relationship with the department in doing this
- facilitate organisational learning to support continuous improvement by providing a practical, strategic tool that service providers can use to monitor and improve the quality of their service provision.

Key performance measures (including client-focused outcome measures) will be identified for the ‘performance domains’ of: effectiveness, efficiency, quality, safety, accessibility, responsiveness and service continuity.

The new performance management framework will come into effect on 1 July 2014.

Workforce development

The use of evidence-based models of care and new approaches and functions may require the workforce to conduct its professional activities in new ways and may require new or enhanced skill sets.

Service providers will have a lead role in identifying the training and development needs of their workforce and responding to these needs.

The Victorian Government, in consultation with key stakeholders, is developing a workforce development framework for the specialist mental health workforce.

This framework provides a comprehensive platform for the ongoing development of the MHCSS workforce in Victoria, including consumers and carers employed in MHCSS in a variety of roles.

As part of this framework, the government will develop a workforce competency framework in consultation with service providers and key stakeholders.

This will articulate the necessary skills, knowledge, and attitudes needed to deliver high-quality services to clients and their families. It will also inform role design and team structures, staff recruitment and learning and professional development.
Over the coming years workforce development activity to support implementation of key aspects of the reform will include:

• the identification, development and delivery of:
  – learning and professional development programs to support the systemic use of evidence-based recovery models that deliver proven outcomes for clients and their carers/families
  – tailored learning and professional development programs to improve the capability, capacity and confidence of the workforce to work with clients with complex needs including those who have experienced trauma and people with a range of complex needs
  – support for the systematic implementation of comprehensive risk management systems, processes and practices (this will involve skill development for managers, supervisors and direct delivery staff).

• investment in leadership development, particularly at a middle management level.

Client information system requirements

A consistent and effective approach to collecting, sharing and reporting client and service delivery data will be important to support the new service delivery arrangements.

Under the new arrangements, providers will require the ability to collect client, service provision and outcome measurement data to support case management, coordination of care, service planning and performance monitoring and improvement.

The department will not prescribe specific information technology (IT) solutions but will describe what capabilities providers should have.

These capabilities may be met through existing provider IT systems, planned enhancements to these systems and/or supplementary collection tools.

Further details of the minimum information and system capabilities required will be described in the service specification. All funded providers will be required to work with the department over the next two to three years as longer term integrated information reporting and feedback solutions are developed.

In developing this aspect of the specification, opportunities to align with other related collections and systems (such as those associated with Services Connect) are being explored.
2. Remodelling programs and funding streams

A key feature of the reform will be the move to individualised client support packages. Over two-thirds of available program funding will be provided to providers to deliver these support packages by collapsing standard, moderate and intensive home-based outreach support (HBOS), day program, care coordination, aged intensive program and specialist client packages into one funding stream.

These funding streams will subsequently cease as discrete programs on 1 July 2014.

The remodelling of existing programs and funding streams will:

- enable providers to ensure clients receive the right intensity and duration of service they need
- enable clients to better exercise choice about their support in partnership with services
- give service providers the capacity and capability to be more responsive to people with increasingly complex conditions, particularly those who have high-level disability and high-risk behaviours, and who may require intensive support over an extended period
- respond effectively to clients who require increased resources due to, for example, distance and those who may be more time intensive to engage, such as people experiencing long-term or repeated homelessness, Aboriginal people and refugees.

To achieve this we need to change the way service delivery is currently organised. This includes structuring functions on a statewide, area and local basis.

Stratification of delivery functions

As depicted in Figure 3, services will be structured as follows.

**Statewide services**, which will include peak bodies and specialist support services with a statewide focus, such as:

- VICSERV
- the Victorian Mental Illness Awareness Council
- the Victorian Mental Health Carers Network
- statewide specialist support services such as Forensicare, Spectrum and the Victorian Dual Disability Service\(^5\)
- statewide information, support and referral services.\(^6\)

**Catchment-level functions** comprising:

- a new area-based community intake assessment function (this function will be delivered on a single or multi-catchment basis, depending on factors such as population size and distribution)
- a dedicated catchment-based planning function
- youth residential rehabilitation (YRR)
- adult residential rehabilitation and supported accommodation services\(^7\).

