

Initial Submission

(Response to Issues Paper)

April 2019

Productivity Commission Inquiry:

*The Social and Economic Benefits of
Improving Mental Health*



Preface

Aftercare is Australia's longest-established mental health charity and has provided specialist mental health services to people with persistent mental illness and complex needs since 1907.

Today Aftercare employs 600 staff providing community outreach, residential and integrated mental health services for over 15,000 Australians. Our two key priorities are (i) services for people with persistent mental illness and complex needs and (ii) an increasing focus on early intervention with children, young people and families.

Our services encompass:

- **Community-based services** for people with persistent mental illness and complex needs – funded through NDIS and the (soon to be abolished) PHaMs and PIR programs in particular.
- **Residential services:**
 - Under NDIS "Supported Independent Living" (SIL) funding, for adults
 - For young people – we operate a range of state-funded services including recovery-oriented services focused on social and emotional wellbeing, education and employment outcomes, and some services for complex cases involving the out-of-home-care system
- **Integrated services centres:**
 - For young people: we operate seven "headspace" centres – Aftercare is the largest operator of headspace centres in Australia
 - For adults: we operate four integrated mental health services centres – two in NSW (under State funding for "LikeMind") and two in Queensland (under our own name "Floresco").
 - For children and families: we operate a pilot mental health centre in Ipswich, called "Poppy".

We welcome this opportunity to contribute our views to the Productivity Commission Inquiry *The Social and Economic Benefits of Improving Mental Health*; specifically, in response to the Issues Paper dated January 2019.

Our extensive history in service provision and our breadth of services across children, young people and adults and across community, residential and integrated/clinical settings means we have an extensive range of experiences and issues to draw from in our response.

Contents

KEYS TO BETTER OUTCOMES (SUMMARY OF OUR VIEWS)	4
Four Keys to System Reform	4
Additional Key Recommendations	5
1. INTRODUCTION	6
2. SCOPE AND APPROACH	6
Inquiry Scope.....	6
Inquiry Approach	7
3. CONTRIBUTING COMPONENTS TO IMPROVING MENTAL HEALTH AND WELLBEING	9
Healthcare	9
“Structural Weaknesses”.....	9
Early Intervention	13
Health workforce and informal carers.....	16
Rural and Regional Workforce.....	16
Reducing Worker Stress & Turnover	16
Professional Development	17
Workforce restrictions	17
Informal carers	18
Housing, income support and social services.....	18
Gaps around the NDIS.....	19
Child protection	20
Skills acquisition and employment.....	20
Education	20
Employment	22
4. FRAMEWORK TO ENHANCE MENTAL HEALTH AND IMPROVE PARTICIPATION AND WORKFORCE CONTRIBUTION	23
Coordinated care and a fully integrated system	23
Mental health services in context: The social-ecological model.....	23
Integrated Service Provision.....	24
Funding Arrangements	27
Measurement and reporting of outcomes.....	28

Contact

Dr Andrew Young
Chief Executive Officer, Aftercare

Keys to Better Outcomes (Summary of Our Views)

Four Keys to System Reform

We believe there are four systemic keys to improving population mental health so as to realise economic and social participation and productivity benefits over the long term.

