Psychiatric Disability Services
of Victoria (VICSERV)

Submission to the Community Sector Reform Council

Reflections from VICSERV on the recommissioning of community managed mental health support services.

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1. Foreword

The VICSERV report "An agenda for the future" outlined key areas for reform and the need for change to promote sustainability and the delivery of quality evidence based services that improved outcomes for people with a mental illness. The vision included more individualized and flexible program structure, area planning, capable organisations, service rationalization, a new name, access to housing and future system planning.

The Department of Health's reform agenda was outlined through a series of documents – the Psychiatric Disability Rehabilitation Support Services (PDRSS) Reform Framework Consultation paper, the Reform Framework for PDRSS and the tender specifications. The Reform Framework outlined a change program to streamline current service delivery arrangements on a catchment basis, introduce individualised and flexible programs, increase accountability and transparency and support the development of a more capable and sustainable workforce. It also introduced new functions – intake assessment and catchment planning.

While there was a high degree of alignment with the directions and proposed outcomes between the department's directions and *An Agenda for the Future*, there was significant disagreement about the way to get there. *An Agenda for the Future* rated open competitive tendering as the least preferable mechanism for achieving change. The consultation report on the proposed framework, echoed concerns about the impact such a process would have in terms of outcomes for clients and the impact on the sector generally.

2. Reform outcomes

Such significant change requires time to bed down and the service system will be in a transition phase for at least six months. While we know the outcomes of the reforms, the actual impact on consumers, the workforce and services will not be known for some time.

However, there are some outcomes which are worthy of comment as they suggest issues with the reform processes and/or question whether the reforms have achieved all that they set out to do. They include that:

- The reforms have not delivered on either diversity of providers or real and genuine choice for consumers in relation to their service provider. For example:
    - In rural areas there is often only one service provider, there are no community health services providing MHCSS and in three of the five areas only standalone MHCSS providers operate.
    - There are no specialist homelessness service providers[1], or any providers targeting groups with particular needs or backgrounds.
    - There are no small providers.

[1] The exception is Sacred Heart Mission in consortia with Prahran Mission in the Bayside catchment.

- The scale of change was much greater than expected. This either suggests issues with the EoI process and/or a significant disconnect between services and the Department with regard to what was to be achieved. It has had implications for meeting transition timelines, and resulted in unexpected (and unplanned) significant financial and personal costs born directly by agencies (but indirectly to Government and the community), its workforce, consumers and carers.

- The catchment based approach in some instances has resulted in a "movement of the deck chairs". Service providers with a long and significant presence in some areas were unsuccessful in that area but successful in others. It is questionable whether this movement from one "quality" organization to another will result in better outcomes for clients. However, the overall costs associated with the change are high and carry significant short – medium term risk for the clients in the transition period. It has also disrupted existing partnerships and collaborative practices which will take some time to rebuild.

- The catchment based approach also led to significant growth in the provision in MCHSS for some organizations and significant decreases for others. While not an explicit outcome, a reasonable expectation was that the process would address the significant dominance of a small number of providers. Instead it changed rather than address the issue. Reliance on a few providers creates longer term market risks if they fail to continue to deliver a quality product while also reducing opportunities for innovation and diversity.

- Less opportunity for joined up service delivery, particularly with Alcohol and Drug Services and primary health services, as a result of the reduction in Community Health Service providers, and with Homelessness services as a result of all but one no longer being funded. The significant contraction of providers may also have longer term implications, as these organizations choose to withdraw completely from working with people with a mental illness, thereby reducing overall capacity of the generalist and specialist service system to provide appropriate responses and interventions to this group of people.

There have been other consequences for which adequate planning did not occur. These include:

- At least 44% of the workforce being on the move – either through redeployment, redundancy or ceasing of contracts.

- A move away from centre based/group programs which catered for larger numbers of people. For many people this has meant an immediate loss of their "community" and sense of belonging.

- In a number of catchments, there appears to be an overall decrease in capacity with significant decreases in overall client numbers expected.

Finally, these reforms have occurred in isolation to the Drug and Alcohol Reform, the proposed housing and homelessness services reforms and Services Connect. The sequencing of the reforms and the siloed approach appears to be contrary to the desire for joined up service delivery and is reducing opportunities for services to respond in a more joined up way. For example, in mental health the issue of access to housing remains outstanding but options and opportunities about how to do this better did not feature in these reforms. Similarly, opportunities for joined up mental health and drug and alcohol responses were not able to be dealt with.

