

**DEFINING THE ROLE AND FUNCTIONS
OF THE PDSS SECTOR-
THE VICSERV CONSULTATION REPORT AND
RECOMMENDATIONS TO DHS**

February 2002

This paper was prepared by VICSERV Policy Worker Michael Clanchy and CEO David Clarke, with input from the VICSERV Committee of Management, and a wide range of member organisations through extensive consultation.

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Growth and development in our field

The psychiatric disability support services sector has developed and grown significantly in the last decade.

In 1992, the sector adopted the principles of psychosocial rehabilitation as the underpinning framework for the delivery of home based outreach, mutual support and self help, planned respite care, residential rehabilitation and psychosocial rehabilitation day programs.

The sector has continued to grow in size, particularly in the past 6 years. In 1995, the sector was funded at \$16.9M per annum. Today, approximately \$45M in services are delivered across Victoria in more than 170 programs by 72 different organisations, employing more than 1000 workers.

Although this growth has been significant, the sector remains relatively small in the context of total state government expenditure in Adult Mental Health, representing approximately 14% of total funding. Given the fact that our rehabilitation and support services are provided to as many as 10,000 people with a severe and enduring psychiatric disability each year, this represents exceptional service coverage with available funds.

Developing rehabilitation practice

Significant advancements have been made in the practice of psychosocial rehabilitation and support practices through a range of workforce and organisational development initiatives.

As the work of these programs has become more professional and targeted toward the most effective psychosocial interventions, there has been a developing need to identify the changes in the field, and articulate those changes more clearly to the human services field and broader community.

Improving linkages

In recent years, the work of the "Cornerstone Project" has resulted in some improvements in working relationships between clinical services and the PDS sector, and a greater understanding of the roles each of these key areas play in the delivery of the continuum of care for people with a mental illness/psychiatric disability.

With the introduction of Primary Care Partnerships, our sector has been developing new and stronger links with a range of primary care providers throughout the state. This has raised issues and questions for the field around which services represent our most important linkages and partnerships.

The need to describe and define our work more clearly – part of a broader agenda

Our ongoing consultative processes with the sector in recent times have identified that there are real challenges in describing and communicating the nature of psychiatric disability support to a range of service providers, in order to ensure effective referrals and partnerships within the primary care system.

The committee of management of VICSERV identified early in 2001 that this was one of four key issues which need to be addressed concurrently. These issues are:

- **Describing and defining our work** more clearly
- **Developing a consistency of quality** across the sector;
- Effectively sharing **high quality practice**; and
- Ensuring a **viable resource base** to deliver quality services.

Establishing the issues and gathering data

With this agenda in mind and building on our existing knowledge of the concerns of our member agencies, VICSERV undertook a consultative project designed to move the sector forward in describing and communicating its work more effectively, both internally and externally.

This work also provides a basis for further developments in the establishment of quality systems in the sector, and identifying the resources required to deliver quality service.

The following paper outlines the results of our recent statewide sector consultation on this issue, and provides a set of recommendations to the Department of Human Services, which we believe will help to further define the role and functions of our sector into the coming decade.

It is important to re-state that this work builds on a range of other sources which VICSERV draws from to determine the sector's position on any issue. These sources include our many networks, sub-committees and professional development programs. The recommendations have been discussed in detail, and are fully supported by the Committee of Management on behalf of the membership.