---

\(^5\) These services have or will be provided with additional capacity to extend their focus to MHCSS providers.

\(^6\) A number of providers, including some currently funded through the MSSH program, provide an information, support and referral function. Future directions for this function on a statewide basis will be informed by the review of MSSH and other relevant programs.

\(^7\) Please note these programs will not be included in the 2013–14 recommissioning process as they are subject to further review. Providers of these services however will be required to accept out-of-area referrals.
Core local service delivery functions will comprise a core set of services and activities that are responsive to the needs and preferences of clients and their carers/families. The delivery of these services will form the basis of an individualised support package.

Figure 3: The structure of MHCSS programs and functions

Service providers of both community and bed-based services will be required to:

- use standardised exit criteria/processes and follow-up processes
- work collaboratively with the client and their carer/family (as appropriate) to develop, deliver and monitor the client’s recovery plan (this includes identifying vulnerable children)
- provide a service response of the right type, intensity and duration based on the client’s assessed needs – providers will structure service delivery in such a way as to be able to scale up or down service intensity dependent on the needs of the individual
- link the client’s carers/family members – with appropriate support services in the community
- use evidence-based models and practices
- maintain a strong, collaborative partnership with public and private clinical mental health services to ensure continuity of care for clients and optimise mental health outcomes
- work collaboratively with local primary healthcare, human services and other key community services to support the client to achieve their goals in respect to physical health, housing, social connectedness and economic participation.
Community intake assessment function

Providers funded to deliver MHCSS will be required to accept all referrals via the intake assessment function, which will replace intake assessment undertaken by individual providers. This approach will improve consistency of targeting, prioritisation of need and management of demand.

People who may ‘walk into’ a MHCS service will be supported by providers to access the community intake assessment function.

This new function will also:
- standardise intake, assessment and referral processes and practice across the state
- support the delivery of more person-centred and individualised support through the initial intake assessment
- improve continuity of care
- better manage access to bed-based rehabilitation and supported accommodation services at the catchment level by coordinating access to these services (including out-of-area referrals)
- better support referral to and from primary healthcare, human services and other social support services.

This function is currently being piloted. Any subsequent refinements to the service model will be informed by the evaluation of the pilot.

The provider of this function in each catchment will be identified through the recommissioning process.

The intake assessment function will be:
- delivered as a core partnership (at a minimum) between a MHCSS provider on behalf of MHCSS providers in the catchment, an area mental health service(s) and primary health service(s)
- largely telephone-based delivery that will operate Monday to Friday during standard business hours
- required to use standardised eligibility criteria, tools and processes to:
  - assess and determine eligibility for MHCSS and priority of need
  - identify intensity and type of psychosocial support required
  - identify risk factors relevant to providing a safe and appropriate service response
  - provide supported referral to a MHCSS provider and local health, human services and other community services as required.
- designed to support people who require MHCSS but may need to wait for service availability and facilitate engagement during this period by providing a structured program to assist people to develop better coping and self-management skills.
**Individualised client support packages**

As part of this support, providers will focus on helping people to develop the knowledge and confidence to make choices about their support needs.

The provision of a support package involves delivering the following functions, as a minimum:

- comprehensive assessment of client need
- a brief assessment of carer/family need
- development of a client-directed recovery plan
- monitoring and review of this plan at regular intervals in partnership with the client and carer/family
- direct client support (based on the person’s recovery plan), focusing on building the individual’s daily living skills and their skills and confidence for self-care and self-management
- indirect client support including case conferencing, cross-sector planning and collaboration and service coordination to support clients to access local health, human services and other social support services
- activity related to planned discharge.

*Please refer to Appendix 2 for more information on support packages.*

The key outputs and functions delivered as part of an individualised support package are described in Figure 4.

**Figure 4: The key inputs into and functions delivered as part of an individualised client support package**
Carer support function

Consistent with a family-inclusive approach, carers and family members of clients of MHCSS will be eligible for targeted support.

