DEPARTMENT OF VETERANS' AFFAIRS

VETERANS AND VETERANS FAMILIES COUNSELLING SERVICE FUNCTIONAL REVIEW

FINAL REPORT

AUGUST 2014

HEALTH OUTCOMES INTERNATIONAL
5A Glynburn Road, Glynde, SA 5070 | P: 08 8363 3699 | F: 08 8365 3560
E: info@hoi.com.au | www.hoi.com.au

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We would like to thank the Adelaide VVCS office staff in particular for helping us set up and use the Adelaide videoconference facilities on so many occasions.

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LIST OF ABBREVIATIONS

ACT	Australian Capital Territory
ADF	Australian Defence Force
ANM	Assistant National Manager
APS	Australian Public Service
BSM	Business Support Manager
CPT	Cognitive Processing Therapy
DD	Deputy Director
DVA	Department of Veterans' Affairs
EL	Executive Level
ESO	Ex-service organisation
FTE	Full Time Equivalent
GP	General Practitioner
HOI	Health Outcomes International
HR	Human Resources
IT	Information Technology
KPI	Key Performance Indicator
MOU	Memorandum of Understanding
NAC	National Advisory Committee
NSW	New South Wales
NT	Northern Territory
OPC	Outreach Program Counsellor
OPCo	Outreach Program Coordinator
PTSD	Posttraumatic Stress Disorder
QLD	Queensland
SA	South Australia
TAS	Tasmania
VERA	VVCS Electronic Record Application
VIC	Victoria
VVCS	Veterans and Veterans Families Counselling Service
WA	Western Australia
WLS	Work Level Standards

GLOSSARY

Effectiveness	Whether the activities or outputs of the organisation are achieving stated objectives (e.g. in terms of client outcomes), and to what extent these outputs are contributing to these outcomes
Efficiency	Whether there are better ways of achieving organisation objectives, including consideration of inputs, costs, governance arrangements and use of resources to provide services
Episode of care	A period of counselling and support with a defined start and end determined by client needs on presentation
Major centre	VVCS centre located in a capital city (or Townsville in North Queensland), with at least two full time equivalent VVCS counselling staff
Outpost site	Regional site at which less than two full time equivalent VVCS counselling staff are locally based and provide services from non-VVCS dedicated centre/s (e.g. in local GP clinics, DVA offices or other community locations), with administrative support provided via the nearest VVCS major centre in that region
Outreach provider	An appropriately qualified and experienced privately practising counsellor (psychologist or mental health accredited social worker) contracted by VVCS to provide services to VVCS clients
Regional centre	VVCS centre located outside a capital city, with at least two full time equivalent VVCS counselling staff and at least one administrative staff member
Satellite site	Location where VVCS counselling staff from major or regional centres provide services on a regular basis (e.g. one day per week, using offices in local GP clinic, DVA or other designated community location), with administrative support provided via the nearest VVCS major centre in that region

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EXECUTIVE SUMMARY

The Department of Veterans' Affairs (DVA) commissioned Health Outcomes International (HOI) to undertake a Functional Review (the Review) of the Veterans and Veterans Families Counselling Service (VVCS), including current VVCS roles, responsibilities and organisational structures. The project commenced in April 2014 and is due for completion in July 2014.

E.1 BACKGROUND, OBJECTIVES AND SCOPE OF THE REVIEW

The DVA has commissioned this Review in the context of the recently released ten year Veteran Mental Health Strategy 2013[1] and a previous review of the VVCS service delivery model conducted in 2010[2]. The recommendation from the previous review that VVCS consider restructuring to ensure structural consistency across states and territories was partially accepted by VVCS, however, the proposed model for restructuring that was presented was not accepted. This Functional Review will implement the recommendation in the previous report regarding the undertaking of an independent structural review.

The objectives of this Review are to:

- Identify opportunities to enhance administrative and clinical efficacy in order to ensure VVCS is well positioned to provide best possible client outcomes into the future; and
- Develop a service delivery model and related organisational structure that is cost neutral and has inherent flexibility for national application in response to changing client demand and internal resourcing constraints, with no adverse impact on client outcomes. The model and associated structure will enable the most efficient combination of responsibilities and skill sets for both administrative and clinical staff to effectively deliver the VCCS services.

The scope of the Review is focussed on the roles and responsibilities of VVCS staff, including job descriptions, and the organisational structures VVCS uses to deliver services to clients.

E.2 PROJECT METHODOLOGY

The project involved conduct of stakeholder consultations, a demand modelling exercise, work practice analysis, and business process mapping.

A total of 96 VVCS staff, representing every role within the VVCS, participated in consultations for the project, and written submissions were received from seven VVCS staff. Interviews were also conducted with the following key stakeholders: Deputy President, Repatriation Commission; Chair, VVCS National Advisory Committee; Principal Medical Advisor to the Repatriation Commission; Assistant Secretary, Mental and Social Health Branch, DVA; and Director, Mental Health Advisory Team, DVA. Findings from consultations were presented in the *Stakeholder Consultations Summary of Findings Discussion Paper*.

[1] Department of Veterans' Affairs (2013) Veteran Mental Health Strategy. *A ten-year framework, 2013-2023*
[2] Final Report. Review of the VVCS Service Delivery Model. Sue Belsham and Associates, July 2010

The demand modelling exercise was based on five year historical client demographic data provided by VVCS (to 2012-13), and also using DVA client projections for next ten years (including data for newly eligible VVCS cohorts from 1 July 2014). The modelling exercise established a profile of the client base including veterans, serving members, partners, children, F111 clients, and newly eligible cohorts, and projected the demand for VVCS services by each of these groups in VVCS regions for the next ten years. Findings were presented in the *Demand Management Modelling Discussion Paper*.

High level process maps were developed for key client contact areas including initial client contact and intake, allocation, counselling (internal and outreach provider) and referral, in order to identify areas for improved service provision. Job roles and functions were also reviewed against DVA Work Level Standards (WLS) for DVA broadbands, which are based on the Australian Public Service (APS) levels. Findings and recommendations from this stage were presented in the *VVCS Role and Work Practice Analysis Discussion Paper*.

Findings and recommendations from each of the above processes informed development of the proposed service delivery model, organisation structure, and recommendations to enhance consistency, efficiency and effectiveness of the service.

Governance of the Review was overseen by a Project Board comprising the National Manager VVCS (Chair); Assistant Secretary, People Services Branch; Assistant Secretary, Mental and Social Health Branch; and a representative of the VVCS National Advisory Committee (NAC).

Note that a review of group programs was conducted by VVCS in 2013. The current Functional Review therefore did not focus on group program processes and service delivery as these have already been subject to an examination to identify and recommend service delivery enhancements.

E.3 Overview of findings

Future role and directions for VVCS

Key Finding 1: The stakeholder consultations found a lack of consistency and clarity within VVCS regarding the future role of the service within the veteran mental health care continuum. VVCS clients present with conditions across a spectrum ranging from psychosocial to complex mental health disorders. There was a lack of clarity and consistency regarding VVCS' role and referral pathways for clients at either end of this spectrum in particular,

Service delivery

Key Finding 2: Different models exist across regions for provision of **intake assessment and allocation**, with these services variously provided by dedicated or rostered counsellors for intake, and intake counsellors, Deputy Director and/or Outreach Program Coordinator (OPCo) for allocation. There is potential for initial client contact and subsequent intake to occur centrally either at a regional level (as currently occurs) or national level. However, there is strong support for allocation decisions to remain local (at regional level) and be based on local staff knowledge.

Key Finding 3: Around one third of VVCS clients are seen by a VVCS staff counsellor, receiving an average of five counselling sessions per episode of care. Other clients receive counselling from external **Outreach Program Counsellors (OPC)**. This model allows VVCS to accommodate changes in demand and provide services to clients unable to attend VVCS site locations. However, management of OPCs was reported to be resource intensive, and self reporting of military trauma expertise by OPCs was reported to result in variable service quality. This Review estimates that following intake, every client seen by an OPC requires on average 1.7 hours of VVCS clinical staff time per episode of care. This is in

addition to an average of six counselling hours provided by the OPC, plus VVCS administrative staff time.

Key Finding 4: Different regional models exist for **oversight of client care** provided by OPCs. These include dedicated regional OPCos for client allocation and management, a 'hub model' of nominated counsellors for client management and service oversight, or each counsellor taking an area coordination role for these clients. Each of these models has potential benefits in terms of efficiency and effectiveness according to regional resourcing and needs.

Roles and responsibilities

Key Finding 5: There is strong support for the current model whereby **counselling** is conducted by appropriately skilled and experienced staff irrespective of their base qualification (e.g. social work or psychology). There was also support for different clinical staff skills to be more formally recognised and utilised, for example via introduction of a senior clinician role providing advice, additional assessment and/or management of more complex clients.

Key Finding 6: It was widely reported during consultations for this Functional Review that inconsistencies exist in job levels for VVCS **administrative staff**, particularly those in field based positions (i.e. outside Central Operations), compared with DVA WLS. The Review found that current positions for administrative staff in VVCS centres were generally at a level below that described by DVA WLS.

Key Finding 7: The delineation of responsibility across the organisation for **community liaison** both at regional and national levels is unclear. In addition, community liaison could be more effectively delineated according to differing aims of community awareness and development of external linkages or partnerships. At a Central Operations level, there is apparent overlap or lack of clarity in responsibility for strategic engagement, coordination of peer and/or project teams, and ongoing responsibility for information management systems.

Service demand

Key Finding 8: Overall numbers indicate that VVCS counselling client numbers will increase over the forward period, but at a reduced rate when compared to the last five years. Over the next 5-10 years, significant client growth will occur primarily in Queensland. Forecast client numbers and share by current region are presented in Table E1.

Table E1: Forecast VVCS client numbers and share of Australia by region and year

Region	2012-13 (actual)		2014-15		2017-18		2023-24	
	No.	%	No.	%	No.	%	No.	%
NSW/ACT	2,881	23.3%	2,964	21.9%	3,134	19.2%	3,388	18.9%
VIC	1,914	15.5%	1,951	14.4%	2,061	12.6%	2,208	12.3%
N QLD	1,884	15.2%	2,322	17.1%	3,325	20.3%	3,720	20.8%
S QLD	3,105	25.1%	3,573	26.4%	4,900	30.0%	5,431	30.3%
WA	1,056	8.5%	960	7.1%	889	5.4%	950	5.3%
SA	720	5.8%	729	5.4%	754	4.6%	820	4.6%
TAS	384	3.1%	368	2.7%	357	2.2%	380	2.1%
NT	594	4.8%	690	5.1%	935	5.7%	1,015	5.7%
Australia	**12,356**	**100.0%**	**13,557**	**100.0%**	**16,355**	**100.0%**	**17,912**	**100.0%**

ORGANISATION STRUCTURE

Key Finding 9: The **broad grouping** of the organisation based on geography and functions (i.e. rather than grouping by client types or programs) is an appropriate model for the organisation to meet future demand. Within this model, ongoing peer groups or time-limited project teams can develop and share best practice approaches for different client types (e.g. Vietnam veterans, contemporary veterans, serving personnel, partners, children, newly eligible cohorts) or programs (groups, outreach, clinical interventions).

Key Finding 10: Whilst the broad grouping model is appropriate for regions, the current **split of counselling staff** does not match current or future service demand across regions. Also, there is substantial variation in size of current regions based on client and staff numbers, resulting in inequitable responsibilities for Regional Directors, and necessitating different models of service provision for intake and OPC client oversight to manage demand in some cases.

Key Finding 11: Forecast client demand in some current VVCS centres supports less than two FTE counselling staff, and an alternative service model at these sites which would improve service efficiency without compromising client outcomes, would be to provide VVCS services as an **outpost site** rather than a VVCS office/centre.

Key Finding 12: The current broad functional **grouping in Central Operations** of clinical, policy/planning and corporate services is appropriate. However, the responsibilities under each of these Directors may require re-alignment to ensure an appropriate mix of externally versus internally focussed functions, efficiency versus effectiveness focussed functions, and short term versus long term focussed functions.

Key Finding 13: A requirement of this Review is to ensure that any recommended structural changes are **cost neutral** for VVCS in terms of executive and administrative budgets. Recommendations presented in this Review allow cost savings of up to $627,987 at a regional level. These savings can be used to support additional positions and/or changes to job classifications at a national level as required, and/or other initiatives.

E.4 OVERVIEW OF RECOMMENDATIONS

A full list of specific recommendations arising from this Review is presented overpage. Recommendations are based on the assumption that VVCS will consolidate its purpose in the short term as:

> *A community based mental health and wellbeing service, providing counselling and group programs for eligible members of the veteran and ex-service community and their families, to address war and service-related psychosocial and mental health conditions.*

However, the functional model developed for VVCS will need flexibility to adapt to possible future changes to purpose such as that proposed by the National Advisory Committee (NAC) to reflect an expanded role in assessment and/or treatment of more serious mental health disorders.

Recommendations can be broadly summarised as:

- VVCS needs to clarify and consistently communicate its vision and future role, and also clarify and strengthen internal and external referral pathways for clients with more complex mental health needs;

- Some changes to the service delivery process are recommended to enhance efficiency and effectiveness of services, with flexibility retained to meet local requirements where possible;
- Some changes to classification of job positions is recommended for consideration;
- VVCS regions should be consolidated from eight to five, namely (1) Northern Queensland, (2) Southern Queensland, (3) New South Wales/ Australian Capital Territory, (4) Victoria/Tasmania, and (5) South Australia/Western Australia/Northern Territory;
- Some staff re-alignment is required across regions to align with predicted future service demand; and
- VVCS should retain centres where client demand supports at least two FTE staff counsellors plus administrative support at that site – VVCS services to clients at other locations should be provided at VVCS outpost sites (VVCS locally based counselling staff who provide services in alternate office space e.g. General Practice Clinic), satellite sites (VVCS counselling staff from major or regional centre providing regular visiting services) or by OPCs, depending on local demand.

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RECOMMENDATIONS

VVCS FUTURE ROLE AND DIRECTIONS

Recommendation 1: That VVCS leadership clarify and consistently communicate VVCS **vision, mission and strategic directions**, with regular review of these to ensure they remain appropriate and responsive to client needs into the future.

Implementation considerations:

- VVCS clarify its role in provision of diagnosis, therapy and treatment for more serious and complex mental health disorders as proposed by the National Advisory Committee (NAC), and also its role in case coordination.
- Where required, VVCS counsellors receive up-skilling in key services identified in VVCS clinical policy to improve national service consistency and minimise need for external referral for these services (e.g. drug, alcohol and gambling counselling and/or other therapies).
- VVCS continue to employ clinical staff with skills (and/or provide up-skilling as needed in key areas as identified in clinical policy) to provide counselling services to clients who present with conditions **across the spectrum** of psychosocial to more complex mental health disorders, noting that clients may move along this spectrum and require a change in counselling focus or referral.
- Future recruitment of clinicians with social work base qualification should specify **mental health accredited social work** qualification as mandatory. This will align with requirements for external counsellors and ensure staff have the range of skills required of a comprehensive mental health service.
- Outreach Program Counsellors (OPCs) continue to be contracted to provide services based on specialisation in psychosocial and/or more complex mental health disorders, and be used to provide services according to client presentation.

Recommendation 2: That VVCS leadership clarify and strengthen internal and external referral pathways, particularly for clients with more complex mental health needs, in clinical policy documentation in order to facilitate nationally consistent, timely and effective provision of evidence based approaches to managing clients within a **stepped care model**.

Implementation considerations:

- Ensure that VVCS clinical policy documentation identifies standards, decision points and referral pathways for additional client assessment/diagnosis, provision of initial and ongoing counselling sessions, referral to group programs and/or referral to other services.
- Expand VVCS' role in assessment and provisional diagnosis of more complex mental health and psychiatric disorders using staff and/or sessional clinical psychologists and psychiatrists/general practitioners (GPs) in regional offices. An alternative approach, which takes note of the difficulties reported by some regional offices recruiting local psychiatrists to sessional positions, is to establish

a national expert panel. Members of this panel will have expertise in diagnosis and treatment of mental health disorders, particularly those seen in veteran populations, and can provide advice and/or assessment as required.