2. Summary of the Consultation Findings- Data and Trends

- Our core business was overwhelmingly seen as most accurately described by the words “rehabilitation and support” or “psychosocial rehabilitation and support”.
- “Rehabilitation” and “support” functions were seen as complementary and not conflictual elements of PDS service. This dual role of PDS services was seen to indicate the need for tailoring and individualising programs/venues/client groups.
- The applicability of the PSR principles to our field was again broadly confirmed.
- The critical importance of the key worker and IPP process was confirmed in most programs. Nevertheless, comprehensive assessment and service planning were not seen as appropriate in Mutual Support and Self-Help Services and informal drop-in settings, which may require specific alternative approaches.
- A clear difference in emphasis was seen between MSSH services and more traditional PDS services. There is a strong perception that psychiatric disability support work is not a simple, homogenous field of practice in terms of client need and service intervention. Services and interventions need to be designed around individual need. This is consistent with psychosocial principles.
- It was indicated that more policy and program definition work needed to occur in terms of a Framework for service delivery in the sector.
- The current name for the sector was widely seen as negative, inaccurate and inappropriate. A number of suggestions for a new name were forwarded by survey respondents (See report).
- There were also suggestions for a sector slogan/motto, with a view to further capturing and promoting the nature of the sector’s work. (See report).
- The profile of clients receiving PDS services was seen to be changing in a number of clearly identifiable ways. (See report).
- This change in the client group and its service needs was seen to be causing clear and identifiable changes in service models, activities, processes and plans for future directions. (See report).
- Respondents indicated that consumers expressed that they found regular, supportive contact with their worker and the social and supportive context of the programs as the most valuable/helpful aspects of services. This is consistent with psychosocial principles in terms of client-staff relationships.

- Advocacy and practical assistance (with regard to matters like housing, finance and transport) tended to be next most highly rated.
- Respondents indicated that carers also tended to nominate the support and social aspects of PDS services as being most valuable/helpful. Worker contact and support, sharing the “load/burden of the consumer’s illness” and the support from fellow carers were rated highly.
- Services confirmed that they undertook community development and education work (including promoting community acceptance and inclusion, the creation of pathways/opportunities for clients and general resource building) and illness/disability prevention work as an integral part of their daily responsibilities.
- Respondents were more equivocal about the role of the sector with regard to Mental Health Promotion work. There appeared to be a lack of consensus and, in some cases, understanding concerning what role our services might have in Mental Health Promotion and building healthy communities.
- At the regional contract management level, there was a high degree of consensus on the purpose, nature and focus of the sector’s work between DHS, as funder, and agencies, as providers. Little conflict was reported on issues such as eligible client group or appropriate service activity.
- Our services predominantly viewed “clinical mental health services” as the agencies with which they have the closest/most natural links. This structural affinity has important implications for joint service sector planning and joint caseplanning/case coordination, and again confirms the role of our services in the continuum of specialist mental health services

It is important to note, however, that a number of MSSH services saw their closest links with primary health providers, such as GPs, psychologists and private psychiatrists.

- Our services were able to clearly differentiate their rehabilitative role from the rehabilitative role of clinical mental health services (See report).
- There was a strong view that the role and value of PDS service sector was not known/understood in the wider community and sometimes not even amongst fellow professionals in the broader health and community service field.

3. Sector Responses In Detail

3.1 Respondents:

There were a total of 47 formal written responses to the consultation questionnaire from 24 separate organisations.

Program managers and co-ordinators formed the largest category of respondents at 49%, followed by 23% of responses from direct care staff and 17% from CEOs. There was one response from an administrative staff member, one from a consumer and two responses from carers. (A small number of these returns were joint or group applications which were classified into the most representative of the abovementioned categories).

A separate process, targeted specifically for consumer and carer input, was also undertaken by VICSERV.

Multiple responses were received from a number of agencies. For instance, seven responses were received from each of two agencies, five responses from one agency, three responses from each of three agencies and two responses from one agency. (While all the qualitative comments of individual respondents were analysed and fed into the findings, in certain fixed choice questions where a representative sectorwide view was sought, a “predominant agency” response rather than the total number of individual responses was used in counting. This methodology was employed to lessen the possibility of systemic bias arising from multiple responses from the one agency).

Although the quantum of responses to this widely advertised survey was relatively low, the quality of the returns was extremely high and yielded very informative data. VICSERV sincerely thanks all the respondents who contributed to the process.

3.2 What Business Are We In?

3.2.1 Core Business

In terms of selecting the most appropriate descriptor (in a fixed and exclusive choice format) of what business we are in, the “predominant agency” responses were as follows:

Support	4% agencies
Rehabilitation and Support	75%
Recovery	4%
Rehabilitation	12%
Mutual Support and Self Help	4%

Some of those who chose “rehabilitation” as core business placed the word “psychosocial” before the word “rehabilitation” to more narrowly define its meaning.