- 1. Invest in a national strategy for early intervention with at-risk/ disadvantaged children, families and young people.**
 - Over 3-5 years invest in action-research - pilot initiatives with rigorous evaluation to test the long-term benefits of early intervention and identify best models
 - Over 5 years develop the business case for a national approach to improving childhood mental health with a particular focus on disadvantaged communities
 - Build to scale using learnings from headspace/other national initiatives
- 2. Recognising that people with mental ill-health live in layered context of family/friends/informal carers, formal supports, community and other systems; invest in models that provide integrated support.**
 - Invest in **integration of services/coordination of services for Individuals:**
 - In the NDIS; by ensuring there is a schedule item designed for long-term coordination of support for mental health Participants and that Participants with mental health needs have sufficient funding for this activity
 - For service users not accessing NDIS funding but with complex mental health needs, ensuring there is sufficient funding for care coordination.
 - Invest in **developing the service model for "adult integrated services" for Disadvantaged Communities** based on LikeMind, Floresco and similar experience to date:
 - Establish a pilot program pathway with clear objectives and decision "gateways" to test and advance service model/s;
 - Ensure there is sufficient resourcing for the "core" staffing for these services and a funding model allowing sustainable engagement and retention of clinical service providers (GPs and allied health);
 - Invest in an overall evaluation framework for these services;
 - Improve data sharing and collaboration between public health services and integrated service centres.
- 3. In the mid-long term, better articulate the desired outcomes of mental health service delivery; create clear measurement frameworks underpinning these desired outcomes, and align funding mechanisms with these outcomes:**
 - Funding agencies better articulate the desired outcomes of mental health service delivery (whether at national, State or regional levels and in individual commissioning processes).
 - Provide in funding contracts for the cost of quality outcomes measurement and, where appropriate, program-level evaluations.
 - Improve access to government data sources that may better inform service providers' outcome measurements.
 - Potentially – identify a range of outcome measurement tools and approaches that are considered "best in class"; allow service providers to design measurement of desired outcomes using a subset of these tools.
- 4. Reform funding** to overcome structural weaknesses in the system and incentivise and support effective delivery of outcomes.
 - **Reduce overlap** between PHN (federal) and LHD/HHS etc (State) funding and responsibilities/ **increase clarity** about respective roles/better integrate these.
 - Create **longer-term funding models** (for example, with minimum performance/outcomes criteria) and stronger certainty for service delivery agencies.

Aftercare Response

- Improve the **quality and consistency of commissioning processes** – develop national standards; conduct training for commissioning staff; provide clearer and more nationally uniform data/evidence where possible; implement a quality audit framework.
- Develop a **“learning system”** by:
 - Developing a process framework for piloting service innovation with clear gateways for continuing to subsequent stages and mechanisms for scaled adoption.
 - Overlaying a national framework for pilots that might be tested in different/relevant PHN/LHN regions so that there can be significant investment in key pilots with successful models adopted across PHNs/LHNs.

Additional Key Recommendations

In addition to these systemic reforms, we would also recommend:

- 5. We recommend consideration be given to adding a fifth element** to the assessment components used in the Inquiry; namely, **“Opportunities for stronger systemic strategies”**
What improvement in outcomes can be gained through:
 - better integrated services and supports designed around individuals?
 - clearer whole-of-community mental health strategies (in specific high-risk communities)?
- 6. To promote a healthy and sustainable workforce with the skills needed for mental health service delivery, tailor funding models to provide service providers with the resources necessary to:**
 - Provide financial and other incentives for workers in rural and regional communities. Build into grant funding models a **loading for employment in regions** where employment and retention proves difficult.
 - Provide appropriate **clinical supervision** to workers in mental health support roles.
 - **Provide reasonable productivity (client-facing) hours**, allowing for supervision, professional development and administration; specifically, funding models must allow for *at least* 20% of hours to be non-client-facing (non-“billable” under NDIS funding).
 - Provide **2% of salaries and wages costs for professional development**, perhaps subject to an acquittal demonstrating the funds were spent accordingly.
- 7. Review the psychosocial service resourcing for those who do not qualify for the NDIS.** We recommend **the Inquiry seek to understand the assumptions and modelling** that has been used to determine the resource allocation quantum for NPS and COS measures – and **make this transparent** so others may also comment and so that service providers can better plan for continuity of client support.
- 8. We urgently recommend investment in specialist residential mental health services for young people in State care.**
- 9. To address the impact of mental ill-health on individual educational attainment** and on classrooms, we recommend:
 - Teacher education (from early childhood centres up) in mental health literacy
 - Investment in childhood mental health services linking with schools in disadvantaged communities, particularly early childhood education centres and primary schools (as many headspace services already do for older young people)
 - Consideration be given to additional mental health services provided within early childhood and school settings in specific cases.
- 10. To support engagement with employment**, we recommend that funding agencies be more transparent with employment objectives, be more open with performance data and consider alignment of funding with employment outcomes.

