Briefing and Recommendations

Community Managed Mental Health Sector Considerations for the *Partnerships for Health* Reform Process

January 2015

Contents

Introduction

The Mental Health Coordinating Council (MHCC) present this paper to the Minister for Mental Health in the context of the *Partnerships for Health* (P4H) reform process, which will significantly impact the non-government community managed organisation (NGO/CMO) mental health sector at a time of major state mental health service delivery reform.

A strong, diverse, specialised and collaborative community managed mental health sector is essential to the success of the NSW Mental Health Strategic Plan 2014-2024.[1] The Strategic Plan is the culmination of years of intensive consultation with extensive contributions, from consumers, carers, workers and senior managers of the mental health sector. The overarching objective of the Strategic Plan is to see a stronger, expanded community-based mental health system with trauma-informed recovery-orientation as its primary principle of practice.

MHCC sees the P4H reforms as an opportunity to align service delivery with the recommendations of the NSW Mental Health Strategic Plan. P4H is an ideal vehicle for the Ministry of Health (MoH) to take a whole of system approach, ensuring optimal allocation of resources and coverage for community based services across NSW. This involves review and inclusion of identified psychosocial rehabilitation and recovery support services delivered through public mental health in the proposed P4H tender mix.

The P4H process involves the end of grant allocation for services currently provided by mental health CMOs, alongside other services that the MoH funds, such as drug and alcohol, women's health, Aboriginal medical services, chronic care and HIV/Aids. New services are then being contracted for Financial Year (FY) 2015/16. Currently the reforms include CMO funding at MoH/Mental Health and Drug and Alcohol Office (MHDAO) as well as, potentially, ad-hoc grants provided both directly by the NSW Health Minister and at the Local Health District (LHD) level. The timeframe for reform is linked to the schedule determined by the MoH Integrated Care Branch (ICB).

While the community managed mental health sector understands the integrated care agenda, it is unclear how both MHDAO and the ICB have aligned with the recommendations of the NSW Mental Health Strategic Plan 2014 to 2014 in their timeframe. As a consequence, there have been minimal opportunities to adequately consult the mental health sector at the LHD level, and ensure that the collaboratively redesigned mental health system envisioned in the NSW Mental Health Strategic Plan materialises. The MHCC are concerned that the Ministry may lock itself into CMO service contracts just as they are beginning to develop their framework for community mental health. Ideally, local consultations and planning inclusive of consumers, carers and the CMO sector should occur before any purchasing decisions are made.

Under the P4H funding framework, from FY2015/16, MoH grants to CMOs (including those made at the LHD level) will be replaced with a contract purchasing model. Most mental health CMOs have completed a transitional process and negotiated 2014/15 contracts with the MoH. New KPIs have been developed aiming to provide greater clarity and accountability around the services being purchased. For a few CMOs this is an unfamiliar process that has given rise to concerns about the sector's inherent flexibility, value-adding potential and capacity for innovation that may reduce if contracts become too proscriptive or fail to reflect their service functions. However, CMOs do recognise the advantage of clearer deliverables, enabling them to better manage client outcomes and expectations from funders.

The organisational readiness of some CMOs for P4H and other related sector reforms has been discussed with the MoH for some time. MHCC most recently met with the NSW Health Minister

[1] NSW Mental Health Commission 2014, *Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2014.*

to discuss these reforms on 14 January (see Briefing Note for NSW Ministry of Health and related supporting documents at Appendix A). This more recent P4H reforms Briefing and Recommendation Paper has been informed by these deliberations and also consultation with the MHCC membership.

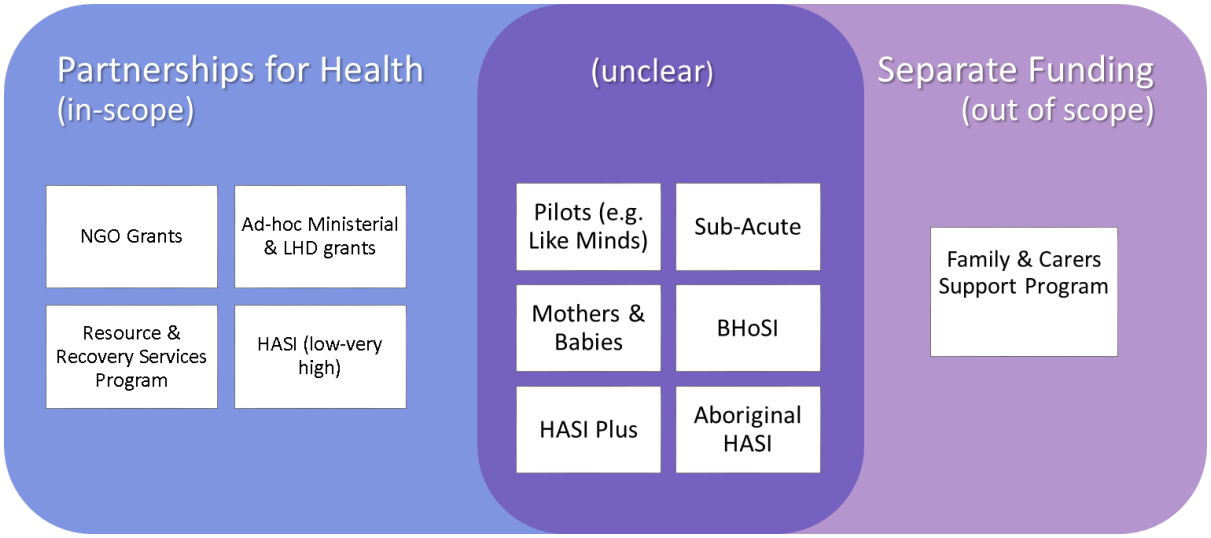
In November 2014, MHCC surveyed its membership regarding their readiness for the P4H reforms (Appendix B). The importance of these reforms is well understood and it is clear that the sector is well progressed in preparation. However, organisations are looking for support in the areas of both client and staff transitions and strengthened shared data analysis systems to support these changes. Greater knowledge of processes for establishing unit price costings and considering organisational financial viability is also needed.

These recent MHCC activities, and including the development of this Briefing and Recommendations Paper, have been part of our ongoing peak body advocacy and sector support to ensure optimal outcomes for the P4H mental health program reforms. This will only be achieved through a MoH commitment to directions within the NSW Mental Health Strategic Plan to articulate a framework for a contemporary NSW community mental health system and development of a Community Managed Mental Health Sector Development Plan. The 2014 Victorian experience provides strong guidance to us that P4H mental health funding reforms can only be optimally realised if they are strongly aligned with well operationalised sector reform directions.

Diagram 1 below provides a brief overview of MHCC's current understanding of the scope of potential community sector mental health programs and services to be potentially impacted by the P4H funding reforms. The diagram below must be understood with great caution.

While it is reasonably clear that Family and Carer Support Services will not be recommissioned there is no certainty elsewhere. This is because the plans for purchasing mental health services and programs from community sector organisations into the future are not yet known beyond some three-year short-term guidance contained within the MoH's 'Strengthening Mental Health Care in NSW' response to the Mental Health Strategic Plan: http://www.health.nsw.gov.au/mentalhealth/pages/default.aspx.

Diagram 1: Scope of Partnerships for Health Mental Health Program Reforms



Caution: The above diagram is not a clear indication of the MoH's directions of P4H mental health services and programs reforms.

Purpose

This Briefing and Recommendations paper first considers the value added to service delivery by the community managed mental health sector. It then highlights some of the future opportunities and challenges developing as a consequence of the P4H reforms; discusses some emerging service models and identifies a set of proposed CMO purchasing principles. The principles, if adopted, will demonstrate the Ministry's commitment to the inclusion of CMOs as essential partners in the NSW Government's newly configured mental health service system.

A set of recommendations are then presented based on the issues addressed in this paper. They are designed to assist the Ministry to purchase the highest quality services from a strong and prepared community managed mental health sector.

Recommendations

1. Establish a P4H Mental Health Working Group to include MHDAO, LHD representatives, the NSW Mental Health Commission, MHCC, Being (NSW CAG) and ARAFMI.

The Terms of Reference of the P4H Mental Health Working Group should include (but not be limited to):

a. Oversight of the Community Managed Mental Health Sector Development Plan.

b. Oversight of a unit-costing project to provide detailed information to P4H decision makers on the components of community mental health programs and the cost-drivers for high quality service provision. This information would usefully feed into the findings of the Mental Health Costing Study currently in work by the Independent Hospital Pricing Authority, where activities and cost-drivers are being studied for hospital-based services, but not for community services.

c. Develop a set of guidelines / purchasing principles to help inform LHD service planning and purchasing decisions, for all of community mental health inclusive but not restricted to existing CMO services and programs.

d. Oversight of administrative arrangements for purchased mental health services, inclusive of: information infrastructure resourcing and support, data collection, implementation of a Minimum Data Set, outcome measurement protocols, feedback processes and public reporting.

e. Oversight of decisions on recommissioning of community services to ensure they are aligned to the service specifications and population planning approaches of the National Mental Health Service Planning Framework.

f. Maintain an active brief on service development activities within the Hunter NDIS trial site to increase understanding of the NSW impacts arising from eligibility criteria, benchmarking report application and emerging population needs.

g. Monitor introduction and contribute to an organisational readiness support package for the sector, including consideration of the findings from the MHCC P4H organisational preparedness survey (see Appendix A and B).

2. Align CMO purchasing decisions with the directions of the NSW Mental Health Strategic Plan and allow enough time to include the development of a Ministry of Health Community Mental Health Framework. In communicating this, MHDAO needs to be clearer to CMOs on the scale of change being planned and the reasons for these changes. Provide a vision for how the consumer journey should happen through new funding arrangements. For example:
    - Easier navigation and access to services
    - Increased individual choice of services and activities
    - Clearer referral process for GPs, LHDs, consumers, carers and other CMOs.

3. Extend funding and refine CMO contracts to current organisations for FY 2015/16 as per FY 2014/15, providing stability to current organisations while the Community Mental Health Framework is developed.

4. Recontract HASI packages that are due to be retendered in 2015 for a one-off period (up to the beginning of P4H purchasing) in a select tender process to allow all CMO program funding to be contracted in line with a newly developed Community Managed Mental Health Sector Development Plan.

5. Provide funding for a 2015/16 sector readiness program to engage with and support the community mental health sector during the P4H transitions.

    - Capacity building grant funding to enhance sector readiness and capacity building similar to those provided in FACS Homelessness and Disability reforms. The relevant community mental health areas are:
        - Client experience (program range and responsiveness)
        - Service provision (organisational capacity)
        - Policy and planning (planning, funding and evaluation)
        - Research and development (innovation and growth).[2]

    - P4H reform readiness communication and training initiatives (to be costed following negotiation of deliverables), including:
        - Managing client transitions
        - Workforce redeployments
        - Minimising sector instability.

Details on communication & training initiatives proposed to be progressed provided in Appendix A.

6. Consult with the community mental health sector on:
    - The opportunities, challenges and intentions of a centralised intake and assessment model.
    - Individual packages of care as the main service delivery model and how to contract for service types not designed be provided as individual packages (e.g. drop-in centres, group activities, infrastructure-based services, etc.).
    - The utility and effectiveness of CMO partnership contracting methods in the context of individual flexible packages of care.
    - The opportunities and advantages of core/infrastructure funding
    - Considerations about accountability and safeguard mechanisms.

7. Review all non-acute public mental health services for their capacity to be more effectively delivered in the community. Where the community integration, rehabilitation and support components of a service outweigh the acute care components, consideration should be given to purchasing the service from a CMO through tendering processes.

[2] These sector capacity development framework elements are derived from: Mental Health Coordinating Council 2010, *Building Capacity in the NSW Mental Health CMO Sector: A Review of the Literature*. NSW Australia.