3.2.2 Psychosocial Rehabilitation Principles

In terms of “predominant agency” responses:

- A large majority of 79% of agencies agreed (subject to minor qualifications in some instances) that our services should be based on the psychosocial rehabilitation principles outlined in the PDSS Draft Framework.
- Only 5% of agencies disagreed with this proposition, 8% were unsure and 8% did not state their view.

3.2.3 Service Philosophy, Concepts and Descriptions

In terms of “predominant agency” response:

- 67% of agencies agreed that the service philosophy, concepts and definitions in the PDSS Draft Framework were an accurate and comprehensive description of what we do
- 21% of agencies thought they were not
- 12.5 % were unsure or did not state their view

Those respondents who were not satisfied with the Draft PDSS Framework’s description of our services made the following comments:

- the service models specified tend to be rigid and constraining. The sector needs maximum flexibility to “mix and match” a whole range of services to client need.
- the philosophical emphasis on learning and reskilling is less relevant to the client population with high prevalence disorders.
- the emphasis on the goals of learning and skill development needs to be balanced with statements about the goals of achieving internal states of personal confidence, sense of mastery and higher self-esteem. This is consistent with one of the underpinning statements to PSR principles that “people are motivated by a need for mastery and competence in areas which allow them to feel more independent and self-confident.”
- the importance of evidence-based practice needs to be noted.
- reference needs to be made to services with a specialist youth focus.

3.2.4 The Use of Key Worker and IPPs

In terms of “predominant agency” response:

- 79% agencies said they used key worker and IPP processes to structure their work
- 12.5% agencies said they did not
- 8% did not specify

Consistent with the PDS framework, mutual help and support services and the drop-in components of day programs were not using the key worker model or IPPs.

3.2.5 Analysis

An analysis of these responses, with the attendant comments, offered a number of important viewpoints about the nature of our work.

- There was a strong view that there was no contradiction between the rehabilitation and support elements of our service. Support was seen as an essential service for those who were not ready or able to pursue an active rehabilitative program. There was an impassioned plea against the exclusion of clients from programs on the grounds they were not ready or able to embark on active rehabilitation.

The fact that some consumers are on an active rehabilitation path and others seek just support/company/assistance was seen as an argument for tailored and individual programs rather than the choice of one client group to the exclusion of another.

It must be recognised, however, that the tailoring of separate individualised programs for clients with different needs does have important resource implications for agencies.

- **Given the acceptance of this dual role of rehabilitation and support, it was not surprising, therefore, that respondents opted overwhelmingly to categorise our work as “rehabilitation and support”, rather than either “rehabilitation” or “support” alone (in response to the fixed choice question about the nature of our core business).**

It is important to note that some differences were noted by respondents between the more traditional PDS services and MS&SH services.

MS&SH services were seen as more organic, less structured services, often provided to a client group with less disability. For this reason, it was suggested that the position of MS&SH services within the broad range of PDS services needed greater clarification and definition.

- There was a strong view that work with consumers must be based upon specialist knowledge, careful individualised assessment and responsive, tailored programs. These complex work requirements mark out mental health rehabilitation and support as a diverse field, requiring highly professional and trained human service practitioners.
- Another matter worthy of note in response to the question on our core business is that practically no respondents wished to assert that their core business was function specific work, such as home-based outreach work, day program work or residential work. Respondents appeared to accept a higher level concept of “rehabilitation and support” work rather than characterizing their work by reference to venue of delivery or service detail (e.g housing work, day program work).

- **There continues to be strong support for the sector to base its work on the principles of psychosocial rehabilitation, as first formally adopted in 1992.**
- While respondents, therefore, confirmed the usefulness of the draft PDSS Framework, there was some argument for updating and expanding this program document in terms of how it defined the sector's work.

There appears to be a need to review service definitions to capture more accurately the nature and new emphases of our services e.g youth, clients with depression and anxiety etc.

- Some respondents also noted that the highly complex and individualised interpersonal processes of our work would be more effectively defined by the development and use across the field of common client assessment and progress/outcome measures on a range of psycho-social indicators.

3.3 The “Name” of the Sector

3.3.1 Name

The current name, or descriptor, for the sector, “Psychiatric Disability Support Services”, attracted a resounding vote of “no confidence” from respondents.