- If VVCS purpose or goals are amended in the future (e.g. towards a more comprehensive mental health service), review intake assessment questions to ensure they assess need for referral for further mental health assessment or other services prior to or alongside allocation to VVCS counselling or group programs. Note that if a more detailed assessment process is adopted, this may require an increase in the average time taken for assessment per client, and a commensurate increase in the number of full time equivalent (FTE) staff allocated to provision of intake services.

SERVICE DELIVERY

Recommendation 3: That VVCS provide all administrative staff with an appropriate level of **training in mental health** awareness and protocols for dealing with distressed clients.

Implementation considerations:

- Develop clear criteria and processes for assessment of urgency of client presentation by front-line administrative staff in order to inform the need for immediate referral to VVCS counsellor.

Recommendation 4: That VVCS move towards a nationally centralised initial client contact telephone line and consider a nationally **centralised intake** process to ensure consistency of service delivery and flexibility to adapt to changes in service demand.

Implementation considerations:

- Separate client allocation (i.e. to individual counsellor) from intake to allow allocation to remain localised (at regional or jurisdictional level) despite move to more centralised intake process.

- Within 12 months, transition from initial client contact and intake centralised at a regional level to **nationally centralised initial client contact,** with subsequent intake assessment continuing to be provided by clinical staff at a regional level (using dedicated intake staff and/or rostered/rotated positions depending on the ability to attract staff to dedicated positions).

- In the longer term, consider moving towards a **nationally centralised initial client contact and intake** for VVCS, with subsequent allocation to internal or external counsellor continuing to occur at a regional level.

Recommendation 5: That VVCS leadership and Regional Directors review reasons for allocation to **OPCs,** and also different models of OPC coordination and management between regions, in order to facilitate consistent service provision and optimise client outcomes by maximising allocation to internal counselling staff and implementing nationally consistent models of OPC management.

Implementation considerations:

- Regional Directors review reasons for allocation to OPCs within each region on an ongoing basis, to ensure allocation to internal counsellors is maximised (e.g. consider internal counsellor caseloads, physical counselling space, review of geographic limits for centre-based counselling, establishment of additional outpost or satellite locations in high demand areas).

- Establish a time limited project team to review different models of OPC coordination and management, with the aim of implementing a nationally consistent best practice management model in the context of specific regional requirements (i.e. number and proportion of clients seen by OPCs and associated VVCS staff time managing this process and oversighting client outcomes). For example, best practice for smaller regions may be dedicated Outreach Program Coordinator (OPCo) responsible for entire process (noting the need for back-up strategy to cover staff leave), while for larger regions the 'hub model' as used in North Queensland may improve the effectiveness and efficiency of day to day OPC client oversight.
- Ensure OPC Provider Notes and contracts reflect VVCS duty of care requirements for clients being seen by outreach counsellors, and ensure that all Deputy Directors and OPCos are familiar with processes for identification and management of underperforming OPCs with the aim of facilitating optimum client outcomes.

Recommendation 6: That pending outcomes of Group Program Review process, VVCS differentiate between the role of clinical staff to provide oversight of **group programs** within each VVCS region, and shift responsibility for program coordination, where possible, to junior clinical and/or administrative staff in regions where this is not already occurring.

Implementation considerations:

- For example, consider Group Program Coordinator role for clinician (0.5 Full Time Equivalent (FTE) per region +/- proposed delivery of psycho-educational workshops[3]), and Group Program Administrator role for junior clinician and/or administrative staff (1.0 FTE per region).

Recommendation 7: That VVCS clarify aims, objectives and responsibilities for **community liaison**, with clear distinction between aims of community awareness and aims of external linkages/partnerships in order to ensure clearly delineated, targeted, and well-coordinated community liaison activities occur into the future.

Implementation considerations:

- Develop a National Stakeholder Engagement Strategy, outlining clear national and regional objectives, mapping target audiences and stakeholder organisations, engagement strategies, activities and key performance indicators (KPIs) to achieve agreed aims relating to community awareness and external linkages.
- Establish a time limited project team to:
  - make recommendations to the National Manager as to the assignment of key activities related to achievement of community awareness and/or external linkages objectives to appropriate positions (both Central Operations and regional staff);
  - incorporate agreed statements relating to ongoing responsibilities for community awareness and development/maintenance of external linkages into job descriptions for identified positions; and
  - consider whether ongoing community awareness activities can be better provided by appointment of a **community liaison officer** within each region (e.g. 1.0 FTE per region).
- Develop and implement processes to establish local authority and accountability (i.e. at a Regional Director level) to make decisions regarding local awareness and engagement activities within clear and endorsed policy and procedures.

[3] From VVCS Review of Group Programs 2013 – Outcomes and Next Steps (point 11)

ROLES AND RESPONSIBILITIES

Recommendation 8: That VVCS introduce a **senior clinical role** to VVCS regions as either a Senior Clinician and/or a Clinical Manager to provide regions with additional access to professional advice, assessment and/or management of more complex client presentations as well as the potential to provide clinical supervision of staff. This will also open additional career progression opportunities for clinical staff.

Implementation considerations:

- The role of a Senior Clinician would be to provide advice, assessment and or/management of more complex presentations, and provide clinical supervision and case management oversight in addition to a counselling caseload. Depending on requisite qualifications and future VVCS service directions, the Senior Clinician may also have a role in provisional diagnosis and therapy for more complex clients. The advantage of this option is that the clinician can provide expert clinical advice, mentoring and support without assuming line management responsibility for clinical staff. There may be more than one Senior Clinician per region reporting to a Deputy Director.
- The role of a Clinical Manager would be similar to the proposed role of a Deputy Director in terms of local clinical leadership plus clinical management responsibility for counselling staff, although without responsibility for outreach and group program oversight (depending on VVCS or regional decisions as to the extent of regional centralisation of these programs). The advantage of this option is that it provides an additional career progression option for counselling staff, noting the potential disadvantage of time that could be spent providing clinical expertise being redirected to operational management issues.

Recommendation 9: That the Department considers the Review finding that centre-based VVCS **administrative positions** are currently classified at a level below their job roles/responsibilities based on DVA Work Level Standards (WLS). Taking into consideration any changes to roles resulting from this Review and from VVCS Electronic Record Application (VERA) implementation, if this finding is supported, VVCS should take steps to re-classify these positions according to Australian Public Service (APS) WLS.

Recommendation 10: That VVCS determine ongoing responsibilities of **Central Operations** staff based on findings of this Review, and consider the following changes to position titles and/or classification of Central Operations staff:

- Consider changing position title and responsibility for the following:
  - Assistant National Manager becomes National Clinical Director with additional responsibility for clinical policy, research and oversight of client focussed programs;
  - National Executive Officer becomes Director Corporate Services, with additional responsibility for information management services;
  - Assistant Director F111 Program becomes Manager, Special Programs with additional responsibility for coordination of project teams and peer groups based around programs (e.g. outreach, groups, clinical programs such as family inclusive practice) and client types (e.g. Vietnam veterans, contemporary veterans, serving personnel, partners, children, new cohorts).
- Consider changing position title and classification for ADF Liaison Officer (APS6) to Communications and Community Liaison Manager (EL1), with additional responsibility for coordinating development and implementation of strategic communication plan and community liaison plan.

- Consider changing classification for Finance Officer from APS5 to APS6 based on review of responsibilities against Work Level Standards (WLS) around managing financial reporting and analysis activities, and developing, implementing and monitoring budget controls and strategies.
- Consider introduction of new position of Information Systems Manager (APS6) to replace temporary position of VVCS Electronic Record Application (VERA) Business Lead (EL1), with responsibility for ongoing management, development, implementation and reporting from VVCS information management systems (e.g. VERA).

Recommendation 11: That once findings and recommendations from this Review have been considered and any executive decisions relating to organisational change are complete, VVCS reassess the **Draft Job Descriptions** provided as an attachment to this Report and finalise these in the context of the approved VVCS structural model and roles for the future.

ORGANISATION DESIGN

Recommendation 12: That VVCS continue to operate under a structure which is essentially **grouped** around specific functions for Central Operations, and geography/function for regional areas, as this allows for the most efficient and effective delivery of services to meet client needs, noting that linkages based on programs and/or client types should be continued or established across the organisation to promote innovation and best practice in these areas.

Implementation considerations:

- The VVCS functional/geographic structure should be supported by clear and consistent governance and clinical policies and procedures, which also underpin a robust Operations Manual setting out administrative and other processes. These documents should be developed centrally to provide a nationally consistent approach across regions.
- Time-limited project teams and ongoing peer groups are recommended to provide linkages and facilitate sharing, adoption of best practice models in the application of policy, and identification of quality improvement activities across the organisation for delivery of programs (e.g. groups, outreach, family based practice) and to consider the needs of different client types (e.g. Vietnam veterans, contemporary veterans, partners, children, serving personnel, newly eligible cohorts).

ORGANISATION STRUCTURE

Recommendation 13: That VVCS **consolidate the number of regions** from eight to five, namely (1) Northern Queensland, (2) Southern Queensland, (3) New South Wales/Australian Capital Territory, (4) Victoria/Tasmania, and (5) South Australia/Western Australia/Northern Territory, with a commensurate reduction in the number of Regional Directors, in order to create similar sized regions as much as possible to ensure equity of workload for regional positions and to align regions with client demand for services.

Implementation considerations:

- The Regional Director for each region should be responsible for regional operation and line management responsibility for at least one Deputy Director, a Community Liaison Officer/Manager (if position is approved), Clinical Managers (depending on outcomes of this Review) and a BSM. Where regions have more than one Major Centre, a Deputy Director at one Major Centre has line management responsibility for the Regional Group Program Coordinator as well as counsellors in that jurisdiction (up to ten, including intake counsellors, counsellor/case coordinators, OPCo, and

senior clinicians, if this role is introduced based on outcomes of this Review). If there is more than one Major Centre in the region or if the major centre has a high staff to management ratio, additional Deputy Directors or alternatively, Clinical Managers, would have responsibility for counselling staff in their jurisdiction.

- Under the proposed new regional structure, Office Managers should report into the BSMs within each region, Administrative Assistants report into the BSMs where these positions exist within a centre, and Administrative Assistants report to Office Managers in centres where a BSM is not based.

Recommendation 14: In order to **align VVCS staff with client service demand** into the future, that VVCS continue to provide services from **dedicated VVCS centres** where client demand supports at least two FTE staff counsellors plus an administrative position. At all other locations, VVCS should consider transitioning service provision to **outpost sites** (services provided by local VVCS counselling staff co-located in alternate office space e.g. General Practice Clinic), **satellite sites** (by VVCS counselling staff from major or regional centre providing regular visiting service), or by **outreach providers** (OPCs), depending on local client demand.

Implementation considerations:

- VVCS Regional Directors review forecast client demand and numbers able to be seen by internal counsellors (based on demand and client location, not current staffing levels), and provide comment against the forecast staffing levels proposed in Table R1 below.
- Based on Table R1 below and input provided by Regional Directors, VVCS National Management Team should review current counsellor and administrative staff locations, substantive numbers and vacancies to determine where staffing resources need to be re-directed to ensure that allocation of resources aligns with current and forecast client demand and need for services both between and within regions.
- Assuming no substantive changes in forecast client numbers or proportions of clients seen by internal/external counsellors, VVCS amend its service delivery model in centres where current and forecast client demand does not support two or more counselling staff (**Newcastle, Lismore, Albury-Wodonga, Hobart and Launceston**) and transition these centres to **outpost sites** where this has not already occurred.

Table R1: Number of forecast VVCS FTE regional clinical and administrative staff required by role, region and site, and time frame (2014-15, 2017-18, 2023-24)[a]

Region	Site location	Type of site (proposed)	Counsellors (incl. intake, counselling/ case coord, OPCo, senior clinician)			Other clinical staff roles (assume no change across 2014-2024)		Total administrative staff by region (assume no change across 2014-2024)			
			2014-15	2017-18	2023-24	Group Program Mngr[c]	Community Liaison Officer[c]	Business Support Manager[c]	Office Manager	Group Program Admin. Assistant	Admin. Assistant
NSW/ ACT	Sydney	Major	3.8	4.2	4.6			1		1	1
	Newcastle	Outpost[b]	1.4	1.5	1.7						
	Lismore	Outpost[b]	1.1	1.2	1.3						
	Canberra	Major	3.6	4.0	4.3				1		1
	TOTAL	-	**9.9**	**11.0**	**11.8**	**0.5**	**1.0**	**1**	**1**	**1**	**2**
VIC/ TAS	Melbourne	Major	6.4	6.4	6.9			1		1	2
	Alb-Wod	Outpost[b]	0.9	0.9	1.0						
	Hobart	Outpost[b]	0.8	0.8	0.8						
	Launceston	Outpost[b]	0.6	0.6	0.6						
	TOTAL	-	**8.7**	**8.7**	**9.3**	**0.5**	**1.0**	**1**		**1**	**2**
N QLD	Townsville	Major	7.0	10.3	11.5			1		1	2
	TOTAL	-	**7.0**	**10.3**	**11.5**	**0.5**	**1.0**	**1**		**1**	**2**
S QLD	Brisbane	Major	10.1	13.6	15.1			1	1	1	3
	Marooch	Regional	2.1	2.8	3.1				0.6		
	Southport	Regional	1.5	2.0	2.2				0.6		
	TOTAL	-	**13.7**	**18.5**	**20.5**	**0.5**	**1.0**	**1**	**2.2**	**1**	**3**
SA/WA/NT	Adelaide	Major	2.9	3.2	3.5			1		1	0.5
	Perth	Major	3.3	3.1	3.3				1		0.5
	Darwin	Major	2.5	3.9	4.2				1		0.5
	TOTAL	-	**8.8**	**10.2**	**11.0**	**0.5**	**1.0**	**1**	**2**	**1**	**1.5**
Australia	***TOTAL***	**-**	***48.1***	***58.6***	***64.2***	***2.5***	***5.0***	***5***	***5.2***	***5***	***10.5***

aBased on forecast client demand and assumptions included in Section 4.2.1 of this Report

bThese sites are nominated as outpost sites (i.e. no VVCS office – staff based in other centres such as GP clinics) based on forecast client numbers and current proportion of clients seen by centre-based staff. If client numbers and/or proportion seen by centre-based staff can be substantially increased, sites may be reconsidered to remain as regional VVCS centre locations.

cThese roles could be based in any major centre within region

1

INTRODUCTION

The Department of Veterans' Affairs (DVA) commissioned Health Outcomes International (HOI) to undertake a Functional Review (the Review) of the Veterans and Veterans Families Counselling Service (VVCS), including current VVCS roles, responsibilities and organisational structures. The project commenced in April 2014 and is due for completion in July 2014.

This document is the Final Report for the project, and presents the proposed VVCS organisational design, service model and associated job descriptions. These are based on a review of findings from the *Stakeholder Consultations Summary of Findings Discussion Paper*, projected VVCS client numbers and analysis by region from the *Demand Management Modelling Discussion Paper*, and findings and recommendations from the analysis of VVCS strategy and business processes (*Role and Work Practice Analysis Discussion Paper*).

1.1 BACKGROUND TO THE REVIEW

The Australian Government, through DVA, has a strong commitment to the mental health and well-being of the veteran and ex-service community and their families, including members of the Australian Defence Force (ADF) with operational service. The VVCS is a leading provider of mental health and wellbeing support to these communities.[4] VVCS operates as a community based mental health service providing counselling and group programs for eligible current and former ADF members and their families.[5]

The DVA has commissioned this Review in the context of the recently released ten year Veteran Mental Health Strategy 2013[6] and a previous review of the VVCS service delivery model conducted in 2010[7]. The Veteran Mental Health Strategy recognises the importance of a person-centred approach to care and recovery, and the importance of different types of care and service provision to meet different patient needs (e.g. coordinated care planning and stepped care models as required). The 2010 VVCS review made 27 recommendations[8], the majority of which have been implemented or are in the process of being implemented. The recommendation that VVCS consider restructuring to ensure structural consistency across states and territories was partially accepted by VVCS, however, the proposed model for restructuring that was presented in the previous review was not accepted. This was due to the potential negative impact of the proposed model on level of service delivery and associated client outcomes. This review will implement the recommendation in the previous report regarding the undertaking of a structural review.

