

Deloitte Access Economics

Final Report: Mental Health Consumer and Carer program review

Department of Health,
Victoria

19 May 2014

Executive summary

Introduction

The Victorian Government is strongly committed to consumer and carer participation, peer support, and recognition and support for carers and families in Victoria's mental health system.

To further improve effort in this area, the Victorian Government commissioned an integrated, independent review of a range of state-funded mental health consumer support, carer support, and consumer, carer and family participation programs and activities.

This review provides advice on how current Victorian Government investment might more effectively support consumers, their carers and families, and strengthen consumer, carer and family participation in mental health services.

The review was established with the following objectives:

- identify what service elements and what modes of delivery are most valued by consumers and their carers/families;
- examine the extent to which current state funded mental health consumer and carer programs/activities align with or contribute to Victoria's policy directions and priorities and deliver outcomes identified by consumers and carers;
- examine how contemporary best practice and evidence should inform investment, including opportunity for innovative approaches involving use of information technology;
- identify the role of the Victorian Government in delivering these functions, taking into account key policy drivers, including Psychiatric Disability Rehabilitation and Support Services (PDRSS) reform and the National Disability Insurance Scheme (NDIS), and current and future Commonwealth investment; and
- provide options for more effective and efficient organisation of Victorian Government investment and delivery to meet agreed consumer and client outcomes and government policy directions.

Methodology

Scope

The following programs and activities are within scope of the review:

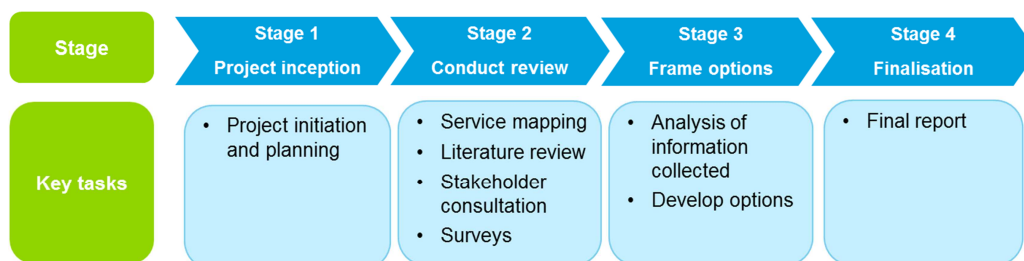
- Consumer Consultant Program, and similar positions, in Area Mental Health Services e.g. in Child and Adolescent Area Mental Health Services (CAMHS), Child and Youth Mental Health Services (CYMHS), Adult and Aged services;
- Mutual Support Self-Help (MSSH) PDRSS Program;
- other state-funded mental health activity with a clear focus on peer support in clinical or PDRS services;
- Carer Consultant Program, and similar positions, in Area Mental Health Services (CAMHS/CYMHS, Adult, Aged);
- Carer Support , including Carer Resource Workers co-located in Commonwealth Carer Respite Centres (PDRSS Program);

- Planned Respite (PDRSS Program); and
- the Carer Support Fund (CSF).

Process

The review comprised four stages:

Figure i: Review stages



A Project Reference Group (PRG) was convened to provide input at key stages of the project and to provide comment on the findings. The PRG membership is listed in **Error! Reference source not found.**

The stakeholder consultation was designed to ensure a broad range of stakeholder input through focus groups, forums, interviews and three surveys. This comprised approximately:

- 10 focus groups attended by 85 consumers and carers
- 16 forums attended by approximately 175 stakeholders
- 17 interviews attended by approximately 35 stakeholders
- Survey of consumers and carers which obtained 403 complete responses
- Survey of workforce which obtained 152 complete responses
- Survey of providers which obtained 156 complete responses.

Policy context

The Victorian policy environment for the provision of mental health services is complex and is influenced by both national and state mental health policy and wider health, human services, alcohol and drugs policy. Relevant Victorian policies include:

- *Victoria's priorities for mental health reform 2013-15;*
- *the Mental Health Act 2014;*
- PDRSS reform and recommissioning as mental health community support services (MHCSS);
- Victoria's consumer and carer participation policy; and
- *Victoria's Framework for Recovery-Oriented Practice.*

Influential national mental health policies discussed in Chapter **Error! Reference source not found.** include:

- *The Roadmap for national mental health reform 2012-2022 (the Roadmap);*
- *The Fourth National Mental Health Plan (the Plan);* and
- *The National Standards for Mental Health Services (the Standards), 2010.*

This review is also occurring during the trial phase of the NDIS. The NDIS is currently being trialled in a number of areas around Australia, and represents a fundamental shift in funding and service delivery arrangements for individuals experiencing a disability, including a psychiatric disability.

