Mental Health Coordinating Council
Submission to NSW Health

PROPOSAL TO PILOT A COMMUNITY MANAGED STEP-UP & HOME BASED OUTREACH (SUB-ACUTE) MENTAL HEALTH SERVICE IN NEW SOUTH WALES 2011 - 2014

November 2010

Contents

The Mental Health Coordinating Council

The Mental Health Coordinating Council (MHCC) is the peak body for community managed non-government organisations (CMOs/NGOs) working for mental health in New South Wales. We represent the views and interests of over 200 CMOs delivering more than 400 mental health programs throughout NSW. Member organisations specialise in the provision of services and support to people with, or at risk to develop, a disability as a consequence of mental illness. MHCC provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services to the community. Facilitating effective linkages between government, non-government and private sectors, MHCC participates extensively in public policy development. The organisation consults widely in order to respond to legislative reform and sits on national and state committees and boards in order to affect systemic change. MHCC manages and conducts research projects and develops collaborative programs on behalf of the sector and is a registered training organisation delivering accredited mental health training and professional development to the workforce.

1. Executive Summary

The *National Standards for Mental Health Services* (2010) and *Fourth National Mental Health Plan 2009-2014* (2009) emphasize the importance of community-based recovery-oriented mental health service provision. Between 1993 and 2005 the proportion of mental health funding spent on community care increased nationally from 29 to 51% (National Mental Health Report, 2007). However, the scale and pace of change varies considerably between states and territories as do directions for mental health service delivery by non-government organisations. In NSW, the proportion of funding to community mental health services only shifted from 30 to 44% and ranks lowest for funding to community managed organisations (CMOs) at just 2.8% of the total mental health budget compared to the national average of 6.3%.

In April 2010, the Council of Australian Governments (COAG) agreed that a significant investment in sub-acute (also known as step-up step-down) care of $1.62 billion across four health areas including mental health. The Mental Health Coordinating Council (MHCC) suggests that based upon the calculation of NSW providing services to almost one third of the Australian population, it is not unreasonable to assume almost one third of this funding would be allocated to NSW ($567M million). This is potentially a signifigant investment in mental health services and there are currently no best-practice examples of “step-up step-down” facilities in NSW.

In this proposal the MHCC recommends a three year pilot of a best-practice community-based step-up mental health service in three geographic areas of NSW at an approximate cost of $15M. The defining characteristics of the proposed sub-acute model are:

- 5-10 bed housing sites in the community;
- 24-hour crisis prevention, promotion and early intervention focus (ie, step-up and home-based outreach service model);
- Average length of stay is 14-28 days (with a maximum stay of three months);
- One each in a metropolitan, regional and rural location to maximise learning from the project;
- Rehabilitation and support services provided by CMO staff;
- Clinical treatment provided by private GPs and mental health practitioners (using Medicare Benefits Schedule reimbursable items); and,
- Priority of access to clients referred by government public mental health services (to encourage early identification and referral of people that are relapsing).

Implementation of the proposed step-up and HBOS would be project managed by MHCC and include a robust external evaluation strategy so that the benefits of the model can be clearly demonstrated.

This document gives a broad outline of the operation of and costs associated with the proposed community managed step-up & outreach mental health service and describes the key features that will underpin it including the use of *Collaborative Therapy* as a core program intervention. The proposal is informed by review of policy and overview of best practice examples in the provision of sub-acute mental health services both in Australia and internationally and includes a review of the current situation in NSW with regard to residential sub-acute mental health service delivery.

2. Proposal for Step-up and Home Based Outreach Service (HBOS) Project

The Service Delivery Model
Sub-acute mental health services target people that are not quite acute (ie, requiring community crisis intervention or acute hospital services) or chronically disabled (ie, requiring long term intensive community support or non-acute hospital services). That is, people who may need intensive treatment, rehabilitation and/or support for a short period of time to intervene early and prevent a health and/or social crisis.

Services may be either "step-up" or "step down". A step-up service typically occurs with a person before becoming so unwell that a psychiatric crisis results potentially requiring time in hospital. Ideally, a person would be supported to identify the signs that they are becoming unwell, to temporarily increase supports at home to avoid relapse (ie, outreach) and, if necessary, to spend a brief period of time at the step-up facility to prevent further deterioration and allow time to stabilise. A step-down service typically occurs with a person who has already become seriously mentally ill and is hospitalised and now needs more intensive care than they could receive at home to continue their recovery. A major concern with step-down approaches is that they are not sufficiently preventative or empowering in their orientation and can foster disability and dependency. Step-down approaches can also result in premature hospital discharges given the pressures to admit newly presenting patients which in turn can translate to "bed blockages" and lack of client throughput in services that primarily have a step-down orientation.

The proposed step-up and home based outreach sub-acute mental health service model is anchored in the concept of supporting recovery and independent self directed care while also reducing demand for specialist public mental health services. When a person enters a step-up facility they identify what it is that they will be achieving during their time there (eg, reduce symptoms, eliminate suicidal thoughts, explore education and employment options, improve cooking and cleaning skills, etc). Individual and group work occurs on a daily basis toward achieving these goals and residents also take leadership in the day-to-day running of the facility. Support Workers and Peer Workers are available 24 hours a day to provide program structure and assistance. Workers may have a university or vocational qualification (eg, Certificate IV in Mental Health) and do not provide clinical support.

Clinical support at the step-up and HBOS is provided by private practitioners including GPs, nurses and other allied health professionals using Medicare Benefits Scheme (MBS) reimbursable items. Other models for this to occur already exist in the form of the headspace program and clinical "in-reach" services that some private psychologists and other allied health professionals are providing in community managed mental health services in NSW and elsewhere. The kinds of MBS items that can be used for the provision of clinical treatment services include but are not restricted to:

- Access to Allied Psychological Services (ATAPS), part of the Better; Outcomes in Mental Health Care (BOiMHC) funded via GP Networks;
- Better Access to Mental Health Care;
- Chronic Disease Management ('Enhanced Primary Care') Program;
- Allied Health Group Services under Medicare for patients with type 2 diabetes;
- National Mental Health Nurse Initiative Program (MHNIP);
- Mental Health Services Rural and Remote Program;
- Multidisciplinary Case Conference;
- Domiciliary Medication Management Review; and,
- Nurse Practitioner rebates.

A description of each of these programs and potential relevance to the proposed Step Up and Outreach Project is provided as Attachment 1 - Overview of Medicare Benefits Scheme Funding Opportunities for Mental Health.

It is likely that further schemes and programs will be identified as the Commonwealth government continues to expand these services as part of National Health and Hospitals Reform. For example, the proposed $58.4M over four years introduction of "coordinated flexible care packages" to better support people with severe mental illness in primary care using ATAPS arrangements to be managed by Medicare Locals with implementation planned to commence between April and June 2011.

Priority of access to the step-up and HBOS will be given to existing clients of public mental health services thus freeing up much needed psychiatric crisis, acute and non-acute services. A service agreement between the facility and the local public mental health service will ensure priority of access and also speak to arrangements for care coordination of shared clients and the management of after-hours emergencies.

In this proposal the MHCC recommends a three year pilot of a best-practice community-based step-up mental health service in three geographic areas of NSW at an approximate cost of $15M. The defining characteristics of the proposed sub-acute model are:

- 5-10 bed housing sites in the community;
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- Average length of stay is 14-28 days (with a maximum stay of three months);
- One each in a metropolitan, regional and rural location to maximise learning from the project;
- Rehabilitation and support services provided by staff employed by non-government community managed organisations (NGOs/CMOs);
- Clinical treatment provided by private GPs and mental health practitioners (using Medicare Benefits Scheme reimbursable items); and,
- Priority of access to clients referred by government public mental health services (to encourage early identification and referral of people that are relapsing).

Collaborative Therapy will be used as a core program intervention and to ensure consistency in the fidelity of the services being provided. An extensive discussion of Collaborative Therapy is beyond the scope of this funding proposal and some additional background information about the therapeutic technique is provided as attachment 7.2.

Implementation of the proposed step-up and HBOS would be project managed by MHCC and include a robust external evaluation strategy so that the benefits of the model can be clearly demonstrated.

Aims of the Project

The major aim of the project is to develop trial and evaluate a step-up and HBOS in three areas in NSW: an urban area, regional area and rural or remote area.

Project Governance and Stakeholder Input

The MHCC will be the project's lead agency and will coordinate the project and provide governance and accountability. The MHCC proposes to establish a small Project Steering Committee comprised of representatives from a number of key stakeholder groups. The Steering Committee will assist with the development of strategic partnerships, policies, guidelines and protocols that are essential for the project's good governance and success.

The MHCC also proposes to provide opportunity for a wide range of further stakeholders to be involved with the project via Reference Group. Stakeholders to be involved in this way will include but not be restricted to:

- The NSW Health Mental Health and Drug and Alcohol Office (MHDAO);
- Representatives of member organizations;
- NSW CAG;
- Individual consumers;
- Key carer and family organizations;
- Individual carers;
- NSW Mental Health Transcultural Network;
- Aboriginal Health and Medical Research Council of NSW;
- Network of Alcohol and Other Drug Agencies;
- General Practice NSW;
- NSW Branch RANZCP:
- NSW Branch Australian College of Mental Health Nurses;
- NSW Branch College of AASW;
- NSW Branch Australian Psychological Association;
- NSW Branch of OT Australia;
- NSW Branch College of Nurse Practitioners;
- NSW Centre for Rural and Remote Mental Health
- NSW Division Royal Flying Doctor;
- Centrelink;
- NSW Housing; and
- Individuals or organizations with relevant expertise.

Project Conduct and Phases
It is proposed that the project run for 3.5 years and comprise the following three key phases:

Phase 1: Establishment Phase of the Project (Months 1-6)
Key tasks will include:

- Establishment by the MHCC of a Steering Committee and a Reference Group;
- Formation by the MHCC of partnerships to guide the project's conduct;
- Employment by the MHCC of a Project Coordinator;
- Identification by the MHCC of possible service locations;
- Development by the MHCC of protocols, guidelines, templates, databases and other;
- Development by the MHCC of request for Tenders or Expressions of Interest documentation; call for tender proposals or Expressions of Interests from partnerships lead by a community managed mental health sector organization; selection of successful bids; signing off on contractual arrangements with each successful tender; and working with successful partnerships to finalize individual project implementation plans;
- Development by the MHCC of request for tenders documentation for the project's evaluation; selection of successful tenderer; and finalization of evaluation plans.