[4] DRAFT VVCS Business Plan 2014-15
[5] DVA Veterans' Mental Health Strategy – A ten year framework 2013-2023
[6] Department of Veterans' Affairs (2013) Veteran Mental Health Strategy. *A ten-year framework, 2013-2023*
[7] Final Report. Review of the VVCS Service Delivery Model. Sue Belsham and Associates, July 2010
[8] 22 recommendations were accepted in full; four were partially accepted; and one (recommendation 25 - automatic conversion of temporary staff to ongoing staff after 12 months employment) was not accepted.

This current Review will provide an independent assessment of VVCS staff roles, responsibilities and organisational structures, in order to strengthen administrative and clinical efficacy and position VVCS for the future. The Review is seeking to ensure an appropriate and sustainable VVCS service model that will assist in positioning VVCS to meet future service delivery requirements and ensure clients achieve high quality outcomes that are consistently delivered across the country.

The Project Board, which comprises the VVCS National Manager, and the Assistant Secretaries of People Services Group and Mental and Social Health Policy, along with National Advisory Committee representation, is interested in using the Review process to test all ideas and concepts that may contribute to ensuring sustainable VVCS services to support veterans and their families into the future.

1.2 Objectives and Scope of the Review

The objectives of this Review are to:

- Identify opportunities to enhance administrative and clinical efficacy in order to ensure VVCS is well positioned to provide best possible client outcomes into the future; and
- Develop a service delivery model and related organisational structure that is cost neutral and has inherent flexibility for national application in response to changing client demand and internal resourcing constraints, with no adverse impact on client outcomes. The model and associated structure will enable the most efficient combination of responsibilities and skill sets for both administrative and clinical staff to effectively deliver the VCCS services.

The scope of the Review is focussed on the roles and responsibilities of VVCS staff, including job descriptions, and the organisational structures VVCS uses to deliver services to clients.

1.3 Project Methodology

The project has been conducted according to the following stages:

- **Stage 1 – Project Planning and Review Framework.** This stage involved the development and approval of a Project Plan and Review Framework, including development of detailed methodology and tools for use in subsequent project stages.
- **Stage 2 – Stakeholder consultations.** During this stage, all VVCS staff were invited to participate in the consultation process either via focus groups, individual consultations and/or via written submission. A total of 96 VVCS staff, representing every role within the VVCS, participated in consultations for the project, and written submissions were received from seven VVCS staff. Staff consulted included Directors, Deputy Directors, clinical staff, administrative staff and staff at Central Operations. Consultations were conducted in May-June 2014.

  In addition to consultations with VVCS staff, interviews were also conducted with the following key stakeholders: Deputy President, Repatriation Commission; Chair, VVCS National Advisory Committee; Principal Medical Advisor to the Repatriation Commission; Assistant Secretary, Mental and Social Health Branch, DVA; and Director, Mental Health Advisory Team, DVA.

Findings from this stage were presented in the *Stakeholder Consultations Summary of Findings Discussion Paper*, submitted June 2014.

- **Stage 3 – Demand management modelling**. A demand modelling exercise was undertaken using Excel. This was based on five year historical client demographic data provided by VVCS (to 2012-13), and also using DVA client projections for next ten years (including data for newly eligible VVCS cohorts from 1 July 2014).

  The modelling exercise established a profile of the client base including veterans, serving members, partners, children, F111 clients, and newly eligible cohorts, and projected the demand for VVCS services by each of these groups in VVCS regions for the next ten years. A series of assumptions (or model variables) that could change the trajectory of demand growth informed the model – these assumptions were discussed and agreed with the VVCS National Manager, Assistant National Manager, Director Policy and Planning, and VVCS and DVA client database experts. The final model output is a 'most likely' scenario that identifies likely service demand and change over time for each VVCS region by client type.

  Findings from this stage were presented in the *Demand Management Modelling Discussion Paper*, submitted July 2014.

- **Stage 4 – Work practice analysis**. Further analysis was conducted during this stage around the VVCS purpose and strategic directions which inform the functional model for the organisation, and also on business processes and administrative staff functions. High level process maps were developed for key client contact areas including initial client contact and intake, allocation, counselling (internal and outreach provider) and referral, in order to identify areas for improved service provision.

  Findings and recommendations from this stage were presented in the *VVCS Role and Work Practice Analysis Discussion Paper*, submitted July 2014.

- **Stage 5 – Final Report preparation**. Findings and recommendations from each of the previous stages were used to inform a preliminary functional model presented in the *Review of Findings and Proposed Organisation Model Discussion Paper,* submitted July 2014. These findings, and assumptions underpinning design of organisation structure, were presented to the Project Team in July (noting that recommendations were not presented to this team). Project Team feedback was sought by the Reviewers on accuracy of work practice process diagrams and assumptions underpinning organisation structural model design. The proposed organisation model has been further developed for this Report to provide recommendations regarding structure, associated staff numbers, classification levels, roles and responsibilities, job descriptions, and an implementation and risk assessment plan.

Governance of the Review was overseen by a Project Board comprising the National Manager VVCS; Assistant Secretary, People Services Branch; Assistant Secretary, Mental and Social Health Branch; and a representative from the VVCS National Advisory Committee (NAC).

1.4 STRUCTURE OF THIS DOCUMENT

This document is structured as follows:

Chapter 1	**Introduction** (this chapter). This chapter provides an overview of the background, objectives and methodology for the project.
Chapter 2	**Review of findings**. This chapter presents a review of findings and recommendations from stakeholder consultations, work practice analysis and demand modelling undertaken as part of this project.
Chapter 3	**Organisation design**. This chapter presents some background discussion on organisational design principles applied to VVCS, followed by the proposed functional and geographic structure and linkages for VVCS. These are based not only on organisational design principles but also on the findings and recommendations outlined in the previous chapter.
Chapter 4	**Proposed VVCS service and organisation model.** This chapter presents the proposed organisation model for VVCS with staff position titles, locations, levels and numbers of staff. These are based on findings, agreed design, and functional and geographic models outlined in previous chapters.
Chapter 5	**Job descriptions.** This chapter presents an overview of the job descriptions developed as part of this Functional Review. Note that actual job descriptions are presented in a separate document, *VVCS Functional Review – Job descriptions*.
Chapter 6	**Implementation and risk management plan.** This chapter presents a structured implementation plan for the proposed VVCS organisation structure, plus a risk assessment of the implementation approach.

2

REVIEW OF FINDINGS AND RECOMMENDATIONS FROM CONSULTATIONS, DEMAND MODELLING AND WORK PRACTICE ANALYSIS

An overview of key findings and recommendations from stakeholder consultations, demand modelling and work practice analysis is presented in this chapter. Note that the full context behind recommendations is not presented in this overview – for this readers should refer to previous reports including the *Stakeholder Consultations Summary of Findings Discussion Paper*, *Demand Management Modelling Discussion Paper*, and *Role and Work Practice Analysis Discussion Paper*.

Findings and recommendations presented in this chapter have informed the proposed VVCS organisation design, structure and associated job roles presented in the following chapters.

2.1 CURRENT AND FUTURE ROLE OF VVCS

The stakeholder consultations found a lack of consistency and clarity within VVCS regarding the future role of the service. Some examples given of the VVCS role include a specialised mental health counselling service, a community based mental health service, a mental health and well-being service or a comprehensive community based mental health service. Whilst similar, these examples of perceived VVCS role into the future have different implications for organisational structure, staffing and responsibilities.

We have worked on the assumption that VVCS will consolidate its purpose in the short term as:

> *"A community based mental health and wellbeing service, providing counselling and group programs for eligible members of the veteran and ex-service community and their families, to address war and service-related psychosocial and mental health conditions."*

The functional model developed for VVCS will need flexibility to adapt to possible future changes to purpose such as that proposed by the National Advisory Committee (NAC) to reflect an expanded role in assessment and/or treatment of more serious mental health disorders. For example, an expanded purpose statement for VVCS may be:

> *"A **comprehensive** community based mental health and well-being service providing **assessment**, counselling, group programs **and other treatment** for eligible members of the veteran and ex-service community and their families to address war and service-related **conditions across the spectrum** from psychosocial issues to **complex** mental health conditions."*

The broad strategic approach for the VVCS, which forms the basis of the organisational structure proposed in this Functional Review, has been assumed to be:

"*To excel in the provision of nationally consistent, yet locally responsive, evidence-based mental health and wellbeing support services to the Australian veteran and ex-service community and their families*" (Draft VVCS Business Plan 2014-15).

Recommendation: That VVCS leadership clarify and consistently communicate VVCS **vision, mission and strategic directions**, with regular review of these to ensure they remain appropriate and responsive to client needs into the future.

Implementation considerations:

- VVCS clarify its role in provision of diagnosis, therapy and treatment for more serious and complex mental health disorders as proposed by the National Advisory Committee (NAC), and also its role in case coordination.
- Where required, VVCS counsellors receive up-skilling in key services identified in VVCS clinical policy to improve national service consistency and minimise need for external referral for these services (e.g. drug, alcohol and gambling counselling and/or other therapies).
- VVCS continue to employ clinical staff with skills (and/or provide upskilling as needed in key areas as identified in clinical policy) to provide counselling services to clients who present with conditions **across the spectrum** of psychosocial to more complex mental health disorders, noting that clients may move along this spectrum and require a change in counselling focus or referral.
- Future recruitment of clinicians with social work base qualification should specify **mental health accredited social work** qualification as mandatory. This will align with requirements for external counsellors and ensure staff have the range of skills required of a comprehensive mental health service.
- Outreach Program Counsellors (OPCs) continue to be contracted to provide services based on specialisation in psychosocial and/or more complex mental health disorders, and be used to provide services according to client presentation.

2.2 CLINICAL DIRECTION

As an extension of the issue discussed above, during stakeholder consultations, clinical and administrative staff outside of Central Operations were found to be generally unaware of the strategic direction of VVCS, or the Business Plan, and how their work contributes to its objectives. Staff felt that the clinical and governance policies, which are in the process of development, should address these concerns and the lack of clarity regarding clinical directions in particular. Whilst in the minority, several staff noted that some clients would benefit from earlier referral for further assessment, diagnosis and/or management of more complex mental health conditions in order to improve outcomes.

Recommendation: That VVCS leadership clarify and strengthen internal and external referral pathways, particularly for clients with more complex mental health needs, in clinical policy documentation in order to facilitate nationally consistent, timely and effective provision of evidence based approaches to managing clients within a **stepped care model**.

Implementation considerations:

- Ensure that VVCS clinical policy documentation identifies standards, decision points and referral pathways for additional client assessment/diagnosis, provision of initial and ongoing counselling sessions, referral to group programs and/or referral to other services.

- Expand VVCS' role in assessment and provisional diagnosis of more complex mental health and psychiatric disorders using staff and/or sessional clinical psychologists and psychiatrists/general practitioners (GPs) in regional offices. An alternative approach, which takes note of the difficulties reported by some regional offices recruiting local psychiatrists to sessional positions, is to establish a national expert panel. Members of this panel will have expertise in diagnosis and treatment of mental health disorders, particularly those seen in veteran populations, and can provide advice and/or assessment as required.
- If VVCS purpose or goals are amended in the future (e.g. towards a more comprehensive mental health service), review intake assessment questions to ensure they assess need for referral for further mental health assessment or other services prior to or alongside allocation to VVCS counselling or group programs. Note that if a more detailed assessment process is adopted, this may require an increase in the average time taken for assessment per client, and a commensurate increase in the number of full time equivalent (FTE) staff allocated to provision of intake services.

2.3 SERVICE DELIVERY

2.3.1 INITIAL CLIENT CONTACT AND INTAKE

Administrative staff play a critical role as the first point of contact with VVCS for most clients, and feel that this role is not adequately recognised by the organisation. There is no standard process or protocol by which administrative staff receiving calls can determine level of urgency for immediate referral.

Various models exist for provision of structured client intake assessment. These range from dedicated centralised intake positions for particular regions to local rostering of clinical staff across a region. Staff expressed opposition to further centralisation of this role, particularly if it did not allow flexibility at the local level as required. However, opposition appeared to be more focussed on subsequent allocation of clients which requires a knowledge and understanding of local staff and services.

Recommendation: That VVCS move towards a nationally centralised initial client contact telephone line and consider a nationally **centralised intake** process to ensure consistency of service delivery and flexibility to adapt to changes in service demand.

Implementation considerations:

- Separate client allocation (i.e. to individual counsellor) from intake to allow allocation to remain localised (at regional or jurisdictional level) despite move to more centralised intake process.
- Within 12 months, transition from initial client contact and intake centralised at a regional level to **nationally centralised initial client contact,** with subsequent intake assessment continuing to be provided by clinical staff at a regional level (using dedicated intake staff and/or rostered/rotated positions depending on the ability to attract staff to dedicated positions).
- In the longer term, consider moving towards a **nationally centralised initial client contact and intake** for VVCS, with subsequent allocation to internal or external counsellor continuing to occur at a regional level.

Recommendation: That VVCS provide all administrative staff with an appropriate level of **training in mental health** awareness and protocols for dealing with distressed clients.

Implementation considerations:

- Develop clear criteria and processes for assessment of urgency of client presentation by front-line administrative staff in order to inform the need for immediate referral to VVCS counsellor.

2.3.2 ALLOCATION

Allocation decisions are variously made by Intake Counsellors, Deputy Directors and/or Outreach Program Coordinators. Decisions rely on local knowledge regarding VVCS staff skills and caseloads, external contractor skills and caseloads, and other local services and networks. There is strong support for allocation decisions to remain local or regional.

2.3.3 CLIENT COUNSELLING AND CASE COORDINATION

VVCS INTERNAL COUNSELLORS

There is strong support for the current model whereby counselling is conducted by appropriately skilled and experienced staff irrespective of their base qualification (e.g. mental health accredited social worker or psychologist). However, many staff wanted greater formal recognition and utilisation of staff who may be qualified to provide specific counselling or other non-counselling roles (e.g. case management or more detailed client assessment). Options for more formalised multidisciplinary teams need to be considered in the context of the future planned role and clinical directions of the VVCS.

Currently, clients present with issues across the continuum of psychosocial to mental health disorders. For example, a total of 25.3% present with one or more psychosocial issues (e.g. 'relationship') and 25.3% present with one or more potentially diagnosable mental health disorders (e.g. 'depression'), noting that clients may indicate issues in each of these areas.[9] The broad mix of clients' presenting conditions has remained relatively stable over recent years. Posttraumatic Stress Disorder (PTSD), while increasing substantially between 2011-12 and 2012-13 to 12.2% of intake presentations, has been relatively constant over the five year data period.

OUTREACH PROGRAM COUNSELLORS

Outreach Program Counsellors (OPCs) are important to allow VVCS to accommodate changes in demand and to provide services to those unable to attend the VVCS office. However, management of OPCs was reported to be resource intensive, and could not always guarantee that clients received services from counsellors with an adequate knowledge of military issues.

On average, **two thirds of VVCS clients are seen by external counselling providers.** However there is significant variation across the regions, for example in South Australia 54.4% of all clients were seen by OPCs in 2012-13, while in North Queensland this figure is 83.8% based on 2012-13 data. This is reflective of the different geographic locales of the centre offices and the distribution of the population within each region. For example there is a much more regional dispersion in the population in NSW, Queensland and Western Australia meaning that the most appropriate service provider for a

[9] VVCS Internal Information Analysis Report 2012-13 (Version 1 created 30 April 2014)

large proportion of clients in those states will be locally based outreach providers. Whereas in South Australia, where the majority of the population live in Adelaide there is a stronger demand on centre based services. Table 2.1 below presents the proportion of clients forecast to be seen by centre-based (non OPC) counsellors in the short to longer term future.

Table 2.1: Percentage of clients forecast to be seen by centre-based counsellors (not outreach providers) by region

Region	2014-15	2017-18	2023-24
NSW/ACT	24.5%	29.7%	29.7%
Victoria	37.2%	30.3%	30.3%
Northern Queensland	16.2%	18.3%	18.3%
Southern Queensland	40.0%	38.6%	38.6%
Western Australia	29.4%	29.4%	29.4%
South Australia	45.6%	53.1%	53.1%
Tasmania	39.2%	47.8%	47.8%
Northern Territory	33.8%	50.7%	50.7%
Australia	***33.2%***	***37.2%***	***37.2%***

SOURCE: Demand management modelling report conducted for this Functional Review

An analysis of **time required by clinical staff to manage and provide quality assurance for OPC services** indicates that, in many regions, this is well over a full time equivalent (FTE) position. For example, it is estimated that in South Queensland 71.1 hours per week is spent by clinical staff managing OPC services, and in NSW/ACT this is even higher at 83.2 hours per week. Table 2.2 below approximates the total hours spent by VVCS clinical staff on OPC recruitment, training and case oversight per year and per week, by current VVCS regions.