Priorities for mental health reform

Victoria's priorities for mental health reform 2013-2015 (DH 2013) identify the need to target a wider range of people and conditions and consistently deliver the right services to the right people at the right time. It makes a case for offering intervention where most benefit can be achieved through shifting focus from a crisis-oriented approach to place a greater emphasis on earlier intervention and community-based care.

Legislative reform

A contemporary legislative framework for mental health services, the *Mental Health Act 2014* (the Act), commences on 1 July 2014. The Act incorporates policy directions provided by Victorian and national consumer and carer policy especially through its strong emphasis on the implementation of a recovery-oriented framework within mental health services. The new Act will require that the points of view, preferences and decisions regarding treatment for consumers and their carer(s), families and significant others, are recognised by mental health services at critical junctures.

PDRSS recommissioning

The program of services that has until recently been known as PDRSS is being recommissioned and renamed as MHCSS. The target commencement date for the new funding and service delivery arrangements is 1 August 2014.

The importance of the function of self-management is reflected in the requirement that MHCSS deliver structured, evidence-based self-management programs to improve capacity for self-management and self-care of (people's) mental illness and psychiatric disability.

As part of the reform a recommissioning process for the delivery of MHCSS, appointed providers will be expected to deliver individualised support packages. Additionally as part of their core service delivery, **carers and family members** of clients of MHCSS may receive various forms of support.

Literature and jurisdictional scan

An exploratory literature scan identified considerable research on consumer and carer support, involvement, advocacy, respite and participation in mental health service and care. A large proportion of this literature focuses on reporting surveys, qualitative studies, and first person accounts. While these studies are valuable in reporting individual perspectives, they are limited in their ability to attribute measurable outcomes.

Further, it is difficult to attribute outcomes to particular functions within support models, because studies and programs vary so significantly in terms of the combination of functions, settings and target groups. However for mutual support and self-help, the reduction in hospitalisations including the reduced use of emergency and crisis care was a commonly reported outcome.

Despite uncertainty in measurable outcomes achieved, there is a consistent message that these types of services are valued by consumers, carers and families. They are commonly identified as making an important contribution to recovery focused care.

One of the purposes of the literature scan was to identify best practice service models. While there is a paucity of evidence regarding best practice, there are clear themes regarding barriers and enablers to effective models of mutual support and self-help, consumer participation and advocacy and respite. Barriers can include:

- role conflict i.e. transitioning from consumer to provider, and difficulties separating mental health issues from work-related issues;
- role ambiguity including unclear role boundaries ; and
- lack of commitment by service providers, planners and professional staff.

The jurisdictional scan had similar findings to the literature scan regarding outcomes, functions delivered and challenges – particularly regarding issues confronting the workforce relating to role boundaries, definition and support. Governance and funding structures were generally not clearly defined across jurisdictions and while the importance of addressing the needs of diverse population groups was often referred to in policy documents there was little evidence to show how this was actually occurring.

The jurisdictional scan identified innovative models that appear to be effective and aligned with Victoria’s priorities. These include:

- **use of technology and creative processes** (music, art, dance, poetry) to engage people from diverse population groups;
- **flexible funding** that recognises non-traditional peer-support approaches which may occur in more informal settings to engage diverse population groups;
- **appropriate management, supervision, support and training** of peer support workers to ensure they have the appropriate skills to deliver programs and are at a stage in their recovery journey where they feel comfortable to do so;
- **peer support delivered in acute settings**, for instance through the Queensland and NSW models;
- **role clarity** for workers and other staff in the service in which consumer and carers are employed so everyone understands the scope of their work and activities;
- **functions delivered through a variety of provider settings** ranging from traditional mental health services to consumer and carer led organisations, including grass-roots organisations; and
- **consumer-led organisations** that may focus on non-health services such as housing and employment or conducting evaluations of programs.