Providers, as part of their core service delivery, will be required to:

- engage carer/family in the development and review of the client's recovery plan
- undertake a brief carer/family needs assessment process
- provide information and advice regarding their caring role and associated challenges, including information on mental illness, how to identify early warning signs and provide positive responses in challenging circumstances
- provide supported referral to a range of relevant support services in the local community that can assist with the needs of the carer/family member.

Funded providers will also be required to facilitate carer participation at the organisational level by engaging carers in service planning and design, program evaluation and research activities.

Responding to the needs of vulnerable children whose parent has a psychiatric disability

Strengthening the role of MHCSS providers to identify and respond to the emotional wellbeing and safety of dependent children who have a parent with psychiatric disability is an explicit focus of the reform agenda.

As part of the whole-of-person needs assessment and review process, providers will engage clients and their carers/family in an ongoing discussion regarding any concerns they may have for the mental health and wellbeing of their dependent children, and provide supported referral to human services and other relevant services.

Bed-based services

Access to all bed-based services will be through the catchment-based intake assessment function.

Youth residential rehabilitation program

The bed-based Youth Residential Rehabilitation (YRR) program will be retained and re-tendered against a new specification, funding model and accountability arrangements, as part of the 2013–14 recommissioning process.

YRR will primarily be a resource for the catchment within which it is located. The service model will be refocused into a goal-oriented 12-month program delivered in collaboration with the young person, their family and relevant community services.

YRR providers will be required to work in close collaboration with health (including clinical mental health, drug and alcohol treatment services and primary healthcare providers) and education, employment and social services (such as housing, youth homelessness and youth justice services) to actively achieve client-directed health, social and economic goals.

YRR providers will be required to ensure staff are dual-diagnosis competent, have skills and competencies in family-inclusive practice and are able to work collaboratively with a range of local partners.
Adult residential rehabilitation services and supported accommodation services

Adult residential rehabilitation services and supported accommodation services will not be included in the 2013–14 recommissioning process because further consideration of the way in which the MHCSS program should support longer term residential services for adults is required.

Change in these programs will require a longer timeframe, with a plan of action being developed in 2014.

In the interim, it is important that adult residential rehabilitation and supported accommodation services benefit from the reform agenda and prepare for future change. To this end, the Victorian Government will ask current providers to work in the new statewide framework.

This will see residential services accessed through the catchment-based community intake assessment function with arrangements for ‘out of area’ referrals. It also includes an expectation that providers will collaborate with clinical mental health, primary healthcare and social support services to actively achieve client-directed outcomes consistent with client recovery plans.

Mutual support and self-help and planned respite

The Victorian Government is undertaking a review of Mutual Support and Self-Help (MSSH) and planned respite programs and other carer support funding to identify strategic directions for providing consumer and carer support services.

This review will take into account Commonwealth investment in similar services. As this review is not anticipated to be completed until late 2013, MSSH and planned respite will not be included in the 2013–14 recommissioning process.

In the interim, as part of the delivery of a client’s individualised support package, funded providers will deliver a core set of carer/family-related functions including: information and advice; supported referral; advocacy; and active engagement of carers/family in the development, implementation and review of the client’s recovery plan.

Aboriginal mental health support services

Aboriginal mental health support services are being reviewed to identify how best to improve social and emotional wellbeing outcomes for Aboriginal people, their families and their communities.

This analysis will be undertaken in consultation with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), the Victorian Aboriginal Health Service, Aboriginal community-controlled organisations, the specialist mental health service system and other relevant stakeholders.

In the interim, all MHCSS providers will be required to actively engage and support Aboriginal people with a mental illness and psychiatric disability as part of their core, ongoing business.

This includes developing and maintaining clear referral pathways with Aboriginal community-controlled health services and other relevant community groups and delivering services in a culturally safe and appropriate manner.
3. Streamlining the configuration of the service delivery system

Current service delivery arrangements will be reconfigured on a catchment basis and service delivery responsibilities streamlined. Funded providers in each catchment area will be required to work in partnership, with one intake point and a common catchment-based plan.

The reconfiguration and streamlining of service delivery arrangements and responsibilities will be achieved through an open and transparent recommissioning process as described in Part C (page 26) of this document.

The Department of Health will directly contract with providers funded to deliver MHCSS.