It is important to note that the total number of hours managing OPCs in Table 2.2 is an **aggregrate number by region**, and does not reflect that within or between regions **enormous variation** may occur. The actual time spent managing, oversighting and providing quality assurance for OPC activities is likely to vary considerably depending on OPC experience and the number of clients being seen by particular OPCs. For example, if a few OPCs within a region are known to provide quality services to VVCS clients, and these OPCs are seeing the bulk of clients, the amount of time spent on OPC review may be substantially less than regions where clients are spread amongst many OPCs who are new, less experienced or require more thorough review.

Each VVCS client seen for counselling by an OPC absorbs a total of **1.7 hours of VVCS clinical staff time on average**[10]. This is **in addition** to the average of six counselling sessions provided by OPCs per client, and the time currently spent by administrative staff in scanning and sending notes for OPC clients (the latter should reduce as VVCS Electronic Record Application (VERA) is embedded within VVCS processes).

[10] Total clients seen by OPC per year divided by total clinical staff hours per year for OPCs

Table 2.2: Approximate VVCS clinical staff hours for OPC recruitment, training and case oversight by year, week and region, 2012-13

Region	Total no. clients for region	No. of OPCs [a]	Approx no. OPCs used (80%)[b]	% clients seen by OPC[c]	VVCS mgt hrs for OPC clients (hrs/yr)[d]	Addit VVCS OPC case audit hrs (hrs/yr)[e]	Recruitmt. and training new OPCs (hrs/yr)[f]	Total VVCS clinical staff hrs for OPCs (hrs/yr)[g]	Total VVCS clinical staff hrs for OPCs (hrs/wk)[h]
NSW/ACT	2,881	231	185	75.5%	2,718.9	897.3	129.4	3,745.6	83.2
VIC	1,914	171	137	62.8%	1,502.5	495.8	95.8	2,094.1	46.5
Nth QLD	1,884	107	86	83.8%	1,973.5	651.3	59.9	2,684.7	59.7
Sth QLD	3,105	180	144	60.0%	2,328.8	768.5	100.8	3,198.0	71.1
WA	1,056	68	54	70.6%	931.9	307.5	38.1	1,277.5	28.4
SA	720	39	31	54.4%	489.6	161.6	21.8	673.0	15.0
TAS	384	30	24	60.8%	291.8	96.3	16.8	404.9	9.0
NT	594	21	17	66.2%	491.5	162.2	11.8	665.5	14.8
Australia	**12,356**	**847**	**678**	**66.8%**	**10,317.3**	**3,404.7**	**474.3**	**14,196.3**	**315.5**

aFrom VVCS 2012-13 Internal Information Analysis Report (p18)
bBased on information provided by four regions during consultations (noting that this may vary across regions)
cFrom Demand Management Modelling Report, data sourced from VVCS Demographic Data Report
dBased on data supplied by WA indicating 1.25 hours/client seen by OPC in referral process, care plan, review and close of case
eBased on data supplied by WA that approximately 10-15% of cases receive case audit taking 2.75 hours per case (2 hours file review plus discussion with Deputy Director, OPC and client)
fBased on data supplied by WA that there will be an approximate turnover of 20% OPCs per year, with recruitment of each new OPC taking approximately 2-3 hours plus one hour training.
gTotal hrs/yr = General management hours per OPC client + additional case audit hours +recruitment and training hours
hTotal hrs/wk assumes 45 weeks/year client contact forVVCS counsellors (allows for 4 wks annual leave, one week sick leave and two weeks 'other' including professional development, team meetings etc).

Recommendation: That VVCS leadership and Regional Directors review reasons for allocation to **OPCs,** and also different models of OPC coordination and management between regions, in order to facilitate consistent service provision and optimise client outcomes by maximising allocation to internal counselling staff and implementing nationally consistent models of OPC management.

Implementation considerations:

- Regional Directors review reasons for allocation to OPCs within each region on an ongoing basis, to ensure allocation to internal counsellors is maximised (e.g. consider internal counsellor caseloads, physical counselling space, review of geographic limits for centre-based counselling, establishment of additional outpost or satellite locations in high demand areas).
- Establish a time limited project team to review different models of OPC coordination and management, with the aim of implementing a nationally consistent best practice management model in the context of specific regional requirements (i.e. number and proportion of clients seen by OPCs and associated VVCS staff time managing this process and oversighting client outcomes). For example, best practice for smaller regions may be dedicated Outreach Program Coordinator (OPCo) responsible for entire process (noting the need for back-up strategy to cover staff leave), while for larger regions the 'hub model' as used in North Queensland may improve the effectiveness and efficiency of day to day OPC client oversight.
- Ensure OPC Provider Notes and contracts reflect VVCS duty of care requirements for clients being seen by outreach counsellors, and ensure that all Deputy Directors and OPCos are familiar with

processes for identification and management of underperforming OPCs with the aim of facilitating optimum client outcomes.

2.3.4 GROUP PROGRAMS

A review of group programs was conducted by VVCS in 2013. The current Functional Review therefore did not focus on group program processes and service delivery as these had already been subject to examination.

Recommendation: That pending outcomes of Group Program Review process, VVCS differentiate between the role of clinical staff to provide oversight of **group programs** within each VVCS region, and shift responsibility for program coordination, where possible, to junior clinical and/or administrative staff in regions where this is not already occurring.

Implementation considerations:

- For example, consider Group Program Coordinator role for clinician (0.5 Full Time Equivalent (FTE) per region +/- proposed delivery of psycho-educational workshops[11]), and Group Program Administrator role for junior clinician and/or administrative staff (1.0 FTE per region).

2.3.5 COMMUNITY LIAISON AND PROMOTION

There is a perception amongst centre staff that there is inadequate service promotion of VVCS to eligible clients, and a lack of clarity regarding the roles of national versus local staff in this regard. Currently, duty statements in job descriptions for VVCS clinical, administrative and managerial staff all contain a role in community liaison. These roles range from liaison and forming partnerships at a Departmental or Agency level (in the duty statements of National Manager, Assistant National Manager, Directors in each region and all counselling staff) to representing VVCS as requested to local veteran and community organisations (in duty statement for Business Support Manager).

Staff in some regional offices reported that due to resource constraints, there is limited liaison with external personnel/agencies. It was felt that greater liaison and linkages had the potential to enhance the outcomes for VVCS clients.

Community liaison activities could be further delineated into those involving community awareness and those involving development and maintenance of external linkages and partnerships. These activities have different and distinct aims which could be articulated as the following (note that wording is proposed as part of this Functional Review, and has not been endorsed by VVCS):

1. **Community awareness aims**: *All eligible VVCS clients and referring agents are aware of VVCS and how to access when needed.*
2. **External linkages and partnership aims**: *Formal (in writing) and informal partnerships with organisations and agencies support client referral both to and from the VVCS as part of a stepped care model of community mental health and well-being service provision.*

Recommendation: That VVCS clarify aims, objectives and responsibilities for **community liaison**, with clear distinction between aims of community awareness and aims of external linkages/partnerships in

[11] From VVCS Review of Group Programs 2013 – Outcomes and Next Steps (point 11)

order to ensure clearly delineated, targeted, and well-coordinated community liaison activities occur into the future.

Implementation considerations:

- Develop a National Stakeholder Engagement Strategy, outlining clear national and regional objectives, mapping target audiences and stakeholder organisations, engagement strategies, activities and key performance indicators (KPIs) to achieve agreed aims relating to community awareness and external linkages.
- Establish a time limited project team to:
  - make recommendations to the National Manager as to the assignment of key activities related to achievement of community awareness and/or external linkages objectives to appropriate positions (both Central Operations and regional staff);
  - incorporate agreed statements relating to ongoing responsibilities for community awareness and development/maintenance of external linkages into job descriptions for identified positions; and
  - consider whether ongoing community awareness activities can be better provided by appointment of a **community liaison officer** within each region (e.g. 1.0 FTE per region).
- Develop and implement processes to establish local authority and accountability (i.e. at a Regional Director level) to make decisions regarding local awareness and engagement activities within clear and endorsed policy and procedures.

2.4 DEMAND MODELLING

The *VVCS Demand Management Modelling Report* conducted for this Functional Review projected VVCS client numbers out to 2023-24 by region and by client type, based on agreed assumptions[12]. Forecast numbers are used later in this document as a basis for suggested staff numbers in each region.

Overall numbers indicate that VVCS counselling client numbers will increase but at a reduced rate when compared to the last five years. From **12,356** counselling clients[13] in 2012-13 our model estimates that the service will grow to **13,556** clients in the current financial year 2014-15, **16,355** clients in 2017-18 and **17,912** in 2023-24.

Although there is a substantial increase in counselling expected across the service in the next five years we consider that the increase can be accommodated within existing substantive staff positions. This is based on the fact that only around one third of the projected increase will be seen by counselling staff at VVCS Centres. The rest will be dealt with by outreach providers. In addition there is a substantial number of staff vacancies across the service that when filled will increase capacity to deal with more clients. We also hypothesise that there are opportunities to improve operational efficiency resulting in the ability to accommodate more clients within existing clinical and administrative resources.

[12] Assumptions not reproduced in this document

[13] The 2012-13 DVA Annual Report lists 11,687 unique counselling clients in the period. The figure in this report represents the number of clients who received an episode of counselling in 2012-13, noting some clients were in receipt of multiple care episodes during the period. These data were used as they provide a breakdown by fields required in the model (e.g. client type).

2.4.1 CLIENT NUMBERS BY REGION

In addition to forecasting growth for the VVCS as a whole, our model was designed to produce forecasts for each of the geographic regions currently defined by the service, specifically: New South Wales (NSW) / Australian Capital Territory (ACT), Victoria, North Queensland, South Queensland, Western Australia (WA), South Australia (SA), Tasmania and the Northern Territory (NT). These forecasts are reproduced in Table 2.3 below and indicate that over the next 5-10 years, significant client growth will occur in North Queensland, South Queensland and NT. There is moderate growth in NSW/ACT, Victoria and SA. WA and Tasmania will decline modestly. This is consistent with historical growth, which has seen faster growth in Queensland and the Northern Territory compared with the other regions.

Table 2.3: Forecast VVCS client numbers and share of Australia by region and year

Region	2012-13 (actual)		2014-15		2017-18		2023-24	
	No.	%	No.	%	No.	%	No.	%
NSW/ACT	2,881	23.3%	2,964	21.9%	3,134	19.2%	3,388	18.9%
VIC	1,914	15.5%	1,951	14.4%	2,061	12.6%	2,208	12.3%
N QLD	1,884	15.2%	2,322	17.1%	3,325	20.3%	3,720	20.8%
S QLD	3,105	25.1%	3,573	26.4%	4,900	30.0%	5,431	30.3%
WA	1,056	8.5%	960	7.1%	889	5.4%	950	5.3%
SA	720	5.8%	729	5.4%	754	4.6%	820	4.6%
TAS	384	3.1%	368	2.7%	357	2.2%	380	2.1%
NT	594	4.8%	690	5.1%	935	5.7%	1,015	5.7%
Australia	**12,356**	**100.0%**	**13,557**	**100.0%**	**16,355**	**100.0%**	**17,912**	**100.0%**

Based on the data presented above, it is clear that VVCS client numbers in Queensland will remain high into the future. This is not unexpected given the location of Australia's defence force bases in the north. In 2012-13 the proportion of all clients that were located in Queensland (North and South Queensland combined) was just over 40% of all VVCS clients. Our model forecasts that this will increase to just over 50% in five years and will rise to 51% over the remainder of the decade.

Given the likely change in client numbers per region there is going to be significant disparities between the responsibilities of Regional Directors. There appears to be merit in consolidating regions to obtain economies of scale and balance the relative responsibilities of each Regional Director. During consultations several staff also proposed a consolidation of VVCS regions into four or five, with a corresponding reduction in number of Directors. Staff in a variety of positions at regional locations commented that staffing models should be based on current and future client demand for services rather than historical placement, and availability of other services locally.

The most obvious consolidation is a five region model – North Queensland, South Queensland, NSW/ACT, Victoria/Tasmania and a region covering SA, WA and NT. This would leave five relatively similar sized regions in terms of client numbers (with the exception of South Queensland which is substantially larger).

Recommendation: That VVCS **consolidate the number of regions** from eight to five, namely (1) Northern Queensland, (2) Southern Queensland, (3) New South Wales/Australian Capital Territory, (4) Victoria/Tasmania, and (5) South Australia/Western Australia/Northern Territory, with a commensurate reduction in the number of Regional Directors, in order to create similar sized regions as much as possible to ensure equity of workload for regional positions and to align regions with client demand for services.

2.4.2 CLIENT NUMBERS BY TYPE OF CLIENT

Whilst the actual number of veterans accessing VVCS continues to increase, the proportion of total VVCS clients who are veterans is expected to fall from 37.1% in 2014-15 to 32.2% in 2017-18. This is primarily due to an increase in the number of serving personnel benefiting from the service under the ADF-MOU, and an expected 1,283 new counselling clients (veterans and families) by 2017-18 as a result of the new eligibility categories introduced on 1 July 2014. VVCS forecasts by client type are reproduced in Table 2.4 below.

Table 2.4: Forecast VVCS client proportions by type of client and year

Type of client	2014-15 (n=13,556)	2017-18 (n=16,355)	2023-24 (n=17,912)
Veteran	37.1%	32.2%	32.2%
Partner	25.0%	22.5%	24.2%
Child	19.7%	16.2%	14.7%
Other*	5.1%	4.2%	3.7%
F-111	0.3%	0.2%	0.2%
ADF MOU	6.7%	16.9%	17.9%
New eligibility criteria	2.4%	7.8%	7.2%

*The 'other' category contains clients that are not eligible for the service but are given counselling under the discretionary (Duty of Care) requirements applicable to any mental health service. Clients may include non-eligible ADF members and family members without direct eligibility but who are seen as part of a couple or family counselling arrangement.

These client groups can have different requirements with respect to expected outcomes and approaches to intervention and support. VVCS is already aware of these differences for current groups, and will need to assess the requirements of newly eligible clients in order to ensure that client outcomes are optimised within the context of VVCS service provision.

2.5 CLINICAL AND ADMINISTRATIVE ROLES

One of the specific purposes of this Functional Review is to provide an independent review of current VVCS roles and responsibilities. This was then used as part of the process for developing recommendations regarding an ideal VVCS organisational model which "allows for the engagement and maintenance of skilled administrative and clinical staff at the appropriate work level standard levels to facilitate high client service"[14].

Discussion regarding the roles of clinical staff has been provided earlier in this chapter, noting that roles will be dependent to some extent on agreed vision, mission and strategic directions of the service. Whilst most clinical staff did not raise issues regarding career progression or APS employment levels, several staff commented that they felt that there was a lack of opportunity for career progression at VVCS, with APS6 being the highest level for a counsellor position.

It was widely reported during consultations for this Functional Review that inconsistencies exist in job levels for VVCS administrative staff, particularly those in field based positions (i.e. outside Central Operations), compared with equivalent jobs levels for other DVA staff. These inconsistencies were noted by Directors, Deputy Directors and administrative staff (APS2-4), and reported to result in VVCS administrative positions being paid at a level below those with a similar level of responsibility and job function in other DVA services.

[14] DVA Official Order – Functional Review of VVCS, Dated 7 April 2014

Administrative job descriptions from duty statements, and roles as described during consultations, were analysed and compared against DVA Work Level Standards (WLS) for DVA broadbands and associated Australian Public Service (APS) levels as part of this review. Positions levels for administrative staff in VVCS centres were generally found to be at a level below that described by DVA WLS.

Recommendation: That VVCS introduce a **senior clinical role** to VVCS regions as either a Senior Clinician and/or a Clinical Manager to provide regions with additional access to professional advice, assessment and/or management of more complex client presentations as well as the potential to provide clinical supervision of staff. This will also open additional career progression opportunities for clinical staff.