Findings – current programs and services

Value

There are important and significant benefits to individuals and the community more broadly flowing from consumer and carer led support and participation in mental health.

All of the functions appear highly valued and if delivered in a timely, responsive and high quality manner, have the potential to contribute to a more easily navigable, carer and consumer responsive mental health system, which supports consumer and carer social inclusion and economic participation.

There is a high value placed on easy to locate and understand information about available services and support. A major theme throughout the findings of the review relates to the need to improve both service information and navigation.

Service models

A desktop based mapping of existing service provision in Victoria identified the following issues.

- The suite of in-scope programs have largely evolved in response to needs identified over time. However this has occurred in a fragmented manner, without a consistent framing policy or rationale.
- There are gaps in service provision on a geographic basis, with some areas appearing to be well served while others lack a physical presence (e.g. MSSH in Grampians and Loddon Mallee).
- There is a lack of clarity regarding eligibility criteria for the Victorian Government funded services or the method for prioritising access based on need. Such considerations, to the extent they exist, appear to be based on managing access to available resources – which are often available on a part time basis or in other ways limited – rather than being driven by actual need; and
- There appears to be some overlap between Victorian funded and Commonwealth funded services. However this observation needs to be balanced by the uncertainty regarding the scope and reach of Commonwealth services, and the clear presence of unmet need for such services across many parts of the community.

Overall, it is clear that a number of service models are currently not well implemented. However, this may reflect in part a lack of structure around the service model, rather than an issue with the service model concept itself. This is clear for example both with the consumer and carer consultant program and the CSF. Further, the current funding arrangements under MSSH, and the resulting distribution of peer support services, indicate that the funding model could be enhanced to enable more equitable distribution of these services across Victoria, including extending reach to diverse population groups. There is also scope to improve the adequacy of current models of non-clinical support for consumers. Better articulation of models of support is an area that many of the programs could address.

The extent to which services should be embedded or provided by discrete or 'stand alone' services was considered. Overall, embedding of services offering consumer and carer support and participation, particularly consumer and carer consultant roles, within existing mental health service structures is preferable to these services being provided by stand alone organisations. Programs are better placed to influence service culture when they are embedded within services.

An organisational culture which supported consumer and carer participation was important for consumer and carer led mental health programs to be effective. If roles supporting consumer and carer participation are not embedded within organisations they run the risk of being tokenistic.

Addressing gaps

Specific service gaps identified that could be addressed include, but are not limited to:

- provision of consumer peer support in clinical (including in-patient) settings via volunteers or paid employees with time demarcated to peer support from other functions such as service participation and/or advocacy – this may also assist in establishing a more recovery oriented culture in clinical settings;
- dedicated funding for carer peer support in clinical settings;
- improved access to peer support for consumers and carers in some regional areas and consideration of how best to provide this kind of support for people from CALD, Indigenous, and GLBTI communities;

- more systematic supervision, guidance and training for consumer and carer consultants supporting by appropriate standards;
- access to consistent training, support and supervision for peer workers and the development of standards to support this; and
- access to flexible respite that meets consumer and carer need.

Consultation findings indicate individual advocacy is a current gap in support available to consumer and carers. It should be noted that individual advocacy to compulsory patients (as per the Act, they are consumers who are not on an Assessment Order, a Court Assessment Order, a Temporary Treatment Order or a Treatment Order) will be available under the new Act.

Organising of investment

In considering how investment in these functions should be organised, it is imperative that the following issues be addressed.

- system navigability and information provision, particularly for carers;
- more effectively engaging consumers and carers in service participation;
- ease of access to information and support provided via peer support;
- ease of access to carer support, including more appropriate application of brokerage funding; and
- more meaningful and flexible use of planned respite for both consumers and carers.

In considering how investment in services is organised, there is a need to ensure that services can better deliver against their intended outcomes, and these outcomes are able to be measured.

Measuring performance

The DH funds the programs being reviewed, including the consumer and carer consultant program and the MSSH program. The extent of current reporting extends to outputs from program service provision. However, the programs lack a performance framework which articulates the outcomes they are intended to achieve. There is therefore a lack of systematic outcome measurement and monitoring and an inability to assess the effectiveness of consumer and carer led support and participation as a suite of service provision.