Guiding principles for catchment-based service reconfiguration

The Victorian Government’s decisions for a reformed delivery of MHCSS will be guided by the following principles.

Auspice/service delivery arrangements

Service delivery arrangements in a given catchment must be efficient and effective, with overlap of responsibilities or duplication of effort minimised.

Diversity in service providers

MHCSS will continue to be auspiced through a range of provider types.

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

Catchment-based self-sufficiency and consistency

Catchment-based functions will be delivered by one or more providers in a catchment to achieve optimal service efficiency, streamlined access, and promote workforce sustainability along with strengthened accountability and improved service quality.

Providers will be funded at a level that optimises efficiencies, enables provision of a full range of core functions and achieves sustainable services.

While consideration may be given to proposals that prioritise service provision to a specific client cohort, submitting providers will need to provide a strong business case including evidence of demand and how such a focus will operate as part of the provider’s overall MHCSS delivery capacity.

Service delivery catchments

The new service delivery structures and responsibilities will be delivered on a catchment basis.

It will make it easier for clients to navigate services and guide planning, resource distribution and local service coordination.

Catchments will not be used to restrict client access and choice in service provider. While it is anticipated most clients will prefer a provider close to where they live, people will be able to choose a provider in another catchment if this is more convenient/or appropriate for them.

The catchment boundaries for the MHCSS program align as far as possible with broader health catchments to facilitate joint local area planning and support coordinated responses to people who need a combination of services.
Alignment of MHCSS catchments in this manner will facilitate improved collaboration, planning and service coordination between mental health community support services, clinical mental health services, primary healthcare and human services.

These catchments will also help reduce system fragmentation and duplication of effort across state and Commonwealth-funded mental health support programs.

**Equitable distribution of services**

The service specification will indicate the total funding available for each catchment.

The distribution has been informed by analysis of the adult (aged 16–64 years) population within each of the 16 catchments and a range of other factors to reduce current inequities in the distribution of services.

Under this distribution the total funding available for service delivery in each Department of Health region will be maintained or increased.

Service volumes for individual providers in each catchment will be determined through the 2013–14 recommissioning process.

Over time, future funding at the catchment level may be varied on the basis of demand modelling and analysis.
Part C: Implementation plan

Reforming the way mental health community support services are delivered will be achieved through a staged program of change.

Some of these changes, such as the recommissioning of core service delivery arrangements and responsibilities, will be undertaken in the immediate term; others will require sustained effort by funded service providers and government over the longer term.

Overview of 2013–14 main recommissioning process

The recommissioning of core service delivery arrangements and responsibilities will be undertaken through an open recommissioning process.

Programs in scope

Interested providers will be invited to submit to deliver the following programs and functions through the 2013–14 recommissioning process:

- individualised client support packages (which replace standard, moderate and intensive home-based outreach support (HBOS), day program, care coordination, aged intensive program and special client packages program streams)
- Youth Residential Rehabilitation services
- A small set of catchment based functions to be delivered through a provider in each catchment:
  - community intake assessment function
  - area-based planning function.

Figure 5 provides an overview of programs in scope of the 2013–14 recommissioning process and how they will be remodelled.

Programs out of scope

The following programs are out of scope of the 2013-14 recommissioning process:

- Adult residential rehabilitation
- Supported accommodation services
- Mutual Support and Self Help
- Planned respite
- Aboriginal mental health support services.
- Service provider eligibility

The process for recommissioning service delivery arrangements will be open to all interested providers including non-government organisations, private and public providers operating in Victoria and providers based interstate.

Interested providers will be required to demonstrate they are able to meet the requirements specified in the service specification.
Figure 5: The program streams in scope of the 2013–14 recommissioning process and how they will be remodelled through this process

Existing program streams

- Standard, moderate and intensive HBOS
- Day program (structured and unstructured)
- Care coordination
- Aged intensive
- Special client packages
- Youth residential rehabilitation

New program streams – 1 July 2014

- Catchment-based intake assessment function
- Individualised support packages
- Area-based planning function
- Youth residential rehabilitation (re-tendered on a revised model and accountabilities)
- Future directions/reform subject to outcomes of separate review processes

Please note the department reserves the right to change all timeframes and processes associated with the recommissioning process. The following information should be treated as a guide only.