Implementation considerations:

- The role of a Senior Clinician would be to provide advice, assessment and or/management of more complex presentations, and provide clinical supervision and case management oversight in addition to a counselling caseload. Depending on requisite qualifications and future VVCS service directions, the Senior Clinician may also have a role in provisional diagnosis and therapy for more complex clients. The advantage of this option is that the clinician can provide expert clinical advice, mentoring and support without assuming line management responsibility for clinical staff. There may be more than one Senior Clinician per region reporting to a Deputy Director.
- The role of a Clinical Manager would be similar to the proposed role of a Deputy Director in terms of local clinical leadership plus clinical management responsibility for counselling staff, although without responsibility for outreach and group program oversight (depending on VVCS or regional decisions as to the extent of regional centralisation of these programs). The advantage of this option is that it provides an additional career progression option for counselling staff, noting the potential disadvantage of time that could be spent providing clinical expertise being redirected to operational management issues.

Recommendation: That the Department considers the Review finding that centre-based VVCS **administrative positions** are currently classified at a level below their job roles/responsibilities based on DVA Work Level Standards (WLS). Taking into consideration any changes to roles resulting from this Review and from VVCS Electronic Record Application (VERA) implementation, if this finding is supported, VVCS should take steps to re-classify these positions according to Australian Public Service (APS) WLS.

3

VVCS ORGANISATIONAL DESIGN

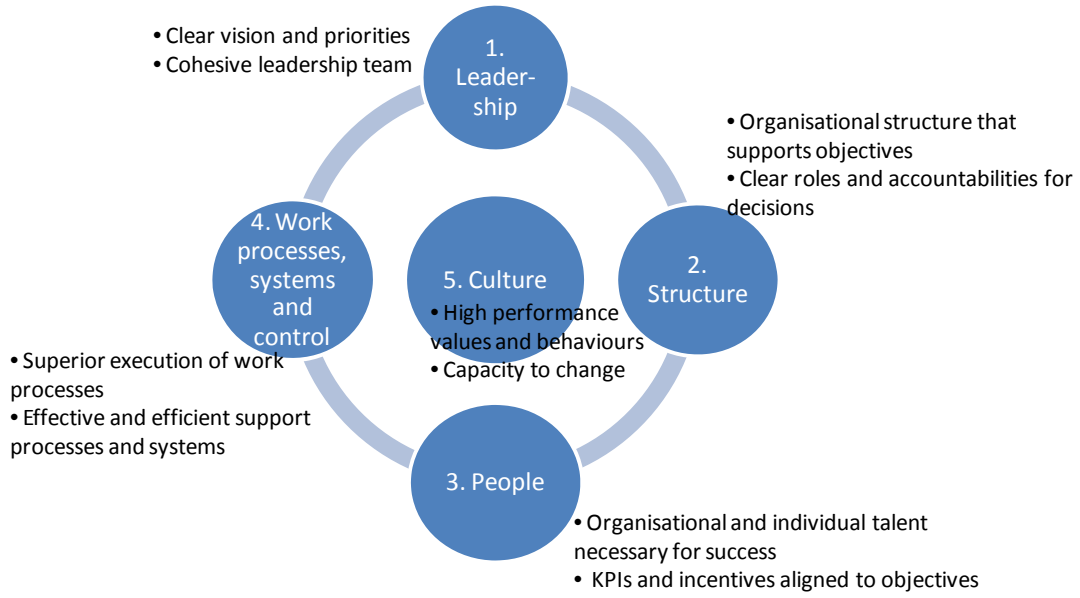
This chapter presents some background discussion on organisational design principles that we have applied to the VVCS, followed by the proposed functional structure and linkages for VVCS. These are based not only on organisational design principles but also on the findings and recommendations outlined in the previous chapter.

3.1 ORGANISATIONAL DESIGN PRINCIPLES

Whilst there are many different methodologies and approaches to organisation design there are commonly agreed best practice considerations. Firstly, one size does not necessarily fit all. Although it is common to look at how similar organisations are designed and be tempted to imitate these, it is highly unlikely that any organisation is exactly the same as another, even in the public sector, and consequently their design should not necessarily be the same. Likewise, the structure will vary depending on organisation context, unique structural characteristics (e.g. geographic dispersion, client location), the overarching purpose and goal of the organisation and the system it sits within.

Effective organisation design considers five interrelated components as presented in Figure 3.1. Each of these is discussed in relation to VVCS in the context of developing an appropriate structure[15].

Figure 3.1: Interrelated components for effective organisation design



SOURCE: Adapted from Bain & Company organisational toolkit and Bridgespan analysis

[15] Culture is not specifically discussed as it is dependent on other components to a large extent and is beyond the scope of this review

This design methodology allows a top-down approach to guide proposed structure, complemented by iterative lower-level issues where appropriate. It is important not to allow lower-level issues to unduly influence design options to the point where options are eliminated based on lower-level concerns. The design process seeks to answer two fundamental organisational design questions:

- how do we divide up the big task of the whole organisation into smaller tasks or subunits, and
- how do we coordinate these smaller subunit tasks so they fit together efficiently to realise the overall organisation goals?

3.2 LEADERSHIP

It is the responsibility of a cohesive leadership team to develop and communicate a clear vision, purpose and strategic direction for the organisation, and to identify short term and longer term priorities, goals and action plans to guide the organisation into the future. As outlined from the review of findings in the previous chapter, **further clarification regarding agreed VVCS vision, mission, and direction** is currently required from leadership. For the purposes of the current review and recommendations regarding organisational design and structure, the following broad strategic approach for VVCS is proposed (note that this has been provided by the reviewers and is not at this point endorsed by VVCS management):

> *To excel in the provision of nationally consistent, yet locally responsive, evidence-based mental health and wellbeing support services to the Australian veteran and ex-service community and their families.*

Organisational goals may relate to improving efficiency and/or effectiveness. For the purposes of organisational design, **efficiency** relates to the inputs, costs and use of resources to provide services. **Effectiveness** describes the services provided by VVCS in terms of client outcomes. VVCS leadership is responsible for considering both these goal areas.

VVCS currently appears low on efficiency insomuch as organisational resources are currently allocated based on historical factors rather than where they can most efficiently be deployed, resulting in a mismatch between resourcing and client numbers across regions. The reviewers consider that the VVCS currently scores moderately on effectiveness despite being highly client driven. This is influenced by some outstanding concerns with regard to the initial assessment process (discussed previously above) and there is currently limited monitoring or data collection around outcomes for clients seen by either internal counsellors or OPCs. The organisation design should allow VVCS to increase efficiency and effectiveness over time, with changes made incrementally to ensure alignment between the elements. In this case **the design methodology recommends that the VVCS seek to increase efficiency first (structural changes) and then effectiveness (improved assessment and monitoring of outcomes)**.

3.3 ORGANISATION STRUCTURAL MODEL

The following section discusses the proposed organisation structural model.

3.3.1 CONSIDERATIONS AND OPTIONS FOR STRUCTURAL MODEL DESIGN

The design of the organisation structure can be considered in terms of **configuration and complexity**. Configuration requirements relate to how individuals, jobs, functions or activities are differentiated and grouped. Complexity of structure relates to the extent of horizontal and vertical differentiation.

There are several common **grouping models** used to **configure** organisations. A high level description of these models and their application to VVCS is presented in Table 3.1 over-page. Note that most organisations end up with a hybrid structure, combining elements of different models but with one dominant approach.

VVCS is currently organised under a hybrid model based on functional groupings (in Central Operations and within regions) and geographic grouping (defining the different regions). Other grouping models based on programs (e.g. groups, outreach) or client types (e.g. Vietnam veterans, contemporary veterans, partners, children, newly eligible clients) also have merit and were considered for VVCS in this review. However, we do not recommend overall grouping by programs due to the difficulty coordinating common clients across these areas, leading to potential loss of focus on client outcomes. Also, we do not recommend grouping by client type, despite the importance of considering different needs of these groups in service delivery, as there is a risk of reducing service efficiency if this model is applied to a small, geographically diverse organisation such as VVCS.

As indicated in Table 3.1, grouping models inherently differentiate organisational areas and can create a heterogeneous rather than unified culture. **Structural linking mechanisms** such as project teams, internal liaison roles and dotted reporting lines can balance the differentiation that occurs from grouping to create a more **cohesive, unified and innovative organisation**. However, it should be noted that overuse of linkages can overwhelm the organisation with too much complexity and detract from key service delivery roles. The use of structured internal linkages should therefore be balanced against the key role of leadership to link units together and stimulate collaboration.

Recommendation: That VVCS continue to operate under a structure which is essentially **grouped** around specific functions for Central Operations, and geography/function for regional areas, as this allows for the most efficient and effective delivery of services to meet client needs, noting that linkages based on programs and/or client types should be continued or established across the organisation to promote innovation and best practice in these areas.

Implementation considerations:

- The VVCS functional/geographic structure should be supported by clear and consistent governance and clinical policies and procedures, which also underpin a robust Operations Manual setting out administrative and other processes. These documents should be developed centrally to provide a nationally consistent approach across regions.
- Time-limited project teams and ongoing peer groups are recommended to provide linkages and facilitate sharing, adoption of best practice models in the application of policy, and identification of quality improvement activities across the organisation for delivery of programs (e.g. groups, outreach, family based practice) and to consider the needs of different client types (e.g. Vietnam veterans, contemporary veterans, partners, children, serving personnel, newly eligible cohorts).

Table 3.1: Examples of grouping models used to configure organisations, and their suggested application to VVCS

Model name	Description	Where should model be used?	Suggested application to VVCS	Approaches to manage potential issues
Functional model	Organised around key functions or departments (e.g. VVCS Central Ops model)	Organisation is small and/or has single program focus No need to manage across large geographic area	Continue to use for VVCS **grouping structure in Central Operations** (even when positions may effectively be located outside head office) and **within regions** Benefit: easy to understand core responsibilities and accountabilities, and promotes functional innovation	Risk that focus is on function rather than organisational goals – ensure staff see role in serving customers through processes Risk that processes across functions break down – ensure key work processes are defined including roles across departments Cross functional decisions get pushed up for executive resolution – ensure decision making is explicit
Geographic model	Organised around major geographies (e.g. current VVCS regions)	Organisation is large with multiple programs across geographies Local differences critical for success	Continue to use as basis for **grouping structure outside Central Ops.** Benefits: enables clear focus and accountability for results within regions, and allows customisation of service provision to suit client needs within regions	Risk that work processes and services differ across regions – implement common approaches wherever possible and identify functions which can be provided centrally Creates confusion about who makes decisions – ensure decision making is explicit Risk that VVCS becomes more heterogeneous, not a unified culture – ensure best practice sharing, linkages and internal peer groups are established
Program (product) model	Organised around major programs (e.g. Groups, Outreach)	Programs are very different from one another although similar across geographies Resources and skills needed to succeed by program are very different	Not recommended for grouping structure due to difficulty coordinating common clients across programs and potential focus on heterogeneity rather than unified VVCS culture. Recommend that cross-unit groups for information sharing and innovation be established or continued as a **structural linking mechanism for group programs, outreach programs**	Not recommended as grouping structure for VVCS
Customer/ market model	Organised around clients served (e.g. Vietnam veterans, contemporary veterans, partners, children, new cohorts)	Customers are very different and have different service requirements resulting in different programs provided	Considered but not recommended for grouping structure due to risk of inefficiency if applied to small, geographically diverse organisation. Recommend that cross-unit groups for information sharing and development of **innovative approaches for different client groups** be established as a **structural linking mechanism**	Not recommended as grouping structure for VVCS

SOURCE: Adapted from Peter Thies, Equinox Organisational Consulting and Bridgespan

The second structural diagnostic is the degree of **complexity** assessed by the horizontal and vertical differentiation. Currently the VVCS has a high horizontal differentiation with twelve subunits reporting to the National Manager. At the same time vertical differentiation (the number of levels between the National Manager and the lowest grade employee) is considered moderate. In organisation design terms the VVCS would currently be described as a tall structure characterised by a large number of subunits and a large middle management. As noted earlier in this report, we recommend that the VVCS move to a flat divisional structure in the short-medium term with a **consolidation of regions from eight to five**. This will require that executives actively focus on coordinating subunits to ensure they stay in synch and that policy and procedures are adhered to.

We have also recommended that **elements of a matrix** structure be applied moving forward. For example, intake be moved in the longer term from a regionally to nationally centralised role, and allocation and OPC management centrally coordinated at the 'new' regional level (noting that the proposed regional structure combines several current regions). This has the potential to significantly increase efficiency, effectiveness, flexibility and resource utilisation.

3.3.2 Proposed functional models

Options for functional models for VVCS are presented in this section. Note that these are functional models only, and do not present staff numbers or actual job titles. Chapter 4 of this document presents a proposed organisation structure based on the functional models presented below, the review of findings and recommendations presented in the previous chapter, and additional assumptions provided. Job descriptions associated with each of these roles have been developed and provided in a stand-alone document.

Functional model – Central Operations

An important tenet of organisational design is that outwardly focussed functions (i.e. with focus on effectiveness) should not report to inwardly focussed functions (e.g. with focus on efficiency), or the organisation runs the risk of becoming so efficient that effectiveness, innovation and adaptation to change may suffer. In addition, functions focussed on long range development (e.g. strategy and planning) should not report into functions focussed on short range results (e.g. finance and administration). However, this is not always possible in small organisations.

However, with this in mind, two models are presented for functional organisation of roles for VVCS Central Operations, noting that we recommend maintaining the three core national leadership functions of clinical (currently Assistant National Manager (ANM)), policy and planning, and corporate services. The two options presented variously address the need for balance between accommodating outwardly focussed functions (clinical, communications, community liaison), internally focussed functions (policy, quality assurance, corporate services), long range development (strategy and planning) and short range results (clinical, finance, administration).

Option A (as outlined in Figure 3.2) presents an allocation of functional responsibility within Central Operations similar to current structure, with the exception of shifting responsibility for the clinical and client focussed functions of clinical policy and special programs (e.g. F111) to the National Clinical Director (previously ANM). Other proposed areas of responsibility for the National Clinical Director will depend on future directions for VVCS and outcomes following this Review (e.g. whilst a fully nationally centralised intake in the future may fit best under the National Clinical Director, responsibility for a national 1800 24hr contact number may fit better under Corporate Services Director, if responsibility for regionalised intake remains under the clinical stream). We recommend moving responsibility for

Veterans Line referrals to the National Clinical Director portfolio of functions, as it is a client/outwardly focussed role.

Option A keeps responsibility for strategic communications and special liaison (e.g. ADF liaison) under the Director Policy and Planning. Whilst this has merit based on these functions arguably being focussed on longer term service development, communications and liaison are also arguably client/outwardly focussed roles which could fit under the National Clinical Director who is responsible for other similarly focussed functions. This latter option is presented as Option B in Figure 3.3.