3. Reform Process

The October 2012 Ministerial Communique on the Reform of the Psychiatric Disability Rehabilitation and Support Service program suggested a well-planned and comprehensive approach. Despite sector concern about the method of recommissioning, the Minister committed to a development phase to be undertaken in partnership with service providers and key stakeholders, regular communication and a transition phase of 6 – 9 months. However, the process fell well short of what was described. Timelines were not met and became shorter, there was infrequent communication and no appearance of a communication strategy, feedback loops did not exist or were not timely

and much work was undertaken in secrecy. From the beginning, it was a process with minimal opportunity to influence, shape or co-design.

Lack of consultation, collaboration and communication

Firstly, there was a lack of authentic consultation, collaboration or communication with the sector as demonstrated by:

- Minimal consultation on the discussion paper.
- The consultation report providing no indication of what was to be taken on board. Some significant concerns raised in the consultation were not addressed in either the final Framework or taken into account in the development of the selection criteria or the implementation of the EoI process.
- The Framework and tender specifications being developed in house and without input from sector. The Framework was released electronically and without information sessions.
- Limited input into the capacity building projects – the reference group roles were limited and generally did not include any role in project design, confidentiality was required and many were not completed before probity/ specifications. Final reports were not released and thus did not contribute to a shared understanding of process, requirements or issues.
- The Stakeholder Advisory Group being presented with confidential material therefore limiting opportunities to consult with membership and other stakeholders. VICSERV requested an independent chair as it had concerns about accountability. This was refused.
- Very strict application of probity provisions which meant that the department shut down most communication with services. It resulted in no sector input into remaining capacity building projects; the ceasing of the Stakeholder Advisory Group and discussion/ communication about change with consumers and carers was unable to occur.
- Infrequent and irregular communication from the department and the Minister.

This lack of communication and consultation had and continues to have a number of implications. It impacted on the tendering process as there was not a shared understanding of the intentions of the framework and selection criteria which ultimately impacted on the decisions services made in their tendering (perhaps to their detriment). It has also contributed to consumers and carers not adequately understanding the directions and the impact it would have on their services; surprises at the outcome of the process (and therefore a general lack of preparedness for the change) and the loss of the opportunity to build on expertise available, reduce risks and costs and ensure best outcomes for consumers, workforce and the community.

Tender design and development issues

The development and capacity projects designed to shape the reforms and prepare services were mostly not completed before the recommissioning, and if they were completed the findings were not made available. The lack of service or program guidelines and the performance management framework, has in retrospect, translated into a lack of clarity about what was being purchased and which is only being worked out now.

There was an apparent lack of risk analysis applied to the reform process, including the impact of using tendering as a re-commissioning tool or with regard to aspects of the implementation of tendering process. As many of the concerns of the sector identified in the consultation process came to the fore, a risk analysis would have enabled strategies to be put in place to mitigate them.

This lack of risk analysis is also evident in some of the decisions made with regard to the tender process which have impacted on the outcomes. They include:

- The decision to actively recruit interstate and private providers. This significantly changed the way many Victorian services approached the EoI with many services deciding to bid beyond their natural catchments. .
- The lack of capacity within the process to differentiate between those catchments which needed change and those that did not.
- The two phase process increased the burden on service providers. The number of "short listed" providers was too high in some catchments. It is questionable whether it also delivered on maximising the service configuration in an area as providers had to submit high level delivery plans without knowing how much or what they might end up delivering and who else was in that area. Providing for some collaboration at this point would have delivered different outcomes.

Transition was poorly planned and resourced

The transition phased was reduced from six –nine months to three months. Given the scale of change was much larger than expected, the three months was grossly inadequate and has been proved so with many services unable to fully recruit, find new premises and be fully operational at 1 August 2014.

Transition planning occurred too late in the process, the transition support package was hastily put together and did not respond to issues being raised by the peak bodies and did not adequately address the scale of change and the risks. Key issues include:

- Significant financial and other costs not being factored into process.
- Resources not being available to enable "duplication" of service system to facilitate and smooth client transfer, including in "high risk" residential settings. Instead resources were largely directed towards information or support for workers to manage the change.
- Not enough time to enable consideration of less disruptive options such as interim subcontracting or transmission of business.
- Inadequate communication – consumers and carers not adequately prepared for or understanding of the change; made more difficult by a lack of clarity and understanding of the service components.
- Variance in regional office capacity, and understanding of the reforms, in assisting the transition of the service system.
- Over reliance on peak bodies and services to provide information and carry key messages. The Department did not step up into the role and own the process.
- Feedback process to "unsuccessful" agencies not timely; and as a result potential withdrawal of organizations working with people with a mental illness.
- Service guidelines not completed and a range of service delivery issues not resolved (such as tenancy and nomination rights) before implementation, leading to confusion, work around solutions and a lack of clarity for consumers.