Responding to diversity

The existing models of service provision are not able to respond to diversity in a structured or systematic manner. Meeting the needs of people of diverse backgrounds is ad-hoc and variable. While there are isolated examples of services being responsive, at a system level, the services require a model that enables diversity and which is achievable in terms of resourcing.

A number of issues arose through the consultation need to be considered in terms of how to better tailor these programs to respond to diversity in the community:

- obtaining accessible and language appropriate information about mental illness, knowledge of the support that is available to carers, cultural beliefs and potential stigma relating to mental illness can present barrier to carers from CALD backgrounds engaging with the programs;
- Aboriginal and Torres Strait Islanders conceptualise mental health differently to mainstream services, and mental health issues are attended to as part of social and emotional wellbeing services, provided through Aboriginal Community Controlled Health Organisations (ACCHOs);

- while technology might provide an opportunity to better reach people in rural and regional areas, many of the older consumers and carers in these areas may not have the technical skills or sufficiently capable IT hardware or software to enable this to occur effectively, although improved use of technology needs to be part of the service mix, it is not a solution to all service gaps caused by isolation or distance; and
- while some MSSH providers reported running GBLTI specific groups, it was noted that this would not always be possible or suitable in areas, due to individuals wanting to keep their sexuality confidential. Technology which could link GBLTI people from a range of geographic regions may be one option for delivering tailored peer support to these groups.

Support for carers

There is a lack of effective centralised or coordinated support for carers and no systematic assessment of carer need, though carer assessment is expected to be a feature of the reformed MHCSS program. Carers need to be better connected with information and support services while interacting with the mental health system.

Findings – future direction

Policy framework

A coherent policy framework for consumer and carer led support and participation is required, encompassing governance, accountability, outcomes and funding streams, recognising:

- there is a need to better measure performance and outcomes on an ongoing basis; and
- there is a need to more clearly align funding streams with both policy and service objectives.

Noting that the programs and services under review have not previously been conceived as a suite of programs that is integrated with the mental health system, the positioning of these functions relative to the wider system requires consideration, particularly given:

- clear policy drivers for service integration as described in Victoria's priorities for mental health reform;
- the imperative to place consumers and carers at the centre of mental health service provision, as participants within organisations providing mental health treatment and support; and
- the critical role of consumers and carers with lived experience in realising this objective.

It is suggested that the conceptualisation of governance, accountability and outcomes comprises three functional tiers, with consumers and carers playing a role within each tier.

- the statewide level – which involves consumers and carers being engaged in policy development and leadership provided by the Minister for Mental Health and Department of Health;
- a provider platform level – which is the mix of service delivery platforms, through which consumers and carer participation is enabled; and
- the workforce level – which are the services and forms of support delivered by the consumer and carer workforce (including volunteers).

Such a policy framework would recognise the value proposition that consumer and carer support and participation programs that are timely, appropriate and high quality, and where possible led by consumers and carers, can deliver improvements in mental health for individuals, ensure services

deliver consumer and carer responsive services, and offer significant social and economic benefits to the Victorian community.

There are principles that underpin this value proposition and which can guide practice. These are that programs will be:

- **Informed by consumers and carers** – to ensure the system continues to evolve with service recipients’ needs and interests at the forefront of decisions. Policy, programs and service delivery must all be informed by consumer and carer views.
- **Accessible to consumers and carers at the time it is needed** – whether this be in a community or acute setting, at diagnosis or later in their recovery journey, so that they can access a program(s) within appropriate time frames.
- **Based on need and available equitably to those in need** – so that all Victorians, regardless of where they reside or diversity in terms of ethnic background, gender, age, Aboriginal or Torres Strait Islander status or sexual orientation are able to access programs and that current unmet need is addressed.
- **Appropriate and supported by evidence** – whether this evidence is peer-reviewed literature, best practice models, or informed by consumers and carers, to ensure Victorian’s receive programs that will have the greatest impact on their health and wellbeing.
- **Delivered by a capable, resourced and supported workforce** – which includes through appropriate governance structures, articulating roles and outcomes, training and supervision.
- **Recognised as a vital component of Victoria’s mental health system** – through all tiers represented in the conceptual framework and the community at large.