1. Introduction

We are at a critical junction in the mental health system journey in Australia. Several key transformational shifts are underway, including:

- Awareness of Mental Health issues in the community is rising – mental health is “coming out of the closet” (while there is still a long way to go in de-stigmatisation).
- Related: Governments and companies are giving increasing attention and priority to improving mental health and wellbeing.
- Funding transformation: the introduction of the NDIS accompanied by significant change in (withdrawal of) other federal and state-funded mental health programs.

This is arguably the time of greatest change in the mental health service landscape in Aftercare’s 112-year history. The Productivity Commission Inquiry (the Inquiry) is very timely and we welcome the systemic approach (broad scope) taken in the Issues Paper.

2. Scope and Approach

Inquiry Scope

We think there is an interesting distinction between the Inquiry’s focus on economic vs social participation in the Issues Paper. The Treasurer’s *Terms of Reference* introduction (page iii) emphasises economic participation¹:

*The Commission should consider the role of mental health in supporting **economic participation**, enhancing productivity and economic growth.*

The Inquiry title (“The Social and Economic Benefits of Improving Mental Health”) and Issues Paper introduction (page 2) refer to both social and economic:

*The terms of reference ask the Commission to make recommendations to improve population mental health so as to realise higher **social and economic participation** and contribution benefits over the long term.*

This is more than a semantic difference. While most would argue that increasing social participation does generally have a positive impact on economic outcomes, this may not be true in all cases. To put it another way, if there are some issues and recommendations that the Inquiry might consider that could positively impact social participation but without economic benefit, is this in scope or out of scope?

More generally, there is an important philosophical question here that has some tangible consequences. **Do we value improved social participation** in isolation from economic outcomes? How should we define our social outcome objectives, and how should we measure these? How much can Australia afford and how much should Australians be prepared to pay for improving these social outcomes?

What’s missing from the Issues Paper?

Overall we think the scope of the Issues Paper is broad and fairly comprehensive.

We do note that there is an absence of focus on/strategies for specific populations – for example, cultural and regional groups – ATSI, CALD, LGBTIQ, regional and remote. We believe that there also needs to be national strategies for improved mental health and wellbeing outcomes for these (and possibly other) specific communities where current outcomes are poor; we believe there is good evidence that strategies of this nature are necessary and can make a significant difference.

¹We acknowledge that the slightly different emphasis may relate to the need to reflect the Productivity Commission’s overall remit in the terms of reference for this inquiry.

Aftercare Response

It may be that specific introduction of these dimensions in the Inquiry would create too complex a scope, but we think consideration should be given to a recommendation that further work include development of key national strategies like these (led by/in conjunction with the relevant communities).

Inquiry Approach

In this paper **we respond to several of the questions posed in the Productivity Commission Issues Paper.** Where we do this we have used the below format and shown the relevant Issues Paper page number:

P10: QUESTIONS ON ASSESSMENT APPROACH

- *What suggestions, if any, do you have on the Commission's proposed assessment approach for the inquiry? Please provide any data or other evidence that could be used to inform the assessment.*

We generally support the Inquiry's assessment approach. At a high level the inclusion of direct costs (cost of human services), costs of reduced economic participation and intangible costs is an appropriately broad framework.

We also agree with the Issues Paper that "Many of the costs of mental ill-health are intangible" and that "these are difficult to value in monetary terms" (page 8). The Issues Paper suggests "we may need to assess their magnitude in other ways (such as by considering disability-adjusted life year measures (DALYs))."