Figure 3.2: VVCS functional model - national (Option A)

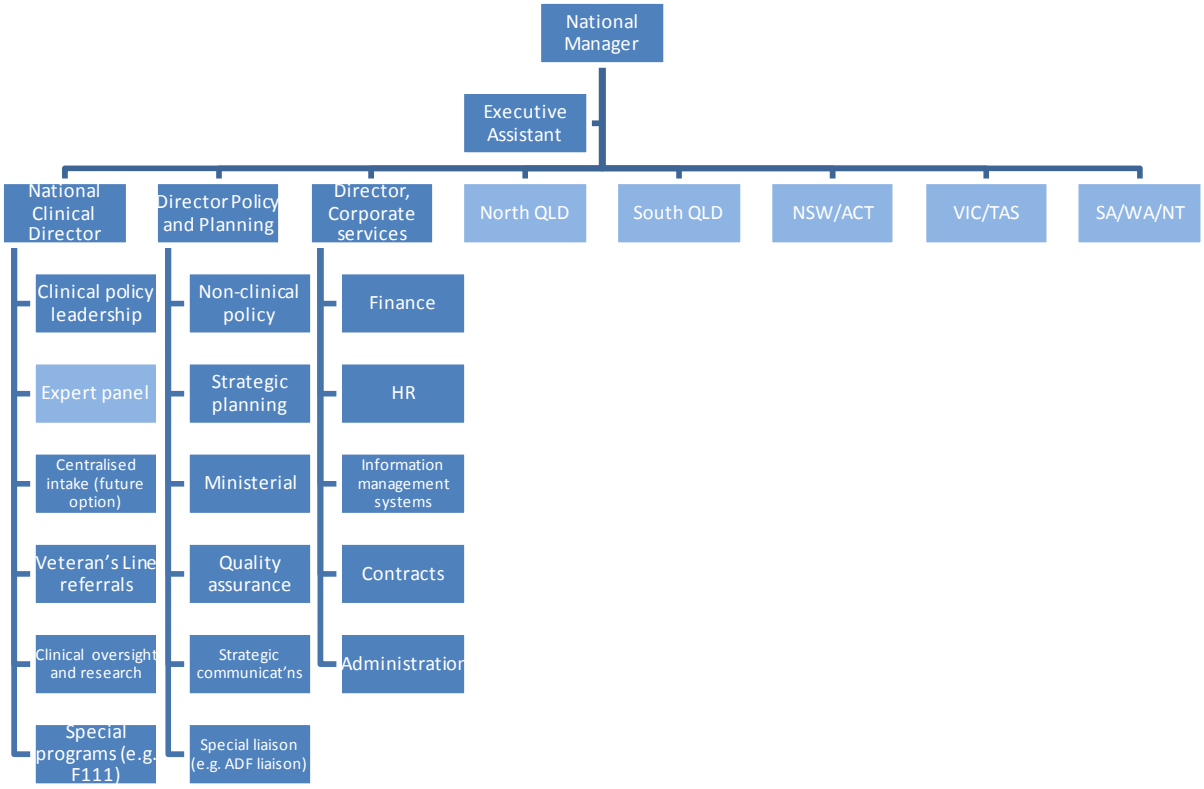
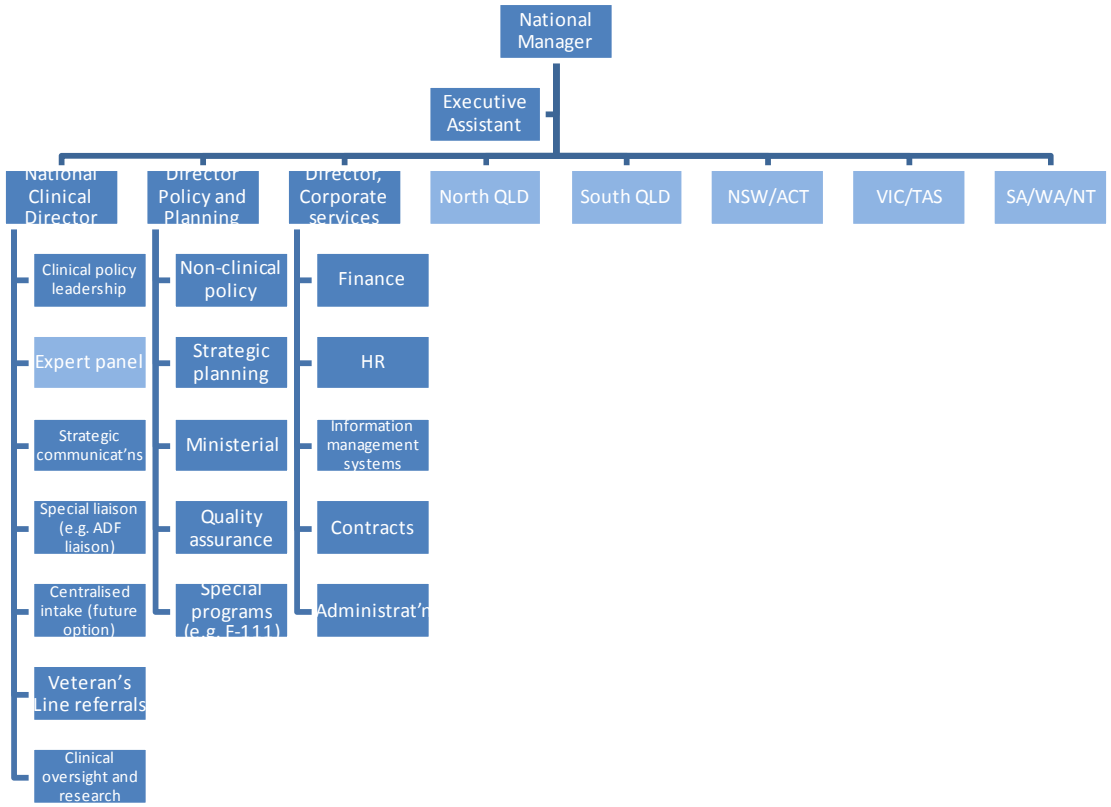


Figure 3.3: VVCS functional model - national (Option B)



FUNCTIONAL MODEL - REGIONS

Two options are also presented for functional operation of the five proposed VVCS regions.

Both options have a Regional Director with responsibility for regional operation and line management responsibility for at least one Deputy Director, a Community Liaison Officer/Manager and a Business Support Manager (BSM) who has administrative responsibility for the region. Where regions have more than one major centre (defined as a capital city or Townsville with at least two FTE counselling staff), a Deputy Director at one major centre (designated as Major Centre A) has line management responsibility for counsellors in that jurisdiction as well as the Regional Group Program Coordinator. Under both options, administrative assistants report to Office Managers where these positions exist, and otherwise to BSMs.

The two options presented below vary based on the introduction of a senior clinical role as either a senior clinician (Option A presented in Figure 3.4) or Clinical Manager (Option B presented in Figure 3.5). In Option A, all VVCS major centres have a Deputy Director, and Senior Clinicians report into the Deputy Director. The role of the Senior Clinician in this model is to provide mentoring to more junior clinical staff across the region and to provide advice, assessment and/or management of more complex clients in addition to having a counselling caseload. This position could be reimbursed at an APS6 level, plus allowance, and this model would support more than one senior clinician per region (senior clinicians in each major centre could report into centre-based Deputy Director).

In Option B, there is only one Deputy Director per region, with other major centres within the region having a Clinical Manager as the line manager for counselling staff in that centre. This would apply to regions with more than one major centre, or where the major centre is large and line management

responsibility for counselling staff should be split (e.g. Southern Queensland). Clinical Managers would have slightly less management responsibility than a Deputy Director, and would not have a deputising role to the Regional Director in their job descriptions. Reimbursement for the Clinical Manager is envisaged to be at an EL1 level under this option.

Figure 3.4: VVCS functional model – Regions (Option A)

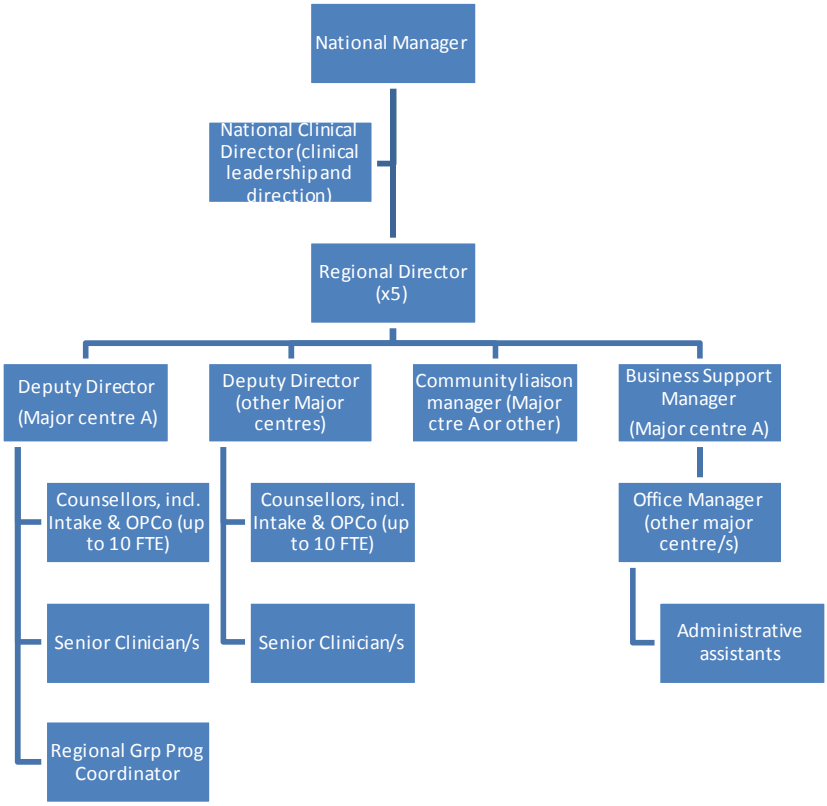
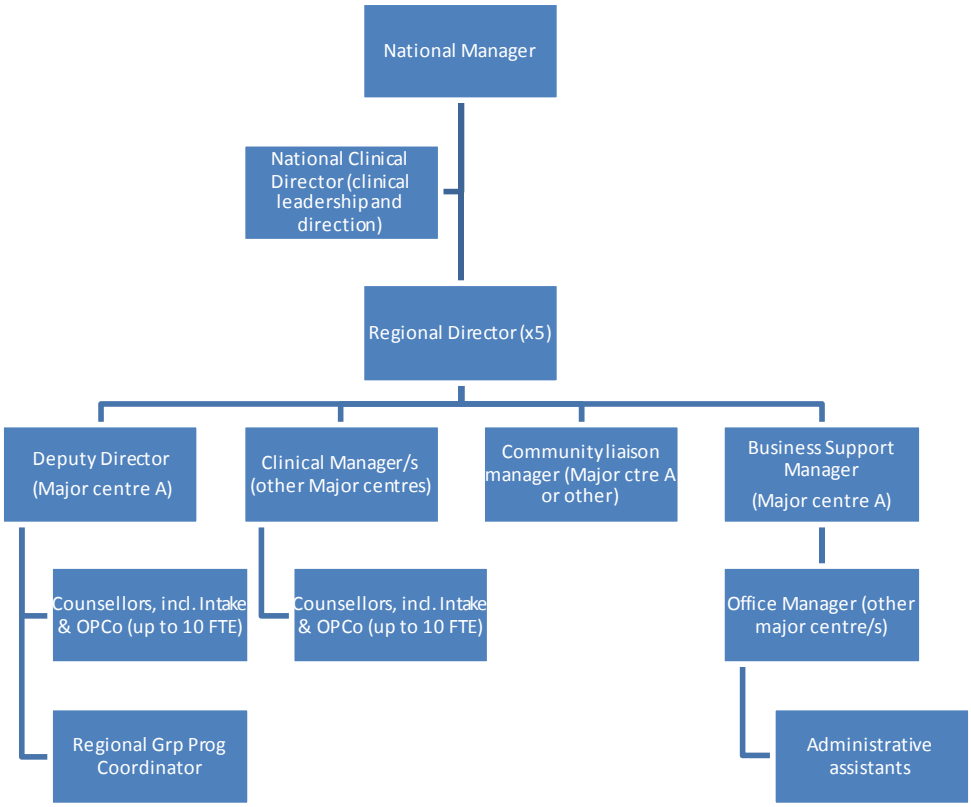


Figure 3.5: VVCS functional model – Regions (Option B)



Recommendation: That VVCS **consolidate the number of regions** from eight to five, namely (1) Northern Queensland, (2) Southern Queensland, (3) New South Wales/Australian Capital Territory, (4) Victoria/Tasmania, and (5) South Australia/Western Australia/Northern Territory, with a commensurate reduction in the number of Regional Directors, in order to create similar sized regions as much as possible to ensure equity of workload for regional positions and to align regions with client demand for services.

Implementation considerations:

- The Regional Director for each region should be responsible for regional operation and line management responsibility for at least one Deputy Director, a Community Liaison Officer/Manager (if position is approved), Clinical Managers (depending on outcomes of this Review) and a BSM. Where regions have more than one Major Centre, a Deputy Director at one Major Centre has line management responsibility for the Regional Group Program Coordinator as well as counsellors in that jurisdiction (up to ten, including intake counsellors, counsellor/case coordinators, OPCo, and senior clinicians, if this role is introduced based on outcomes of this Review). If there is more than one Major Centre in the region or if the major centre has a high staff to management ratio, additional Deputy Directors or alternatively, Clinical Managers, would have responsibility for counselling staff in their jurisdiction.

- Under the proposed new regional structure, Office Managers should report into the BSMs within each region, Administrative Assistants report into the BSMs where these positions exist within a centre, and Administrative Assistants report to Office Managers in centres where a BSM is not based.

3.3.3 PROPOSED GEOGRAPHIC MODEL FOR REGIONS

Overlaying the functional model for each region is a geographic model. The proposed geographic model for VVCS regions is presented in Figure 3.6 below. It presents how VVCS services will be physically located in each region, based on centre location and number of FTE staff required at each site. Note that this is a **geographic model** only, and does not present actual numbers or staff for each region. These are presented in the organisational model presented in Chapter 4 following.

As presented in Figure 3.6, regions may comprise one or more of the following VVCS centres or sites:

- **Major centre/s**: VVCS centres located in capital cities of a region (or Townsville in North Queensland), where there are sufficient clients seen by VVCS staff for ≥2 FTE counsellors (covering counselling, intake and/or OPC management). Where there is more than one major centre in a region, the Regional Director, Deputy Director, Business Support Manager, Community Liaison Officer (where approved), Senior Clinician (where approved) and Regional Group Program Coordinator are located in one major centre (Major Centre A) wherever possible. Clinical staff at other major centres in the region report to their centre-based Deputy Director or to the Clinical Manager, depending on the model adopted. Business Support Managers head the administrative team across the region and have managerial responsibility for Office Managers across the region.

  There may be one or more major centres for each region, provided they are located in a capital city (or Townsville) and support ≥2FTE counsellors (based on modelling undertaken for this project and subsequent VVCS review). Counsellors include those providing counselling, intake, outreach program coordination and /or area coordination of OPCs, case management. 'Major centre A' may also house the regional OPCo and intake staff, depending on the regional model adopted.

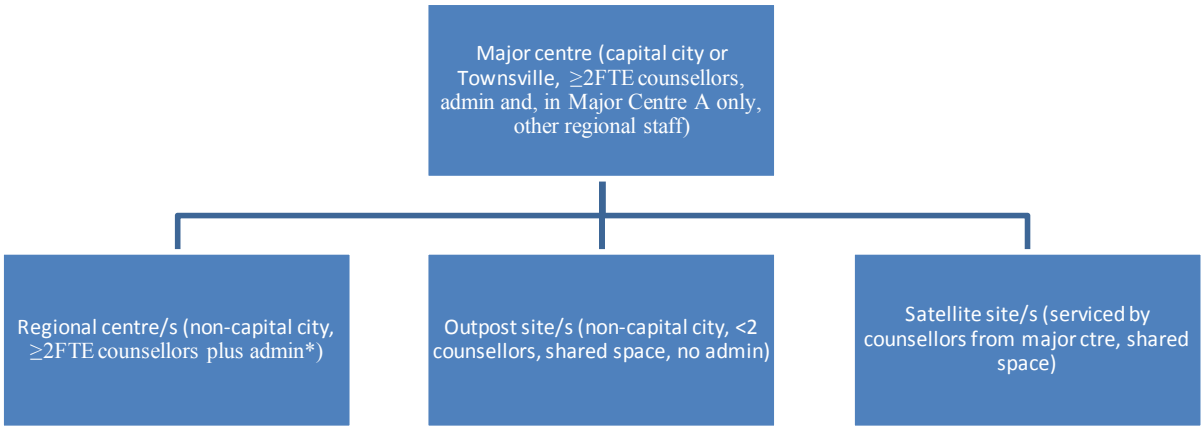
- **Regional centre/s**: VVCS centres located in non-capital cities within a region, where there are sufficient clients seen by VVCS staff for ≥2 FTE counsellors (covering counselling, intake and/or OPC management). These centres are supported by Office Managers reporting into the Business Support Manager for the region.

- **Outpost site/s**: VVCS counsellors in outpost locations requiring <2 FTE VVCS counsellors, based at non-VVCS centres such as local GP clinics, DVA offices or other community locations. Administrative support is provided from the major centre office.

- **Satellite site/s**: VVCS counsellors located in major or regional centres provide services to these sites on a regular basis. For example, counsellor drives to satellite location one day per week to see VVCS clients at non-VVCS centres such as local GP clinic, DVA office or other designated community location.

VVCS clients not able to be seen by counsellors at one of the above locations are seen for counselling by external counselling providers (OPCs).