Figure 6 summarises the phases of the 2013–14 recommissioning process and indicative timeframe.

**Phase 1: Selection of ‘preferred’ providers**

**Stage 1: Call for submissions**

Written submissions from eligible and interested providers will be invited through an advertised call for submission process. The Advertised Call for Submission document, which includes the service specification, is anticipated to be released early in first quarter of 2013–2014, with a submission period of eight weeks.

**Stage 2: Lodgement of submissions**

Interested providers lodge their written submission, which details their proposal to deliver activities in accordance with the requirements of the service specification. Interested providers will also indicate the service volume they would like to provide in each catchment for which they seek to deliver services.

Lodgement will close in October 2013.

Interested providers will be required to lodge their submission by the date and time specified. Submitting providers will be advised via email that their submission has been received.

All submissions received after the specified closing date and time will be deemed as non-complying and will not be evaluated. Providers that submit incomplete submissions will also be deemed as non-compliant and will not be evaluated. Submitting providers will be advised of this outcome as applicable.
Providers interested in delivering MHCSS in more than one catchment will only be required to submit one submission. The submission proforma will make provision for this circumstance.

The department will, however, address submissions for delivery in each catchment separately. Interested providers may elect to submit multiple submissions if they prefer.

**Stage 3: Evaluation of submissions**

All submissions will be evaluated against weighted selection criteria. Short-listed providers will be identified through this process. Short-listed providers will be interviewed over October–November 2013.

Evaluation panels will be convened to assess the submissions. The panels will interview all short-listed providers on a catchment-by-catchment basis and identify recommended ‘preferred’ providers for each catchment, proposed functions to be delivered by each ‘preferred’ provider and indicative service volumes.

This recommendation will be considered by an overarching coordination panel, which will make final recommendations to the Minister for Mental Health.

‘Preferred’ providers identified through this process will be offered a without-prejudice service offer.

Please note the coordinating panel may recommend to the Minister for Mental Health that Phase 2 of the process be used to identify the final provider group in circumstances where the field is highly competitive in a given catchment.

All submitting providers will be notified of the outcomes of this process in late December 2013.

*Please note: The Department of Health reserves the right to supplement the field if in the judgement of the department there are limited suitable applicants in a given catchment(s).*

**Phase 2: Determination of service delivery responsibilities**

As part of Phase 2 ‘preferred’ providers will be invited to submit a delivery plan based on a without-prejudice service offer by the department.

During this phase the programs and functions, targets, service volumes and related funding will be determined for each ‘preferred’ provider, drawing on an assessment of the delivery plan.

The delivery plans will also be used to confirm/finalise how ‘preferred’ providers will manage the transition process (if relevant) to new service delivery arrangements and new delivery model(s) and functions and how they will address any particular concerns of the evaluation panel based on feedback provided.

As indicated previously, where the ‘preferred provider’ group is over prescribed in a given catchment at the commencement of Phase 2, the delivery plan will be used to identify the final recommended providers for consideration by the Minister for Mental Health.

Service delivery arrangements in each catchment will be recommended to the Minister for Mental Health. Both successful and unsuccessful providers will be notified of the Minister’s decision.

This process is expected to be completed by the end of the third quarter of 2013–2014.
Phase 3: Transition to new service delivery arrangements and responsibilities

Successful service providers will transition to the new delivery arrangements in the fourth quarter of 2013–14.

During the transition period time, all contractual arrangements related to new service delivery responsibilities will be finalised.

New contractual service delivery arrangements will take effect on 1 July 2014.

Please note existing providers that are unsuccessful will be responsible for any potential costs that may occur as a result of any changes to their service delivery responsibilities under MHCSS.

Existing and new service providers will be required to work collaboratively to achieve a smooth, planned transfer of responsibilities and clients during the transition to any new service delivery arrangements.

It is particularly important that all providers involved in the transition process actively support existing clients and carers throughout this process to minimise disruption as much as possible.