We've already introduced some key philosophical questions relating to the Inquiry scope (page 5 of this paper), including:

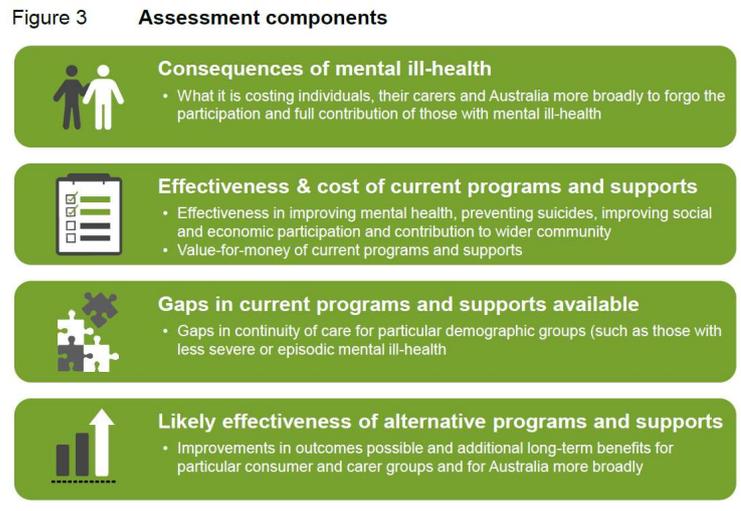
- Do we value improved social participation in isolation from economic outcomes?
- How should we define our social outcome objectives, and how should we measure these?
- How much can Australia afford and how much should Australians be prepared to pay for improving these social outcomes?

There is a critical issue in deciding how we value non-economic outcomes. The Issues Paper suggests DALYs as one method. There are a range of other mechanisms that have been developed in response to this issue (for example, Social Return on Investment or SROI).

While we don't have many better proposals, we don't love DALYs or similar approaches.

- From prior experience **we're not convinced that Treasury** (for example) **seriously values improved DALYs** when considering options for investment. In considering any measurement proxy or assessment approach, one key question for the Inquiry might be – how will this measure inform policy or investment decisions?
- We think that **attempts to calculate proxy values** like DALYs or SROI **sometimes detract** from a simpler and often more meaningful question: **what are we trying to achieve, and are we making progress?** We think we sometimes fail to effectively define the social outcomes we are collectively aiming for. Many of the Issues Paper questions do point to this kind of thinking.

We make one further point about the Inquiry approach, which relates to **Figure 3 – Assessment Components** (page 7):



This figure suggests a very “program-focused” approach overall – that is, that individual programs are more or less effective and there may be gaps between programs.

In our view we need to have a strong focus on higher-level thinking. One of the key issues in the current system is precisely that our approach is broken down into a myriad of fragmented programs, and that **stronger whole-of-person** and in many cases **whole-of-community strategies are needed**.

Recommendations

With reference to Figure 3 above – we recommend **consideration be given to adding a fifth element** to the assessment components used in the Inquiry:

- **Opportunities for stronger systemic strategies:** What improvement in outcomes can be gained through:
 - better integrated services and supports designed around individuals?
 - clearer whole-of-community mental health strategies (in specific high-risk communities)?

We also expand on these ideas in later sections.

Throughout this response we summarise our key recommendations in blue boxes like this one.