Valuing the Community Managed Mental Health Sector

The essential contribution of the mental health CMO sector in supporting recovery of people with lived experience of mental health conditions in NSW has steadily gained recognition. This acknowledgement is clearly stated in the actions to be progressed with implementation of the NSW Mental Health Strategic Plan. The Strategic Plan highlights the need to correct the state imbalance of community-based and community managed mental health services in preference to costly hospital based alternatives that are not well placed to progress the social inclusion principles associated with recovery.

CMOs are central to a community-based mental health service response. A majority of CMO staff are tertiary qualified mental health professionals. Unfortunately their skillsets are regularly minimised when compared to those of nursing and allied health, even when those professionals are untrained in mental health specific competencies. According to the *National Mental Health Workforce NGO Scoping Study (Health Workforce Australia 2011)* 43% of workers in CMOs identified as having health qualifications — mostly in social work, psychology or nursing — and 34% of workers had a vocational qualification with the majority of these being at the Certificate IV and Diploma levels. This recognition issue is one of the main obstacles to integrated service delivery and effectively realigning mental health services towards community and recovery orientation.

The mental health CMO sector in NSW has been at the forefront of recovery oriented care and practice. Multiple reports and organisational resources have been developed by the sector to progress implementation of recovery orientated practice throughout the human service system. The civil society underpinnings of CMO ensure that every dollar spent results in high quality value-added services that are not able to be provided as affordably by public or private for-profit agencies. CMOs are driven to expand their competitive advantage in generating social capital by developing new and innovative service models, such as hybrid cross-agency services, social enterprises and social movements aimed at enhancing public health.

A further value-add that has historically been considered in grant-making processes has been the capacity for clients accessing CMO-provided services to be provided access to the range of other supports and services available from those CMOs. It is part of many CMOs' missions to enable, where appropriate, the cross-utilisation of skills and services funded by multiple agencies. Community managed mental health services in NSW have strong local networks and are proud of their reputation for 'No Wrong Door' approaches when co-existing conditions are present, such as alcohol and drug misuse, physical and cognitive disability issues and risk-factors such as housing instability, social isolation and involvement with the criminal justice system.

However, CMOs should not just be considered for what is often wrongly viewed as their traditional 'disability/community support' expertise. CMOs provide a broad range of promotion, prevention, early intervention, rehabilitation and medical services. In line with the Strategic Plan, there are considerable efficiency, practice and quality benefits to be gained by reviewing all voluntary public inpatient/outpatient components of LHD mental health services for their potential to be contracted to community-based and community managed organisations. Recent examples of these in NSW are the "Like Minds" community hub model in Western Sydney and sub-acute mental health services such as the step-up/step down services in Orange and Broken Hill. In addition there are a number of residential rehabilitation and living skills programs across the state that could be effectively transferred to community sector providers.

There is a compelling case for establishing a test for every planned service that assesses whether an external CMO service provider could deliver comparable or better outcomes more efficiently. The MHCC propose that where the community integration, rehabilitation and support components of a service outweigh the acute care components they are more effectively placed with a CMO. As the CMO sector continues to mature more treatment services will be integrated into CMO options, and the Ministry and LHDs as contract managers should assess the financial and performance management advantages to CMO provision.

A strong case for mental health services managed by the community

There are a number of advantages to contracting CMOs to deliver mental health services in an expanded range of service areas:

- Recovery orientation as the core service rationale
  One of the major findings from the NSW Mental Health Commission's Report is that mental health service design remains encumbered by the hospital-centric focus embraced by some planners and decision-makers. The centre of gravity has remained that of 'hospital services with community outreach' rather than that of 'community services with hospital backup'.

  The NSW CMO sector is recognised as pioneers in recovery oriented service delivery and trauma informed care and practice. It is arguable that many CMO workers receive more training in specific mental health care and practice than is available in the generalist health qualifications of public mental health staff.

- Performance management through purchaser/provider split
  Contracts are an effective mechanism to achieve LHD objectives for population mental health planning. When properly implemented they clarify partnerships, allow for negotiation and shared aim, and greatly increase accountability for outcomes. CMOs are flexible structures, whereas in public services it is difficult to switch the staffing and service model if they are not effectively meeting consumer and carer needs.

  When a government purchaser of services is also a provider of services there is tendency to retain services in-house to maximise resources. Externally provided services are the first to be lost even if this is not the appropriate balance of service provision for the local population. Contracting services where they are able to be defined and managed is a viable solution to this dilemma.

- Workforce and asset flexibility
  Hospital-based mental health services in particular are subject to rigid workforce governance and regulations. Clinicians can be allocated to activities that do not inherently require medical competencies, and have entrenched levels of high remuneration and industrial conditions. CMOs are not bound by these requirements and so can be tailored exactly to the requirements of a mental health program specification.

- Innovation
  Collaborative competition breeds innovation and feeds back into improving the overall mental health system. Many CMOs are able to demonstrate flexibility, innovation and creativity in supporting service users. They work collaboratively with other providers and adopt person-centred models of care that can address all of a person's needs.

- Competition
  Competition leads to greater self-reflection and assessment of what can be done with the resources available and in partnership or consortia with others. It creates an environment where clear articulation of practice approaches is required and where demonstration of outcomes is the major focus of service implementation.
  This is less the case in the public system.

- Value Adding
  Community organisations are able to attract funding and resources from a range of sources outside of NSW MoH funding streams. This capacity enables organisations to extend services, programs and activities provided to service users.
  Value adding is also achieved through access to property owned by the CMO, a volunteer base, business partnerships, philanthropy, fundraising, community participation and development of social capital.

Partnerships for Health - Opportunities

Realising the Ministry of Health Community Mental Health Framework and the Community Managed Mental Health Sector Development Plan

It is important that MHDAO and LHDs have had the opportunity to respond to the recommendations of the NSW Mental Health Strategic Plan, prior to decisions about the contracting of community based services. Many of the actions of the Strategic Plan have considerable implications for the MoH and LHD mental health services. Of particular note is Strategic Plan recommendation 5.1.1:

NSW Mental Health Commission (2014). Living Well: A Strategic Plan for Mental Health in NSW 2014-24.

Recommendation 5.1.1 – Rebalance our mental health investment to transform NSW from the lowest spending to the highest spending Australian jurisdiction, per capita, on community mental health **by 2017**. This will involve:

- The NSW Ministry of Health directing all mental health growth funding to community mental health.
- The NSW Ministry of Health using its service agreements with Local Health Districts to purchase greater community activity volumes to rebalance existing investments.
- Local Health Districts adjusting the mix of local services to achieve the rebalancing required and reporting regularly on activity levels and against service performance measures established with the NSW Ministry of Health.
- Local Health Districts forging new partnerships with community-managed organisations and/or the private sector to: coordinate mental health care in the community; leverage and integrate with general practice, and private psychiatry and psychology; and explore opportunities for new models and service arrangements that offer efficiencies and meet the needs of people with mental illness and their families and carers.
- The **NSW Ministry of Health providing leadership to the reforms through the articulation of a new framework for a contemporary NSW community mental health system**, underpinned by recovery-oriented values.
- Supporting the development of innovative community-based alternatives to hospital admissions. This could include the use of social benefit bonds and other mechanisms.

This is a clear policy direction for the MoH to increase community based alternatives to hospital, to work collaboratively with the CMO sector, and to develop a broader community mental health framework inclusive of CMOs. The development by the MoH of a Community Mental Health Framework is an important piece of foundational work, especially since the previous NSW community mental health strategy was concluded in 2012.[3]

As a result of the establishment of the Mental Health Commission and the resultant Strategic Plan for NSW, mental health is in a uniquely advantageous position to implement the P4H reforms against a '*new framework for a contemporary NSW community mental health system*'. MHCC strongly believes that the framework should be developed before the sector undergoes the P4H funding restructure.

The proposed MoH Community Mental Health Framework (2014 to 2024) would allow for longer term planning and more strategic approaches to NSW mental health sector reform that are also consistent with national directions. It would also provide a vehicle upon which the NSW Government's three year $115M funding commitment to mental health – as a first stage response to the Mental Health Strategic Plan - could be taken forward and further built upon.

In addition, the new Community Mental Health Framework will provide a comprehensive reform direction against which to address Strategic Plan Recommendation 8.3.2 (i.e., the development of a Community Managed Mental Health Sector Development Plan).

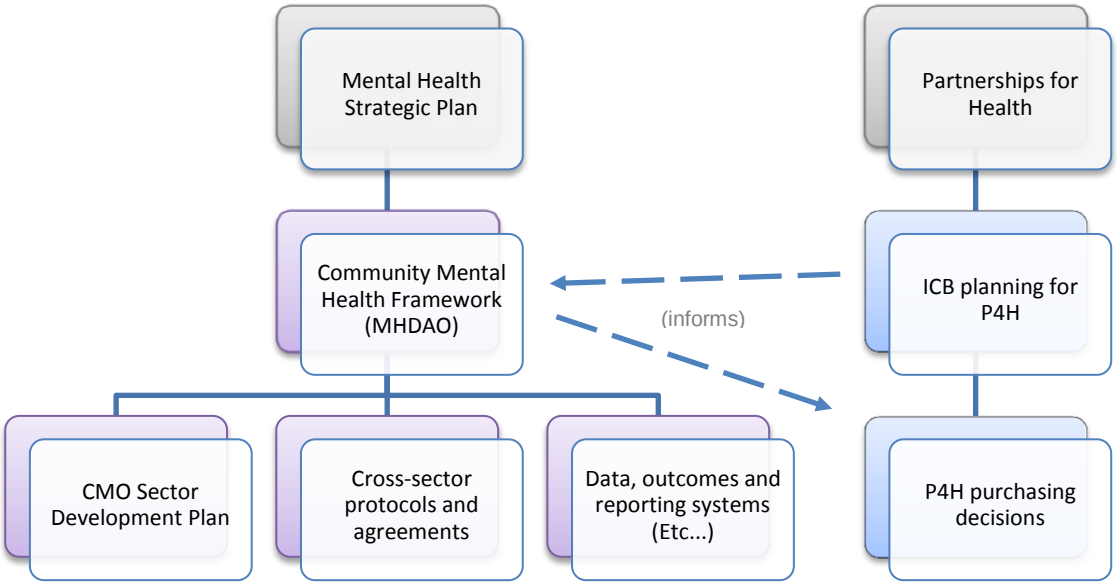
NSW Mental Health Commission (2014). Living Well: A Strategic Plan for Mental Health in NSW 2014-24.

Recommendation 8.3.2 – The NSW Ministry of Health will establish a community-managed sector development plan which includes strategies to strengthen and expand the community sector workforce, and improve the management and collection of data. The plan should be modelled on the successful development work being undertaken in the disability sector and supported through National Disability Services.

As this Briefing and Recommendations Paper has already argued, it makes little sense to implement the mental health components of P4H reform without aligning them with the policy directions and commitments of the NSW Mental Health Strategic Plan. A Community Mental Health Framework and interdependent Community Managed Mental Health Sector Development Plan would comprehensively outline the MoH role and responsibilities in providing community services to address the mental health conditions of people in NSW. The Community Mental Health Framework and Community Managed Mental Health Sector Development Plan would inform resourcing decisions, including P4H purchasing. The inter-relatedness of these activities, processes and document required to support P4H funding reforms is illustrated over page in Diagram 2.

[3] NSW Health (2008). *Community Mental Health Strategy 2007-2012 (NSW): From prevention and early intervention to recovery.*

Diagram 2: NSW Health Reforms Affecting Community Mental Health



Broaden the components of service provision considered under Partnerships for Health

P4H should be considered a major opportunity to pursue the broader aims of the NSW Mental Health Strategic Plan. As demonstrated above, while P4H is about funding reform it is equally about sector reform. The risk of not associating CMO/NGO funding reforms with sector reform directions have been well learnt through the recent Victorian experience that is further discussed in the 'P4H Challenges' section of this paper.