On a “predominant agency” response to a fixed choice question,

Only 12.5% of agencies believed that PDSS was an appropriate name for the sector

An overwhelming 79% of agencies believed it was a poor name for the sector
8% did not state their view on the current name of the sector.

The criticism of the current sector name was strong and emotional. Many commented that the name was negative and stigmatizing. For instance, some said that we should be referring to “mental health services” rather than “psychiatric services”. Others pointed out that we should be emphasising ability rather than disability. One respondent pointed out the illogicality of the current name by stating: “We do not support disability”.

In terms of suggestions for a new name, many emphasised the following words:

“community”- the process of reconnecting with and functioning in society
“mental health”- promoting good mental health rather than focusing on illness

”recovery”- the process of retrieving a life, refinding a way; the concept of recovery was also seen to include the important notion of hope.

”rehabilitation and support” was favoured by some as a name because it most closely described the sector’s core function.

“psycho-social rehabilitation” was seen as more specific by many than “rehabilitation”

There was, however, a view expressed that the word “rehabilitation” as a name for the sector conjured up a medical model and had some stigmatizing overtones. “Psychosocial rehabilitation” received strong support as the specific area of practice in which we operate; but an alternative view was that it was not a good public name for our sector because it had bad (“psycho” and “rehab”) connotations within the broader community.

Some of the more promising suggestions for a sector name were:

- a) “Mental Health Recovery Services”
- b) “Mental Health Rehabilitation and Support Services”
- c) “Community Rehabilitation and Support Services”
- d) “Community Rehabilitation Services in Mental Health”
- e) “Mental Health Rehabilitation, Recovery and Support Services”

3.3.2 Use of a Slogan

While there was lively and informative debate about a new name for the sector, respondents showed less enthusiasm for a slogan or motto. A high number of respondents by-passed this question.

One respondent suggested a sense of desperation in looking for a motto while another said that the development of a symbol or logo for the sector might be a more appropriate use of energy.

A few good suggestions for a slogan, however, were forwarded from respondents. They emphasised skills development, personal empowerment, independent living, self-help and recovery themes.

One of the better suggestions was a simple, clear, aspirational statement, with which most agencies would be able to identify:

“Improving Mental Health and Well-Being in Local Communities”

Other descriptive and mottos included:

“Supporting the Recovery Process”

“Working Together to Maximise Ability(Independence)”

3.4 The Client Profile:

3.4.1 Client Group

When asked to define their client group, few agencies specified that their services were restricted merely to people with “a severe and enduring psychiatric disability”.

Most agencies stated that their services were available to all persons with a psychiatric diagnosis and rehabilitation or support needs. A number of agencies specified 16 to 64 years as the eligible age span for clients but others indicated the importance of their continuing service for people passing beyond retirement age. This suggests that there is further work to be done in the area of defining our client group.

3.4.2 Changes in Client Profile

In terms of “predominant agency response”, 100% of agencies stated that the characteristics of their client group were changing. Respondent after respondent identified the following changes occurring in the profile of their consumers:

- A marked increase in dual diagnosis (mental illness and alcohol/substance abuse) and in the prevalence of drug-induced psychoses.
- More consumers with anxiety/depression diagnoses (higher prevalence disorders) and more people with the diagnosis of personality disorder.
- More severe conditions, where psychiatric disability was complicated by other psycho-social problems, such as homelessness, substance abuse, child protection matters, poverty and imprisonment.
- Increased numbers of younger consumers (16-25 years).
- Increased numbers of women consumers.
- A decrease in the proportion of clients with long histories of institutionalization.
- More clients presenting with early onset symptoms.

Other discernible, though less frequently mentioned changes in client profile included:

- A higher proportion of better educated consumers presenting for service.
- A more demanding, assertive and rights-focused consumer group.

- A carer population with higher expectations for participation and for their own support services.
- A increase in the total numbers of clients seeking service, both in traditional PDS services and in mutual help and self-help services.
- More consumers without case management from clinical mental health services.
- More consumers from culturally and linguistically diverse backgrounds.

It is logical that these changes in the profile and needs of PDS service consumers have translated into new service emphases and emerging new directions in service delivery.