3. Contributing components to improving mental health and wellbeing

Healthcare

P13: QUESTIONS ON STRUCTURAL WEAKNESSES IN HEALTHCARE

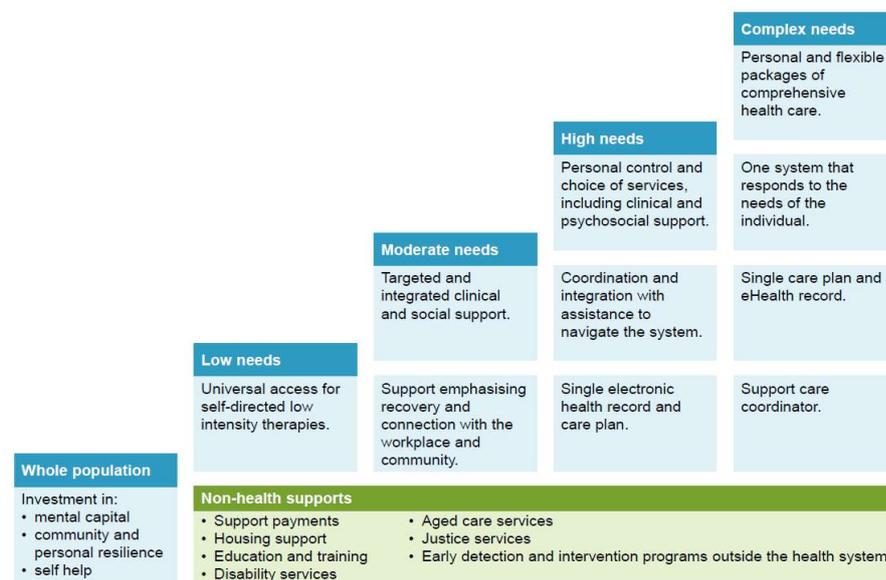
- Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?
- What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity?

“Structural Weaknesses”

Our first comment is that a part of the answer to the question “why have past reform efforts . . . had limited effectiveness in removing the structural weaknesses **in healthcare** . . .” is embedded in the question – that is, that people with a mental illness interact with a range of informal supports, community, services and systems *and not just healthcare services*.

The structural weaknesses stem in part from viewing the healthcare system/healthcare services in isolation. Take, for example, the Issues Paper’s own **Figure 5: Stepped Model of Care** which includes many elements that are not healthcare services or healthcare-funded:

Figure 5 Stepped model of care



Source: Adapted from (NMHC 2014a).

We will comment further on this the need to better integrate health and other services in later sections, and limit our comments in this section to healthcare services.

Fragmentation of Service Funding

There is merit in the concept of “local health districts” – whether the Federal PHNs or State LHDs, HHSs etc. The ideal of local, integrated health (and mental health) strategies is the right direction.

Aftercare Response

However, there is a **strong lack of clarity/confusion** in implementation about the roles of each of the Federal (PHN) and State Local Hospital Network (LHN²) bodies when it comes in particular to mental health strategy and funding. In our recent experience:

- There is a lack of clear regional strategy for mental health in many/most regions. In our experience there is little correlation between Federal mental health strategies and needs assessments and LHNs' MH strategies and needs assessments. Where these do have commonality there is generally variance in what is funded due to opposing perspectives of priorities.
- There is very significant overlap in perceived role - PHNs and LHNs often tender for similar services without reference to the other; we have at least one recent experience where we could submit the same proposal to either body.
- In at least one case we are aware that a PHN mental health branch and the State equivalent were not even on speaking terms - each would openly criticise the other.

The **costs to "the mental health system" are on several levels**. Most simply there is a bureaucratic cost to having two or three teams (one PHN and one or more LHNs³) with overlapping roles. However, we believe the costs to improved outcomes are far greater.

From a not-for-profit service provider perspective the Federal-State divide in mental health not only causes confusion about local strategies but also means that **we have far greater tender, compliance, reporting and relationship costs** than would otherwise be the case. In Aftercare's case we operate in 16 PHN districts with close to 30 State equivalents. These all operate different strategies with different tender processes, different reporting requirements and different stakeholder complexities. The quality of the mental health teams in these agencies varies widely.

This issue is **exacerbated by the introduction of the NDIS** and the corresponding reduction in "other" mental health funding available - it means that local grant tenders are for less money, increasing the relative cost in the duplication of effort and the lack of strategic clarity.

If we could overcome the politics of our national Federation model, we would recommend the **integration of regional mental health strategies, funding and reporting**. Any model considering this would need to create mechanisms to ensure effective coordination with PHNs and LHNs - it's imperative that there is effective integration with policies and other services administered by both.

Constant Change/Short-Termism

For decades Aftercare has operated with the **ongoing uncertainty of short-term funding contracts** - often annual. In many cases a funding contract is not determined for a new financial year until within weeks of the new year starting (and in some cases, not until after the new year has started). We are again in a situation as we submit this response where several key services don't have funding confirmation (one way or the other) for next year at all, many more have a verbal confirmation but as yet nothing in writing.