Innovative service models, such as the *LikeMinds* community hub model, will help achieve greater service integration. Other partnership models that should be profiled by the ICB and MHDAO to LHDs when facilitating their involvement in the design, implementation and evaluation of the P4H funding approach include:

- Step-up / step-down
- Sub-acute
- Headspace
- Coordinated community program intake and assessment (e.g. Victorian model)
- Consortia approaches to specific services based on the Partners in Recovery (PiR) contracting model
- Service coordination service models, e.g. *LikeMinds*
- Integrated case management
- Promotion and prevention
- Early intervention
- Work readiness and employment support
- Family and carer support
- Family therapy
- Suicide prevention
- Peer support
- Access to psychological and other talking therapies.

Many NSW Mental Health Strategic Plan recommendations present opportunities for the MoH to shift services to the community, truly innovate, and find efficiencies. These should be worked through in detail between MHDAO, LHDs, MHCC, NSW CAG (Being) and ARAFMI.

In 2012 the MHCC reviewed LHD level mental health rehabilitation and support services being provided by public services to identify those services easily able to be outsourced to the CMO sector. Examples included housing integrated support programs, day care and drop-in centres, and various residential and community rehabilitation services.

The MHCC provided this document to MHDAO to highlight the range of services that would be more rationally provided by externally contracted CMOs. Many services were identified, and while it requires some updating, there are many services which should be considered for transfer that may not be without leadership from MHDAO. This information has subsequently been provided to the NSW Health Minister.

Population planning for all community mental health services

The NSW mental health CMO sector is strongly invested in the work of the MoH funded MHCC Sector Benchmarking Project[4], which was developed as a further layer of depth to National Mental Health Service Planning Framework (NMHSPF) modelling for community mental health service need. CMOs contributed extensive time and resources (over two years) to the Ministry to assist in the development of these planning models.

Diagram 3 on the following page describes the service types currently being delivered by the NSW CMO sector and demonstrates the diversity and complexity of the current community managed mental health sector. They are divided by those modelled in the Sector Mapping Project report[5] and those un-modelled (where individual packages would not make sense for the service design). Emerging and non-mainstream mental health services are also considered.

We emphasise that there are service types that have not been modelled at a population level due to their delivery format (e.g. promotion/prevention, advocacy; see more information in Diagram 3 below and also in Appendix C). These will also be expected to continue to be delivered by the MoH to ensure continuity in sector coordination and infrastructure support.

It is important to note that a core principle of the National Mental Health Service Planning Framework is that all of community mental health should be planned without consideration to whether it is provisioned publicly or purchased externally ('provider agnostic'). This is a clear indication that P4H should be incorporated into a broader community mental health review and planning process.

MHCC, through its partnership with the Mental Health Commission of NSW, has been advocating for local level population based planning approaches to mental health sector reform and development. An early practical example of this as related to the profoundly changing local environment in the Hunter NDIS trial site is provided as Appendix D. This illustrates that there are many more people with severe and persistent mental illness than are known to the Hunter New England Mental Health Service (HNEMHS). Of those that are known to HNEMHS discussions are required about their access to a full range of treatment, rehabilitation and support services and the outcomes being achieved through this access. This needs to include consideration of existing local health district mental health service and other community infrastructure.

[4] Mental Health Coordinating Council (2012). *Sector Benchmarking Project: Final Report.*
[5] Mental Health Coordinating Council (2010). *NSW Community Managed Mental Health Sector Mapping Report.*

Another example of using a specific needs population modelling approach to determine service responsibilities is provided in Appendix E (i.e. rural and remote residents, Aboriginal people and people with culturally and linguistically diverse backgrounds). This shows how the specific needs issues of certain population groups might influence the population estimates for community based psychosocial rehabilitation and recovery support services against the seven key service types considered in the Sector Benchmarking Project.

The NSW Sector Benchmarking Project went further than the National Framework by collecting a detailed snapshot of CMO services provided across the state. This allowed an approximate gap-analysis to be undertaken. The findings of this analysis was of substantial inequalities of service access across NSW. Many state and Commonwealth programs appeared to have been purchased with little regard to the other services available within their regions.

Development of a Community Mental Health Framework, Community Managed Mental Health Sector Development Plan or P4H mental health program purchasing plan must be cognisant of the specific shortfalls identified within individual LHDs and across some specific population groups which will require special attention.

Diagram 3: Summation of CMO Services Provided in NSW as per the MHCC Sector Benchmarking Project – Modelled, Un-modelled and Emerging Service Types

Modelled services

- Counselling
- Group Support
- Mutual support and self-help
- Residential services
- Personalised support
- Family and carer support
- Education, employment and training

Un-modelled services

- Information, referral and advocacy
- Care coordination (e.g. PiR, before NDIS subsumes it)
- Service coordination (e.g. LikeMinds)
- Sector development and representation
- Mental health promotion
- Mental illness prevention

Emerging services

- Community intake & diversion (e.g. Victorian service)
- Sub-acute services
- Step-up/step-down
- Recovery colleges
- Peer-run services
- Case management
- Access to psychological/ talking therapies
- Suicide prevention
- Supported decision-making

Partnership models

The MoH wants to reduce administration and increase efficiencies by managing less contracts in each LHD. The Ministry has signalled that the P4H reform process will lead to purchasing from a smaller number of providers. CMOs are concerned that if the government adopts a consolidation agenda, reducing both the number of CMOs and the types of services they provide, that the advantages of a diverse community sector may be reduced. Small and medium-sized organisations provide local community responsiveness, innovation and creativity. Larger organisations provide comprehensive quality systems and economies of scale. A healthy CMO sector requires the existence of a diversity of organisation sizes and types in order to remain energetic and flexible.

For mental health consumers living in the community to transition safely between services it is important that the CMO sector be supported to adapt to new purchasing conditions in an open and orderly fashion. MHCC have already exposed its membership to a variety of partnership options including Australian and New Zealand case-studies of successful consortia, mergers and takeovers.

As a result of research and consultation feedback from members, MHCC takes a position that partnership approaches to service delivery have the potential to improve service quality, access and efficiencies. A mix of service types and capacity enables retention of smaller providers and their value add whilst extending the economies and infrastructure of larger providers.

The key to success in a sector support approach will be timely communication with the MoH and sufficient resourcing of organisational readiness activities. When clear purchasing directions and tender conditions are announced the CMO sector will work fast to respond, and indeed has already begun to adapt as best it can, given the information available. If CMOs are well-supported during reform then they are more likely to configure themselves in the way the Ministry prefers while retaining their collaborative relationships.

MHCC has investigated recent organisational readiness initiatives implemented by FACS and ADHC to support sector reform and the process of organisational support provided to Victorian mental health providers to support the recommissioning of community services undertaken in that state in 2014. The potential composition of an organisational readiness program of support to underpin P4H is provided in Appendix A (Briefing Note for the NSW Ministry of Health).

Develop a new CMO Data Management Strategy

Should most services be recontracted at the same time there is an opportunity to finally develop a single Minimum Data Set (MDS) for the NSW community managed mental health sector. When the MoH decides on the services and tendering arrangements for P4H, reporting requirements for successful CMOs will then become an area of focus that could benefit from revisiting Phases 1 and 2 of the NSW Community Managed Mental Health Data Management Strategy (DMS).

The MHCC initially developed the DMS as a component of the NSW Health funded Mental Health NGO Infrastructure Grant Project to provide an exhaustive blueprint for data collection, system design and reporting standardisation for mental health CMOs in NSW. The initial Minimum Data Set (for organisations in the sector, rather than for NSW Health) enabled organisations to collect data once and provide reports to over 20 government funders of community mental health services, both state and national.

The delivered Minimum Data Set was accompanied by a Comprehensive Data Set, intended to provide a starting point for negotiation between NSW Health and the CMO sector on a single data set specification that would be publicly available so that any organisation funded to provide a mental health service in NSW would be able to seamlessly collect and report data that can be usefully analysed by NSW Health and reported publicly. An additional advantage of developing an agreed data set between CMOs is that standardisation provides collaboration opportunities to do large-scale research and quality improvement, service benchmarking and cross-sector social impact measurement.

The MoH acknowledged that developing a Minimum Data Set for the sector would require resourcing and quality improvement support for organisations to ensure compatibility between CMO data systems, high levels of system usability and staff competence, and minimal reporting errors or omissions. The MoH funded the MHCC in 2010 to undergo a second phase of the Data Management Strategy in which it co-developed a Draft Business Plan with Deloitte to resource, support and test a comprehensive data collection and reporting program for the NSW community managed mental health sector. The work was unable to be actioned by the MoH in 2011, however the quality of the MHCC's strategy was acknowledged by the Commonwealth Government when it used the DMS as the basis for development of the National Mental Health NGO Establishments Minimum Data Set.

Recently the National Mental Health NGO Establishments Minimum Data Set has been transitioned to a Data Set Specification until more jurisdictions are able to collect the required information. However this Data Set Specification would provide a solid basis for the development of an updated NSW Minimum Data Set which would open up all the advantages inherent in a standardised sector data collection.

Partnerships for Health - Challenges

Insecure funding and limited engagement with the sector

Since release of *Partnerships for Health: A Response to the Grants Management Improvement Program Taskforce Report* (March 2013) there has been limited communication about subsequent P4H funding reform directions. CMOs are uncertain about the number and locations of services being tendered for, the unit-costs of expected services, or the types of programs to be purchased. Since the P4H response to the Grant Management Improvement Program, instability around continuation of funding has resulted in unnecessary staff turnover and lost social capital as staff move to more secure employment opportunities. In unstable environments organisations must assume the worst and plan accordingly to remain financially viable. This includes reducing staff training budgets and other infrastructure spending.

Much of this instability is reminiscent of the recent *Going Home Staying Home* (GHSH) reform of the Specialised Homelessness Sector. It became clear during GHSH that the downsized Housing division of the NSW Department of Family and Community Services (FaCS) was being asked to implement a new purchasing program without reflecting on whether they held all of the requisite information or skills to ensure an orderly and equitable transition. Many CMOs subject to major change processes and agendas were insufficiently supported and this resulted in some organisational closures that may not have been necessary. The process of tendering for women's refuge services was particularly problematic and resulted in substantial unplanned costs to secure safe client transitions and sector reconfiguration.

In the P4H process, it is still unclear when or how LHDs, local communities and organisations will be consulted – beyond the level of peak bodies and LHD Mental Health Directors, etc. - and how these consultations will be meaningfully reflected in purchasing decisions. Without a clear program of organisational readiness support and consultation on local consumer, carer and community needs, the sector remains concerned that P4H is fated to repeat the mistakes of GHSH.

The information and consultation forum scheduled by MHDAO in late February 2015 is a welcome commencement to what will hopefully be the first initiative in a comprehensive process of information sharing and sector feedback opportunities.

Avoiding the chaos of the Victorian 2014 community mental health reforms

Consumers, carers and CMO mental health service providers experienced disruption and confusion during the retendering of community managed mental health services in 2014. Partially this is due to the medium-term intention of the reforms to wind-down Victoria's CMO mental health funding program (further detail is provided on page 21), but its many disruptive effects may have been reduced had there been more thorough engagement and communication with the CMO sector prior to designing and implementing the change process.

The Victorian CMO mental health peak body VICSERV reported[6] the experience of a mental health CMO sector that embraced the need for changes to service purchasing to promote sustainability and deliver quality evidence based services. They advocated for the introduction of individualised and flexible program structures for some service types, a population planning

[6] VICSERV 2014, *Submission to the Community Sector Reform Council: Reflections from VICSERV on the recommissioning of community managed mental health support services*, Melbourne.

approach, sector development to ensure CMOs could best deliver the new services and engagement with the sector on future service planning. The Victorian Department of Health responded through a set of consultations and a reform framework which had a high degree of alignment with these expressed directions, however there was significant disagreement about how to achieve the reforms.

The changes that occurred were substantially larger than that indicated during the consultation process and little planning or resourcing eventuated to support consumers, carers and CMOs through the upheaval that has shaken the sector. While it is too early to evaluate the success of various components of the Victorian reforms, there are some outcomes that have already been observed:

- Poor diversity and lack of choice
  The primary rationale given for the Victorian purchasing decisions was that the introduction of individualised packages as the main purchasing method would enable access and choice for consumers between a range of community mental health service providers. It quickly became clear that insufficient organisations were funded, especially in the regional locations, to provide a genuine choice for consumers. There was also an apparent decrease in the number of service packages available in each region, effectively creating a system of winners and losers based on the unfinished eligibility definitions of the NDIS.