Phase Two: Development and Establishment Phase of Step-up and HBOSs (Months 7-14)
During this phase each of the partnerships will establish the step-up and HBOS in their areas. Major tasks will include:

- Publicizing the project locally by contracted community-managed mental health organizations;

- Establishment local Steering and Reference Committees by the contracted community-managed mental health organizations;
- Employment by the contracted community-managed mental health organizations of Site Project Coordinators and IT/Project support staff;
- Each site seeking expressions of interests from locally-based primary health and mental health practitioners who are accredited with Medicare Australia and who are interested in providing services through the step-up and HBOS;
- Selection of practitioners and establishment of contractual arrangements and service agreements at each site by the contracted community-managed mental health organization;
- Establishment at each site of MOUs or service agreements with locally-based primary health providers, mental health services and psychosocial and recovery support organizations;
- Introduction and implementation of referral, intake, assessment procedures at each site;
- Development of care coordination procedures, protocols and enabling information systems at each site;
- Setting in place at each site project data systems;
- At each site meeting with Evaluation team and setting in place the systems that are required for Project Evaluation;
- Purchasing or hiring of necessary equipment at each site;
- Launch and opening of the step-up and HBOS at each site.

Phase Three: Fully Operational Phase (Months 14-42)
During this phase the step-up and HBOS will provide access to residential sub-acute services – both at the facility and in people's own homes. Six monthly reports documenting progress, activity, outcomes, learning and issues will be provided by each site. The evaluation team will provide a report on a 12 monthly basis as well as an overall project evaluation report towards the completion of the project.

During this period MHCC and the project sites will discuss with key stakeholders continuation or expansion of the step-up and HBOSs following the completion of the project phase.

Staffing Requirements
The following staffing requirements are proposed.

- Staff to be based at MHCC are:

Overall Project Coordinator (1 FTE) – employed by and based with the MHCC to coordinate the project conduct, implementation and evaluation; a person with significant project management expertise and experience in working community mental health organizations and providers of primary health care and who has an understanding of relevant Medicare programs and schemes.

IT & Project Support (1 FTE) – a person with administration and IT expertise and with working with community agencies who will be employed by and based with the MHCC to provide data management and administrative support services to the project; to help the MHCC and each site to set in place consistent information systems and data recording & reporting systems; and to trouble shoot where required.

- Staff to be based at each of the three program sites are:

Team Leader (1 FTE) – a person to be employed by and based with each of the partnership lead agencies; responsible for coordinating the conduct, implementation and evaluation of the project locally and initiating local partnerships, contractual arrangements and service agreements; with

skills in human resources, management and delivering outcomes against Funding and Performance Agreements.

Reception/Administration (1 FTE) – a suitably experienced person to be employed by and based with each contracted organization to provide administrative and reception services and to assist with data recording and reporting.

Support/Peer Workers (8.5 FTE @ $60K per FTE = $450K per annum) – this is 5.5 FTE Support Workers including at least 2 FTE Peer Workers. Workers will have a minimum Certificate IV in Mental health or equivalent qualifications/experience with exceptions and mentoring arrangements for Peer Workers as this is a developing workforce (ie, no nationally recognized qualification although this is under development). This is to achieve a 5.5 FTE 24-hour seven day a week roster at the step-up facility with 3 FTE seven day a week outreach capacity.

Rostering
Step-up facility Support/Peer Workers will be available 24 hours seven days a week with a sample roster provided below.

8:30 am – 4:30 pm	2 staff
3:00 pm – 11:00 pm	1 staff
4:00 pm – 12 midnight	1 staff
11:30 am – 9:00 am	1 staff

This sample roster ensures that two staff are on-site at all times with the exception of the overnight shift.

Data Recording and Reporting
Consistent with the directions, principles and policies outlined in the recent *NSW Community Managed Mental Health Sector Data Management Strategy Report: Phase One* (MHCC 2010b), the Project Coordinator based with the MHCC will oversee the development and establishment of consistent data and information systems across the project and each project site, including the *Routine Consumer Outcome Measurement (RCOM).* Six monthly reports against agreed outcomes will be required from each site. An evaluation report will be received on a 12 monthly basis and as well as at the conclusion of the project.

Evaluation
As stated above, the evaluation will be contracted out to an independent and appropriately provider through an open tendering process. The evaluation will commence with the commencement of the Project. Key questions to be investigated via qualitative and quantitative methods during the evaluation will include:

- What was the perceived need or drivers that motivated the introduction of the project locally?
- How have the purpose of the project and the role of the Recovery & Wellbeing Locals been interpreted and/or implemented in the different sites? What factors influenced this?
- What service model(s) have been implemented at each site?
- What have been the establishment and sustainability challenges? What strategies have assisted with overcoming or minimizing these?
- What partnerships and working relationships have been built and how?
- What have been the outcomes for consumers and how did consumers assess the service and assistance they received?
- What successes has the project achieved? What has contributed to these?

- What were the project's limitations? What contributed to these limitations?
- What are the ongoing challenges and what might assist with overcoming these?
- What are the opportunities for enhancement?

Key inquiry and research domains are summarized in the following table.

Domains	Areas to investigate
Commencement	Perceived need, establishment, time operational
Auspice body	Type of organization, governance arrangements, partners in the project
Location of program	Region covered, population demographics
Workforce	Employment model, Size of program, Capacity
Service Models	Role of salaried staff; role of providers of Medicare-based primary health & psychological services; where they provide services, management, clinical support & supervision; referral, intake and assessment processes
Implementation, evolution of project	
Partnerships	Service provision; Care Coordination Strategies
Clients and carers	Access; Demographics, involvement in treatment plans, Diagnosis/es, outcomes for consumers and their families and carers
Service provision	Service Activity levels; Outcomes; Impact on demand
Quality mechanisms	Clients; agency & partnership; Providers of primary health and psychological services
Program themes	Strengths, enablers, barriers, opportunities & issues, areas for improvement

It is likely that at least five data collection processes will be conducted across the project sites throughout the project:

- An initial project site survey of partnership and stakeholders;
- Stakeholder consultation in each of the three project sites at the 12 month, 24 month & 36 month stage;
- Client survey at points to be determined;
- Annual snapshot of service data collection at each project site (e.g. services provided across a week);
- Overall service, client and outcome data analysis;
- In addition, information about the project and the concept and utility of the step-up and HBOS will be sought from a range of national and state-based stakeholders; and,
- Evaluation reports will be received on a 12 monthly basis and as well as at the conclusion of the project.

Milestones and Timelines

The key milestones and timelines for project implementation are provided as Attachment 7.3.

Project Costs

Proposed project costs are outlined in the table overpage and accompanying narrative.

A total project cost of $15M is proposed.

Table 1: Known Costs Associated With Establishment of a Step-Up and HBOS Service

ITEM	RATE/FEE	ITEM COSTS
Salaries		
Overall Project Coordinator	$100,000 per annum for 3.5 years (inclusive on-costs)	$350,000
IT & Project Support	$50,000 per annum for 3.5 years (inclusive on-costs)	$175,00
Team Leaders (3 FTE)	$100,000 per annum for 3 years x 3 sites (inclusive on-costs)	$1,050,000
Site Admin & Reception (3 FTE)	$50,000 per annum for 3 years x 3 sites (inclusive oncosts)	$525,000
Site Support/Peer Workers (12.5 FTE)	$60,000 per annum for 3 years x 3 sites (inclusive on-costs)	$6,750,000
Salaries Subtotal		$8,850,000
Establishment Costs[1]	$50,000 per site	$150,000
Project Evaluation		$200,000
	Sub total	**$9,075,000**
	GST of 10%	$907,500
	Total known costs	**$9,982,500**

There are significant operational costs associated with the running of the step-up and outreach service whose details remain unknown at this early stage of planning including but not limited to: accommodation acquisition/rental; food/catering services; utilities; cleaning/laundry service; motor vehicles (lease and operations); mobile phone service.

The approximate cost of running a Victorian PARC unit is $1.4M per annum with 70%/about $1M of this being CMO services and 30% being clinical services (ie, public mental health services). The approximate cost of running a HBOS team of 8 FTE in Victoria is also about $1 M per annum. MHCC estimates that the approximate cost of running a step-up and HBOS service in NSW is about $1.5M per annum. Three sites for three years is $13.5M plus $525K for MHCC staff related costs is $14,025M.

This is potentially a signifgant investment in mental health services and there is currently little policy that speaks directly to best-practice examples of sub-acute services in Australia or NSW. The policy context within which this project is being proposed is discussed next and this is followed by a review of best practice in the provision of residential sub-acute mental health services.

[1] For the first year of the program only.

2. Review of Policy Related to Sub-acute Mental Health Service Delivery

The service delivery model being proposed is new to both Australia and NSW and is not spoken to directly by key policy documents including:

Commonwealth
- National Standards for Mental Health Services (2010)
- Fourth National Mental Health Strategy (2009)
- National Mental Health Policy (2008)

State
- Strategy for NSW Mental Health Non-Acute Inpatient Units 2010-2015 (2010, draft)
- NSW Community Mental Health Strategy 2007-2012 (2007)
- New Directions for Mental Health (2006)
- Framework for Rehabilitation for Mental Health (2002)

All these policy documents speak in varying degrees to the imperative for services to be "recovery oriented" without clearly articulating service delivery model/s beyond the concept of them being: either "hospital" or "community" based; and, either "treatment" or "support" in orientation. The lack of agreed community mental health service delivery models at both the Commonwealth and State levels given the policy imperative for recovery oriented service provision.