Figure 3.6: Proposed VVCS geographic model - regions



3.4 PEOPLE

A key component of effective organisational design is ensuring that the organisation has the collective and individual talent necessary for achieving its purpose and meeting goals. VVCS is essentially a lean organisation with a small number of people who have a high level of professionalization aligned with their job tasks. Discussion and recommendations regarding future requirements for clinical staff are provided in the previous chapter. A high level review of job descriptions for Central Operations staff has been conducted to ensure that all functional areas identified in the proposed functional model (see Figure 3.2 and Figure 3.3 above) are accounted for (see recommended model in Section 4.3).

We do not envisage that major changes to administrative roles in field locations will be required to meet future organisational goals, noting that changes are already occurring with respect to information management processes. However, based on feedback from both administrative and managerial staff, a review of the extent to which current administrative roles are aligned with Australian Public Service (APS) Work Level Standards has been conducted, with findings and recommendations incorporated in Chapter 2 of this document.

3.5 WORK PROCESSES, SYSTEMS AND CONTROL

A review of key business processes has already been provided in a previous report for this project (the *Work Practice Analysis Discussion Paper)*, with findings and recommendations incorporated in Chapter 2 of this document.

The extent to which VVCS support systems and processes facilitate effective and efficient practice has previously been analysed as part of the development of the *VVCS Quality Workplan 2013-14*. One of the strategies presented in the Quality Workplan is the implementation of VERA and the use of VERA to better manage program delivery and enable greater standardisation in data collection. A review of VERA and its impact on effectiveness and efficiency is beyond the strict scope of this functional review, and may be premature at this time given that VERA is still being rolled out to OPCs.

To analyse the coordination and control requirements of an organisation we consider the degree of formalisation of processes and decentralisation of decision making. Formalisation occurs through sharing of consistent information with organisational staff, training and customs. VVCS currently exhibits a high degree of variation across subunits (regions) in terms of the way work is done and monitored, and could currently be described as a market model characterised by low formalisation.

This review would recommend that VVCS, in the short term, emphasise formalisation and centralisation to set a solid foundation before moving back to a less centrally controlled model with decentralised decision making. We note that VVCS is already adopting this strategy, with several measures currently underway to strengthen formal processes (e.g. VERA, clinical and governance policy documentation, Quality Management Framework).

Once formal processes are established, we recommend that VVCS move back to a market model where data is used in developing innovative approaches to service delivery aimed at optimising client outcomes. This will be important given changes which are occurring in the VVCS client base (e.g. increasing number of contemporary veterans, serving personnel, families and children, newly eligible cohorts) and given differing client requirements or expectations of services (e.g. after hours services, focus on return to work etc). It will also facilitate the "*provision of nationally consistent, yet locally responsive, evidence-based services*" as per the broad strategic approach for VVCS. **The future organisational design will need to allow active innovation and development of new products or services and ways of delivering these products**.

4

PROPOSED VVCS SERVICE AND ORGANISATION MODEL

This chapter brings together findings and recommendations from previous chapters to present the proposed service and organisation models for VVCS into the short to medium term future, based on assumptions regarding VVCS role in this time frame. As indicated previously in this review and in this document, VVCS will need to review and clarify its mission and strategic direction for the medium and longer term as this will further inform organisation structures required to support these directions and objectives.

As outlined in Chapter 2 of this document, VVCS service and organisation models are based on the assumption that VVCS will consolidate its purpose in the short term as:

> "*A community based mental health and wellbeing service, providing counselling and group programs for eligible members of the veteran and ex-service community and their families, to address war and service-related psychosocial and mental health conditions*",

and its broad strategic approach as:

> "*To excel in the provision of nationally consistent, yet locally responsive, evidence-based mental health and wellbeing support services to the Australian veteran and ex-service community and their families*".

The model allows flexibility to specify the inclusion of staff with more specialised skills for additional client assessment and diagnosis should this model be adopted by VVCS in the future. Alternative longer term options are discussed in Section 4.4, noting that these are dependent on the future vision and directions decided for the service.

4.1 SUMMARY OF VVCS FUTURE SERVICE MODEL (TO 2017-18)

The VVCS service delivery model will comprise five regions, with major and regional centres along with outpost and satellite sites in some locations. Major and regional centres will comprise dedicated VVCS offices, whilst outpost sites will comprise VVCS clinical staff based in other facilities (e.g. GP clinics, DVA offices). Satellite sites involve VVCS clinical staff from major or regional centres travelling to these locations on a regular basis to provide services. VVCS has around 60 full time equivalent counsellors and a network of over 800 contracted outreach counsellors, who are registered based on their skills and their understanding of veteran and military culture.

Clients can access services by 'walking in' to a VVCS centre, or by phoning a national 1800 number [1800 011 046], with or without referral. Clients will either be transferred directly to a counsellor for initial intake assessment or contacted by a VVCS counsellor later that day at an appropriate time. After-hours support is provided by Veterans Line on the same 1800 number, which is manned by

trained crisis counsellors who provide supportive, confidential counselling for those in crisis, along with support and advice to assist veterans and their families in dealing with the challenges associated with serving in the military. Following initial assessment, clients will be contacted by a centre-based or outreach counsellor to organise appropriate individual counselling and/or group program involvement.

VVCS counsellors (centre-based and outreach) are required to hold qualifications in psychology, or be mental health accredited social workers. VVCS National Clinical Director, Deputy Directors and Clinical Managers, who are responsible for clinical services nationally or in their regions, are also required to hold qualifications in psychology or social work (mental health accredited). Where not available at a regional level, a panel of clinical experts is available nationally for counsellors to refer to for additional clinical opinion and/or assessment. This panel includes a psychiatrist, GP and clinical psychologist with skills and experience in assessment, diagnosis and management of clients with issues relating to military trauma.

In addition to clinical staff, VVCS has administrative staff in each Centre and in Central Operations who provide reception and general administrative duties in Centres, and national coordination and management of VVCS centrally.

VVCS has strong links and partnerships with other community mental health and wellbeing service provider organisations, and can refer clients for stepped up or stepped down care as needed.

4.2 Proposed VVCS organisation model - Regions

This section first presents the assumptions used in developing the organisation model for regions, then presents the proposed organisation structure with staff numbers and position levels. The regional organisation structure allows for VVCS to adopt Option A, Option B or a combination of these functional models as presented in Figure 3.4 and Figure 3.5 of this document.

4.2.1 Assumptions underlying development of regional organisation model

The following assumptions and data sources have been used in regional organisation model development:

1. **Number of clients by region**: Forecast numbers are taken from demand management modelling conducted earlier in this project, based on VVCS five-year data to 2012-13 and DVA data projections (see Table 2.3). Note that client numbers relate to each episode of client care (as per how data are currently available in VVCS database).
2. **Percentage of clients seen by centre-based or outreach providers by region**: Forecast numbers are taken from demand management modelling conducted earlier in this project, based on VVCS five-year data to 2012-13 (see Table 2.1).
3. **Intake hours**: Intake assessment for each client takes 0.55 hours on average (based on VVCS Balanced Scorecard Report 2012-13), plus average 10 minutes additional write-up (based on feedback from Project Team). An estimated 25% of clients may have complexities which require up to 30 additional minutes for the intake process (e.g. working clients who may require several calls to reach them, or for complex clients where additional calls may be required).

4. **Centre based counselling hours**: Each client receiving centre-based counselling receives on average five counselling sessions (per episode of care, noting that client numbers are currently defined by episodes of care), with each session taking on average one hour (based on DVA Annual Report 2012-13).

5. **Number of outreach providers**: The number of outreach providers used per region is 80% of the total OPCs listed for each region from the *VVCS 2012-13 Internal Information Analysis Report* (based on information provided by four regions during stakeholder consultations, and agreed by Project Team).

6. **Outreach provider client case management**: Each client seen by an outreach provider requires 1.25 hours of VVCS clinical staff time to manage referral, care plan review, other review, case close. In addition, 10-15% of cases receive case audit (assumed 15%) requiring 2.5 hours per case including two hours file review plus discussion with Deputy Director, OPC and client (information agreed by Project Team). Based on total clients seen by outreach providers in 2012-13, this results in each client seen by outreach provider absorbing an average of 1.7 hours of VVCS clinical staff time (see Section 2.3.3 for further details).

7. **Outreach provider recruitment and training**: The approximate turnover of outreach providers is 20% each year for each region, with recruitment of each new OPC taking approximately 2-3 hours plus one hour of training once recruited. Note that time taken for OPC training is likely to reduce with the introduction of on-line training. Also, some regions report a lower turnover than 20%. This figure has been kept however as a conservative estimate which also accommodates time reported by Deputy Directors for management of under-performing OPCs.

8. **Counsellor staff client contact and management hours**: Total clinical staff client contact or management hours per region per year equals total intake hours plus total counselling hours plus total outreach provider case management, recruitment and training hours. It has been assumed that FTE clinical staff will spend 4.5 hours per day in these client contact/management activities including intake, counselling, case coordination and/or OPC case management or review (based on *VVCS Clinical Governance Policy*) for 45 weeks of the year (this assumes four weeks annual leave, one week sick leave, and two weeks 'other' including professional development).

9. **Allocation of FTE counselling staff within regions**: The number of FTE clinical staff indicated by the model per region have been allocated to major centre, regional centre, or outpost locations based on the proportion of regional centre-based clients and outreach clients for that location in 2012-13, and proportionate hours spent by centre-based staff with centre-based clients versus outreach client case management. These data were used as the basis for allocation within regions, as data used for demand management modelling were only available at a regional level rather than centre level. Proportions of centre based versus outreach clients are based on Table 10.1 of the *2012-13 VVCS Internal Information Analysis Report* (Version 1 created 30 April 2014), with the exception of Albury Wodonga data which was omitted from the table[16]. Albury-Wodonga data was sourced from the VVCS Intake Spreadsheet 2012-13.

   The formula used is: Number of forecast FTE counselling staff for region by forecast year X (Number centre-based clients for centre in 2012-13 X 5hrs + Number outreach clients for centre in 2012-13 X 1.7hrs) / (Number centre-based clients for region in 2012-13 X 5hrs + Number outreach clients for region in 2012-13 X 1.7hrs).

10. **Group programs**: We have estimated that group program coordination and administration will require an ongoing commitment of 0.5FTE clinical staff time (Group Program Coordinator, APS6)

[16] It has been assumed that 'NSW' data referred to in Table 10.1 of the *2012-13 VVCS Internal Information Analysis Report* refers to Sydney data, reflecting how information is reported for other regions and noting that data for Lismore and Newcastle are reported separately in the table.

and 1.0FTE administrative staff time (APS3) for each region, noting that this may need to be adapted based on outcomes of recent Group Program Review process.

11. **Community liaison**: We have included a 1.0FTE Community Liaison Officer (APS6) in the model based on previous recommendations in this report, noting that this may need to be adapted based on the outcomes of this review and any subsequent VVCS strategic communications plans developed.
12. **Change over time**: Projections over time have been included for counselling staff based on forecast client numbers and proportions seen by internal counsellors. However the number of executive and administrative staff has been assumed constant based on balance between increased workload arising from greater client numbers and more immediate increases due to recent conversion to VERA, and a future decreased workload resulting from efficiencies introduced by measures such as VERA (when fully established and operational).
13. **Administrative staff**: We have assumed that the proportion of administrative to counsellor staff will approximate the current proportions in Victoria, where current staff vacancies are reported to be minimal and ratio of administrative to counsellor staff reported to be appropriate. This ratio is 2.55 counselling staff for every one administrative staff, noting that each region will also have a balance between BSM, Office Manager and Administrative Assistants as per the previous functional models presented. Some additional consideration has also been given to number of major centres across regions, with slight upwards adjustment of FTE administrative numbers to accommodate support requirements across multiple sites.
14. **Geographic structural model**. It has been assumed that dedicated VVCS centres should only be located at sites where the current or predicted future client demand supports two or more FTE VVCS counselling staff (plus administrative staff). At other sites, VVCS counselling services may be provided via an outpost, satellite or outreach provider model.
15. **Sensitivity**. A variation in one or more of the above inputs can influence the number of counsellors required per region and/or per site to provide services to VVCS clients. In particular, number of clients by region, percentage of clients seen by outreach providers at each site within a region (and region as a whole), and hours required for intake and management of outreach clients need to be reviewed and monitored as part of model implementation. Excluding intake and outreach program responsibility, **each VVCS internal counsellor** should be able to provide services to **180 clients per year** (based on one client equating to one average episode of care, and each counsellor seeing four clients per day, working 45 weeks per year, and average number of sessions being five per client). However, actual staff numbers will be dependent on the model adopted for management of intake and outreach services in each region.

4.2.2 Proposed organisation structure - Regions

Table 4.1 and Table 4.2 below outline the proposed organisation structure with staffing numbers and levels by region for both clinical and executive/administrative staff, **based on assumptions and recommendations previously outlined in this report**.

Recommendation: In order to **align VVCS staff with client service demand** into the future, that VVCS continue to provide services from **dedicated VVCS centres** where client demand supports at least two FTE staff counsellors plus an administrative position. At all other locations, VVCS should consider transitioning service provision to **outpost sites** (services provided by local VVCS counselling staff co-located in alternate office space e.g. General Practice Clinic), **satellite sites** (by VVCS counselling staff from major or regional centre providing regular visiting service), or by **outreach providers** (OPCs), depending on local client demand.

Implementation considerations:

- VVCS Regional Directors review forecast client demand and numbers able to be seen by internal counsellors (based on demand and client location, not current staffing levels), and provide comment against the forecast staffing levels proposed in Table 4.1 and Table 4.2 below.
- Based on Table 4.1 and Table 4.2 below, and on input provided by Regional Directors, VVCS National Management Team should review current counsellor and administrative staff locations, substantive numbers and vacancies to determine where staffing resources need to be re-directed to ensure that allocation of resources aligns with current and forecast client demand and need for services both between and within regions.
- Assuming no substantive changes in forecast client numbers or proportions of clients seen by internal/external counsellors, VVCS amend its service delivery model in centres where current and forecast client demand does not support two or more counselling staff (**Newcastle, Lismore, Albury-Wodonga, Hobart and Launceston**) and transition these centres to **outpost sites** where this has not already occurred.