- Poor communication on the scale of change
  While CMOs were given broad policy directions and engaged in superficial discussions of the approach being taken to reform, CMOs were never provided with concrete numbers ahead of time to allow them the time to assess their place in the sector and to plan for their future. The small number of contracts made available, the number of packages being financed and the unit costings for those packages were not made available for comment ahead of the tendering process. This took most organisations in the sector by surprise as it was more of a departure from standard process than most had been led to understand from earlier presentations on the reform directions. The direct financial and personal costs born to CMOs were indirectly costs to Government and the community in the form of unnecessary workforce, consumer and carer instability.

- Consolidation of service providers weakened perpetuated market risk
  The dominance of a small number of service providers was perpetuated and extended due to the design of the tendered services. Smaller organisations had little way of being able to provide the services being tendered for. Many small organisations spent large amounts of unfunded time developing consortia at the encouragement of the Department of Health, only to find that this was not a preferred option when purchasing decisions were made. Only one substantial consortia won a contract in the retendering process.

  Concerns from consumers and carers were not addressed regarding the potential for market risk should one of the larger organisations fail to deliver quality services. Opportunities for innovation are also perceived as having been stifled in Victoria. Many organisations have also decided or been forced to withdraw from the community mental health sector which has resulted in less joined up service delivery in relation to the Alcohol and Drug, primary care, and specialised homelessness services provided in the state.

- Workforce mobility and shortages
  The community managed mental health sector already struggles with similar workforce capacity issues to those being experienced in the public mental health workforce. VICSERV reports that 44% of the total CMO mental health workforce has been estimated to be on the move – either through redeployment, redundancy or ceasing of contracts. In addition, around 2,500 consumers were identified as needing to move services, with other services expecting to manage a higher number of consumers than they have been funded for through natural attrition. It remains unclear what percentage of this skilled workforce has permanently exited the sector.

- Poor consideration of services not suited to individualised packages of care
  Overall the sector reforms resulted in a move away from site-based and group-based community mental health programs which catered for large numbers of people. Many consumers expressed feelings of immediate loss of their "community" and sense of belonging.

In addition, the process of change itself was overwhelmingly an experience for CMOs of a rushed agenda without clear explanations of the timeframes or processes involved. The process continually fell short of the initial promises made by the Department. Timelines were not met and became shorter, communication was infrequent and vague, feedback loops did not exist and much work was undertaken in secrecy. There were many instances of poor collaboration practices, and where peak bodies were presented with reform material it remained unnecessarily confidential, limiting opportunities to consult with broader membership and stakeholders.

There were also many tender design and development issues which appeared to stem from a lack of capacity within the Department to comprehend the nature and composition of the sector, and the psychosocial rehabilitation and recovery support needs of consumers and carers. Finally, the transition itself was poorly planned and poorly resourced.

Unclear contracting approach

The draft and confidential ICB guidelines specify a range of different contracting responses that should be used depending on the availability and appropriateness of the sector 'market'. Options include competitive tendering, closed tender processes, invited applications and establishment of sole provider status. Rationale as to why MHDAO may support any single or any mix of approaches should be made transparent in terms of reform directions in the mental health sector. This is especially so given that many of the tendered services currently provided are widely regarded as high quality and the number of viable service providers need to be grown, not reduced, to achieve mental health sector reform directions.

In relation to 'sole providers', there is currently no apparent rationale for which organisations would attract this status. Funding uncertainty affects an organisations ability to plan resourcing and maintain its workforce. If it is demonstrable that a CMO and/or its funded program is a unique offering, holds a respected stakeholder status, or that there is no realistic market for the service, then a competitive tendering process is resource intensive and wasteful.

Consideration needs to be given to the range of contracting options such as local level collaborative tendering processes, similar to that which occurred with the establishment of Partners in Recovery (PIR) organisation consortium. This approach could be understood to be more consistent with directions for mental health sector reform (in line with the NSW Mental Health Strategic Plan and including greater reliance on local level population based planning approaches).

State-wide and sole provider services

In line with the NSW Government's commitments, the MoH has been decentralising many of its functions and processes to the LHD level. This allows greater local community control and responsiveness to health needs. The P4H reforms appear to also involve a move toward decentralisation of CMO purchasing where LHDs will more often be the decision-making and purchasing bodies of community mental health services.

The MHCC maintains that there will continue to be a need for some services to be provided at a state level. While detailed recommendations would require better access data on programs currently funded by the MoH, the MHCC propose that three rationales for maintaining state funding are where:

- Activities require interaction at a state departmental and/or legislative level (e.g. peak and representative bodies)
- Their service model requires access/intake to be from across the state (e.g. telephone based support lines)
- The expertise offered by service is not realistically able to be provided across the state by every LHD (e.g. Black Dog Institute, Mental Health Association).

In addition to considerations about the governmental level at which a service is funded, consideration should be made on reducing unnecessary effort when purchasing services that clearly can only be provided by one organisation.

The MHCC maintains that, as state-wide peak bodies, the following community mental health organisations should be allocated Sole Provider status and considered exempt from the P4H tendering processes:

- Being (previously NSW CAG; consumer peak body)
- ARAFMI (carer peak body)
- MHCC (community sector peak body).

Some services that may also be considered for Sole Provider status as a result of specific functions include: those meeting the needs of a specific population group state-wide or in a specific region e.g. STARTTS, Weave; those providing a unique therapeutic or support approach e.g. GROW; and those where the model of care should be made accessible across the state e.g. NALAG. Other providers may also be considered for sole provider status, however this is difficult to determine without greater understanding of the P4H tender design plans.

Emerging Approaches

Individualised Flexible Packages of Care

A funding trend in New South Wales (e.g. homelessness and disability funding) and Victoria (community mental health) has been the development of service contracts into individualised[7] and flexible packages of care; enabling the client to partially determine the services they receive to facilitate their recovery.

It is important to acknowledge that the Victorian purchasing model undertaken with the reform of community mental health services was adopted because of that government's three year commitment to phase out community mental health services due to their funding source being "cashed in" to the NDIS. It is not, and never was, intended to be a comprehensive or sustainable community mental health service response. This is most evident by the decision to base eligibility criteria on the NDIS Tier 3 threshold. (The new Victorian government has committed to review this funding model in response to sector concerns.)

The key characteristics of an individualised package of care are:

Modelled and costed activities
Organisations tender for a set amount of funding modelled on a certain number of clients for a certain number of activities. In the case of the Victorian model this is then broken down to a costed hourly rate, however in other cases it can be a modelled budget per client with a flexible and negotiable set of KPIs depending on individual variations in need, much like HASI.

Inclusive costings
Unlike traditional and current CMO funding methods, no other funding is provided for core, infrastructure, administrative or workforce resourcing. This is the most destabilising effect of package-based funding reforms that replace grant programs. Sometimes the costs for administrative overheads are fully factored into the overall modelled cost. Just as commonly these costs are not calculated realistically.

Choice as program driver
Individual client choice becomes the primary driver of the packages. Organisations have the flexibility to provide or outsource components of the packages of care they provide. This is contingent on a range of services and service providers being available to the consumer.

Aside from the NDIS, which involves a larger set of reforms and assumptions, the two most relevant reforms that have adopted the individualised flexible packages of care model occurred in 2014. They are the community mental health reforms of the Victorian Department of Health and the *Going Home Staying Home* reform of Specialised Homelessness Services by the NSW Department of Family and Community Services (FaCS). Both reforms have been ambitious and there have been a number of observable issues from the outset, including:

- Communication focused on the structure and process rather than providing a coherent rationale and vision for how the reforms would benefit consumers and how organisations would be supported as respected partners in the service system. This was especially exacerbated by the Victorian Department of Health strictly forbidding CMOs from communicating the changes occurring throughout the reform process. Some clients still don't understand why services have changed or how to engage with the new process.

[7] Note: an *individualised* package of care, such as those provided by ADHC, is not the same thing as an *individual* package of care, which is a standard method of establishing resourcing targets for health populations as used by MH-CCP and the National Mental Health Service Planning Framework.

- The timeframes for reform were well communicated but poorly planned. Substantial changes to historical funding models require a period of support and change management to ensure that good services comprehend the scale of change occurring, plan accordingly and remain viable. Substantial consumer, carer and community sector hostility could have been avoided through a timeframe that allowed for the scale of organisational restructure required.

- Unit costings were not transparent and hastily developed. Similar to the NDIS, when a package of care becomes the unit of funding, organisations focus their attention on the apparent rationale for how the packages have been costed. It is essential that package costings are realistic enough to enable CMOs to deliver on the KPIs set by government.

  HASI is notable in this regard. The positive outcomes achieved through HASI can largely be attributed to its pricing framework. This would therefore be an appropriate benchmark, particularly if there is flexibility to allow for the variable levels of service need that an individual client can experience.

- While the Victorian reforms highlighted the need for choice and control of service offerings, only a small number of organisations were funded to provide packages in each region. This invalidated any real sense of choice, especially as most services appear to be running out of available packages and in some regional areas only one provider exists. Worryingly, much of the time the organisation making the referral was also a major provider of packages in that region raising a question about conflict of interest.

Regardless of the inherent risks, there is great potential for individualised packages of care to deliver better experiences for consumers of community mental health services in NSW. However packages of care are only designed for modelled services (see Diagram 2), which is only a subset of the full range of community mental health services as specified in most mental health planning frameworks and reports.

<u>Proviso: Individualised packages of care are not appropriate for all service types</u>

Individualised packages of care will not be appropriate for people where engagement in services is difficult, even though these are some of the most important people to provide services to.
Current methods employed by the community managed mental health sector include: Drop-in centres, Clubhouses, Assertive outreach, Social and recreational programs, Recovery colleges, and a range of mutual support and self-help services. Drop-in centres in-particular have demonstrated sound recovery and social inclusion outcomes for people recovering from mental health conditions.

A strong evidence-based example of a multi-program centre-based service is that of the Day to Day Living (D2DL) program – a highly successful program that would not easily be funded through individualised packages. The D2DL program has been "cashed in" to the NDIS and appears to be directed toward Tier 3 participants only, meaning that the gap between those receiving group-support services and those determined to need group-support services is already growing (based on NMHSPF or Sector Benchmarking targets).

Non-individualised package services are some of the most important for those who are unable to be proactive with their own care. They are also some of the most vulnerable people in the community. Consideration may be required for a way to find this capability outside of a formal individualised funding approach. Perhaps linking funding toward moving these people into formal packages of care over time would be an expected outcome of such services.

The lack of core-funded drop-in centres and group support services has been one of the major structural deficiencies of the Victorian 2014 community mental health reforms (as discussed earlier in the *P4H Challenges* chapter).

Potential Consolidation of Intake and Assessment

A recent service development in Victoria is the introduction of telephone-based consolidated intake and assessment services. This service is provided by three CMOs covering different regions of the state. In most regions the CMO providing the intake and assessment service also provides a range of services that the intake service can refer to.

It is difficult to find detailed information about the exact service model in operation, however according to the Neami National website the service is intended to:

- Screen and determine eligibility to receive support
- Prioritise referrals
- Refer eligible people to support services for a comprehensive assessment
- Provide screening information to support services - with the person's consent - to avoid people having to repeat their information
- Follow up referrals to make sure people are getting access to the services they need
- Provide self-management information and follow-up contact with people on the needs register
- Provide general mental health information and facilitate referrals to other services as needed
- Convene Regional Bed-Based Selection Panel for Youth/Adult Residential Rehabilitation and Supported Accommodation Services
- Ensure that the transfer of information to support providers is only undertaken with a person's consent.