Core functions

The following have been identified as core functions that the Victorian Government should invest in. In some instances the functions include related activities which are linked in both their purpose and the outcomes they contribute towards.

- **Information provision and referral** – this function is clearly critical and consumer and carer led support is to be available when it is needed. Shortcomings regarding current access to information and referral advice and system navigation were repeatedly raised throughout the review, particularly by carers, as areas of service delivery which require strengthening. It is recognised that information provision and referral are distinct activities, however they are linked in purpose as contributing to both system navigation and service accessibility.
- **Peer support** – whilst the evidence base is still in its infancy for many of these kinds of programs, there is reasonably consistent evidence to support the impacts of peer support, in particular in reducing the likelihood of rehospitalisation and in being able to reach “hard to reach” groups.
- **Service participation and individual advocacy** – the function of service participation and advocacy was highly valued by consumers and carers, and is supported by a range of state and national policy documents, including the *National Standards for Mental Health Services 2010* and the *National Safety and Quality Health Service Standards*. It is recognised that participation and individual advocacy are distinct activities however they are linked in purpose as being targeted at improving service quality and responsiveness.
- **Professional (non-peer) carer support** – professional (non-peer) carer support was highly valued by carers, and for those who had accessed Carer Resource Workers, this was felt to be a very valuable program for assisting carers from both a practical and emotional perspective.
- **Planned respite** – planned respite was rated highly by consumers and carers as contributing to outcomes such as increasing the ability to deal with stress, to perform day to day tasks, in improving connections to other people and in improving quality of life.

Allocation and prioritisation of state funds

In determining the optimal allocation and prioritisation of state funds, optimal investment models have been developed for consumers and for carers.

Features of these models include:

- an information and referral web hub (with helpline) for consumers and carers;
- funding through the program service settings of: state-wide MSSH organisations; primary health; AMHS; MHCSS; and 'other' platforms; and
- alignment of functions to be funded with these platforms as appropriate, recognising the profile of consumer mental illness severity that each platform supports.

Options are described below for funding across the core functions for consumer and carer mental health support which include consideration of the impact of funding arrangements on both flexibility and accountability. Options have been designed to enable a degree of flexibility but also enhance accountability for these programs. A range of service models are provided as options which could be considered for each of the core functions of consumer and carer mental health support.

Options

Options and recommendations to improve the way these functions are currently structured and organised have been identified. These are designed to deliver a more easily navigable, consumer and carer responsive mental health system, which supports consumer and carer social inclusion and economic participation.

A number of options for redeveloping current and future investment have been considered. Options both inform specific recommendations, and provide guidance regarding the potential range of reforms that could be pursued or further refined by the DH.

For each function, there is a choice between re-engineering existing programs to better deliver the existing program concept and redesigning from first principles.

The options proposed within each of the functions should not be read as mutually exclusive. A number of options, or a mix of options, may be pursued within a single function, although pursuing additional options would have corresponding resource implications.

Through the menu of options for redeveloping current and future investment for each of the core consumer and carer mental health support functions presented, we have considered both options which embed the service offering and the options which offer these functions in a stand-alone capacity, and have canvassed the potential benefits and risks associated with each option.

Options have been provided across the following functions:

- information provision and referral;
- peer support;
- service participation and individual advocacy;
- professional (non-peer) support for carers; and
- planned respite.

Key considerations in developing options corresponding to these areas and the specific options developed are summarised below.

Information provision and referral

In assessing options for information provision and referral a number of contextual issues were considered. The new MHCSS program will have a centralised intake provider which will include carer assessment. This suggests that MHCSS might become an important source of information and referral for carers, and that it would be useful for the intake services to have up to date information on local areas services available to carers, such as peer support groups or Carer Resource Workers. Additionally, improving health literacy and access to information is a priority under the ACSQHC and the Victorian Health Priorities Framework. Carer identification and needs assessment is understood to be expected in AMHS, but is variably enacted.

Peer support

In assessing options for peer support a number of contextual issues were considered. The potential transfer of MSSH programs to the NDIS would mean that this program in its existing form would be limited to consumers who have severe mental illness and enduring psychiatric disability, and their carers. Peer support can be provided by paid and/or volunteer workers depending on resources available and noting that there are resource implications regarding both types of workers.