With this drive to re-orientate service to a recovery focus many mental health services world wide are adopting the label of "recovery orientated" or "recovery focused". Some individual services have gone so far as to adopt a model of service delivery that addresses recovery related issues. However, the MHCC suggest that a "one model fits all" view of recovery fails to recognize that clients at different stages of their recovery need different interventions. Whilst the consensus in the literature refers to there being core principles in recovery - the more widely accepted of these being hope, meaning, identity and responsibility - a new development is the proposal by Andresen, Oades and Caputi (2003) that there are five identifiable stages to recovery. These NSW researchers propose that the five stages are:

1. Moratorium – A time of withdrawal characterized by a profound sense of loss and hopelessness;
2. Awareness – Realization that all is not lost and that a fulfilling life is possible;
3. Preparation – Taking stock of strengths and weaknesses regarding recovery and starting to work on developing recovery skills;
4. Rebuilding – Actively working towards a positive identity, setting meaningful goals and taking control of one's life;
5. Growth – Living a meaningful life, characterized by self-management of the illness, resilience and a positive sense of self.

It's important to recognize that "model' is not intended as a linear process but more of a continuum that an individual may move back and forth along.

The MHCC suggests that this is a useful framework with which to look at service provision. Indeed if one accepts this framework it is rational to direct service provision and interventions according to the various stages of the recovery journey. In doing so service providers are then addressing the challenge issued in the *COAG National Action Plan on Mental Health 2006-2011*, to enable the right care to be accessed at the right time. This proposal looks specifically at service provision in

the space between awareness and preparation. Traditionally this area may be known as sub-acute.

The revised *National Standards for Mental Health Services, National Mental Health Policy* and *Fourth National Mental Health Strategy* emphasize the importance of community-based recovery-oriented mental health service provision. The most recent statistics available indicate that between 1993 and 2005 the proportion of mental health funding spent on community care increased nationally from 29 to 51% (National Mental Health Report, 2007). However, the scale and pace of change varies considerably between states and territories as do directions for mental health service delivery by CMOs. In NSW, the proportion of funding to community mental health services only shifted from 30 to 44% and ranks lowest for funding to CMOs at just 2.8% of the total mental health budget compared to the national average of 6.3%.

The *Statewide Service Planning Model/Mental Health Clinical Care and Prevention (MHCCP) Model Review* and *Strategy for NSW Mental Health Non-Acute Inpatient Units* both highlighted the need for new and alternative models for community-based recovery-oriented rehabilitation and support services – including additional supported accommodation and residential sub-acute services.

In discussing step-up step-down facilities NSW Consumer Advisory Group (CAG) stated:

> *"These types of services address not only the issues of continuity and coordination between acute, hospital based care and return to the community, but provide the important buffer between a consumer's need for increased support and acute care services as a first resort"*. (NSW CAG, 2008)

The WHO (2008 & 2003) model for mental health service delivery is based on known best practice and promotes the involvement of individuals in their own mental health care, a community-based orientation, a human rights focus and embraces the following principles:

- No single service setting can meet all population health needs;
- Essential components of any mental health system include: support, supervision; collaboration; information-sharing and education across different levels of support; and,
- Individuals experiencing mental illness need to be involved, to a degree which suits them, in their own recovery.

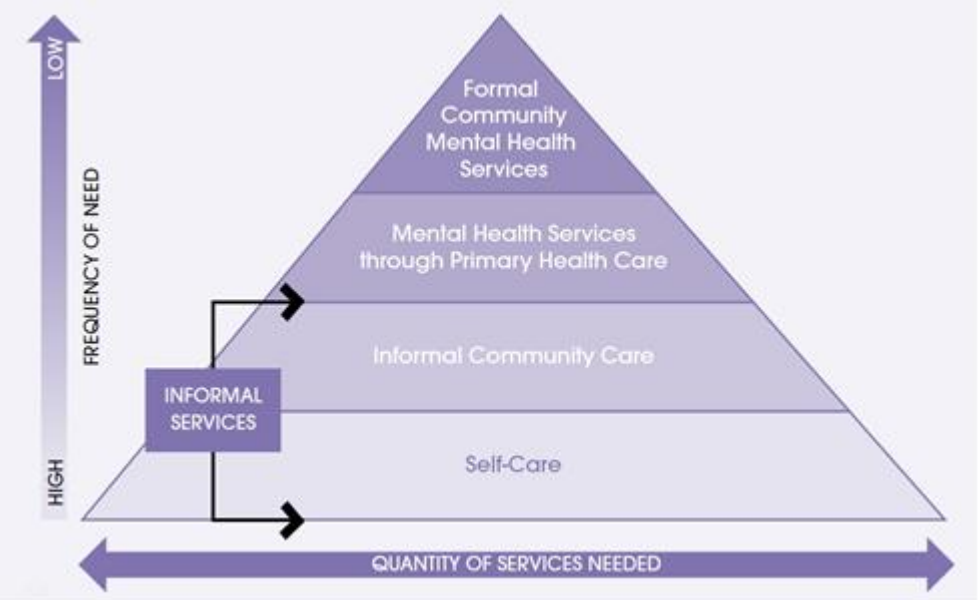
WHO note that mental health services should exist in primary health care, community-based and institutional settings. For community based settings there should be both "formal" (ie, treatment) and "informal" (ie, support) mental services. The Optimal Mix of Services Pyramid developed by WHO 2007 indicates that:

- Psychiatric hospitals should be the least frequently used service type in the mental health system;
- Psychiatric services based in general hospitals and specialist community mental health services should be available;
- Primary healthcare is an essential component supporting mental health; and,
- Informal community mental health services provide broad based, general support.

Figure 1 shows an extraction of the community mental health services components of the Optimal Mix of Services Pyramid which was elaborated upon by WHO and the World Organization of Family Doctors in 2008. The model indicates that "informal" mental health services (comprising of "informal community care" and "self care") should be the most frequently used mental health

support followed by mental health services through primary care and then “formal” community mental health services. Informal mental health services are delivered by CMOs.

Figure 1: Community Mental Health Component of WHO Optimal Mix of Services Pyramid (2007 & 2008)



The WHO model provides a good vision for a best practice system for service delivery but it does not give guidance as to how countries might best re-orient service delivery in-line with the model or the nature of the services (ie, medical, psychological and social interventions) to be provided. To re-orient services in Australia it is critical to strengthen the research and development base of the mental health sector and this must also involve improved service delivery, workforce and consumer/population outcome data collections as well as a more clearly articulated model/s of community mental health services.

Services for people with severe mental illness will be improved by the Commonwealth government’s $1.6 billion investment to expand sub-acute care facilities. Extra community-based residential mental health beds will ease transitions from hospital to the community and reduce the need for hospitalisation.

The proposed step-up and home based outreach/sub-acute model provides a template for NSW Health to pursue in reorienting mental health services to be both community based and recovery oriented. The evidence base underlying the proposed model is reviewed next before moving on to consider the current situation in NSW for residential sub-acute mental health service delivery.

4. Overview of Best Practice in Residential Sub-acute Mental Health Service Delivery

The Australian evidence-base for residential sub-acute mental health services is currently limited though developing. Australian best-practice in sub-acute mental health service delivery most notably includes the Victorian *Prevention and Recovery Care* (PARC) services which have been operating for more than seven years and are essentially a partnership between government provided clinical mental health services and CMOs. This is the model upon which the National Hospitals and Healthcare Reform Commission (NHHRC) made recommendations for enhanced COAG funding for sub-acute mental health services.

Other emerging models include Queensland's proposed *Time Out Housing Initiative* which targets young people and is wholly CMO managed with clinical support provided by private sector general/GP and mental health practitioners through Medicare rebates thus freeing up government delivered acute MHS for both client intervention and consultation to primary health care services.

This section explores both international practice and use of short-term community-based residential rehabilitation programs – like *PARC* and *Time Out Housing Initiative* - is considered best practice. Some consideration is also given to consumer operated services and programs in this area of programming.

Australian Residential Sub-acute Mental Health Services

<u>New South Wales</u>

New South Wales has chosen so far not to adopt the PARC model. However, the Housing and Accommodation Support Initiative (HASI) model of housing adopted in NSW is worth noting as it provides a level of security of tenure and choice in housing to tenants (NSW Department of Health, 2006). There is strong evidence that the model is successful in averting homelessness and reducing the need for hospitalisation. Evaluations of the program demonstrate success with people maintaining their tenancies, increasing their participation in the community, and developing and strengthening social and family networks.

A sector wide approach to evaluating the HASI program took place and was carried out by the Social Policy and Research Centre of the University of New South Wales in 2006. This extensive evaluation of HASI has shown that applying interventions of assisting consumers to gain skills and confidence and make connections with their community along with taking a holistic view of consumers needs has produced the following outcomes:

- 80% reduction in hospital bed stay days
- 66% consumers reported an increase in their mental health
- 46% of consumers with identified substance use issues were no longer experiencing substance use issues
- On entry 23% reported not having any friends, reduced to 6% over 2 years
- Majority of consumers reported an increase in connectedness with their community
- Global Assessment of Functioning - mean score shifted from 38, indicating 'serious impairment' to 65, signifying 'generally functioning pretty well'
- On entry 23% reported not having any friends, reduced to 6% over 2 years

- Majority of consumers reported an increase in connectedness with their community
- On average consumers increased their level of independence across all 14 areas of living skills; exercise, diet, transport, banking, cooking, laundry, shopping, medication, cleaning, budgeting, accessing community services, making appointments, dressing and bathing/showering

This said, it has been argued that an extended care (ie, with access to 16 to 24 hour support staff) version of HASI would fill the gap in the service continuum that PARC or PARC like facilities provide elsewhere. MHCC argues that whilst the results demonstrated above are impressive these service types are different and discreet, each providing a unique piece in the overall framework. Furthermore, the MHCC proposes that the evidence internationally and elsewhere in Australia suggests that PARC like facilities provide a vital component in a comprehensive service system.

NSW has, however, adopted the strategy of introducing Non Acute In-Patient Units (NAIPU). This commitment is reflected in the announcement of additional funding to establish new rehabilitation inpatient units. These units combine the skills in clinical mental health care and rehabilitation within a recovery framework. They remain very clinical in nature and do not reflect key features of recovery focussed services outlined above. Again the MHCC suggests these units are not an alternative to the development of PARC facilities but are a useful addition to the range of service provision in NSW. MHCC contends that one of the strengths of a PARC model is the strong connection to community provided by the significant presence of community managed organisations. This component is weakened within the NAIPU structure.

More detailed information on the current situation in NSW with regard to residential sub-acute mental health services is provided in Section 5.