The department will work closely with all relevant providers, consumer and carer peak bodies and VICSERV as well as other stakeholders throughout this process to achieve the smoothest transition possible.

Phase 4: Consolidation of new arrangements and next stage of reform

The department will work with successful providers to consolidate new service delivery arrangements, introduce new performance management accountabilities and reporting processes, build workforce capability and refine the intake assessment function.

As part of the next stage of reform, outcomes of program reviews will be implemented. This will occur during 2014–15.

Overview of service specification requirements and criteria

Please note this information has been provided as a guide only. The department reserves the right to change any aspect of these requirements and associated criteria. The final requirements and criteria will be stipulated in the service specification.

The service specification to be released in the first quarter of 2013–14 for the recommissioning of service delivery responsibilities will set out a range of explicit requirements. It will also specify:

- available funds in each catchment
- the unit price offer for each program/function
- criteria against which all providers will be evaluated.

The service specification, as a minimum, will specify provider requirements in regard to the following.

- **Expertise in high-quality service provision.** Submitting providers will be required to demonstrate they have the capacity and expertise to effectively deliver mental health or similar support to adults with a mental illness and psychiatric disability.

- **Roles and responsibilities in a reformed system.** Submitting providers will be required to demonstrate how their proposal will achieve desired reform outcomes at the client, provider and system levels.
- **Capability to work collaboratively in a local delivery environment.** Submitting providers will be required to demonstrate understanding of local catchment-level needs and the delivery environment in which they are seeking to deliver MHCSS. They will also need to demonstrate they have the capability to work collaboratively with other mental health community support services, clinical services, primary healthcare and key human services.

- **Client and carer participation.** Submitting providers will be required to demonstrate their commitment to meaningful engagement of clients and carers in service planning, design and evaluation and in day-to-day service delivery and that they have effective approaches and strategies to achieve this.

- **Governance and accountability.** Submitting providers will be required to demonstrate how they will:
  - deliver effective high quality services including compliance with relevant accreditation and quality requirements
  - create value through innovation, development and exploration using strategic and business planning capability
  - comply with relevant legislative requirements and manage risk.

Arrangements involving a grouping of two or more agencies will need to explain their financial, legal and decision making structures.

Submitting providers will be required to provide their strategic plan and demonstrate how the provision of MHCSS aligns with their strategic directions and priorities.

- **Operational capability.** Submitting providers will be required to demonstrate they have the organisational capability required to support the efficient and effective provision of MHCSS in a range of areas including:
  - financial management capacity
  - human resource management and workforce development
  - quality and performance management and reporting
  - information management and reporting
  - incident reporting
  - client and carer complaint management.

Other areas that may be covered relate to government policy including:

- environmental sustainability
- occupational health and safety.

**Legal entity**

Providers interested in delivering MHCSS must be/have a legal entity that the department can fund under a service agreement/contract.

Submitting providers must provide evidence of their legal status, including their Australian Business Number (ABN).
**PHASE 1**  
First–second quarter 2013–14  
Selection of catchment-based ‘preferred’ providers  
- Release of service specifications  
- Submission period open for 8 weeks  
- Providers submit written proposals  
- Submissions assessed against evaluation criteria  
- Short-listed providers interviewed  
- ‘Preferred’ providers identified and recommended to the Minister for Mental Health

**PHASE 2**  
Second-third quarter 2013–14  
Determination of service delivery responsibilities  
- ‘Preferred’ providers invited to submit a high-level delivery plan based on without prejudice service ‘offer’  
- Providers and service delivery responsibilities for each catchment recommended to the Minister for Mental Health

**PHASE 3**  
Third-fourth quarter 2013–14  
Transition to new service delivery arrangements  
- Transmission to the new service delivery arrangements over a minimum 3 month period  
- New contractual arrangements entered into with new providers  
- New service delivery arrangements commence on 1 July 2014.