3.4.3 Service Trends and Future Directions

The respondents identified/predicted the following trends in the nature of PDS service work:

- The need for better case coordination between PDS services and other treatment/community service providers, particularly drug and alcohol services, counselling services and more practical services such as housing.
- The need for developing productive client pathways and options through the establishment of strategic alliances with mainstream services, particularly in the areas of employment, education and recreation/leisure.
- The need for more assertive and intensive outreach services for consumers with high and complex needs.
- The need for more tailoring and individualisation of programs for consumers with different needs.
- The need for greater use of less institutionalised and less stigmatized settings for services to clients.
- The need for more emphasis on consumer advocacy, especially in the areas of housing and social inclusion.
- The need for more sophisticated support and psycho-educational programs for consumers with higher prevalence disorders.
- The need for empowering consumers towards self-help and management of their own programs.
- The need for more programs with a specialist youth focus.

- The need for more mutual help networks for carers and empowering them to manage their own programs.
- The need for more specialist aged-care services for an ageing cohort of consumers.
- The need for more direct delivery of pre-employment/employment readiness programs.
- The need for systematic use of program evaluation tools and client progress/outcome measures.
- The need for exploration of a casemanagement function for PDS services.
- The need for more time-limited, outcome-focused rehabilitation for consumers pursuing specific goals.

3.5 Consumer and Client Perspectives

3.5.1 Consumers

When PDS staff were asked to identify what their consumers indicated were the most and least valuable aspects of their services, specific and thought-provoking trends emerged. (Direct consumer perspectives from a recent VMIAC consultation covering similar questions will also be examined later in this section).

One respondent captured a broad truth by noting what was most/least helpful varied from consumer to consumer and from one time to another. Indeed, a wide range of responses to the most/least helpful aspects of PDS services was recorded.

Notwithstanding this spread of responses, the consumer's supportive relationships with their key worker/other staff and, secondarily, their supportive relationships with selected other consumers were overwhelmingly identified as having the most value to consumers.

The importance of the support that consumers received from staff was expressed in a many ways: "being listened to, being respected, trust, friendship, emotional support, continuity of staff". The critical importance of the consumer-staff supportive relationship was also evident in what consumers indicated were the least helpful aspects of service-"no weekend service, no evening service, no holiday access, turnover of workers, consumers being moved on or discharged from the service, no time with workers when they were busy, getting the answering machine". All these comments underline the high value that consumers place on the support they receive from interactions with workers.

The questionnaire responses also found that consumers valued the socially supportive context of group services. Comments included: "safe, secure, having a say, drop-in, group activities, eating together, going out together, group activities, companionship, fun". Again the worth of the socially supportive context was reinforced by reference to what was least helpful about services: "not open at night, weekends, holidays, poor matching with other difficult clients, (transport) difficulties in getting to services".

The weight of responses strongly suggested that consumers rated the social and supportive aspects of services most highly- matters like being respected, listened to and being part of a community. Although matters like psycho-education, symptom management, skills enhancement, promotion of independence and outcome-focused rehabilitation were also recorded as valuable, these (rehabilitative) elements were mentioned less frequently than personal and group support.

Another area which emerged as rating highly with consumers, according to the respondents, was advocacy work and the provision of practical assistance, particularly in areas such as housing, financial/material aid and transport. Correspondingly, consumers were likely to express that services were not helpful when they were unable to provide advocacy or practical assistance on

matters like housing and transport. Once again, advocacy and practical assistance were cited more often than specifically rehabilitative elements such as skills enhancement, education and the promotion of independent living.

These results about consumer expectations and evaluation of services present the sector with a genuine and major philosophical dilemma about the focus and function of its services.

If services are to be truly driven by consumer participation and responsive to consumer demand, must the sector give priority to the expressed need for personal support and practical assistance? Or, as some agencies argued very strongly in their responses, does this support-focused service approach merely reinforce consumer dependency and fail the rehabilitative challenge of enhancing capacity and independence? When is motivating a client to adopt a rehabilitative plan “pushy” and “harmful” and when is it “responsible and constructive”?

Obviously there are no easy policy answers to these complex questions and dilemmas. Perhaps they are questions which must be considered carefully in the individual practice context of a respectful relationship between an individual consumer and the skilled practitioner.