Additionally, under the new service specification, MHCSS may provide structured and social/recreational group support as part of their core funding, and this could provide the potential for peer support to be an embedded feature of such supports. A number of policy directions at both the Victorian and Commonwealth level emphasise the importance of enhancing a recovery-oriented culture in clinical mental health services, and while they do not necessarily explicitly mention peer support, it has been noted in other jurisdictions that peer support has the potential to create a more recovery oriented culture in clinical mental health settings.

Service participation and individual advocacy

In assessing options for service participation and individual advocacy a number of contextual issues were considered. A new state-wide Advocacy Service will be established as part of the new Victorian Mental Health Act which will deliver individual advocacy to compulsory patients. There may also be a Mental Health Complaints Commissioner appointed to deal with complaints and advocacy issues for the broader population of mental health consumers. As new services are being established to respond to the need for individual advocacy, we have avoided additional service or program options for individual advocacy. The National Standards for Mental Health Services and the National Safety and Quality Health Service Standards by the ACSQHC emphasise importance of consumer and carer participation in service design and delivery, and both of standards are linked to accreditation for mental health or the broader health service. We understand that the Consumer and Carer Consultant program has to date been a strong feature of the accreditation response by Victorian health services to the National Safety and Quality Health Standards.

Professional (non-peer) support for carers

In assessing options for professional (non-peer) support for carers the likely transfer of the Commonwealth Carelink and Respite Centres to the NDIS was considered. This would mean that access to Carer Resource Workers would be limited to carers of consumers who were eligible for the NDIS, i.e. those who have a psychiatric disability that is likely to be permanent. This is not necessarily an issue as these roles are currently a very limited resource and appropriate prioritisation of these to carers with higher needs is a key improvement which is required in the current program.

Planned respite

In assessing options for planned respite, a number of contextual issues were considered. Respite has traditionally been delivered by a range of providers, both PDRSS and specialist providers, leading to a range of different models of how planned respite is delivered, from reasonable unstructured and social, through to highly structured with a therapeutic intent. Additionally, it is important to note that the new MHCSS program will be funded through Individualised Client Support Packages, through which recovery plans for consumers will be delivered. Currently this funding stream does not cover respite services.

The table below lists the options for redeveloping current and future investment in consumer and carer mental health programs'. These are presented in considerably more detail in section 10.8. All options have considered the resource implication, enables, risks, as well as the links to the current service system. Table i identifies each option by function, and briefly states the rationale and notable benefits.

Table i: Options for redeveloping current and future investment in consumer and carer mental health programs

	Option 1	Option 2	Option 3	Option 4
Information provision and referral				
Options	Build an information hub with multiple channels for carers	Peer support workers for consumers and carers in AMHS provide information and referral	Improve information provision through existing workforce channels	
Rationale and benefits	Provides access to timely, coordinated information about what services and resources are available.	Provides access to timely, coordinated information about what services and resources are available	Strengthens existing provision of information and support with minimal resource implications	
Peer support¹				
Options	Consumer and carer peer support workers operating in AMHS	Grants program for peer support, including specific mental health conditions	Provide structured group peer support as part of MHCSS Individualised Client Support Package	Commissioning of new discrete stand-alone peer support function delivered as part of local networks
Rationale and benefits	Improves access of AMHS consumers and carers to peer support given the evidence base for peer supports benefits to recovery	Considers and funds peer support where there is an identified need. Creates ongoing flexibility to address gaps in diverse groups.	Group peer support appeared to be highly valued and this option promotes its inclusion in a systematic way into recovery plans.	A stand alone service may be well positioned to provide high quality peer support across the spectrum of need in the community
Service participation and individual advocacy²				
Options	Expand FTE funding for existing consumer and carer consultant programs	Retain existing consultant program and provide better clarity and guidance around the role	Consumer and carer consultants to support information and referral for individual advocacy	Create consumer and carer engagement roles

¹ Peer support could be provided by either paid or volunteer peer support roles

² As noted no options were developed which address individual advocacy specifically as there are new services being established as part of the new Mental Health Act to address the advocacy needs of mental health service users.