Victoria

Much has been written about the *Prevention and Recovery Care* (PARC) service model adopted in Victoria. PARC services are a new supported residential service for people experiencing a significant mental health problem but who do not need or no longer require a hospital admission. In the continuum of care, they sit between adult acute psychiatric inpatient units and a client's usual place of residence. PARC aims to assist in averting acute inpatient admissions and facilitate earlier discharge from inpatient units. They are not a substitute for an inpatient admission rather they provide clinical treatment and short-term residential support. PARC services are usually but not exclusively a partnership between Psychiatric Disability Rehabilitation Support Services (PDRSS, ie, CMOs) and clinical mental heal services.

PARC presents a step-up and step-down alternative to hospitalisation for people with complex health and social problems and is a partnership between CMOs (ie, who provides individual support, psychosocial rehabilitation, therapeutic group activities) with 24-hour community clinical mental health services (ie, provides clinical treatment and support through at least twice daily visits to the PARC and access to other clinical services as needed).

"Step-up" occurs when a person is becoming unwell. The client will enter PARC and receive early intervention services to avoid a hospital stay. "Step-down" provides short-term transitional support after discharge from an acute admission, providing supported discharge, to minimize problems associated with early discharge.

PARCS are an example of step up, step down services offering accommodation as well as clinical and non-clinical support. These services commenced in 2003 in that state. While the Victorian PARC model does not extend into the community beyond supported accommodation, independent external evaluation has shown the PARC model to be highly valued by consumers and clinicians

and is considered to have made a significant contribution consumers' wellbeing and improved their outcomes (Dench McClean Carlson, 2008).This Victorian model demonstrates the effect a commitment to innovative community based service models can have on better outcomes for mental health.

The Mental Health Council of Australia's October 2006 *Smart Services* report describes these services:

> *"It is clear from the three PARC examples that the model has important strengths and is very capable of providing strong community support to people in the sub-acute stage of their illness".*

In a study of 161 persons Goodwin and Lyons (2001) described *"significant decline in acuteness of psychiatric symptoms"* for clients using step up step-down programs. It would appear that this service type offers not only the efficacy described by MHCA and Goodwin & Lyons but also is cost effective.

Hawthorne and colleagues (1999) conducted a study comparing the outcomes of acute care in five short term residential treatment and two psychiatric hospital settings. They found that costs of treatment were considerably lower for the short term residential treatment programs.

Also in their evaluation of the Victorian PARC services Dench McClean Carlson (2009) conclude:

> *"The likely cost of a 10-bed acute mental health adult inpatient unit is ~33% higher than the average labour cost of a PARC service".*

Carers Victoria state election campaign factsheet (2010) calls for the:

> *"Urgent expansion of Prevention and Recovery Care services (PARC's) across all regions. These 'step up' and 'step down' programs offer a real alternative to acute hospital care for some people with a mental illness."*

In evaluating the PARC services in Victoria, Dench McClean Carlson (2009) describe where these services fit in the continuum of care:

> *"In the service continuum, PARCs sit between adult psychiatric inpatient units and the provision of intensive community treatment in a client's usual place of residence. In their 'step up' capacity, PARC services provide an early intervention opportunity for people who are becoming unwell and need a residential 24-hr supported service but who do not yet need a hospital admission. PARC services also provide a 'stepdown' opportunity for people leaving hospital who are not ready to go home but no longer require the intensity of treatment an inpatient unit provides."*

As previously stated the adoption of PARC like services has not been limited to Victoria. A number of other states have recognised the value of this service delivery model and responded accordingly. Examples from Queensland and the current position in South Australia are outlined here.

<u>Queensland</u>
In 2005 the Cairns District Health Service proposed that:

> *"A 'transitional' Prevention and Recovery Care Service be established, aiming for an average stay of 21 days (8 weeks maximum). This requires 8-10 beds in*

a cluster residential unit. The focus of the service is to provide short-term transitional residential care and support, which aims to assist people's reintegration into their community following episodes of acute care, and to provide additional intensive short-term support for people who are at risk of relapse."

They further argued that this service would bring together clinical, non-clinical and community services in a place where these can be centred around the person's needs. Additionally stating that:

"There is a recognition of the complimentary role non-government organisations play in delivering practical and innovative services"

The Time Out Houses Initiative (TOHI) is a new project that has just been announced aimed at Queenslanders aged between 18 and 25. This is a collaborative initiative between Community Mental Health (the Queensland Department of Communities) and the Queensland Alliance (ie, mental health CMO peak body in Queensland. There are two sites planned for Cairns and Logan (Brisbane South) and project implementation commenced in mid 2010.

Both services will be staffed 24 hours a day, seven days a week by two support workers. Outreach workers will also be available to support people for up to three months after they leave the program as well as those in home-based care. As mentioned above this innovative development includes the use of Medicare funding to provide the clinical component of service delivery.

The TOHI will improve the capacity of the community mental health sector to provide a comprehensive care and support continuum and care pathways for young people who are showing early signs of mental illness and their family through:

- Intensive clinical and non-clinical care coordination and lifestyle support;
- Support for families and nuture support networks;
- Articulation with existing youth mental health services/networks; and,
- Capacity to respond to the changing needs of the young person.

The CEO of the Queensland Alliance, Mr Jeff Cheverton, described this service:

"This initiative demonstrates the Queensland Government has listened - Time Out Houses will eventually pay for themselves, providing young people under 25 with somewhere safe, friendly and welcoming to go when they first experience mental illness, preventing hospitalisation and an often traumatic experience for families".

<u>South Australia</u>

In it's mental health reform agenda "Stepping Up"' the SA state government states:

"The important reforms taking place in South Australian mental health services include building and delivering services closer to where people live, so that they receive the help they need to stay well in their communities. These localised services allow people to 'step up' to more intensive health care if they are becoming unwell and 'step down' to other support services as they get better.

We have begun by examining the development of PARC facilities in Australia but Australia has not been alone in developing such services. Internationally

others have adopted variations on the short intensive residential model to address the needs of those in this part of their recovery journey".

International Residential Sub-acute Mental Health Services

USA

Step-up and step-down hospital alternatives similar to the Victoria PARC services have operated in the USA for some years and are typically known as "residential treatment centers" (RTCs). An emerging evidence base has demonstrated that RTCs are not only cost effective but more consistent with rehabilitation/recovery directions and, as accessible and essentially voluntary environments, are consistently valued by consumers and carers.

Loren and colleagues (1978) report on a trial of a facility echoing some of fundamentals of a PARC like program. This facility is described as a "small home-like facility in the community". They conducted two year follow-up research in to the treatment of individuals with a diagnosis of schizophrenia in this facility with a comparison to "treatment as usual". They describe significant improved outcomes for the "experimental group" when measured using psychosocial functioning measures.

Gateway Homes provides a transitional residential treatment program for adults with mental illness whose goal is to live as independently as possible. Gateway's mission is to assist individuals with developing the psychological, social, nutritional, physical, financial, and vocational skills needed to live independently within three years. Under the supervision of a licensed clinical psychologist, professionally trained staff, provide independent living skills training, counselling, and social, psychological, and vocational rehabilitation in a continuum of three residential settings and a large activities centre. Every resident receives at least two hours of individual skills training and counselling and approximately 15 to 20 hours of social, psychological, and vocational rehabilitation each week.

The first residential setting is a licensed assisted living program providing around the clock supervision and skills training for 15 individuals. All residents begin their stay in this program. The second residential setting consists of supervised apartments on campus capable of housing 24 individuals. In this setting, residents focus on developing the interpersonal, social, financial, and vocational skills needed to live independently in the community. The third residential setting is independent living in the individual's community of choice. After graduating to the community, residents continue to receive supportive counselling, case-management, regularly scheduled home visits, involvement in social activities, and transportation services from Gateway.

Since 1996 Recovery Innovations has run one of the two crisis centres in Phoenix Arizona. The service has two components – a relatively traditional locked sub-acute unit with eight beds, and a sub-acute eight-bed alternative called the Living Room. On arrival at the facility a person is met by a peer triage worker, so their first contact is with someone who has lived experience of mental illness. This creates a positive initial experience, which is especially important since this is the first contact with mental health services for 40% of attenders. The focus in the peer triage is on the individual's needs, and the peer may share some of their own story. The goal is to communicate a 'chronic message of hope'.

The Living Room is staffed by three shifts of two peer support crisis specialists. They influence the environment, which is intended to be supportive to those in crisis – guests (as they are described) have full access to things such as food, drinks, television and videos, and plants and other decorations reduce the clinical feel of the service. Guests stay an average of two or three days, during which time they are left alone if wanted, and offered the chance to develop a recovery plan with the peer, or attend any of the daily groups. These optional groups are facilitated by peers and

counsellors, and cover both recovery topics (e.g goal-setting, low mood) and social activities. Mental health professionals provide input in the Living Room as needed, but none is based in the unit. Each guest is evaluated by a psychiatrist or nurse practitioner daily, and a treatment plan is developed by a counsellor or social worker.

Canada

The Residential Rehabilitation and Treatment Program is run to assist with the community re-integration for persons with an extended in-patient history. This is a structured rehabilitation and treatment program for clients with severe and persistent mental illness, which strives to facilitate a return to their home community. Residents are assisted to develop and practice skills such as meal planning and preparation, shopping, budgeting, use of transportation, leisure, job readiness and personal coping. An individualized rehabilitation plan is developed jointly with the resident. Client's strengths and rehabilitation needs are identified through a formal bio-psycho-social assessment process. The service is a tri partite partnership between Regional Mental Healthcare - St. Thomas and the Essex A.C.T. teams of the St. Joseph's Regional Mental Healthcare.

Transition House is a time limited residential service that provides 24-hour staff supports for individuals with severe and persistent mental illness. This service provides housing for clients who need a short residential stay for support during medication review/changes or for stabilization purposes. Individuals are assisted to create linkages to mental health and community services and transition to independent community based housing. Services provided include, support for community living and decision making, support of residents in conflict resolution, creating opportunities for residents to socialize and participate in activities that meet their needs, supporting residents in creating a home like environment, providing education and training, activities of daily living, medication support, assisting with symptom management and advocacy.

UK

In the UK, a model like the Surrey County cluster model that provides a step-down home-based environment with 24 hour outreach support in a home like environment provides a cost effective solution to hospital based clinical care that can be utilised by patients in the early days of recovery.