This assessment model appears to solve a number of lingering issues relating to coordination and referral to community managed mental health services in each region. The availability of a simple standardised referral system for LHDs, GPs, consumers and carers would greatly encourage mental health services to better integrate and would simplify navigation through the community managed mental health.

As a peak body it is difficult for MHCC to take a stance on a model that would change the gatekeeping relationships for and between member organisations without undertaking broad consultation and developing consensus on the practical effect of such a change.

Issues that might come up during such consultations could include:

- Perceived and actual conflicts of interest where the CMO providing the intake/referral service also provides one of the community services in the region that a consumer is being offered.
- Potential duplication of coordination activities in conflict with Partners in Recovery, LHD care coordination and the NSW government *LikeMinds* community hub service model.

- Elements of the Victorian experience that have not been as successful as planned e.g. regional areas only contracting an individual community mental health provider, negating consumer choice and leaving a referral service redundant.
- There does appear to be an element of compulsion built into the Victorian intake system to place clients into local community mental health services without the provider having the right to refuse the referral.
- The combination of intake and referral with an eligibility and triage service raises concerns around risk for organisations in safely meeting the needs of individuals with complex conditions. Single points of entry can also become blockage points.
- Duty of care issues may arise for people who do not meet eligibility.
- Centralised assessment and referral running counter to the NSW MoH strategy of empowering LHDs to organise and plan services according to local and community needs.

Nevertheless the potential to reduce to number of assessments required for an individual to receive a range of community mental health services warrants further investigation in partnership with the CMO sector.

Essential Service Planning Principles

The community managed mental health sector has a strong history of operating in partnership with the MoH and LHDs. A key quality of the sector is its willingness to compete when funding processes require this and then, when decisions have been made, to collaborate and focus on what is best for people experiencing mental health conditions in NSW.

The MHCC proposes that a set of principles are endorsed by the Ministry to reflect the respect and value that the Ministry places on the contribution of their CMO partners.

1. The community managed mental health sector is an important partner in service delivery and will be engaged during planning, service design, and purchasing decisions. MoH/MHDAO and LHDs will respectfully draw from the sector's expertise in good faith prior to commencing each tender.

2. Consumers and carers will have access to the broad range of early intervention and community based rehabilitation and recovery supports as outlined in the National Mental Health Service Planning Framework and the MHCC NSW Sector Benchmarking Report (see Appendix B). In whichever way responsibilities are divided between MHDAO and the LHDs, the MoH has a responsibility to ensure access and equity to the range of mental health services required by local communities.

3. CMO service planning is an integrated process within the planning of all community mental health services to ensure seamless community-based intake and rehabilitation pathways. A Community Mental Health Framework will be established prior any major CMO service purchasing decisions.

4. Existing infrastructure, including public mental health services, Commonwealth programs, ad-hoc LHD grants and Ministerial grants are identified and considered when planning CMO service purchasing so that service types are balanced according to needs and the amount of servicing that already exists (i.e. local level population based planning approaches).

5. Public sector services and programs delivering rehabilitation and/or psychosocial recovery/disability support will be considered for inclusion in the P4H recommissioning process along with existing MoH funded community sector programs and services (i.e. thus freeing much needed acute resources).

6. Consumer safety and MoH service system quality will be safeguarded through organisational readiness funding. The MoH will support CMOs who have lost longstanding legacy funding with transitional and change management support.

7. The NDIS is accounted for during service planning. However, the NDIS is an enhancement to, rather than a replacement for, mental health services. The Ministry remains responsible for community mental health service provision.

8. Assessment of the capacity of CMOs to provide services in the community will include recognition by purchasers of the value adding produced by CMOs.

Conclusion and Recommendations

The NSW mental health CMO sector is committed to consumers and carers being the beneficiaries of any reform process.

The P4H reform process has the advantage of being able to consider the challenges faced by similar recent reform processes undertaken by NSW FaCS and the Victorian Department of Health.

The MHCC proposes a set of recommendations to ensure that the hard-won trust between the MoH and the CMO sector is safeguarded during this transition period, which is one of the largest reform processes since the Richmond Report.

The first four recommendations are especially urgent as a show of good faith from the NSW Government to the dedicated organisations who have shared the Ministry's goals and multiplied the value of their grant contributions exponentially. The remaining recommendations are a reasonable request to be consulted and engaged in a co-design process with the Ministry to ensure that purchasing decisions are based on a sufficient understanding of the community mental health sector and the needs of consumers and carers in the community.

The MHCC, its board and its members hold out hope that the NSW Mental Health Strategic Plan will herald a new era of truly community-based, recovery-oriented and trauma-informed mental health services. To achieve this, the mistakes of similar sector reforms must be headed so that the sector is stable and primed to deliver the innovative services needed to re-orient the mental health service system.

Recommendations

1. Establish a P4H Mental Health Working Group to include MHDAO, LHD representatives, the NSW Mental Health Commission, MHCC, Being (NSW CAG) and ARAFMI.

The Terms of Reference of the P4H Mental Health Working Group should include (but not be limited to):

a. Oversight of the Community Managed Mental Health Sector Development Plan.

b. Oversight of a unit-costing project to provide detailed information to P4H decision makers on the components of community mental health programs and the cost-drivers for high quality service provision. This information would usefully feed into the findings of the Mental Health Costing Study currently in work by the Independent Hospital Pricing Authority, where activities and cost-drivers are being studied for hospital-based services, but not for community services.

c. Develop a set of guidelines / purchasing principles to help inform LHD service planning and purchasing decisions, for all of community mental health inclusive but not restricted to existing CMO services and programs.

d. Oversight of administrative arrangements for purchased mental health services, inclusive of: information infrastructure resourcing and support, data collection, implementation of a Minimum Data Set, outcome measurement protocols, feedback processes and public reporting.

e. Oversight of decisions on recommissioning of community services to ensure they are aligned to the service specifications and population planning approaches of the National Mental Health Service Planning Framework.

f. Maintain an active brief on service development activities within the Hunter NDIS trial site to increase understanding of the NSW impacts arising from eligibility criteria, benchmarking report application and emerging population needs.

g. Monitor introduction and contribute to an organisational readiness support package for the sector, including consideration of the findings from the MHCC P4H organisational preparedness survey (see Appendix A and B).

2. Align CMO purchasing decisions with the directions of the NSW Mental Health Strategic Plan and allow enough time to include the development of the Ministry of Health Community Mental Health Framework. In communicating this, MHDAO needs to be clearer to CMOs on the scale of change being planned and the reasons for these changes. Provide a vision for how the consumer journey should happen through new funding arrangements. For example:
    - Easier navigation and access to services
    - Increased individual choice of services and activities
    - Clearer referral process for GPs, LHDs, consumers, carers and other CMOs

3. Extend funding and refine CMO contracts to current organisations for FY 2015/16 as per FY 2014/15, providing stability to current organisations while the Community Mental Health Framework is developed.

4. Recontract HASI packages that are due to be retendered in 2015 for a one-off period (up to the beginning of P4H purchasing) in a select tender process to allow all CMO program funding to be contracted in line with the newly developed Community Mental Health Framework.

5. Provide funding for a 2015/16 sector readiness program to engage with and support the community mental health sector during the P4H transitions.

    - Capacity building grant funding to enhance sector readiness and capacity building similar to those provided in FACS Homelessness and Disability reforms. The relevant community mental health areas are:
        - Client experience (program range and responsiveness)
        - Service provision (organisational capacity)
        - Policy and planning (planning, funding and evaluation)
        - Research and development (innovation and growth).[8]

    - P4H reform readiness communication and training initiatives (to be costed following negotiation of deliverables), including:
        - Managing client transitions
        - Workforce redeployments
        - Minimising sector instability.

More details on the types of communication and training initiatives proposed to be progressed is provided in Appendix A.

6. Consult with the community mental health sector on:
    - The opportunities, challenges and intentions of a centralised intake and assessment model.
    - Individual packages of care as the main service delivery model and how to contract for service types not designed be provided as individual packages (e.g. drop-in centres, group activities, infrastructure-based services, etc.).
    - The utility and effectiveness of CMO partnership contracting methods in the context of individual flexible packages of care.
    - The opportunities and advantages of core/infrastructure funding.

7. Review all non-acute public mental health services for their capacity to be more effectively delivered in the community. Where the community integration, rehabilitation and support components of a service outweigh the acute care components, consideration should be given to purchasing the service from a CMO through tendering processes.

[8] These sector capacity development framework elements are derived from: Mental Health Coordinating Council 2010, *Building Capacity in the NSW Mental Health CMO Sector: A Review of the Literature*. NSW Australia.

Appendices

A. Briefing Note the NSW Ministry of Health – Partnerships for Health Reform Readiness of the NSW Community Managed Mental Health Sector (14/1/2015)

   A1. NSW Government Industry Development Fund Initiatives

   A2. NSW Government (FaCS/ADHC) Organisational Transition Fund Outcomes as at January 2015

B. MHCC Member Needs Survey, November 2014 – Summary Findings of Questions Related to the NSW Partnerships for Health Reforms

C. Community Managed Mental Health Sector Service Categories

D. Hunter New England NDIS Trial Site Population Projections for People with Severe and Persistent Mental Illness

E. An Example of Adjusting Population Based Planning Approaches for Specific Needs Groups

Appendix A

Briefing Note for the NSW Ministry of Health

PARTNERSHIPS FOR HEALTH REFORM READINESS OF THE NSW COMMUNITY MANAGED MENTAL HEALTH SECTOR

14 January 2015

Summary
The Mental Health Coordinating Council (MHCC) has for some time been raising awareness about inequities in access to organisational readiness funding support between NSW Family and Community Services (FaCS)/Ageing, Disability and Homecare (ADHC) and NSW Health funded NGOs as this relates to both implementation of the National Disability Insurance Scheme (NDIS) and the Partnerships for Health (P4H) funding reform initiatives.

The recent experiences of Victoria's reforms of community sector mental health services tell us that greater consideration needs to be given to the sector reform readiness needs of NSW Health funded not-for-profit community managed mental health services. These needs are far greater than simply providing training for tender writing. Following some background information, recommendations for achieving this are provided.

In summary, this briefing note expands on the recommendation of the full MHCC Briefing and Recommendations document that funding be made available to provide a sector readiness program of support.

This recommendation requires the delay of P4H mental health program reforms until 2016/17, thus allowing a longer lead-in time for sector readiness activities and including the opportunity to provide a MHCC administered reform readiness program during 2015/16. The activities of the program would include:

- $1 million sector P4H capacity building grants fund to enhance sector readiness and capacity building in the areas of:
    - Client experience (program range and responsiveness)
    - Service provision (organisational capacity)
    - Policy and planning (planning, funding and evaluation)
    - Research and development (innovation and growth).[9]
- P4H reform readiness communication and training initiatives (to be costed following negotiation of deliverables):
    - Managing client transitions
    - Workforce redeployments
    - Minimising sector instability.

More details about potential approaches to the above communication and training initiatives is provided in the main narrative of this briefing note (next page).

[9] These sector capacity development framework elements are derived from: Mental Health Coordinating Council (2010). *Building Capacity in the NSW Mental Health CMO Sector: A Review of the Literature*. NSW Australia.

Background

- MHCC, the NSW Consumer Advisory Group and Mental Health Carers ARAFMI wrote to the Mental Health Minister in September 2013 regarding 'Access to NSW Capacity Building Funds for Organisations Providing Psychosocial Disability Services'. This Briefing Note is provided in follow-up to that letter.

- A November 2013 survey has subsequently been undertaken of the MHCC membership and it indicates an understanding that the impacts of P4H reforms on the sector will be high. It also confirms that considerable activity related to P4H reform readiness has occurred, especially for larger organisations, but that there is much more remaining to be done in anticipation of the forthcoming reforms.

- MHCC now understands that a likely focus of the P4H reforms to the NSW Health NGO Mental Health Program will essentially be creating 1,850 individualised care packages for people with severe mental illness to live in the community (i.e., consistent with the NSW Mental Health Strategic Plan). This is to be achieved through reforms to, and enhancements of, the current Housing and Accommodation Support Initiative/HASI program. It is unclear how group-support and drop-in based services will be catered for within or beside this model of service purchasing. One enhancement may be the establishment of local level centralised intake and assessment services, as has been the case in Victoria and in preparation for Commonwealth health and disability sector reforms.