Some other aspects of services appreciated by consumers according to respondents were: voluntary involvement, favourite activities (e.g. music) and consumer participation. Aspects of service found unhelpful were lack of funds for varied and quality activities, red tape and restrictive rules.

A recent comprehensive consultation by VMIAC of consumers’ views about mental health services confirms the salient findings of our questionnaire as noted above.

In the VMIAC consultation, consumers also placed heavy emphasis on the importance of their supportive relationships with workers and selected fellow consumers. The importance of worker contact and support received high approval ratings. Consumers’ comments about the negative aspects of PDS services also hinted at how they highly they valued the personal and support roles of PDS services. They wanted more access to services, especially after hours and on weekends. Many consumers reported considerable loneliness and isolation when they could not access services. Others commented on the unfairness of being excluded from programs and being discharged if they were not in active rehabilitation mode.

(On the other hand, some consumers referred to poor matching/selection in groups and the fact that many people in the same group programs were at different levels. These comments would suggest that consumers have different types of need and motivation and that some consumers are adversely affected when group participants are not carefully selected. Some responses to the VICSERV questionnaire made explicit that aggressive and disruptive consumers can be distressing to other participants).

3.5.2 Carers

According to respondents, social and emotional support were the dominant positives seen in PDS services by carers also. Carers indicated to workers that they most appreciated the following aspects of PDS services:

- sharing the load/burden of the consumer's illness;
- being listened to, understood and accepted;
- access to support and back-up during crises;
- respite during the time the consumers are involved at the service;
- the provision of other types of respite;
- the provision of some social outlet for otherwise isolated consumers;
- the provision of mutual support through networking with other carers.

In terms of least helpful aspects of PDS services, carers also focused on the support dimension:

- unavailability of support services on the weekends, nights and holidays;
- unavailability of worker when support was wanted;
- the need for more planned respite;
- not being allowed to participate or be involved because of confidentiality or other considerations;

Further direct study of carers' evaluations of PDS services (rather than the evaluations as interpreted through workers) is currently being carried out by VICSERV to test the validity of the above data.

3.6 The role of PDS services in Illness Prevention, Mental Health Promotion and Community Development

Responses to this set of questions clearly indicate that all PDS services are involved to some extent in the areas of prevention, health promotion and community development on a daily basis.

It is important to stress that many respondents saw their prevention, promotion and community development work as an integral part of their client rehabilitative and support functions as well as seeing it as an extension of it. That is to say, good consumer service was seen as involving appropriate attention to elements of prevention, promotion and community development.

Certain general conclusions could be drawn from an analysis of the responses to this set of questions:

- There is a need for a clearer definitional framework to address differences in the way that members of the sector understand and use the terms of prevention, promotion and community development. For example, the differing emphases on the notion of prevention- e.g., primary prevention, secondary prevention, early intervention to prevent illness, early intervention to prevent or minimize disability, relapse prevention-seem to call for greater standard definition within a program development context.
- While the imperatives of prevention, promotion and community development work were recognised on a universal basis by respondents, it was frequently noted that work in these areas was severely curtailed because of funding restraints for these activities.
- Community development work was seen as a clear priority by services within the sector. The major components of community development highlighted in responses were:
 - i. educating the community to foster an atmosphere of understanding, acceptance and social inclusion
 - ii. developing services partnerships and community capacity/resources to provide accessible and feasible pathways for consumers into mainstream community life.
 - iii. empowering consumers and carers through the facilitation of mutual support and self help networks/opportunities.
- Agencies were also clear about their involvement and initiatives in relation to effective relapse prevention approaches and early interventions to minimize disability with their existing client base. This area was again perceived as part of the daily core work for PDS services.
- Much less clear were the sector's directions with regard to primary mental illness prevention and general mental health promotion. While there was again broad and strong interest, PDS service activities reported in these arenas appeared more diverse and less specific in focus.

Policy and program development work is needed to provide evaluation and coordination of the sector's place in these functions.

The fundamental question needs to be asked whether or not PDS services have a viable role and mandate in primary prevention and general mental health promotion. If so, how much of a role? And how and with what other agencies do we share this role?

Then follow second-order policy and program development questions to identify most effective strategies, the prioritization and coordination of effort and the adequate resourcing for this work.