Colham Green Road is a 15- bedded in-patient unit providing a specialist rehabilitation service to people with enduring mental health problems between the ages of 18 and 65 living in the Borough of Hillingdon. It is a purpose build unit comprising 10 single en-suite rooms and 5 self-contained studio flats.

The overall aim of the therapeutic program is to empower service users to take decisions about their future needs, maximise independence and increase participation in community life. Emphasis is placed upon linking service users into a range of community services including Day Services, Employment Link Team, Voluntary Work, Sports and Leisure Centres, Local Educational Colleges and Voluntary Agencies. Crucially there is a Rehabilitation Outreach Service that can provide flexible community rehabilitation programmes to service users whose preference is for a home-based programme, or who do not need admission for in-patient rehabilitation. This service also provides discharge follow up, support and resettlement to service users returning to live in the community.

Cobwebs is an intensive rehabilitation unit based in Cambridge city. The service aims to provide a safe and homely environment, with an emphasis on maximising opportunities for growth and independence. The unit is staffed 24 hours a day.

Consumer Run Residential Sub-acute Mental Health Services

In looking at examples of best practice internationally it would be a mistake to ignore the development of consumer led services and The Living Room in the USA was previously provided as an example of this. Whilst not proposing this at this stage, the MHCC argues that this service type remains an interesting development worthy of further consideration. The need to elevate access to and availability of consumer operated services and programs is one of the reasons for the current proposal including the employment of Peer Workers. Therefore some background is included here for future discussion.

These services, also described as "user-controlled alternatives," are one manifestation of the self-help ideology of the consumer/survivor/ex-patients movement. Their specific offerings may include peer-support and self-help networks, drop-in centres, wellness programming, crisis and respite care, and hospitalisation alternatives. Founded, governed, and run by consumers (although some have a degree of non-consumer involvement as well), they are typically organized non-hierarchically and emphasize mutual aid and support. Proponents argue that, because of their ideological heritage, such programs are the only truly "recovery-oriented" services available.

With the current emphasis on recovery, several US states are looking to consumer-run and self-help services as essential elements of the core service array and these now also include mechanisms by which consumer-operated services are reimbursed through Medicaid.

As with consumer involvement, there is a growing awareness that support for consumer-run services requires more than just lip service. Several states are exploring how to support these services through adequate funding, leadership and management training and mentoring, and accountability mechanisms that reflect the spirit of a self-help orientation. Bringing consumer-run services into the mainstream of mental health services can be problematic. For example, accepting public funding means finding a way to balance "from the heart" mutual aid and professionalised services with mandates for accountability, demonstrable outcomes, and adequate staff credentials.

Overall, research on consumer services reports very positive outcomes for clients. This review of effectiveness found some studies that reported higher levels of satisfaction with services, general wellbeing and quality of life while others reported no significant differences between service user-run services and mental health services run by non-service user providers. No studies reported evidence of harm to service users or that consumer services were less effective than the equivalent services offered within a traditional setting.

The evidence base supporting the effectiveness of service user-run services is gradually expanding. The findings to date have to be interpreted with caution as the majority of service user-run services identified by this review were operated alongside clinical staff, peer specialists on case management teams or crisis teams. This implies that the setting in which studies were conducted fulfils the definition of a consumer provided or partnership service but may not meet the more stringent operational definition of a consumer run service in terms of the level of autonomy, self-governance and the level of consumer control required. The positive effect on outcomes could potentially be greater for consumer run services than those with a participation model of consumer involvement. This is as yet unknown. Therefore it is vitally important that in the future effectiveness research measuring meaningful outcomes for service users is carried out on a wider range of different models or types of services in existence and that any differences in effect are formally evaluated. Consumer-run services worldwide receive very limited funding from mental health budgets despite a growing trend that suggests they may represent an effective model of mental health service delivery.

Furthermore, to justify their place in the array of services offered within the mental health sector, a strong case can be made that services should only be required to demonstrate equivalent

effectiveness compared with traditional services rather than superiority in regard to outcomes for clients.

An example of this service model in operation is Key We Way a four-bed peer-run residential alternative to an acute in-patient mental health unit. The service operates from a standard house overlooking a beautiful beach on Kapati Coast, north-west of Wellington in New Zealand. No mental health professionals work in the service which is instead staffed by 14 "recovery agents" – people with their own histories of using mental health services. Two recovery agents work in the home between 8:00 am and midnight, and one from midnight to 8:00 am. People are generally referred by the acute services co-ordinator or the local Community Mental Health Team, although self-referral is also welcomed.

What happens during an admission?
The average length of stay is three weeks. Residents do "normal" healing things – walk on the beach, make things, cook, go for a drive, go on group outings, watch comedy on TV do some gardening. The aim of the house is to be a place which is conducive to recovery. As part of this, family members are actively encouraged to visit and stay for meals.

During their stay, the intention is that residents work actively on future-focussed plans with the recovery agents. Initially plans are focussed on short-term goals, such as staying safe. Over time, the focus shifts to the development of a personal plan – a creative process to facilitate the individual re-connecting with their personal dreams and aspirations. It may be written, or can be a collage, an audio recording, a mind-map, a portfolio of work, a song – anything that re-connects the person with their life. The aim is to move past a maintenance model of focus on process – the generation of hope, motivation and ultimately healing. After discharge, residents are offered an outreach programme for up to 6 weeks, which may involve further work on their personal plan.

Who does the service work with?
Key We Way works with both detained and non-detained patients. The proportion of compulsorily detained people is small, because each resident must consent to going there, and because some people consent to voluntary admission to Key We Way although they would need to be compulsorily admitted to the local statutory service, The intention is that the choice of where to be admitted rests with the person, although in reality it is normally the clinician who decides.
Key We Way seems to be most valuable for people who are having their first experience of in-patient mental health services.

How does the service compare with a professional-led in-patient unit
There are similarities with good acute in-patient units. For example, the importance of supervision is emphasised by the recovery agents, and there is a willingness in supervision to discuss both personal and professional challenges of the role. This includes the extent to which self-disclosure is helpful.

One notable difference is in terminology. For example, residents may have favourites among the staff whom they want to focus on, or may want more self-disclosure from the recovery agent than is helpful, or may evoke strong emotional responses in the recovery agent. These challenges would be framed clinically in terms of "maintaining boundaries", but in Key We Way the challenge is framed as "developing sustainable relationships". In supervision this involves discussion of the same boundary issues that would feature in a statutory setting, but the implicit communication in the language is more strategic and less defensive. A second difference is in role markers, indications of status (i.e who are the recovery agents and who are the residents) are notably absent in dress, talk and behaviour.

5. The Current Situation for Residential Sub-acute Mental Health Service Delivery in NSW

As previously mentioned, NSW Health is currently establishing six new 20 bed non-acute in-patient units (NAIPU) that are part of the sub-acute rehabilitation service stream (ie, these are essentially capital asset replacements for the large psychiatric institutions with increased access for non-metropolitan clients). It is thought that the existing large psychiatric institutions make available about 600 hospital beds across NSW. People with chronic and continuing mental illness can receive clinical treatment, rehabilitation and support in a NAIPU setting for up to two years.

In recent years, NSW Health has also increased access to supported accommodation programs delivered by community managed organisations (CMOs). The availability of supported accommodation reduces the need for hospital based services. This most notably includes the very successful *Housing and Support Initiative* (HASI) which offers low, medium and high level support to people with mental illness in their own home. Figure 2 Provides an overview of HASI Stock available in NSW.

Figure 2: Overview of HASI Stock in NSW as at November 2010

Roll-Out	Year	# People	Support Levels
Stage 1	02/03	100	High level support in public/community housing
Stage 2	05/06	460	Lower level support for exisiting public/community housing tenants
Stage 3A	05/06	126	High level support in public/community housing
Stage 3B	06/07	50	Very high level support in public/community housing
Stage 4A	07/08	100	High level support in public/community housing
Stage 4B HASI in the Home	07/08	240	Lower level support for people with existing private housing
Stage 5A Aboriginal HASI	09/10	58	Targeted support for Aboriginal families across all support levels
Total HASI		1134	

An “extended care” very high support HASI model is currently under consideration (ie, 16 to 24 hour care). NSW Health’s demand estimates for Extended Care HASI (16-24 hour support) are as follows:

Long stay inpatients	144
Frequent readmissions	55
Boarding house residents	66
Consumers sleeping rough	700
Homeless aboriginal consumers	50
At risk of failed tenancies	145

Forensic	5
TOTAL	1115

The development of the new NAIPU inpatient units and Extended Care HASI has been cited as the reason for MHDAO not pursuing other residential sub-acute service models. However, the important points must be made that:

- NAIPUs are hospitals and achieving preventative, early intervention approaches and recovery oriented service provision in these environments is challenging at best;
- HASI support is intended to be time unlimited with most clients receiving care for many years (ie, it is available as long as there is a need, the accommodation is the consumer's home and their rights are protected through Residential Tenancy Agreements);
- There is no-where in the NSW spectrum a current short-term and time-limited residential sub-acute service type and the demand for such a service is known to be very high.

In addition to the above, NSW Health also provides and funds CMOs to provide approximately 1000 mental health supported accommodation beds across the State whose establishment predated HASI. The last time NSW Health surveyed the non-HASI housing stock was late 2007. At that time there were 238 sites of 405 dwellings housing 990 residents (ie, about 80 vacancies). The vast majority of this stock is group homes which are no longer considered best practice. For example, there were identified instances of some people not even having their own bedroom. That's a lot of vulnerable people receiving what might be argued to be inequitably funded supported accommodation when compared to the 1000 HASI clients and what they receive – the concern is we just don't know. There is some potential that some of this existing housing stock may present opportunities for establishing the step-up and HBOS.

In summary, current non-acute, sub-acute and supported accommodation stock in NSW is believed to be:

- 720 NSW Health NAIPU beds (ie, non-acute);
  - 600 NAIPU beds in large psychiatric institutions
  - 120 new NAIPU beds being build (6 X 20)

- 2134 NSW Health funded supported accommodation beds;
  - 1134 HASI beds (with more than half being a very low levels of support);
  - 1000 other non-HASI supported accommodation beds (support levels unknown); and,

- There are no known residential sub-acute services (although it is believed that some of the non-HASI supported accommodation programs may be operating in this manner)

This totals 2854 non-acute and supported accommodation residential places for NSW. Population benchmarking of mental health rehabilitation and support service types is only in its infancy in NSW (eg, see MHCC *Sector Mapping Project Report*, 2010). However, the *Queensland Mental Health Plan 2007 – 2017* (2007) does set some targets for residential programming as follows.