- MHCC has been closely monitoring the Victorian community sector mental health reforms with a view towards learning and benefiting from these experiences. The Victorian experience has taught us that close collaboration between community sector mental health services and government is essential. In Victoria, reform meant that the government pursued a planned reform process including the release of a sector specific discussion paper and consultative planning and implementation structures. While the reality of the reform process did not match the stated consultation structures, those structures are still viable for the P4H reforms. Structures pursued to help maximise reform efficiencies and effectiveness included the establishment of working groups to consider a:

    - Performance management framework
    - Data collection and reporting schedule
    - Workforce capability framework
    - Operational guidelines for Individualised Client Support Packages
    - Intake and Assessment Service Review
    - Youth residential rehabilitation service operational guidelines
    - Local area catchment based planning functions.

- The proposed NSW Health P4H reforms are occurring in the context of a range of complex Commonwealth and state community sector reforms including but not limited to implementation of the NDIS, retendering of Department of Social Services (DSS) NGO programs and the tendering of primary healthcare networks. P4H reforms in mental health must not occur without greater consideration of this larger context, including the forthcoming 'efficiency and effectiveness' review of the national Mental Health Commission that was tabled to government in November 2013 that has not yet been made public.

- Continuing 'ad hoc' mental health reforms have contributed to an unstable and uncertain environment for community sector mental health services and reform support is urgently required if the aspirations of an enhanced role for the non-government sector in the NSW Mental Health Strategic Plan are to be optimally met.

- For example, even with the structures noted above having been established the Victorian experience as documented by that state's peak body – VICSERV - is that 50% of the sector experiencing significant and wide spread movement in their workforce with 44% of FTE having been redeployed or made redundant due to contracts not being renewed or resigned. In addition, around 2,500 consumers were identified as needing to move services, with other services expecting to manage the higher number of consumers than they have funding for through natural attrition. Services also reported more than 797 hours of additional legal and other business related costs. NSW needs to learn from these significant and unnecessary service delivery disruptions.

- Furthermore, a recent Mental Health Australia survey has demonstrated vast uncertainty related to mental health services reform and that for community sector mental health organisations and programs:

    - 40% report they have already experienced loss of staff
    - 46% report a difficulty attracting new staff
    - 53% report a reduction in services to clients
    - 81% report a decline in staff morale
    - 85% report a loss of trust in government amongst management and staff
    - 56% report they have had no communications regarding the future of their Commonwealth funding after June 2015, and
    - 91% of organisations said if they did not find out about their funding, they would need to reduce staff, and
    - 88% said they would need to reduce services.

- At the same time, it has quickly became apparent that the NDIS presents opportunities to increase whole-of-population capacity for acute/sub-acute assessment and treatment services provided by Local Health District (LHD) mental health services by increasing access to community support services for people with high levels of psychosocial disability related to a mental health condition. P4H reforms need to compliment these directions.

- The recent three year $115M budget allocation responding to the NSW Mental Health Commission Strategic Plan 2014-24 does not address the sector reform readiness of community sector mental health services.

- In the 2009/10 State Budget, the NSW Government allocated $17 million for an Industry Development Fund (IDF) in the disability services sector: http://www.idfnsw.org.au/idf-toolbox. The IDF is designed to enhance the readiness of ADHC funded community sector disability support services for NDIS and also NSW 'Stronger Together 2' reforms. Current IDF initiatives are summarised as Attachment A1.

- From 2013/14, the IDF has been complemented by Commonwealth DSS Sector Development Funds directly to ADHC (known in NSW as the Organisational Transition Fund/OTF; the national allocation to states/territories in 2013/14 was $15.9M and FaCS advise that for NSW this allocation was $0.5M). Health funded NGOs who are providers of mental health/psychosocial disability support services have not benefited from this targeted funding unless also ADHC funded. MHCC estimates that only 33 (or 29% of our member organisations) are ADHC funded (i.e., 71% or 79/112 organisations have no access to the IDF or OTF.

- For example, in 2013/14 the NSW Government's OTF allocated $2.5M to 102 recipients, none of which were mental health/psychosocial disability specific: http://www.idfnsw.org.au/organisation-transition-fund-resources. Attachment A2

provides the outcomes of the grant program and included the buying in of expertise in IT, marketing, managing change and financial viability as recurrent requests.

- While the IDF/OTF organisational readiness resources available on the National Disability Services (NSW) website have recently become accessible to any interested stakeholder this does not include consultancy, access to training or capacity building funding unless an organisation is ADHC funded.

- This is because mental health related disability was seen as a Health Minister responsibility under the former Disability Services Act (1993). The new 2014 Disability Inclusion Act includes mental health related disability but, as legislation, is silent on the subject of financial responsibility.

- It is important that NSW Health funded mental health NGOs have access to community sector reform organisational readiness funding and support.

- The risk of not doing this is that community sector organisations providing services to people with mental health conditions become increasingly unstable and inefficient, and that there are less organisations available to provide services and respond in innovative and flexible ways to unmet community needs.

Recommended Actions

1. The NSW Health Minister needs to ascertain the amount of Commonwealth Department of Social Services funding being provided to the NSW Government from the $149 million NDIS Sector Development Fund (i.e., 2013 to 2017) and allocate an amount to relevant Health funded NGOs not in receipt of ADHC funding to support their reform readiness, with a particular focus on mental health NGOs given directions of the NSW Mental Health Strategy and ongoing negotiations for whole-of-government responsibilities for the strategy's implementation.

2. Health funded NGOs require access to reform readiness funding and consultancy support in ways that are similar to that of the ADHC IDF and OTF (e.g., establishment of a Mental Health NGO Industry Development/Organisational Transition Fund; sector capacity building grants of $1M in 2015/16).

3. Other funding needs to be set aside for reform readiness education and training initiatives that will be required to maximise outcomes of NSW P4H reforms beyond the NSW Health Integrated Care Branch minimally proposed 'tender writing' related initiatives, and including but not limited to:

   Managing Client Transitions
   - Client records up to date (workshop and user manual; preferably using the nationally mandated PIR CANSAS assessment schedules)
   - Consumers and family/carers informed (frequent communique to advise about sector changes; forums to inform consumers and carers of impending service delivery changes)
   - Staff fully briefed (frequent communique to advise about sector changes; structured redeployment opportunities)

   Workforce Redeployments
   - Managing Redundancies (workshop/s to facilitate human resource and organisational financial impacts, e.g., long service leave payouts)
   - Resume Writing and Job Search (workshops/s to facilitate redeployment opportunities)

   Minimising Sector Instability
   - Business Contingency Planning (continuing encouragement of consortia, mergers, etc.)
   - Managing Change and Building Resilience (resources to facilitate manager/team leader preparedness for significant sector change).

4. The proposed NSW Health Mental Health NGO Industry Development/Organisational Transition Fund and MHCC delivered NSW Health ICB communication and training initiatives need to be conducted interdependently of one another and informed by the activities of the NSW Mental Health Strategic Plan beyond the component that relates to the transition of the current HASI places to 1850 individualised care places, e.g., family and carer support services, , integrated service delivery models, consumer operated services.

NSW Government Industry Development Fund Initiatives

NSW Industry Development Fund (IDF) targets only NSW Ageing, Disability and Homecare (ADHC) funded organisations. The Department of Family and Community Services (FaCS) advise that this is because there will be no ADHC to support the development of these organisations following the full roll-out of the National Disability Insurance Scheme (NDIS) in 2019.

The IDF has seven key platforms:

- Strategy
- Corporate Governance
- Clients & Market Focus
- Financial Sustainability
- People & Capability
- Information & Knowledge
- Quality & Improvement.

Organisational readiness capacity building products currently as available include:

- Productivity Tool - this tool focuses on the back of house functions in your organisation.
- NDIS Organisational Readiness Toolkit - the tool looks at the 7 key domains you need to address in moving your organisation forward to be ready for the NDIS.
- ADHC Cash Flow Management Tool - this suite of resources will assist you to effectively identify, forecast and control the flow of money coming in and out of your business.
- ADHC Investment and Loan Financing Tool & Resources - examines the potential role of loans for service providers.
- ADHC Unit Costing Tool & Resources - An Excel based unit costing tool and related resources, as well as exploring unit costing software options.
- Social Impact Measurement Tool - provides the opportunity to measure outcomes for people with disability and the impact that the services you have on your community.
- Progress for Providers for Managers - this self-assessment tool assists managers to check their progress in implementing person centred approaches.
- NDS Online Quality Pathway - NDS hosts a simple online system that guides service providers through completing their self-assessment against a wide range of standards including the NSW Disability Service Standards. A free Workbook is also available.
- Board Recruitment Toolkit - this toolkit provides a guide and template to assist organisations in the recruitment of new board members.

Projects being funded through Commonwealth DSS NDIS Sector Development Fund (SDF) are:

- Unit costing tool with online access.
- Options for NGOs to respond to cash flow issues associated with moving from block funding to individual funding.
- Project on the potential role of loans in the NGO sector.

FaCS advise that the above three projects are being provided with $0.5M provided in 2013/14. Directions for the remaining $120M of the SDF are pending the development of a future directions 'framework' by DSS.

NSW Government (FaCS/ADHC) Organisational Transition Fund Outcomes as at January 2015

Project Description	Organisation Name	Location	Project End Date
Strategy			
Employ Consultant to assist with Partnership Transition/Strategy	Newcastle Community Transport Group Inc **(lead organisation)**	Hunter NDIS Launch Site	18 December 2014
	Mercy Community Services	Hunter NDIS Launch Site	
Employ Consultant to assist with alliance and strategy	Orana Early Childhood Intervention & Education Project Inc **(lead organisation)**	Regional	1 November 2015
	Orange and District Early Education Program Inc	Regional	
	Bathurst Early Childhood Intervention Service Inc	Regional	
Consultant to scope service model	Christian Community Aid Service Inc **(lead organisation)**	Metro	30 April 2015
	Hunters Hill Ryde Community Services Inc	Metro	
Employ staff to project manage transition to NDIS	Kurri Kurri Community Centre Inc	Hunter NDIS Launch Site	1 May 2015
Employ Transition Coordinator	Muscular Dystrophy Association of NSW	State-wide	31 December 2014
Equipment purchase and compliance with building modification contracts	Home Modifications Lake Macquarie/Newcastle Inc	Hunter NDIS Launch Site	30 June 2015
Transition Project Officer	Macarthur Diversity Services Initiative Ltd	Metro	31 May 2015
Transition Project Officer	ACSN Inc	Metro	30 September 2015
Development of strategic alliance	Peninsula Community Centre Inc t/a Coast Community Connections	Regional	30 June 2015
Clients and Market Focus			
Strategic marketing and communications development - with a focus on the development of marketing material	Kempsey Respite Services Inc **(lead organisation)**	Regional	31 October 2015

Project Description	Organisation Name	Location	Project End Date
	Bucketts Way Neighbourhood Group Inc	Regional	
	CRANES Community Support Programs Limited	Regional	
	Inverell Disability Services t/a Brighter Access	Regional	
	National Respite Association Inc	State-wide	
Strategic marketing and communications development - with a focus on website development	Interchange Illawarra Inc **(lead organisation)**	Regional	31 October 2015
	Interchange Shoalhaven Inc	Regional	
	Hastings District Respite Care Inc.	Regional	
	Riverlink Interchange Inc.	Metro	
Marketing, Staff training and IT Solutions - CRM and ITC infrastructure	Byron Shire Early Intervention Association Inc. **(lead organisation)**	Regional	1 December 2015
	Ballina Early Intervention	Regional	
	Jumbunna Community Pre-School & Early Intervention Centre	Regional	
	Tweed Valley Early Childhood Intervention Service Inc.	Regional	
	Summerland Early Intervention Programme	Regional	
Conversation Starter' Tool	Mai-Wel Ltd	State-wide	30 June 2015
Marketing and Advertising Strategies and Activities	Beresfield & District Community Care Inc.	Hunter NDIS Launch Site	1 April 2015
App 'My Pre-Planning Tool'	House With No Steps	State-wide	30 June 2015
IT Solution - Client communication hub	Sunnyfield	State-wide	17 March 2015
Employ Service Engagement Consultant	Vision Australia Limited	State-wide	28 February 2015
IT Solution - Integrated website and online booking service	Newcastle Temporary Care Ltd	Hunter NDIS Launch Site	30 June 2015
IT Solution - Single entry web based system	Response Services Inc.	Hunter NDIS Launch Site	30 June 2015