4 Outstanding issues

- A workforce strategy to ensure that Victoria retains, maintains and develops the skills required to provide quality mental health care into the future is required. This includes managing and responding to the demands created by the State reforms, the impending introduction of the NDIS and the growing demand for a peer workforce.

- Access to safe and affordable housing is an integral component to improving health, mental health and wellbeing outcomes for people with a mental illness. There is concern that the reforms have further distanced the relationship between mental health and housing services.
- A plan is needed to manage the transition to and introduction of the NDIS, including to prepare consumers and service providers. This is a separate and distinct activity from the implementation of the State reforms but could benefit from the learnings of the reform process.
- Reform has also been suggested for the other PDRSS funding streams - MSSH, Carer and Consumer Programs, Aboriginal mental health services and residential rehabilitation. Providers involved in the review of the consumer and carer programs have been highly critical of the review process and the outcomes to date. There is a need for a new process and a new approach to manage these reforms, including one which is cognoscente of NDIS implementation from 2016.

5 Recommendations for future reform processes

- The resourcing received by VICSERV through the reform process enabled it to participate in reference and advisory groups, where possible (and allowed) to seek sector input into projects, provide information – through forums, its website and regular bulletins, work with the Carer and Consumer peak bodies to improve messaging and understanding of issues and provide more comprehensive training and other resources to prepare for the reform process and transition than it would have been able to do otherwise. In addition, the ongoing financial support received by VICSERV provides it with capacity to work with services to reflect on current practice and identify the need for change. This produced 'An Agenda for the Future" which provided Government with the confidence to commence reform. Developing and supporting peak bodies to work with their services should be seen as a key ingredient for success in reform.
- Ensuring Government has the skills and resources to undertake the process in a timely and effective manner. It is recognized that the Mental Health Branch had been significantly reduced in size and had reduced capacity. However, recommissioning requires expertise and understanding of the services and the broader service system, and capacity to understand, analyse and lead the range of options available for reform as well as the technical skills associated with such work.
- Undertake a cost benefit analysis which identifies the real costs of the process, acknowledging that costs to the not for profit sector impact on future service delivery capacity and that this funding will be a combination of public money and from the community through fundraising and philanthropic efforts. If Government had been required to directly meet the costs of the process it is possible that it would have been managed quite differently.
- Service and program guidelines and other important aspects which impact on service delivery, such as performance management frameworks, should be developed before recommissioning with broad input.
- Ongoing risk analysis, done in collaboration with the services and service users, should occur before and during any reform process.
- Plan and publicize consultation and communication strategies and ensure adequate time for real discussion, debate and co-design.
- Recommissioning should not automatically mean re-tendering. There is a need for a more sophisticated approach and consideration of options, opportunities and risks.
- Competitive processes should be preceded by appropriate market analysis and development, including ensuring that the market understands the requirements and has an opportunity to respond and prepare and be underpinned by good communication and information.

- Fund, resource and plan transition to support optimal outcomes for clients.
- Ensure timeframes are realistic.

6 Continuing Reform – What next for community mental health support services?

The MHCSS reforms include many positive features, including more flexibility, a move towards client centred support and a catchment focus. VICSERV and its members believe that ultimately many of these new features will result in better outcomes for people with a mental illness. However, how the implementation of these reforms is managed will have an impact on whether these outcomes are achieved. There is also a range of other reform and development activity needed to ensure a strong and responsive community mental health service system into the future and better mental health outcomes for the community:

The following actions are recommended:

- Develop an implementation plan for the next 12 months to guide the implementation of the reforms and ensures that they deliver on positive outcomes for consumers. A new way of working is required from the department, which embraces the principles of collaboration and co-design and inclusive of service providers, the broader service system, consumers and carers. At the very least it should include the establishment of working groups to develop, guide and monitor the new functions, strategies for ongoing review and reflection, and a communication strategy.
- Develop a transition plan to support the introduction of the NDIS which dovetails with the implementation plan. This should also address the need to ensure that there remains a specialist community based mental health response which will meet the needs of people who are ineligible for the NDIS and/or who need specialist community based mental health services not available through the NDIS.
- Ensure that the proposed recommissioning/ reform of community mental health services that is still to be undertaken occurs in collaboration with services, consumers and carers and is responsive to the issues raised in this submission.
- Develop a workforce strategy to address the future needs of a specialist community based mental health response and the NDIS, including supporting growth in the peer workforce.
- Invest in safe and affordable housing linked to support for people with a mental illness.