Beds per 100K population	
Hospital beds	40
<u>CMO</u>	
Residential Recovery	15
Supported social housing	35
Support hostels/private homes	35

Crisis/respite services	3
TOTAL CMO	88

The NSW population at the end of March 2010 was 7,221,000 (ie, 72.21 X 100K). If the
If the Queensland population formulae is applied to NSW then one would expect to see 6354 non-hospital based supported accommodation beds available (ie, 88 X 72.21). Even if the demand estimates for extended care HASI are fully realised – and we note that this doubling of HASI stock is predicted for over the next 10 years in the MH-CCP model – then NSW will still be considerably below population needs for mental health supported accommodation stock and lacking in a range and diversity of service delivery models to allow the promotion of choice when selecting services.

NSW Health's draft NAIPU Strategy (2010, p 32-33) notes that the current averaged amount of supported accommodation for an Area Health Service in NSW is 27.8 places per 100,000 population and this figure ranges considerably from 19 to 80 places per 100,000. It also notes that the majority of the supported accommodation is low support (12.3 places per 100,000) with rates for both medium and high support needs being similar (4.1 and 6 places per 100,000). Very high supported accommodation averages 0.7 places per 100,000 population.

This exploration of the current situation for residential sub-acute mental health service delivery in NSW has not been inclusive of other existing non-residential community based rehabilitation and support services either public, private or community managed. This bigger picture of rehabilitation and support service availability needs to be considered for non-acute and subacute community mental health sector development and capacity building to be effectively achieved. This is also critical for discontinuing the entropy toward acute and hospital based mental health services that has hindered effective implementation of the National Mental Health Strategy and delivery of recovery oriented services. The proposed community managed sub-acute service is aligned with emerging best practice and also meets a gap in the existing spectrum and quantum of bed-based mental health services in NSW.

The report concludes with a consideration of the latest evidence and research in the recovery paradigm which supports the positioning of services according to consumer's stage of recovery.

Recovery

Given that we intend to address best practice in the implementation of recovery services, it would appear remiss to end this report without briefly examining what we know and don't know about the recovery paradigm.

Many definitions of recovery exist; some focus on the process and others point towards the outcome of recovery. How ever it would appear reasonable to argue that process and outcome in recovery are part of the same continuum. Mental health recovery is a concept that has been championed in the writings of consumers of mental health services. The use of the term ''recovery'' was in part a political gesture but it was also influenced by the self-help movement, Alcoholics Anonymous (AA) in which people identify as being ''in recovery'', accept they have a problem and struggle to maintain abstinence irrespective of the presence or absence of overt symptoms or impaired functioning. In common with the conception of recovery in AA, early attempts at integrating mental health recovery with mental health care emphasized personal insight or acceptance of mental illness as pivotal to successful recovery.

The need to accept one's experience as a symptom of illness or disorder has long been contested in the mental health field and in relation to mental health recovery. Nevertheless, there is an intersection between clinical notions of recovery and mental health recovery. For example, proponents of mental health recovery point out that most people diagnosed with schizophrenia achieve clinical recovery (reduction or amelioration of ''symptoms''), or social recovery (improvements in occupational and social functioning) or both. In 2004 there was an attempt to examine client and service user factors associated with dimensions of recovery and this research found that there appeared to be a strong relationship between low severity of depressive symptoms and a recovery orientation. However, recovery-orientated care entails more than what might be considered good ''clinical'' or symptom focused care. Many people have argued that the iatrogenic effects of routine psychiatric care and treatment are impediments to mental health recovery. Indeed some have argued that routine practices such as standardization of services, involuntary treatment and seclusion and restraint may be incompatible with ideas of mental health recovery. Others, notably NSW researchers Oades et al. have attempted to identify particular ''evidence-based'' practices that are congruent with a mental health recovery ethos or orientation.

Deegan described mental health recovery as a self directed process of healing and transformation. This is in contrast to some mainstream mental health services in which the process of care is directed by professionals and symptoms are seen as essentially meaningless. Mental health recovery is employed in a number of discourses and social movements (e.g., the Hearing Voices Network) which have reinvigorated old ideas that ''symptoms'' may have inherent meaning, and which emphasize acceptance of some experiences by both individuals and the wider social group. Whilst, mental health recovery might largely be a personal process it is also, at least in part, a social process. Some leading authorities suggest that there is an emerging consensus that this healing and transformation can be promoted or hindered through an interaction between individual factors (e.g., hope), characteristics of the environment (e.g., opportunities) and an exchange between the individual and the environment (e.g., choices). The factors (individual, environmental and interactive) described as being associated with recovery are fairly consistent e.g., living well, finding or maintaining hope, optimism and meaning, taking personal responsibility or maintaining ones autonomy, engaging in meaningful activities, enjoying supportive relationships, having access to a range of services and participating fully in the community These factors imply in one sense ''ordinary living'' but also the possibility to grow, develop and even thrive given access to a range of valued and effective services.

7. REFERENCES

Andresen, R. Oades, L. & Caputi, P. (2003). The experience of recovery from schizophrenia: towards an empirically-validated stage model of recovery, *Australian and New Zealand Journal of Psychiatry,* 37, 586-594

Armstrong, Nikki Panasci & Steffen, John J. (2008). The Recovery Promotion Fidelity Scale: Assessing The Organizational Promotion of Recovery, *Community Mental Health Journal*, 45, 163-170

Carers Victoria. (2010). Fact Sheet 3: *Community support for people with a mental illness and their families*, State election campaign 2010

Commonwealth of Australia (2010), *National Standards for Mental Health Services*.

Commonwealth of Australia (2009), *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009-2014*.

Commonwealth of Australia (2008), *National Mental Health Policy*.

Commonwealth of Australia (2007), *National Mental Health Report 2007*.

Council of Australian Governments. (2006). *National Action Plan on Mental Health 2006 – 2011*

Dench McClean Carlson. (2008). *Final report for: evaluation of the Prevention and Recovery Care (PARC) Services Project*

DHS Victoria (2005). Expanding support and treatment options within mental health services: Prevention and recovery care services Service guidelines

Gilbert, M. et al (2003). Scope for psychosocial treatments in psychosis: an overview of collaborative therapy, *Australasian Psychiatry* , 11, 2, 220-224

Goodwin & Lyons (2001). An emergency housing program as an alternative to inpatient treatment for persons with severe mental illness. *Psychiatric Services,* 52, 92-95

Hawthorne et al. (1999). Comparison of outcome of acute care in short-term residential treatment and psychiatric hospital settings. *Psychiatric Services,* 50*,* 401-406

Loren et al. (1978). Community Residential Treatment for Schizophrenia: Two-Year Follow-up, *Hosp Community Psychiatry*, 29,715-723

Mental Health Council of Australia. (2006). *Smart Services: Innovative Models of Mental health Care in Australia and Overseas.*

NSW CAG (2009). Position Statement: *Community Mental Health Services the cornerstone of better*
outcomes for mental health

NSW CAG (2008). *Submission Special Commission of Inquiry Acute Care Services in NSW Public Hospitals*

NSW Health (2007), *NSW Community Mental Health Strategy 2007-2012.*

NSW Health (2006), *New Directions for Mental Health*

NW Health (2002), *Framework for Rehabilitation for Mental Health (2002)*

Slade, M. (2009). *Personal Recovery and Mental Illness, A guide for Mental Health Professionals*, Cambridge University press

South Australian Government. *Stepping Up: The State Government's Mental Health Agenda*

Social Policy Research Centre. (2007). *Housing And Accommodation Support Initiative Evaluation*

World Health Organisation & World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (2008) Integrating mental health into primary care: a global perspective. Geneva. Switzerland.

World Health Organisation (2007) The optimal mix of services for mental health. Mental Health Policy, Planning and Service Development Information Sheet (accessed July 2009). Geneva.

World Health Organisation (2003) Organisation of services for mental health. (Mental Health Policy and Service Guidance Package). Geneva.

7. ATTACHMENTS

1. Overview of Medicare Benefits Scheme funding Opportunities
2. What is Collaborative Therapy?
3. Project Milestones and Timelines

Overview of Medicare Benefits Scheme Funding Opportunities for Mental Health

The following are just nine relevant Medicare-based schemes that could be accessed by clients of the proposed Step-up and home based outreach Project via partnerships with primary health services and practitioners. It is possible that further schemes and programs will be identified during the planning and initial phases of the proposed project. For example, the Commonwealth governments proposed $58.4M over four years introduction of “coordinated flexible care packages” to better support people with severe mental illness in primary care using Access to Allied Psychological Services arrangements to be managed by Medicare Locals.

1. Access to Allied Psychological Services (ATAPS)

The ATAPS enables GPs under the *Better Outcomes in Mental Health Care* (BOiMHC) Program to refer consumers to allied health professionals who deliver focused psychological strategies. Allied health professionals have been defined to include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with specific mental health qualifications.

Through ATAPS, service users are eligible for a maximum of 12 sessions per calendar year; six time-limited sessions with an option for a further six sessions following a mental health review by the referring GP. Sessions can be individual and/or group therapy sessions. The ATAPS provides patients with assistance for short-term intervention. If further sessions are required it may mean that a longer term program is necessary in view of the complexity of needs.

In addition, the referring practitioner may consider that in exceptional circumstances the person may require an additional six individual focused psychological strategies above those already provided (up to a maximum total of 18 individual services per service user per calendar year). Exceptional circumstances are defined as a significant change in the person's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. It is up to the referring practitioner to determine that the person meets these requirements.

Through ATAPS, service users are also eligible for up to 12 separate group therapy services, within a calendar year, involving 6-10 people. These group services are separate from the individual services and do not count towards the 12 individual allied mental health services in a calendar year.