	Option 1	Option 2	Option 3	Option 4
Rationale and benefits	Roles are split across a range of activities, increased funding would allow an increased focus on education to clinical staff and systematic engagement with consumers and carers to broaden views	Strengthen the impact of the existing investment in this program concept and enable better engagement with and be informed by service users	There is a gap in access to individual advocacy for consumers and carers and this would assist consumers and carers to feel informed and empowered to access individual advocacy	This role would create platforms for engagement, and would feed views and experiences of consumers and carers into service design and delivery
Professional (non-peer) support for carers				
Options	Expand FTE funding for Carer Resource Workers based in Commonwealth Carelink and Respite Centres	Re-allocate funding for Carer Resource Workers to MHCSS, to provide similar model of support to carers of MHCSS clients	CSF to Carer Resource Workers to increase FTE and facilitate carer support plans	CSF remains with VMHCN but guidelines including eligibility are tightened and accountability improved
Rationale and benefits	They are also seen as experts in carer system navigation in their local areas. This would provide greater access to professional and practical support for carers of people with a psychiatric disability	Where carers had gained access to these workers the support provided had been highly valued, and was linked to a care or action plan for the carer.	The transfer of this funding to the Carer Resource Workers would ensure that brokerage and other funds could be provided within the context of a carer support plan and clearly linked to needs and goals of the carer	Tightening the guidelines should ensure that the goods and services funded more closely reflect the purpose of the fund.
Planned respite				
Options	Provide planned respite as part of individualised client support package	Provide respite through specialist respite providers	Transfer responsibility for planned respite to the Commonwealth Government	
Rationale and benefits	Consumer access to respite appears to be limited and ad hoc. Respite could be used in a meaningful way to facilitate progress towards recovery	Specialist providers are more likely to deliver highly structured respite services which aim to build skills and confidence	Formalise lead Commonwealth role, recognising the Commonwealth's significant existing role in respite funding and brokerage.	

In addition to the menu of options described for each of the functions, we have combined the options to form illustrative options packages. These packages have been constructed to provide a set of options across each of the functions which represent a gradation from minimal restructuring of current functions and a greater focus on refinement of these, to moderate restructuring, through to major restructuring and reshaping of functions.

The illustrative options packages are designed as a guide, it is important to emphasise that the Department could select a different combination of options given further consideration of given resource constraints and policy developments, such as NDIS, in the operating environment.

Complementing the options and options packages, the following overarching recommendations are provided, as an accompaniment to whichever suite of options is taken forward.

Recommendations

It is recommended that:

1. The following recommendations be pursued in conjunction with the specific options taken forward.
2. Subject to the accompanying recommendations, the Department of Health continues to direct public funding towards consumer and carer mental health support programs
3. A coherent policy framework for consumer and carer mental health support programs is established, encompassing governance, accountability, outcomes and funding streams.
4. The options selected as a basis for the future direction of consumer and carer mental health support programs be guided by these principles:
 - informed by consumers and carers
 - accessible to consumers and carers at the time it is needed
 - based on need and available equitably to those in need
 - appropriate and supported by evidence
 - delivered by a capable, resourced and supported workforce
 - recognised as a vital component of Victoria's mental health system.
5. Detailed consideration is given to the service platforms and models that will be most effective in delivering expected outcomes in a manner that aligns with related reforms including MHCSS recommissioning, the *Mental Health Act* and the NDIS. This includes the Department identifying the options they wish to take forward, identified in Table i and guided by the combination of these options based on level of resources committed.
6. The Minister for Mental Health and Department of Health publicly recognise the value of consumer and carer mental health support programs as a means of raising the profile of these activities and increasing recognition of them across the mental health sector and the wider community.
7. In recognition of the importance of these activities to the mental health system and the community, both the Minister for Mental Health and Department of Health provide enhanced state-wide leadership for consumer and carer mental health support programs.
8. The value of functions provided by consumers and carers with lived experience is better articulated and linked to outcomes. Specifically, that the value is in linking lived experience to the recovery journey.
9. Accountability for the performance of providers undertaking consumer and carer mental health support activities through public funding be strengthened through clearer performance standards and articulation (by the Department of Health as funder) of expectations regarding outcomes.
10. A service quality framework be established to support enhanced accountability requirements.
11. A monitoring and evaluation framework be instituted for consumer and carer mental health support programs.
12. Data collection and reporting by service providers to the Department of Health be strengthened and undertaken in alignment with the monitoring and evaluation framework.