3.7 Perception of the funder's perspective on the sector

Questionnaire responses showed that approximately two-thirds of respondents reported relatively high level of agreement on the purpose, nature and focus of PDS services between the Department of Human Services as funder and agencies as providers.

In terms of "predominant agency" responses,

62.5% of agencies agreed with their regional DHS contract manager on the nature and focus of services

29% of agencies had disagreements on service definition issues

8% did not state their views

When the type of disagreements between DHS and agencies were analysed more closely, however, three quarters were found to be basically disagreements about funding levels/service output levels/reporting arrangements rather than disagreement on the nature and focus of services. One quarter of agencies in disagreement with DHS cited disagreements related to conflict about service definition, such as service eligibility criteria, priority client groups and appropriate service activities/goals.

This relatively low level of disagreement may indicate a high degree of flexibility and negotiation on service definition and service priorities at regional level between the Department and agencies. Or the low level of disputation may also be partly explained by the wry comment of one CEO respondent. Asked if the agency agreed with the Regional Office on service definition and focus, the manager replied "Yes, because I have no alternative".

3.8 Links and Relationships with Other Services

3.8.1 Closest Links

Within the format of a fixed choice question, respondents were asked to nominate with which other service did PDS services have the closest working/natural link.

According to a “predominant agency” response:

62.5% of agencies nominated clinical mental health services

12.5% of agencies nominated welfare agencies

4% of agencies nominated General Practitioners

4% of agencies nominated private psychologists/psychiatrists

4% of agencies nominated a forensic service

12.5% of agencies did not express a view.

Many respondents emphasized the need for more communication and a closer working relationship with clinical mental health services to ensure better client service. Collaborative work was seen as essential in a number of areas: service planning, service protocols, case coordination, especially joint caseplanning and managing hospital discharge, joint training and joint community education activities.

While PDSS respondents also emphasized the importance of their services’ relationships with a number of other health and community service providers, the importance of the natural structural link with the clinical mental health service sector emerged as dominant.

3.8.2 Differences Between PDSS and Clinical Services Work

Respondents were asked to differentiate the rehabilitative work done by clinical services and that done by PDS services.

PDS services were identified as holistic services, which worked with the consumer in a total life context.

While PDS services were seen as having an all-encompassing client focus, clinical mental health services were defined as more focused on acute illness and the alleviation of symptoms. Clinical services were seen as based upon a medical model, which emphasized medication, authority and expertise.

Some respondents challenged the notion that clinical services had a rehabilitation focus at all, in the sense that they were not seen as attending to enhancing client abilities, maximizing independence and re-integrating people back into valued social roles. Because of the demands of excessively high caseloads in clinical services, many respondents described clinical workers as being confined to managing crises, statutory matters and duty of care issues.

Reference was regularly made to the lack of time clinical casemanagers had to allocate to their clients and to the pressure on casemanagers to discharge clients from their caseload.

The expressed view was that PDS services offered consumers much more face-to-face time with a helping professional in a less threatening and less hierarchical environment. It was stated that consumers remarked that they felt far more secure, comfortable and in control in PDS settings.

PDS services were seen as promoting a social model of wellness, which focused on all aspects of the consumer's life. Group work and community involvement, not emphasized in clinical services, increased consumers social adjustment and recovery capacity.

3.9 Marketing PDS services

There was an enthusiastic response to the invitation for suggestions about how the role of the PDS services and the sector could be better marketed.

Many respondents stated that PDS services were often neither known nor understood in the general community or even among fellow professionals in the health and community services field.

There was a broad call for a clear statement on PDS work and better public promotion of this message.

One respondent commented that there was no vision or clear documentation from the Department of Human Services to drive the sector. He argued that the place of PDS services had been neglected "from the top" in terms of the broad health policy framework.

The PDS sector itself was also seen as partially responsible for its poor definition and marketing.

There was a strong call for statewide coordination of community information and education about the sector. Respondents recommended the production of professionally created and informative education resources (pamphlets, videos, resource kits) to identify the mission and work of the sector. Some respondents indicated that VICSERV had an important role to play in educating the community about the sector through mass media.

A number of respondents referred to the fact that workers in the sector often did not receive the respect and cooperation they needed to work effectively with their clients in the broader service system. GPs and clinical mental health workers were named as two groups who often did not work in a collegial fashion because PDS staff were still perceived as untrained and unprofessional.