Service users are not to be referred for treatment through *Better Access* to Psychiatrists, Psychologists and General Practitioners through the Medical Benefits Schedule (Better Access) Program and ATAPS at the same time. Treatment through both Better Access and ATAPS may occur within one calendar year, provided the total number of individual or group services provided under both programs does not exceed the maximum allowable in a calendar year.

Divisions of General Practice act as fund holders in this component of the BOiMHC program. The AGPN provides an on-line Network Directory on its website at http://www.agpn.com.au/ which allows searches using maps or a search interface to obtain information on divisions of general practice.

The ATAPs has played a critical role in helping people access psychological services through Medicare in areas where there are few registered practitioners or in areas where there is little bulk-billing. In some areas Divisions of General Practice have complemented the ATAPs-based

services through the services of salaried mental health professionals or with services provided on a contractual basis by health service providers including for example the Royal Flying Doctor Service.

The proposed step-up and HBOS will be able to draw on and link to the arrangements and partnerships established by Divisions of General Practice for utilising the benefits of the ATAPS.

2. Better Access to Mental Health Care

On 1 November 2006, the Australian Government introduced the Better Access to psychologists, psychiatrists and GPs through the Medicare Benefits Schedule (MBS) Program. Rebates are available for consultations with psychiatrists, clinical psychologists, psychologists, social workers and occupational therapists. To qualify for rebates under the Better Access program, a person with depression, anxiety or other mental disorder first needs to get a referral from a General Practitioner (GP), psychiatrist or pediatrician. Conditions covered under the scheme include:

- Depression;
- Anxiety;
- Panic disorder;
- Obsessive compulsive disorder;
- Post-traumatic stress disorder;
- Generalized anxiety disorders and phobias;
- Bipolar disorder;
- Drug-use disorders; and
- Alcohol-use disorders.

The GP assists the person to develop a plan for the treatment of the individual's particular mental health problems. The plan nominates the health professional/s to whom the person will be referred and the available rebates for those services. Similar to the ATAPs, in one calendar year, a person with depression or another mental health problem, who is eligible for the rebates, can receive up to 12 individual consultations and up to 12 group therapy sessions with a mental health professional under Medicare. Extension of sessions is also possible.

The referring GP is required to assess the person's progress after each block of six sessions with a psychologist, or other mental health professional, using the Mental Health Treatment Plan as a guide. Review is required of whether the whether the person is receiving the right treatment or if other options need to be explored.

Psychological services available through Better Access include:

- *Psychological Therapy* – for example Psycho-education, Cognitive Behaviour Therapy (CBT, Behavioural and Interpersonal Therapy;
- *Focused Psychological Strategies* – for example relaxation and stress management strategies and skills training in problem solving, anger management, improving social skills, improving communication, better parenting etc.

These sessions can be conducted individually or in a group setting.

The proposed step-up and HBOS will develop partnerships with accredited mental health professions to establish bulk-billing arrangements for people with severe menta illness who would benefit from the psychological approaches now available but who may not be able to obtain these service for themselves or who may not feel comfortable accessing them in formal clinical settings.

3. Chronic Disease Management ('Enhanced Primary Care') Program

A chronic medical condition is one that has been (or is likely to be) present for six months or longer. It includes conditions such as asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke. People have complex care needs if they need ongoing care from a multidisciplinary team consisting of their GP and at least two other health or care providers. People may be eligible if their GP has provided the following MBS Chronic Disease Management services:

- A GP Management Plan; AND
- Team Care Arrangements.

Medicare rebate is available for a maximum of five (5) services per patient each calendar year. Allied health professionals included in this scheme include:

- Aboriginal Health Worker;
- Audiologist;
- Chiropractor;
- Diabetes Educator;
- Dietitian;
- Exercise Physiologist;
- Mental Health Worker;
- Occupational Therapist;
- Osteopath;
- Physiotherapist;
- Podiatrist;
- Psychologist;
- Speech Pathologist.

Many people will severe mental illness would benefit and qualify for this scheme in view of their frequently complex set of health care needs. Despite this many miss out because of limited access or difficulty in accessing a GP. The proposed step-up and HBOS will support service users to access this scheme by establishing arrangements for on-site sessions with GPs, other primary health professionals and allied health professionals.

4. Allied Health Group Services under Medicare for patients with type 2 diabetes

People with type 2 diabetes can receive Medicare rebates for group services provided by eligible diabetes educators, exercise physiologists and dietitians, on referral from a GP. The group services items provide another referral option for GPs in the management of patients with type 2 diabetes. The allied health professional will initially conduct an individual assessment to prepare the person for an appropriate group services program. If the person is assessed by an eligible allied health professional as suitable for group services, the patient may then receive up to eight (8) group services each calendar year. Allied health group services may be delivered by one type of allied health professional (eg 8 diabetes education services) or by a combination of providers (eg 3 diabetes education services, 3 dietician services, and 2 exercise physiology services). The combination of group services to be offered will be determined as part of the assessment by the allied health professional.

In some areas, different types of group services may be offered by allied health providers (eg courses targeting newly diagnosed patients, refresher courses or courses covering specific types of treatment and self management).

Given the high incidence of diabetes 2 among people with severe mental illness, by easing access to this scheme, the proposed step-up and HBOS will play a key role in improving health outcomes and quality of life for service users.

5. National Mental Health Nurse Initiative (MHNIP)

In 2010, the Australian Government announced an additional $13.0 million would be allocated to the MNHIP nationally, to engage 136 extra mental health nurses under the program. This brings the total funding for the MHNIP to $79.777million over six years (2006/07 – 2011/12). At the end of April 2010, a total of 42,696 patients had been treated since the program's inception. This program provides non-MBS incentive payments to eligible community based general practices, private psychiatry services and other appropriate organisations (such as Divisions of General Practice or Aboriginal Medical Services) who engage mental health nurses to coordinate treatment and care for people with serious mental illness and complex needs.

Responsibility for the MHNIP rests with the Australian Government Department of Health and Ageing, while funding for the program is administered through Medicare. MHNIP Guidelines outline how payments are made on a half-day, sessional basis and allow credentialed mental health nurses to work closely with the patient's psychiatrist or GP to facilitate the provision of coordinated clinical care and treatment for people with severe mental health disorders. A 25% loading applies to organisations operating in outer regional, remote and very remote areas, and one-off establishment grants are available. There is little or no charge to the client.

The MHNIP provides mental health nurses who are 'credentialed' under the ACMHN's Credential for Practice Program with an opportunity to work in primary practice**.** An aim of the program is to provide mental health clients with a more integrated treatment plan, improved continuity of clinical care and increased access to other health care professionals.

Services can be provided in a range of settings such as in clinics or at a patient's home. Support provided under this program targets people with severe mental health disorders during periods of significant disability. A general practitioner or psychiatrist determines eligibility for the service on the basis of the following criteria:

- The client must have a diagnosed severe mental health disorder, and
- The disorder must cause significant disablement to social, personal and occupational functioning, and
- The client has had at least one episode of hospitalisation for their mental health disorder, or be at risk of future admissions, and
- Requires continuing treatment over the next two years, and
- The general practitioner or psychiatrist is principally responsible for the client's clinical mental health care, and,
- The client consents to treatment by the mental health nurse.

A Mental Health Treatment Plan must be prepared in collaboration with the mental health nurse, outlining the roles and responsibilities of both the treating doctor and the mental health nurse. The plan must be reviewed regularly by the GP or psychiatrist with input, where appropriate, from a clinical psychologist or other allied health professional.

Mental health nurses address both the mental health and physical needs of clients and undertake relevant record keeping and reporting which is directly related to the program, or their scope of practice as a mental health nurse.

The range of client-focused services mental health nurses provide under the MHNIP includes:

- Periodic reviews of mental state;
- Information on physical healthcare to patients;
- Medication management and monitoring;

- Provision of health promotion information;
- Undertaking home visits;
- Integrated clinical services from GPs, psychiatrists, and allied health workers e.g. Psychologists; and,
- Improving patient links to other health professionals and clinical service providers.

There are a range of ways mental health nurses choose to work under the program (ranging from direct employment or shared employment, to working in private practice under self-funded arrangements) and a number of practice and funding models exist. Some examples include the following.

Mackay - The MHNIP is run by the Mackay Division of General Practice (MDGP) in a direct employment model. MDGP also provide a psychology service and other allied health services to the community. There are six full-time nurses employed through the program, with one based at Airlie Beach.

Ballarat - For the MHNIP, Ballarat and District Aboriginal Corporation has entered into a partnership agreement with Australian Mental Health Services (AMHS), a private company. Nursing staff are employed by AMHS, which also provides their clinical supervision and professional development. BADAC contributes office space, computers, transport, mobile phone and all on-site expenses. There are two mental health nurses at BADAC; one is employed full time in a clinical role, the second nurse delivers a range of organisational development activities in addition to two days clinical work under the MHNIP.

Geelong - There are two separate MHNIPs that are delivered through the General Practice Association of Geelong (GPAG). The larger program is the result of a partnership between GPAG and Barwon Health, and is designed to build effective working relationships between mental health services and GPs, provide an earlier intervention and better access to mental health services, and prioritise acute services. This program uses a shared employment arrangement to place seven (6.8 FTE) mental health nurses from Barwon Health across 29 practices, and provide support to more than 100 GPs. Barwon Health makes a significant financial contribution to the arrangement, providing a clinical coordinator, underwriting employment costs of the nurses and providing ongoing supervision for the nurses.

Ipswich - The current MHNIP model has four part-time nurses employed by Ipswich Mental Health, but contracted to the MHNIP. Ipswich West Moreton Division of General Practice (IWMDGP) is the auspice for the program, and works in close partnership with GPs and the mental health service. The mental health nurses employed under this scheme are working hard to establish partnerships and sound working relationships with community mental health organisations to enable their clients to access the psychosocial and recovery support services they require.

There are a number of sustainability issues faced by the program including availability of credentialed mental health nurses, existing funding guidelines and funding models and parity of employment conditions. Some have retained their employment with public mental health services whilst also working with the program. A possibility worth exploring by the MHCC is the establishment of shared employment arrangements between a community mental health organisation with an established presence in a particular area, an Area Mental Health Service, a Division of General Practice, an Aboriginal Medical Service or another appropriate organisation (e.g. private provider).