**PHASE 4**  
July 2014 onwards  
Consolidation and implementation of the next stage of reform  
- Consolidation of reform with focus on new functions and responsibilities; performance management requirements and workforce development  
- Implementation of outcomes of the program reviews related to MSSH, Planned Respite, Aboriginal mental health support services and adult bed based services (SAS and ARR)
Appendix 1: Service catchments

Psychiatric Disability Rehabilitation and Support Services catchments – metropolitan Melbourne

<table>
<thead>
<tr>
<th>Catchment</th>
<th>16-64 years population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Metropolitan</td>
<td>274,299</td>
</tr>
<tr>
<td>Inner East Melbourne</td>
<td>408,381</td>
</tr>
<tr>
<td>Northern and Western Metropolitan</td>
<td>329,709</td>
</tr>
<tr>
<td>Inner North Melbourne</td>
<td>331,444</td>
</tr>
<tr>
<td>North Melbourne</td>
<td>380,585</td>
</tr>
<tr>
<td>South Western Melbourne</td>
<td>173,051</td>
</tr>
<tr>
<td>Southern Metropolitan</td>
<td>397,893</td>
</tr>
<tr>
<td>Bayside</td>
<td></td>
</tr>
<tr>
<td>Frankston - Mornington Peninsula</td>
<td>175,205</td>
</tr>
<tr>
<td>South-Eastern Melbourne</td>
<td>319,718</td>
</tr>
</tbody>
</table>

Psychiatric Disability Rehabilitation and Support Services catchments – regional Victoria

<table>
<thead>
<tr>
<th>Catchment</th>
<th>16-64 years population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barwon South-West</td>
<td>168,691</td>
</tr>
<tr>
<td>Barwon</td>
<td>62,783</td>
</tr>
<tr>
<td>Great South Coast</td>
<td>160,275</td>
</tr>
<tr>
<td>Grampians</td>
<td>141,743</td>
</tr>
<tr>
<td>Hume</td>
<td>92,194</td>
</tr>
<tr>
<td>Loddon Mallee</td>
<td>73,719</td>
</tr>
<tr>
<td>Loddon Mallee</td>
<td>191,660</td>
</tr>
</tbody>
</table>
Appendix 2: Overview of support packages

Comprehensive assessment
On referral of clients through the area-based intake function, the MHCSS provider\(^8\) will undertake a more comprehensive needs assessment, drawing on the findings of the intake assessment. This will inform the development of a client’s recovery plan.

The assessment process may occur over a period of time and will identify the individual’s support needs in respect to: capability for self-management; daily living skills; social skills; parenting skills; housing needs; carer/family and other relationship support needs; and what the client wants to achieve in respect to physical health (including drug and alcohol problems as relevant), relationships, housing, social connectedness, education and employment.

The comprehensive assessment will inform the development of the client recovery plan.

Individual recovery plan development, monitoring and review
All clients of MHCSS will have a recovery plan.

The recovery plan will include key domains of:
• mental health self-care and self-management
• daily living skills
• physical health
• housing
• relationships
• social connectedness
• education, vocational training and employment
• parenting and carer/family support needs.

The intensity and duration of support provided to an individual will be based on this assessment and subsequent reviews, which must be undertaken in partnership with the client and (where appropriate) their carer(s), family or significant others.

Delivery of a support package
The person’s recovery plan will directly inform the type and intensity of support a client will receive as part of their individualised support package. The delivery of the package will involve both direct and indirect client support.

A core component of the individualised support package will be the provision of direct support to assist clients to develop day-to-day living skills, improve their capacity for self-management and social and relationship skills.

This support may be delivered on an individual basis or a group basis (depending on the individual’s preferences, best practice evidence and the nature of the support itself).

---

\(^8\) Providers funded to deliver individualised support packages will be required to accept all referrals via the community intake assessment function, which will replace intake assessment undertaken at the provider level. Client preference will determine which provider they are referred to wherever possible.
The coordination of care will be an embedded function in delivering an individualised support package. This function will be prioritised to people who require a coordinated response across numerous services due to high-level disability and their capacity for self-management.

Other functions that form part of the individualised support package include:

- supported referral to assist the client to access and engage with local health, human services and social support services they need
- structured, evidence-based self-management programs
- information and advice
- individual advocacy
- liaison and coordination with mental health treatment and other key services to facilitate a joined-up response to the person’s needs (this includes facilitation of, or participation in, case conferencing with the client)
- carer and family support to assist them in their carer role – this includes a brief assessment to identify their needs (including those of dependent children), advice and information, and supported referral to appropriate services
- activity related to planned discharge, including when a client moves to another MHCSS provider and from a bed-based service.