Respondents addressed a number of sector characteristics and practices which contributed to this negative image.

It was pointed out that the PDS sector maintained no minimum qualifications/minimum training pre-requisites/registration process for worker entry. It was argued that without the establishment of such staffing standards, the work performed would always be devalued. This is despite the fact that the qualifications of many of the people working in the field are actually high.

In a similar vein, one respondent was highly critical of the widespread use of the title “support worker” within the sector. The term “support worker” was considered to convey no specialist knowledge or skill.

The poor salaries of our staff were seen as related to the poor image of the sector and its work. Better salaries (or wage parity with similarly qualified professionals in similar fields) were seen as vital to quality staff recruitment and to staff retention. Workforce instability was seen as contributing to poorer client service and a negative image of PDS work.

The lack of appropriate funding for congenial client facilities and for quality program activities were cited as other Q indicators, which reinforced a less than professional image for the sector.

As one respondent noted, “our consumers and their families are no less important” than persons in any other area of rehabilitation. “Their disability is no more or no less important.” This respondent appears to be presenting a rallying call to the sector to reject any subtle assumption that there is anything “second-rate” about its work or the clients it is working for.

The introduction and consistent use of client assessment and progress/outcome measures were also identified as critical factors to support better service definition and marketing of the sector’s work.

Respondents insisted that we must be able to demonstrate what we can do for clients and how effective our services are. Without the existence of such measures, the value of our work will always be queried.

But rehabilitation outcome measures were not only seen as helping to define the value of our work. They were seen as contributing to the definition and clarity of the work we do. Our casework relationship with clients involves a set of very complex and highly individualised interpersonal processes. They are hard to unravel and define. However, if we are able to measure the quality of rehabilitation provided on a number of critical indicators, we will be much better able to illustrate the essence of our work to others in tangible ways.

4. VICSERV-For further action:

VICSERV, on behalf of the sector, will inform the Department of Human Services:

- of the changing profile of services users as detailed in this report. e.g. increasing complexity and diversity of consumer needs; and.
- that the change in consumer profile and need is changing and impacting on service strategies, priorities and processes, as detailed in this report.

VICSERV will seek to engage in partnership with MHB to:

- Produce materials which more clearly define the terms “mental health promotion”, “illness and disability prevention”, “relapse prevention”, “early intervention”, “timely intervention” “primary community prevention” and “community development” in the context of the sector in order to promote common understandings in sector discourse;

VICSERV will also:

- Initiate policy debate to determine the role for the sector in Mental Health Promotion and Primary Prevention;
- Promote the outcomes of the VICSERV resources/viability paper which presents a clear case for a base requirement unit cost per EFT levels to deliver effective rehabilitation and support services.
- Advocate for the funding of adequate physical facilities in services.
- Continue to support the principles of psychosocial rehabilitation as the underpinning framework for service delivery, through working with DHS on the sector framework, and through professional development programs and activities.

5. Recommendations to DHS

Recommendation One:

The sector has determined that its services are more appropriately named:

Community Mental Health Rehabilitation and Support Services

We recommend that the Department of Human Services in partnership with the sector, formally adopt this name.

Recommendation Two:

That, in collaboration with VICSERV, the Department reconvene its working party to update and develop the Draft PDS Framework document. This activity should be consistent with and incorporated into the work of the state mental health plan, and should ensure that it defines practice as continuing to be based on psychosocial rehabilitation principles.

Recommendation Three:

That DHS set up processes to further define Mutual Support/Self-Help program, services and processes.

Recommendation Four:

That through a quality initiative, DHS provide funding for the development of common consumer and program assessment and outcome tools.

Recommendation Five:

That DHS provide funding for outcomes measures research, to better define the purpose and work of the sector and provide evidence of its effectiveness.

Recommendation Six:

That DHS introduce quality incentive bonuses to enhance inter-service strategic partnerships and links, and that quality projects which support joint case planning/case co-ordination and continuity of care be funded.

Recommendation Seven:

That DHS in partnership with VICSERV conduct a sector workforce review which examines issues relating to the recruitment and retention of adequately qualified, competent and trained staff.