6. Mental Health Services Rural and Remote Access Program

The Mental Health Services Rural and Remote Access program complements the Better Access to Mental Health Care program. Organisations operating under the program in NSW include:

- Royal Flying Doctor Service of Australia - NSW section;
- NSW Outback Division of General Practice;
- New England Division of General Practice;
- Southern General Practice Network;
- Hunter Rural Division of General Practice;
- Dubbo Plains Division of General Practice; and,
- NSW Outback Division of General Practice.

The program uses a flexible service model and funds organisations to provide allied health and nursing mental health services in rural and remote areas. The majority of organisations funded under this program are Divisions of General Practice, although other service types such as the Royal Flying Doctor Service of Australia and Aboriginal Medical Services have been included.

Again, the MHCC could usefully explore the possibility of partnerships being established between community mental health organisation and the above organisations.

7. Multidisciplinary Case Conference

The case conferencing MBS items are for GPs to organise and coordinate or to participate in, a meeting or discussion held to ensure that a person's multidisciplinary care needs are met through a planned and coordinated approach. Clients with a chronic or terminal medical condition and complex care needs requiring care or services from their usual GP and at least two other health or care providers are eligible for a case conference service.

A 'chronic medical condition' is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular disease, diabetes mellitus, musculoskeletal conditions and stroke; many of which people with long standing mental illness are higher risk of developing.

Examples of persons who may be included in a multidisciplinary care team are:

- allied health professionals
- home and community service providers
- care organisers such as education providers, "meals on wheels" providers, personal care workers and probation officers.

The patient's informal or family carer can be included as a formal member of the team, but does not count towards the minimum of three service providers. A case conference can occur face-to-face, by phone or by video conference, or through a combination of these. The minimum three care providers (including the GP) must be in communication with each other throughout the conference.

The step-up and HBOS could liaise with GPs about the need for case conferencing and could also be involved with their conduct.

8. Domiciliary Medication Management Review

The Domiciliary Medication Management Review (DMMR), also known as a Home Medicines Review (HMR), is an MBS item for patients living in the community setting. This may only be initiated by a patient's GP after assessing a person's need for the service. The goal of a DMMR is to maximise an individual benefit from a person's medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community

pharmacy. It may also involve other relevant members of the health care team, such as nurses in community practice or key support workers.

The DMMR process utilises the specific knowledge and expertise of each of the health care professionals involved. In collaboration with the GP, a pharmacist comprehensively reviews a person's medication regimen in a home visit. After discussion of the pharmacist's report and findings, the GP and patient agree on a medication management plan. The person is central to the development and implementation of this plan with their GP. Payment for the review under the MBS will not occur until after the second patient consultation.

Given the complex mix of medications frequently prescribed for people with severe mental illness and numerous physical health care needs, this is a further MBS item which could assist people receiving services from the step-up and HBOS.

9. Nurse Practitioner Rebates

Under changes, which came into effect recently on 1 November 2010, Medicare benefits will be payable for services provided by eligible privately practicing nurse practitioners working in collaboration with a medical practitioner. These items are time tiered and take into account the complexity of the patient's condition, enabling nurse practitioners to provide a broad range of services within their scope of practice. Participating nurse practitioners will also be able to request certain pathology and diagnostic imaging services for their patients and refer patients to specialists and consultant physicians, as the clinical need arises rebates will be payable for visits to a nurse practitioner, nurses who have been trained to a higher level than registered nurses, who are already commonly employed in GP surgeries.

Rebates for nurse practitioners will vary according to the time of the consultation and complexity of the service. For a simple attendance of up to five minutes, the rebate will be $9.20, while for a standard consultation of up to 20 minutes the patient will receive $20.15 back from Medicare. Longer consultations, lasting from about 20 to about 40 minutes, will qualify for a rebate of $38.25, while longer than 40 minutes will earn $56.30.

Though the new rebates are small, they do afford new opportunities for nurse practitioners who are working in their private practice. It is possible that the new rebates may assist nurse practitioners to widen the settings in which they practice or conduct sessions to include community mental health organisation such as the proposed step-up and HBOS.

Collaborative Therapy

Collaborative Therapy is a comprehensive therapeutic approach for consumers, workers, services and others to work systematically towards the achievement of optimal health outcomes (Gilbert et al, 2003). A service delivery framework and programs based on the *Collaborative Therapy* approach have been developed and evaluated by Frameworks for Health (formerly the Collaborative Therapy Unit).

The purpose of Collaborative Therapy is to provide a consistent approach for the worker to work together, or collaborate, with individuals or groups with a range of illnesses, mental and physical, to develop strategies to maintain optimal health and prevent episodes of illness or relapse. This is achieved through learning about the "I Can Do" model, which places the individual at the centre of their health care and increases their involvement in managing vulnerability and stress and using effective coping strategies to optimise their health.

Supporting self-efficacy

The concept of 'self-efficacy' is an integral component of Collaborative Therapy. Using a systematic approach, self-efficacy is enhanced within the framework of education, coping strategies, skills development and adaptation. This supports the philosophy that a person's health should not be dependent on' but 'supported by' the services they need to utilise, thus in theory, promoting an internal locus of control. The Health Journal is an important tool used to promote self-efficacy within this approach.

Education

- Knowledge of the "I Can Do" Model
- Increase sense of Control

Coping Strategies

- Maintenance of health and well-being
- Focuses on individual's strengths
- Learning new strategies

Skills Development

- Symptom recognition
- Increased variety of techniques to promote optimal health
- Using Collaborative Therapy Journal

Collaborative Therapy has traditionally been delivered as an eight week program via weekly group sessions. This does not always fit well with the length of stay and service needs of a sub-acute service. The Gippsland PARC, Victoria in partnership with Frameworks For Health (FFH) adapted Collaborative Therapy to be delivered on a more frequent basis. This "new" version of Collaborative Therapy is currently undergoing research and early evidence (Holdsworth & Pawsey as yet unpublished) is proving very promising.

In order to strengthen this evidenced based approach the MHCC proposes that the HBOS component of this service model delivers the traditional version of Collaborative Therapy. Given that this version of Collaborative Therapy is delivered over an eight week cycle it is proposed that this be the minimum post discharge period of support from the outreach component of service delivery. This is in keeping with the proposal to offer up to three months post discharge support from the Queensland youth TOHI service.

Whilst the service model will be significantly underpinned by *Collaborative Therapy* both the adapted and traditional version the service will provide a range of other options including, but not limited to: psychosocial education and community integration, vocational support and providing an opportunity for consumer identified needs (ie, family issues and social and environmental issues) to be addressed without the need for hospital admission.

Attachment 3

Project Milestones & Timelines

Task	Milestone	QPC	Date completed
Establish project governance arrangements & arrangements for stakeholder input	Steering Committee and Reference Group established with TORs and commenced meetings	MHCC Board satisfied with governance arrangements & both the Board and MHDAO satisfied with inclusiveness of Reference Group and with the opportunities for stakeholder input	End 1st Six months
Employment of Project Coordinator & IT & Project Support Officer	Project Coordinator & IT & Project Support Officer employed and commenced work	MHCC employment policies and procedures followed	End 1st Six months
Tender process conducted to engage community-managed mental health organisation at 3 sites to establish the step-up and HBOS	Community-managed mental health organisations engaged and contracts executed	Process complies with best practice open tendering	End 1st Six months
Tender process conducted to engage an external & independent evaluator	Evaluator engaged & contract executed	Process complies with best practice open tendering	End 1st Six months
Service models and protocols, guidelines, templates & database established	Project operating manual inclusive of models, protocols, guidelines, templates complete and ready for implementation; database ready for implementation	Sign off by Steering Committee of major items	End 1st Six months
Establishment local Steering and Reference Committees by the contracted community-managed mental health organizations	Steering Committees and Reference Groups established with TORs and commenced meetings	MHCC satisfied with arrangements; arrangements comply with contractual requirements	End 14 months
Employment by the contracted community-managed mental health organizations of staff for their Site	Staff employed at each site and fully operational	Community-managed sector employment P&Ps complied with	End 14 months
Introduction and implementation of referral, intake, assessment procedures at each site	Referral, intake and assessment processes operational	Reviewed by external and independent evaluator	End 14 months
Establishment at each site of MOUs or service agreements with locally-	Service agreements & MOUs in place and local service provides	Comply with all legal requirements; consistent with	End 14 months

Task	Milestone	QPC	Date completed
based primary health providers, mental health services and psychosocial and recovery support organizations	providing services	contractual advice, guidelines & templates provided by MHCC	
MOUs with service providers in place at each site for in-reach sessions or outreach programs e.g. Centrelink, local employment services, TAFE, Financial Counselling services, Child Support Agency, Department of Housing, Diabetes Educators etc	MOUs in place and in-reach and outreach sessions being conducted by a range of service providers		End 14 months
Development of care coordination procedures, protocols and enabling information systems at each site	Care coordination arrangements in place & operating	Reviewed by external & independent evaluator; consumer and other key stakeholder review positively	End 14 months
Setting in place at each site project data systems	Data systems in place and working effectively	MHCC & contracted agencies satisfied with efficacy	End 14 months
At each site meeting with Evaluation team and setting in place the systems that are required for Project Evaluation	Evaluation arrangements in place and proceeding	Steering Cttees review positively	End 14 months
Purchasing or hiring of necessary equipment at each site	Sites equipped	Reviewed by external & independent evaluator; consumer and other key stakeholder review positively	End 14 months
Launch and opening of the Recovery & Wellbeing Local at each site	Step-up and HBOSs launched	Steering Cttees review positively; Reviewed by external & independent evaluator; consumer and other key stakeholder review positively	End 14 months
Step-up and HBOSs established and providing access to mental health and social support, psychological services & primary health care	Step-up and HBOSs fully operational	Reviewed by external & independent evaluator; consumer and other key stakeholder review positively	By end first 14 months
Quarterly reports by Project sites	Quarterly progress and activity report produced by contracted organisation at each site	Sign off by local Steering Committee; complies with contractual	Quarterly from 12th month

Task	Milestone	QPC	Date completed
		requirements;	
12 monthly evaluation reports & final project evaluation report	Evaluation reports prepared 12 monthly at conclusion of the project	Evaluation report prepared to the satisfaction of MHCC Board, overall Project Steering Committee & MHDAO	At 12 month, 24 month, 36 month & 42 month stage