Project Description	Organisation Name	Location	Project End Date
Training courses for individuals and organisations to support the transition to the NDIS	Cerebral Palsy Alliance	State-wide	30 June 2015
Branding package and other marketing solutions	Novacare Inc.	Hunter NDIS Launch Site	31 October 2014
Employ 'Community Voice Officer' in Transition	Brain Injury Association of NSW Inc.	State-wide	30 June 2015
Marketing Project Officer and Website	Northern Beaches Interchange Inc.	Metro	31 July 2015
IT Solution - Client management system	Essential Employment and Training Ltd	Regional	31 May 2015
Development of a Marketing Strategy and Framework	Inala	Metro	28 February 2015
IT solution - Client management system	On-Focus Inc.	Regional	31 July 2015
IT Solution - Case management software	Ningana Enterprises Inc.	Regional	30 June 2015
Website and consumer portal	St George & Sutherland Community College	Metro	31 August 2015
Website - promoting early intervention for parents of deaf children	The Shepherd Centre	Metro	1 September 2015
Aboriginal Client Project Officer	Bathurst Seymour Centre Inc.	Regional	30 June 2015
Employ Marketing Officer	Newcastle Meals on Wheels Inc.	Regional	31 August 2015
Pilot client engagement and service provision model 'New Directions Community Program'	NADO Inc.	Metro	30 June 2015
Employ Marketing and Fundraising Consultant	The Housing Connection Ltd	Metro	30 June 2015
Fund staff to manage period of transition to NDIS marketplace	Bankstown Community Resource Group Inc.	Metro	30 July 2015
Website development and other promotional material	FOCAS Shoalhaven Inc.	Regional	31 July 2015
Digital Media Strategy and Website	Warrah Society	Metro	31 May 2015
Marketing and Advertising Strategies and Activities	Special Needs Support Group Inc.	Regional	15 November 2015
Marketing and Advertising Strategies and Activities	Minimbah Challenge Inc.	Metro	30 April 2015

Project Description	Organisation Name	Location	Project End Date
Market research	The Salvation Army New South Wales Property Trust	State-wide	30 June 2015
Communications/Marketing Strategy and Implementation	Awabakal Newcastle Aboriginal Co-op Ltd	Regional	30 June 2015
Client and Staff Management System and Project/Change Manager	Central Coast Post School Options Inc. t/a Options Disability Support	Regional	30 October 2015
IT Solution - Client management system	Greenacres Disability Services	Regional	31 July 2015
IT Solution - Website development and extend current database	Mater Dei Ltd	Metro	1 February 2016
IT Solution - Client management system	Early Education (EarlyEd) Inc.	Metro	30 June 2015
Develop new website	Australian Foundation for Disability (AFFORD)	Metro	1 December 2015
IT Solution - Client management system	Multitask Human Resource Foundation Ltd	Regional	1 November 2015
IT Solution - Website upgrade	Job Centre Australia Ltd t/a First Contact Human Resources	Regional	3 February 2015
IT Solution - Client management system	Community Gateway Inc.	Regional	30 June 2015
Financial Sustainability			
Financial Sustainability Workshops	Firstchance Inc. **(lead organisation)**	Hunter NDIS Launch Site	30 June 2015
	Hunter Prelude Early Intervention Centre Inc.	Hunter NDIS Launch Site	
	Early Links Inclusion Support Service Inc.	Hunter NDIS Launch Site	
IT Solution - Accounting package	The Junction Works Ltd	Metro	13 March 2015
IT Solution - Accounting package	Kyogle District Care Connections Inc.	Regional	30 June 2015
Financial advice on managing individual budgets and person centred training	Accessible Living Options	Regional	1 July 2015
IT Solution - Accounting package	Respite & Recreation Inc.	Regional	31 January 2015
IT Solution - Accounting package	Christie Centre Inc.	Regional	30 June 2015

Project Description	Organisation Name	Location	Project End Date
IT Solution - Accounting package	Thorndale Foundation Ltd	Metro	30 September 2015
Staff to build/develop new business system	Lifestart Co-operative Ltd	Metro	30 September 2015
IT Solution - Accounting package	Lifeskills Plus Inc.	Regional	31 January 2015
IT Solution - Accounting package	McCall Gardens Community Ltd	Metro	31 March 2015
IT Solution - Accounting package	Alliance Health Services Group Pty Ltd	State-wide	30 April 2015
People and Capability			
Transition Project Officer	The Ascent Group Australia Ltd **(lead Organisation)**	Regional	30 September 2015
	Care for Children with Disabilities Inc. - Armidale	Regional	
	Pedal Early Childhood Intervention Service Inc.	Regional	
	Armidale Dumaresq Council	Regional	
Training - person centred approaches to behaviour management	Currajong Disability Services Inc. **(lead Organisation)**	Regional	31 July 2015
	Westhaven Association	Regional	
Employ project officer to create a 'competency map'	The Northcott Society	State-wide	21 November 2014
Web based application to strengthen workforce management system	ConnectAbility Australia Incorporated	Hunter NDIS Launch Site	15 December 2014
Paper on Employment Scope for Auslan Users and online tool for guided RPL process for Cert Iv Auslan	The Deaf Society of NSW	State-wide	30 June 2015
Transition Project Officer and IT hardware	Greystanes Disability Services	Regional	31 August 2015
IT Solution - Rostering software	Blackheath Area Neighbourhood Centre Inc.	Regional	1 August 2015
Information and Knowledge Management			
Specifications Manual for Integrated Client Management System	Royal Institute for Deaf & Blind Children	State-wide	31 December 2014
Person-Centred Client Information Management System Development	CatholicCare Social Services Hunter-Manning	Hunter NDIS Launch Site	31 March 2015

Project Description	Organisation Name	Location	Project End Date
Upgrade website to link with the backend of existing database	Motor Neurone Disease Association of NSW Inc.	Metro	31 January 2015
IT Solution - Equipment and promotional materials	New Deal Association	Regional	31 October 2014
IT Solution - Enhancement of current intranet capabilities	Assisted Community Living Ltd t/a ACL Disability Services	Metro	30 April 2015
IT Solution - Server and equipment upgrade	Family Link Care & Support Service Inc.	Regional	1 November 2014
IT Solution - Software to integrate multiple platforms	Manning Valley Respite Care Service Inc.	Regional	31 August 2015
IT Solution - Mobile devices for staff	ADSSI Limited	Regional	30 June 2015
Technology for live streaming assessments	South Coast Home Modification and Maintenance Service Ltd	Regional	31 October 2015
IT Solution - Mobilise custom solution via multiple devices	New Lake Peer Support Inc.	Regional	30 April 2015
IT Solution - Laptops and software	Lane Cove & North Side Community Services	Metro	31 December 2014
IT Solution - Information management	Junee Community Centre Inc.	Regional	30 September 2015
IT Solutions - Laptops and tablets	Windgap Foundation Ltd	Metro	30 June 2015
IT Solutions - Server and smartphones	Fairhaven Services Ltd	Regional	31 January 2015
Communications Upgrade	3Bridges Community Inc.	Regional	31 March 2015

Appendix B

MHCC Member Needs Survey, November 2014 – Summary Findings of Questions Related to the NSW Partnerships for Health Reforms

In November 2014 the MHCC surveyed its members to help determine the priorities of the community managed mental health sector regarding the range of sector reforms currently under-way. Two key reforms were focused on: the NSW *Partnerships for Health* (P4H) CMO purchasing reform and the implementation of the National Disability Insurance Scheme (NDIS).

There were 43 respondents of which 39 were confirmed as financial members. Respondents included a range of organisation sizes, service types and geographic locations.

Below is a summary of the key feedback relevant to this paper informing the MHCC's advocacy to the NSW Government.

Reform most likely to affect the sector

Respondents overwhelmingly indicated that P4H is the most influential reform affecting the services they deliver. The NDIS received a split opinion, where some organisations saw it as the most important and some saw it as the least important. The diagram below demonstrates the results.

	1	2	3	4	Total	Average Ranking
NSW Health – Partnerships for Health (previously the NGO Grant Management Improvement Program)	**44.74%** 17	**23.68%** 9	**13.16%** 5	**18.42%** 7	38	2.95
National Disability Insurance Scheme	**34.21%** 13	**21.05%** 8	**0.00%** 0	**44.74%** 17	38	2.45
NSW Mental Health Strategic Plan	**2.63%** 1	**31.58%** 12	**52.63%** 20	**13.16%** 5	38	2.24
National Mental Health Reform	**18.42%** 7	**23.68%** 9	**34.21%** 13	**23.68%** 9	38	2.37

The impact of the NDIS importance spilt has not yet been analysed and may impact upon the P4H sector readiness analysis which follows.

Indications of sector readiness for Partnerships for Health

Notable findings:

- Members feel prepared with clearly defined service offerings somewhat aligned with MoH priorities (as understood to date)
- Members report being unprepared for workforce increases/decreases that are likely to be a result of P4H
- Most organisations are not considering, or preparing for, possible redundancy impacts and other impacts on employment uncertainties
- Members are prepared, or are in the process of preparing, to support peer workforce development
- Respondents are mostly ready to tender, however, financial health and especially price unit costing were identified as areas where support may be required
- Respondents report good data system readiness, except for systemic capacity to analyse and report on collected data
- There appears to be considerable implementation activity to get ready for change involving partnership arrangements and developing mergers. Especially noteworthy is that almost all organisations are either not considering mergers or are already well underway with little in-between. Most members are in the early stages of developing consortia.

Results tables are provided are provided below for further detail.