Admission to a bed-based residential rehabilitation service will form part of the client’s individualised support package. Service providers are expected to work together to ensure an integrated individual recovery plan is developed, in situations where the provider of the MHCSS-funded bed-based service is not the client’s ongoing MHCSS provider.

For continuity of care, service providers will organise service delivery in such a way as to ensure clients receive their direct support through a consistent lead worker, wherever possible.

**Short-term self-management function**

The self-management function will enable MHCSS providers to support a larger number of people who may only require short-term support while providing a more structured entry process for those requiring a longer term intervention. In this sense, this activity may function as an ‘early intervention’ in psychiatric disability response.

The aim of this function is to support people to develop the skills, capability and confidence they need to better self-manage their mental illness in collaboration with service providers, carers and others.

This function can be delivered on a group basis or individually and should cover areas such as: plans and approaches to cope with daily stress triggers; skills to identify and manage early warning signs; strategies for responding to an episode of illness; and identifying social supports.

Service providers will be required to offer this function to all new and existing clients as appropriate, using an evidence-based model.
Appendix 3:

Please check the PDRSS reform webpage for regular updates on these projects as they progress: www.health.vic.gov.au/mentalhealth/pdrss-reform

Table 1: Overview of key developmental projects

<table>
<thead>
<tr>
<th>Developmental projects</th>
<th>Description</th>
<th>Indicative timeframe</th>
</tr>
</thead>
</table>
| Community intake assessment pilot and evaluation | The pilot involves developing and trialling a catchment-based intake assessment function across five sites.  
The pilot will explore how to: streamline access to MHCSS; achieve consistency in targeting and prioritisation of need; standardise intake assessment and referral processes and practice; improve continuity of care for people with a severe mental illness, their carers and families and referring services; and better support referral to and from primary healthcare, human services and other social support services.  
The findings of the evaluation of the pilot will inform the refinement of this function in the lead up to its full implementation in 2014–15. | The five pilot sites commenced in June 2013 and will conclude on 30 June 2014. |
| Development of a performance management framework | The department will develop a robust outcome-focused performance management framework to:  
• drive intended outcomes for clients, carers and their families in line with program objectives  
• hold funded providers accountable for achieving these outcomes through efficiently and effectively using government funding  
• clearly define service deliverables, requirements and quality standards  
• support organisational learning and continuous quality improvement by using data to inform and drive results.  
The framework will link to provider standards and accreditation requirements and will also detail key outputs, client and program outcomes and processes that are known to relate to improved outcomes as well as measurement tools, reporting and information technology requirements. The performance framework will come into effect from 1 July 2014. | The performance management framework will be completed in the first half of 2014. |
| Development of a workforce competency framework | A workforce competency framework that will articulate the necessary skills, knowledge, values and attitudes needed to deliver high-quality services to clients and their families will be developed. It will also inform role design and team structures, staff recruitment, learning and professional development.                                                                 | The workforce competency framework will be completed in the first half of 2014. |
The department is undertaking an integrated review of state-funded mental health consumer and carer support and participation initiatives, which includes the MSSH and planned respite programs. The review will provide advice on how Victorian Government investment in a range of specific programs might more effectively support consumers and their carers and strengthen consumer and carer participation in policy and service development. This will involve a focus on recognised best practice in designing and managing consumer and carer programs. It is anticipated the review will be completed in 2013.

The review will identify how best to improve psychosocial outcomes for Aboriginal people aged 16–64 years with social and emotional health issues, their families and communities through the strategic use of this investment. This will take into account key interdependencies such as the requirement of MHCSS providers to prioritise the needs of Aboriginal people as part of core business. The review will be undertaken in collaboration with the Victorian Aboriginal Community Controlled Health Organisation and funded Aboriginal providers. It is anticipated the review will be completed by mid 2014.

The review will consider how, and to what extent, the Victorian Government should continue to invest in adult bed-based residential models, taking into account analysis of demand. This review will commence in 2014.