Table 4.1: No. forecast VVCS FTE regional clinical staff by role, region and site, staff level and time frame (2014-15, 2017-18, 2023-24)

Region	Site location	Type of site (proposed)	Counsellors (incl. intake, counselling/case coord, OPCo, senior clinician) (APS5-6)			Other clinical staff roles (no change across 2014-2024)^		Total counselling staff by region		
			2014-15	2017-18	2023-24	Group Program Manager (APS6)^	Community Liaison Officer (APS6)^	2014-15	2017-18	2023-24
NSW/ ACT	Sydney	Major	3.8	4.2	4.6					
	Newcastle	Outpost*	1.4	1.5	1.7					
	Lismore	Outpost*	1.1	1.2	1.3					
	Canberra	Major	3.6	4.0	4.3					
	TOTAL	-	**9.9**	**11.0**	**11.8**	0.5	1.0	**11.4**	**12.5**	**13.3**
VIC/ TAS	Melbourne	Major	6.4	6.4	6.9					
	Alb-Wod	Outpost*	0.9	0.9	1.0					
	Hobart	Outpost*	0.8	0.8	0.8					
	Launceston	Outpost*	0.6	0.6	0.6					
	TOTAL	-	**8.7**	**8.7**	**9.3**	0.5	1.0	**10.2**	**10.2**	**10.8**
N QLD	Townsville	Major	7.0	10.3	11.5					
	TOTAL	-	**7.0**	**10.3**	**11.5**	0.5	1.0	**8.5**	**11.8**	**13.0**
S QLD	Brisbane	Major	10.1	13.6	15.1					
	Marooch	Regional	2.1	2.8	3.1					
	Southport	Regional	1.5	2.0	2.2					
	TOTAL	-	**13.7**	**18.5**	**20.5**	0.5	1.0	**15.2**	**20.0**	**22.0**
SA/WA/NT	Adelaide	Major	2.9	3.2	3.5					
	Perth	Major	3.3	3.1	3.3					
	Darwin	Major	2.5	3.9	4.2					
	TOTAL	-	**8.8**	**10.2**	**11.0**	0.5	1.0	**10.3**	**11.7**	**12.5**
Australia	***TOTAL***	**-**	***48.1***	***58.6***	***64.2***	***2.5***	***5.0***	***55.6***	***66.1***	***71.7***

*These sites are nominated as outpost sites (i.e. no VVCS office – staff based in other centres such as GP clinics) based on forecast client numbers and current proportion of clients seen by centre-based staff. If client numbers and/or proportion seen by centre-based staff can be substantially increased, sites may be reconsidered to remain as regional VVCS centre locations.
^These roles could be based in any major centre within region

Table 4.2: No. proposed VVCS FTE regional executive and administrative staff by role, region and site, time frame and staff level

			Executive			Administrative				
Region	Site location	Type of site (proposed)	Director^ (EL2)	Deputy Director (EL1)	Deputy Director/ Clinical Manager (EL1)	Business Support Manager (APS5)	Office Manager (APS4)	Group Program Admin. Assistant (APS3)	Admin. Assistant (APS3)	*Regional total (admin)*
NSW/ ACT	Sydney	Major	1	1		1		1	1	3
	Newcastle	Outpost*								
	Lismore	Outpost*								
	Canberra	Major			1		1		1	2
	TOTAL	**-**	**1**	**1**	**1**	**1**	**1**	**1**	**2**	**5**
VIC/ TAS	Melbourne	Major	1	1		1		1	2	4
	Alb-Wod	Outpost*								
	Hobart	Outpost*								
	Launceston	Outpost*								
	TOTAL	**-**	**1**	**1**		**1**		**1**	**2**	**4**
N QLD	Townsville	Major	1	1		1		1	2	4
	TOTAL	**-**	**1**	**1**		**1**		**1**	**2**	**4**
S QLD	Brisbane	Major	1	1	1	1	1	1	3	6
	Marooch	Regional					0.6			0.6
	Southport	Regional					0.6			0.6
	TOTAL	**-**	**1**	**1**	**1**	**1**	**2.2**	**1**	**3**	**7.2**
SA/WA/NT	Adelaide	Major	1	1		1		1	0.5	2.5
	Perth	Major			0.6		1		0.5	1.5
	Darwin	Major			0.6		1		0.5	1.5
	TOTAL	**-**	**1**	**1**	**1.2**	**1**	**2**	**1**	**1.5**	**5.5**
Australia	***TOTAL***		***5***	***5***	***3.2***	***5***	***5.2***	***5***	***10.5***	***25.7***

*These sites are nominated as outpost sites (i.e. no VVCS office but based in other centres such as GP clinics) based on forecast client numbers and current proportion of clients seen by centre-based staff. If client numbers and/or proportion seen by centre-based staff can be substantially increased, sites may be reconsidered to remain as regional VVCS centre locations.
^Note that Director, Business Support Manager and other regional staff could be based in either of the major centres – they have only been placed against one as an indicative model.

A requirement of the Functional Review is for the service delivery model and related organisational structure to be **cost neutral** with respect to administrative and executive salary costs. Salary costs based on current substantive positions in regions (as advised by VVCS) have been compared with salary costs under the proposed model. These findings are presented in Table 4.3 below, and demonstrate that **cost savings of up to $627,987** can be realised under the proposed model at a **regional level**. These savings result primarily from consolidation of regions to five, closure of some regional offices, and a matching of administrative staff numbers to counsellor staff requirements.

These 'savings' at a regional level can be used to support:

- reclassification of any positions
- the introduction of an expert panel (if these positions are supported from executive rather than professional salary funding)
- any additional community liaison positions adopted at the regional level (if these positions are supported from executive rather than professional salary funding)
- supporting additional travel for Directors who are now responsible for more than one jurisdiction
- additional national positions including those addressing information management services, communications and policy.

Table 4.3: Total salary costs for regional executive and administrative staff in current and proposed VVCS organisation structures

Job levels and total salary costs	Director	Deputy Director	Business Support Manager	Office Manager	Administrative Assistant	TOTAL
Current structure (July 2014)						
APS level	EL2	EL1	APS4	APS3	APS2	
Salary rate (pay band 3)*	$130,894	$105,836	$69,209	$61,726	$55,680	
No. substantive staff	8	7	3	11	21	
Total salary cost	$1,047,152	$740,852	$207,627	$678,986	$1,169,280	$3,843,897
Proposed structure						
APS level	EL2	EL1	APS5	APS4	APS3	
Salary rate (pay band 3)*	$130,894	$105,836	$75,389	$69,209	$61,726	
No. substantive staff	5	8.2	5	5.2	15.5	
Total salary cost	$654,470	$867,855	$376,945	$359,887	$956,753	$3,215,910

*From 1 July 2013

4.3 PROPOSED VVCS ORGANISATION MODEL – CENTRAL OPERATIONS

This section presents the proposed organisation structure for Central Operations, with associated staff position levels. This information is presented in Table 4.4 below. Where changes to position title or responsibilities are proposed, these changes are outlined in the table. The structure allows for VVCS to adopt Option A, Option B or a combination of these functional models as presented in Figure 3.2 and Figure 3.3 of this document, with different functional responsibilities for National Clinical Director and the Director Policy and Planning.

Recommendation: That VVCS determine ongoing responsibilities of **Central Operations** staff based on findings of this Review, and consider the following changes to position titles and/or classification of Central Operations staff:

- Consider changing position title and responsibility for the following:
  - Assistant National Manager becomes National Clinical Director with additional responsibility for clinical policy, research and oversight of client focussed programs;
  - National Executive Officer becomes Director Corporate Services, with additional responsibility for information management services;
  - Assistant Director F111 Program becomes Manager, Special Programs with additional responsibility for coordination of project teams and peer groups based around programs (e.g. outreach, groups, clinical programs such as family inclusive practice) and client types (e.g. Vietnam veterans, contemporary veterans, serving personnel, partners, children, new cohorts).
- Consider changing position title and classification for ADF Liaison Officer (APS6) to Communications and Community Liaison Manager (EL1), with additional responsibility for coordinating development and implementation of strategic communication plan and community liaison plan.
- Consider changing classification for Finance Officer from APS5 to APS6 based on review of responsibilities against Work Level Standards (WLS) around managing financial reporting and analysis activities, and developing, implementing and monitoring budget controls and strategies.
- Consider introduction of new position of Information Systems Manager (APS6) to replace temporary position of VVCS Electronic Record Application (VERA) Business Lead (EL1), with responsibility for ongoing management, development, implementation and reporting from VVCS information management systems (e.g. VERA).

Table 4.4: Proposed VVCS organisation structure – Central Operations

Position	APS level	Immediate supervisor	Previous position title/ level (where relevant)	Changes or additions to current role or responsibilities (where relevant)
National Manager	SE1	Deputy President Repatriation Commission	(No change)	Reduction in number of direct reports as per functional model presented in Section 3.3.2 of this document
National Clinical Director	EL2	National Manager	Assistant National Manager	Responsibility for clinical policy, leadership, and client focussed functions (e.g. communications, liaison, referral protocols)
Director Policy and Planning	EL2	National Manager	(No change)	Responsibility for non-clinical policy, ongoing quality assurance and Ministerial correspondence Additional responsibility for coordinating development and ongoing review of VVCS 5 year strategic plan
Director Corporate Services	EL1	National Manager	National Executive Officer (EL1)	Additional responsibility for management of information management systems and HR
Manager, Special Programs	EL1	National Clinical Director	Assistant Director F111 Program	Additional responsibility for coordination of project teams and peer groups based around programs (e.g. outreach, groups, clinical programs such as family inclusive practice) and client types (e.g. Vietnam veterans, contemporary veterans, serving personnel, partners, children, new cohorts)
Communications and Community Liaison Manager	EL1	National Clinical Director or Director Policy and Planning	ADF Liaison Officer (APS6)	Additional responsibility for coordinating development and implementation of strategic communication plan and community liaison plan
Information Systems Manager	APS6	Director Corporate Services	Business Lead MIS Project (EL1, non-ongoing)	Responsibility for ongoing management, development, implementation and reporting from VVCS information management systems (e.g.VERA)
Senior Policy Officer	APS6	Director Policy and Planning	(New position)	Additional responsibility to assist with development and ongoing review of VVCS 5 year strategic plan Responsibility for scoping and development of communication plan/strategy shifted to proposed Communications and Community Liaison Manager position
Project Officer	APS6	Director Corporate Services	(No change)	(Position description not available for review)
Finance Officer	APS6	Director Corporate Services	Previously APS5	Responsibilities suggest alignment with WLS APS6, particularly noting responsibility for managing financial reporting and analysis activities, and developing, implementing and monitoring budget controls and strategies
Contract Manager	APS5	Director Corporate Services	(No change)	(No change)
Executive Assistant	APS4	National Manager	(No change)	(No change)
Administrative Assistant	APS2	Communications and Community Liaison Manager	(No change)	Immediate supervisor changed from Director Corporate Services to better align with reported responsibilities around client satisfaction surveys and Veterans Line

4.4 ALTERNATIVE VVCS ORGANISATION MODELS – LONGER TERM

As previously stated, this Functional Review is not able to provide detailed options for longer term VVCS organisation models and structures without knowing the longer term vision, mission and strategic direction of the service. However, the model presented allows VVCS to implement some changes to staff structures should the vision or direction of the service support these (e.g. employment of clinical psychologists as senior clinicians, employment or contracting of a panel of experts).

Longer term alternatives for VVCS organisation structure and service model will depend not only on the vision and direction of the service, but also on the future environmental context and other services available for VVCS clients. For example, should other services offering counselling and support programs for veterans and veterans' families become established and strong partnerships developed with VVCS in the future, VVCS may consider moving further towards a comprehensive intake and assessment service, but then provide full outsourcing of counselling, therapy, treatment and support services. VVCS clinical staff, via a national telephone line and/or web-based link, could provide initial assessment, referral to local service providers, and follow-up phone service to ensure quality care is being provided to meet client needs and ensure optimal outcomes.

The difficulty transitioning to such an outsourced model is that it requires a comprehensive database of local service providers available for intake staff, otherwise client outcomes risk being compromised. The development of such a database would be largely reliant on the knowledge of current counselling staff in each of the regions, who may lack motivation to record such knowledge given that their positions may become redundant in this scenario.

5

JOB DESCRIPTIONS

Draft VVCS role categories and job descriptions have been developed as part of the Functional Review process. These have been based on the following:

- discussions regarding job roles during stakeholder consultations
- review of current VVCS job descriptions
- review of DVA Capability Framework, APS Work Level Standards and the APS Commission Integrated Leadership System.

Draft job descriptions are provided in a separate document (*VVCS Draft Role Documentation*). This chapter provides information on which job descriptions have been included, and considerations for their use.

5.1 REGIONAL ROLES

Draft job descriptions are provided for current and proposed regional roles. However, it should be noted that there may be regional variation as to how these roles are implemented in practice. For example, in regions where major centres are small (e.g. SA, WA, NT), different roles may be combined as in the following examples:

- a Deputy Director may also have responsibility for outreach program management
- counsellors may have intake responsibility if dedicated intake counsellor is not appointed for the region
- if the Regional Group Program Coordinator role is split amongst major centres within the region, incumbents may also have a counselling caseload.

Revised and new job descriptions are provided in the separate document (*VVCS Draft Role Documentation*) for the positions outlined below. Job descriptions specific to Group Program Coordinator and associated Group Program Administrative Assistant have not been developed as they will be dependent on the outcomes of the Group Program Review process.

REVISED JOB DESCRIPTIONS - REGIONAL

- Regional Director
- Deputy Director
- Outreach Program Coordinator

- Group Program Coordinator
- Counsellor/Case Coordinator
- Counsellor - Intake
- Business Support Manager
- Office Manager
- Administrative Assistant

NEW JOB DESCRIPTIONS - REGIONAL

- Senior Clinician
- Community Liaison Manager

5.2 NATIONAL ROLES

Draft job descriptions are provided in the *VVCS Draft Role Documentation* for current and proposed national roles as per the list below. Where job descriptions are not provided, it is either because there has been no change to current job description, and/or because roles need to be further reviewed by VVCS to ensure that all activities needed to support or lead the service at a national level are appropriately described and allocated.

REVISED JOB DESCRIPTIONS - NATIONAL

- National Manager
- Executive Assistant to National Manager
- National Clinical Director
- Director Policy and Planning
- Director Corporate Services

NEW JOB DESCRIPTIONS - NATIONAL

- Information Systems Manager

Recommendation: That once findings and recommendations from this Review have been considered and any executive decisions relating to organisational change are complete, VVCS reassess the **Draft Job Descriptions** provided as an attachment to this Report and finalise these in the context of the approved VVCS structural model and roles for the future.

6

IMPLEMENTATION AND RISK MANAGEMENT PLAN

This chapter presents a recommended approach for staged implementation of the proposed organisational model, with a risk assessment of potential issues associated with implementation.

6.1 STAGED IMPLEMENTATION PLAN

The staged implementation plan presented in Table 6.1 below assumes that requisite review and approval processes for the recommendations proposed by this Functional Review are completed by end September 2014. Timeframes presented in the table can be adjusted as required based on the timing of this first stage.

Table 6.1: Staged implementation plan for new VVCS organisation structure

Broad stage	Timing	Activities
Review and approval of new structural model	Aug – Sept 2014	Submission to, and review by, Commission Based on Commission decisions, VVCS Executive review as required
Stakeholder engagement and preparation	Oct – Dec 2014	Develop a change management and consultation plan for internal staff Develop a communication plan for all key stakeholders (internal and external, including unions and professional associations) Develop a risk management and mitigation strategy Finalise job roles and job descriptions based on approved structure Where required, implement process to reclassify job position levels and seek approval for new positions Institute Employee Assistance Program for affected staff Develop office closure plan as needed to address such things as lease arrangements, asset repatriation or liquidation Develop transition strategy to move service from regional offices to outpost sites (e.g. GP practice) where indicated
Preparation for region consolidation	Oct – Dec 2014	Spill Regional Director positions Advertise and recruit Regional Directors under new structure
Implement new structure	Jan – Mar 2015 Post March 2015 for med-long term changes as approved	Continue implementation of change management and communication strategies as required Newly appointed Regional Directors advertise and recruit to existing and newly created vacancies within regions as approved Advertise and recruit to existing and newly created vacancies within Central Operations as approved Close regional offices as agreed and transition to new facilities at these locations Review and amend IT systems to align with new structure as required

6.2 RISK ASSESSMENT

Risk assessment of the model and associated implementation is presented in this section. Table 6.2 presents the risk assessment matrix used in evaluation of risk likelihood and severity of impact. Table 6.3 presents a risk assessment for implementation of the VVCS organisation structure and job roles recommended by the Functional Review. The grades of risk presented in the risk assessment should be used to develop an appropriate risk management and mitigation plan once the proposed structure has been reviewed and finalised.

Table 6.2: Risk assessment matrix

Impact / Likelihood	Negligible	Minor	Moderate	Significant	Severe
Very high	Low risk	Moderate risk	High risk	Extreme risk	Extreme risk
High	Minimal risk	Low risk	Moderate risk	High risk	Extreme risk
Moderate	Minimal risk	Low risk	Moderate risk	High risk	High risk
Low	Minimal risk	Low risk	Low risk	Moderate risk	High risk
Very low	Minimal risk	Minimal risk	Low risk	Moderate risk	High risk

Table 6.3: Risk assessment for VVCS Functional Review implementation

Broad risk area	Specific risk	Risk severity*
Review process	Commission does not approve all or some recommendations for functional and structural review	Moderate risk
	Delay in decisions regarding recommendations from Functional Review	Low risk
Stakeholder engagement	Leadership do not fully support recommendations and approach, impacting roll-out to other staff in regions and centrally	High risk
	Inadequate and/or poorly managed change management process	High risk
	Negative response from staff resulting in negative impact on culture, loss of corporate knowledge if staff seek alternative employment, and subsequent potential negative impact on client outcomes in the short to medium term	Extreme
	Negative response from external stakeholders including clients, external service providers and/or organisations resulting in political or media response	Moderate risk
	Industrial action resulting from administrative or professional staff concerns	Low risk
Service demand	Client growth rates, percentage seen by internal VVCS staff, and/or distribution between or within regions is significantly different from forecast resulting in change to staff requirements within and between regions	Moderate risk
Processes	Delays in recruitment of new Director positions impacting ability to implement new structure and recruit other staff within regions	High risk
	Delays in recruitment of other administrative and clinical positions impacting client service provision	Minimal risk
	Negative cost implications of long term office lease arrangements in regional locations	Low risk
	Delay in securing new facilities for new outpost locations	High risk

*Based on assessment of risk likelihood and impact as per risk assessment matrix in Table 6.2