Q5: Service definition

Please select from dropdown options:							
	Not considering	Aware but not prepared	Preparing - In Development	Preparing - Implementing	Prepared	N/A	Total
Clearly defined service offering.	4.35% 1	13.04% 3	21.74% 5	13.04% 3	34.78% 8	13.04% 3	23
Understanding of the need for services to align with stated NSW health priorities.	8.70% 2	17.39% 4	21.74% 5	13.04% 3	26.09% 6	13.04% 3	23
Grasp of the directions within the NSW MH Commission Report 'Living Well'.	4.35% 1	21.74% 5	26.09% 6	4.35% 1	26.09% 6	17.39% 4	23

Q6: Workforce readiness

(no label)	Not considering	Aware but not prepared	Preparing - In Development	Preparing - Implementing	Prepared	N/A	Total
Workforce planning for services increase/decrease after contestable tendering process	**8.70%** 2	**34.78%** 8	**30.43%** 7	**8.70%** 2	**8.70%** 2	**8.70%** 2	23
Strategies for redundancies	**30.43%** 7	**13.04%** 3	**17.39%** 4	**4.35%** 1	**13.04%** 3	**21.74%** 5	23
Staff training for "working with uncertainty"	**17.39%** 4	**30.43%** 7	**13.04%** 3	**4.35%** 1	**17.39%** 4	**17.39%** 4	23
Training, personal development and supervision for the peer workforce	**4.35%** 1	**13.04%** 3	**26.09%** 6	**13.04%** 3	**34.78%** 8	**8.70%** 2	23

Q7: Readiness to tender

(no label)	Not considering	Aware but not prepared	Preparing - In Development	Preparing - Implementing	Prepared	N/A	Total
Financial health	**8.70%** 2	**8.70%** 2	**34.78%** 8	**13.04%** 3	**26.09%** 6	**8.70%** 2	23
Effective Corporate Governance	**4.35%** 1	**0.00%** 0	**21.74%** 5	**26.09%** 6	**39.13%** 9	**8.70%** 2	23
Up-to-date policies and procedures	**4.35%** 1	**0.00%** 0	**17.39%** 4	**34.78%** 8	**34.78%** 8	**8.70%** 2	23
Tender writing skills	**8.70%** 2	**17.39%** 4	**43.48%** 10	**0.00%** 0	**21.74%** 5	**8.70%** 2	23
Unit costing processes	**8.70%** 2	**30.43%** 7	**13.04%** 3	**21.74%** 5	**13.04%** 3	**13.04%** 3	23
Risk and compliance processes	**4.35%** 1	**4.35%** 1	**21.74%** 5	**21.74%** 5	**39.13%** 9	**8.70%** 2	23

Q8: IT and knowledge systems

(no label)	Not considering	Aware but not prepared	Preparing - In Development	Preparing - Implementing	Prepared	N/A	Total
Client management systems	**0.00%** 0	**13.04%** 3	**13.04%** 3	**26.09%** 6	**34.78%** 8	**13.04%** 3	23
Data analysis and reporting systems	**0.00%** 0	**21.74%** 5	**13.04%** 3	**13.04%** 3	**43.48%** 10	**8.70%** 2	23
Outcome measurement and evaluation processes	**4.35%** 1	**4.35%** 1	**26.09%** 6	**17.39%** 4	**39.13%** 9	**8.70%** 2	23
Continuous Quality Improvement systems	**0.00%** 0	**17.39%** 4	**13.04%** 3	**30.43%** 7	**30.43%** 7	**8.70%** 2	23

Q9: Change management strategies

(no label)	Not considering	Aware but not prepared	Preparing - In Development	Preparing - Implementing	Prepared	N/A	Total
Leadership in uncertain times	**4.35%** 1	**4.35%** 1	**26.09%** 6	**26.09%** 6	**30.43%** 7	**8.70%** 2	23
Building workforce resilience	**4.35%** 1	**13.04%** 3	**34.78%** 8	**21.74%** 5	**21.74%** 5	**4.35%** 1	23
Team building and cohesion strategies	**0.00%** 0	**13.04%** 3	**26.09%** 6	**30.43%** 7	**26.09%** 6	**4.35%** 1	23
Partnerships and consortia	**4.35%** 1	**8.70%** 2	**34.78%** 8	**34.78%** 8	**8.70%** 2	**8.70%** 2	23
Mergers	**39.13%** 9	**13.04%** 3	**21.74%** 5	**0.00%** 0	**13.04%** 3	**13.04%** 3	23

Appendix C

Community Managed Mental Health Sector Service Categories[10]

The MHCC Sector Benchmarking Project focuses on the elements of community mental health sector services in the Australian Institute of Health and welfare (AIHW) NGO Establishments Minimum Data Set (NGOE NMDS) that can be modelled on individual packages of care.

Over page is an extracted table from the final Sector Benchmarking Project Report noting the service categories that were counted across NSW against the NGOE NMDS. Population modelling then used a sub-set of service categories marked 'In scope, not modelled' which are still essential components of the service system, but are generally not able to be broken down into an individual package of care, and tend to be block funded.

The categories of CMO services used in the Sector Benchmarking Project population targets are:

- Counselling
- Group support activities
- Mutual support and self-help
- Accommodation
- Personalised support services
- Family and carer support
- Education, employment and training.

Note: The above service categories are necessary but not sufficient as a set of service categories for community mental health rehabilitation and recovery/disability support. The categories of service that also need to be funded (but are not reasonably modelled as individual packages) are:

- Information, referral and advocacy
- Care/service coordination
- Sector development and representation
- Mental health promotion
- Mental illness prevention.

In addition, sub-acute and non-acute CMO proxies should be considered for community-based Local Health District (LHD) mental health services. Examples include step-up / step-down units and LHD case management/care coordination.

[10] Extract from: Mental Health Coordinating Council 2013, *NSW Community Managed Mental Health Sector Benchmarking Project: Final Report* (confidential document that has been made available to LHDs).

AIHW NGO Establishments National Minimum Data Set Taxonomy[1]	**Sector Benchmarking Project 'As is' Analysis Categories** (January 2013 data)
1. Counselling—Face-to-face	1. Counselling, support, information & referral
2. Counselling, support, information & referral—telephone	
3. Counselling, support, information & referral—online	
4. Self-help —online	
5. Group support activities	2. Group support
6. Mutual support and self-help	3. Mutual support and self-help
7. Staffed residential services	4. Staffed residential services
8. Personalised support—linked to housing	5. Personalised support—linked to housing
9. Personalised support—other	6. Personalised support—other
10. Family & Carer support	7. Family & carer support
11. Individual advocacy	In scope, not modelled
12. Care Coordination	In scope, not modelled
13. Service Coordination	In scope, not modelled
14. Education, employment & training	8. Education, employment & training
15. Sector development & representation	In scope, not modelled
16. Mental health promotion	In scope, not modelled
17. Mental illness prevention	In scope, not modelled
	9. Step-Up/Step-Down (not in NGOE NMDS)

[1] Source: AIHW (2012a)

Appendix D

Hunter New England NDIS Trial Site Population Projections for People with Severe and Persistent Mental Illness

MHCC's 2013 *Sector Benchmarking Project*[11] builds on earlier work undertaken through the 2010 *Sector Mapping Project*[12] and incorporates the methodology of the National Mental Health Service Planning Framework (NMHSPF)[13]. The *Sector Benchmarking Project* makes NSW Local Health District (LHD) and LGA level projections for non-government community managed mental health services per 100,000 of population aged 18 to 65 years. The project also contains a 2013 stocktake of community sector mental health services and presents a gap analysis between this stocktake and the population targets of the NMHSPF, thus providing an assessment of need across the range of service types.

An example of how this data can be useful for community-based mental health service planning (e.g. for comparison to estimated NDIS Tier 3 package availability) is provided in the table below. Reliable population estimates for the number of people with severe/profound mental illness/psychosocial disability are made for the HNELHD, the two sub-catchments and the NSW NDIA trial site. Tier 3 package estimates are based on the current knowledge of funded packages to be made available nationally[14], which is less than 60,000.

Population 18-64 years in Various Parts of the HNELHD Catchment with Severe and Persistent Mental Illness

Geographic Area	2011 Census Population	Number of People with Severe Mental Illness	Estimates of people known to HNEMHS
Hunter New England	527,090	9,277	5,367
Hunter	421,907	7,425	4,096
New England	105,131	1,850	1,271
Newcastle LGA	99,762	1,756	1,737
Lake Macquarie LGA	117,338	2,065	1,126
Maitland LGA	49,671	874	637
NDIA trial site (3 LGAs)	266,771	4,695	3,500

The calculation of population need is made using NMHSPF assumptions and estimates. The Sector Benchmarking Project population estimates are 3,469 people with 'severe and persistent' mental illness per 100K population (3.5%), of which 1,760 have an identified needs to access psychosocial rehabilitation and recovery/disability support services per 100K (i.e., both 'clinical' and 'non-clinical' services).

[11] Mental Health Coordinating Council 2013, *NSW Community Managed Mental Health Sector Benchmarking Project: Final Report* (confidential document that has been made available to LHDs).
[12] Mental Health Coordinating Council 2010, *NSW Community Managed Mental Health Sector Mapping Report*.
[13] Commonwealth of Australia (unpublished). *National Mental Health Service Planning Framework*.
[14] Mental Health Council of Australia 2013, *Position Paper – Mental Health and the National Disability Insurance Scheme*.

There is currently no detail on which part of the psychosocial rehabilitation and recovery/disability support figure is the responsibility of the Ministry of Health (MoH) and which part is the responsibility of the NDIS, however, these people would all require full packages of care (either a MoH funded set of program places and/or a Tier 3 NDIS package with multiple components).

Furthermore, the role delineations between 'clinical' rehabilitation (noted in the NDIS 'in-principle agreement' to be a mainstream health services responsibility) and psychosocial rehabilitation needs further operationalisation.

While the Sector Benchmarking Project makes population level projections for unmet psychosocial rehabilitation and recovery support services, a limitation is that it does not include a mapping for or consideration of existing public sector mental health service or other relevant local level infrastructure. The projections also do not accommodate for the differing needs of specific population groups (e.g. regional and rural residents, Aboriginal people, and people with culturally and linguistically diverse backgrounds; see Appendix E). Directions for addressing these activities will be important actions in MoH and Local Health District (LHD) direction for taking NSW mental health sector reforms forward, including the opportunities presenting through the *Partnerships for Health* funding reforms.

Appendix E

An Example of Adjusting Population Based Planning Approaches for Specific Needs Groups[15]

Specific need population groups recognised as requiring extended and/or enhanced care and support included regional and rural residents (common problems include limited clinical and other services and support groups, travel times and isolation), Aboriginal people, and people with culturally and linguistically diverse (CALD) backgrounds (emerging and established communities). Their needs were raised by participants in all three consultations, and were discussed at length by three Reference Group members. In NSW, these issues are not usually considered in state-wide planning but factored in at the local level.

Some examples of how the specific needs issues of certain populations groups might influence the population estimates for community based psychosocial rehabilitation and recovery support services against the seven key service types considered in the Sector Benchmarking Project are provided below.

For example, an overarching theme for working with Aboriginal people was the need to work with and be seen within their extended family and kinship networks. The concept of 'social and emotional wellbeing', which is a much broader concept than 'mental health', is particularly relevant in this context. Cultural mapping skills training, extra hours and general flexibility are required for effective assessment, intervention and support.

Accommodation

- Aboriginal and CALD consumers with extended families are not suited by some housing options.

Personalised support services

- In rural areas, extra time is needed to compensate for scarce resources and transport problems; support needs to be more intense and longer duration.
- CALD consumers require extra time due to language and cultural barriers, with the greatest need in the first six months after which it may taper off.
- Service providers working with Aboriginal consumers may have minimal qualifications and/or little experience with this population group, in which case additional hours are required for supervision and diversity training.
- Workforce issues such as recruitment are particularly acute in remote areas of NSW where a social brokerage model (accessing specific services and/or resources from different human service providers as needed) often works best. Contemporary responses have involved activities such as building service hubs as practical and close to the remote communities, and training programs linked to employment opportunities for local residents of serviced communities.

Group support activities

- For some Aboriginal and CALD consumers, gender-separate activities may be needed.
- Language and cultural barriers may limit CALD consumers' ability to engage in standard groups; they may require their own group or additional support to engage (e.g. through additional hours or a bilingual worker).

[15] Extract from: Mental Health Coordinating Council 2013, NSW Community Managed Mental Health Sector Benchmarking Project: Final Report (confidential document that has been made available to LHDs).

Mutual support and self-help

- No specific issues raised.

Education, employment and training

- For many Aboriginal consumers employment prospects are limited by a range of issues including low literacy and levels of education, so there is a need to facilitate access to education support. Additional hours are needed on top of the generic care package.
- CALD consumers may require support to get overseas qualifications, experience and skills recognised, or to adapt their skill set and ambitions to the Australian context. Intensive input (10-15 hours a week) for first six months, dropping back to the generic package for 6-12 months.

Counselling

- Additional hours for Aboriginal consumers may be required to build up requisite knowledge of the consumer's cultural, community and extended family contexts.
- Add 50% to counselling time for CALD consumers requiring interpreter assistance, plus interpreter time.

Family and carer support

- Rural areas need to factor in travel.
- For Aboriginal communities it is essential that get this right, with education for family (including extended family and carers) early in the process since mental health literacy is likely to be lower than in the general population.
- Similarly, many CALD communities are collective in orientation with family members (not necessarily blood relatives who may not be in Australia or reluctant to engage due to stigma) and community leaders being critical to engage. Intensive input (an extra 2 hours a week on top of generic care package of 5 hours) required for first six months, dropping back to generic care package for 6-12 months.