As a direct consequence:

- there is **enormous uncertainty created** for our **staff** and ultimately for our **service users and carers**. Each year we've seen a spike in staff turnover in the April - June period. We can go some way to quantifying this effect:
 - In previous years our total staff turnover in April-July has approached 50% pa (annualised turnover) - this includes end-of-contract turnover (where funding was not renewed) and voluntary turnover (staff resigning for another role usually with more security). More than half our turnover was the latter.

²Eg LHD (NSW), HHS (Qld) etc

³PHNs sometimes have 1:1 geographic overlap with State equivalents; often 1:2)

Aftercare Response

- In March 2018 we made almost all our service staff roles permanent⁴. Our annualised turnover is now just below 20%. We will see in coming weeks whether there is a spike in turnover this year – many staff know their service does not yet have future funding confirmed, and there is still the risk of turnover in these teams (in spite of permanent employment contracts).
- our **ability to make long-term plans and significant investment** in capital or service improvement is highly limited.
- our ability to make **effective longer-term strategies** is also limited.

In the bigger picture, this short-termism also hurts client outcomes because **it takes time to establish effective services** (especially “integrated” services, where relationships and referral pathways etc take time to develop) and **develop evidence of delivery of outcomes**.

In addition to the short-term (often annual) issue of grant funding uncertainty, **changes in governments** impact full evaluation of reforms due to changes in government priorities and commitments.

We recommend the development of **longer-term funding investment** models (5-10yrs), especially for established models with robust evidence of efficacy. These longer-term contracts would have minimum performance expectations built-in but subject to this create certainty for the service provider, the community and individuals supported by these services.

Quality of Tendering/Commissioning

We’ve already commented earlier this section about fragmentation of MH funding across PHNs and LHNs, with one implication that in our opinion there is **high variability in commissioning processes and quality**. We’re aware that we are not alone in this view.

We would recommend the **development of stronger national standards** for commissioning; training for commissioning staff; provide clearer and more nationally uniform data/evidence where possible; and implementing a commissioning quality audit framework.

Public Service Distrust of Community Services’ Clinical Quality

In several recent (over the past 12 months or so) cases we have tendered for service provision for services with residential or community dimensions, but also requiring clinical service provision in an integrated service model. These opportunities include opportunities where we were invited to present a service model to a specific funder.

In several of these cases we have proposed providing clinical services elements as part of our tender service model to address the specific needs of the identified cohort. In our view we could provide a much stronger integrate service with direct provision of the clinical service component than by working with a range of public health system clinicians.

In more than one case **our tender proposal has been rejected** and the feedback provided (we’re paraphrasing) was that **the funder did not trust a “community mental health service provider” to provide and effectively govern clinical service components**. This is in spite of the fact that the managers named in the tender in some cases have 20 years + public health service clinical service provision experience, and in many cases, stronger experience than their equivalents in the funding body or public health service.

⁴Aftercare made the decision to make staff permanent in spite of short-term funding contracts, absorbing the risk of high redundancy costs, with the aim of improving staff engagement, reducing turnover and being a better employer.

LHNs in particular highlight the impetus of hospital avoidance to better service communities acute and complex needs, yet dismiss this opportunity to engage with community services to meet this agenda.

We recommend consideration be given to **overcoming the common mentality** in public health services that only the public system can provide high quality clinical service provision and governance.

Failure to Create an Effective “Learning System” – Pilots to Scale

The Issues Paper context statement includes the following:

*“Mental health in Australia is characterised by . . . a variety of programs and supports that have been **successfully trialled or undertaken** for small populations **but have been discontinued** or proved difficult to scale up for broader benefits.”*

- Issues Paper, Page 1

We wholeheartedly agree! As we submit this paper we have at least five current examples of services established effectively as pilots to address specific mental health issues in difficult communities. All have been operating three years or less. Several can demonstrate successful growth in client numbers and occasions of service, strongly integrated services, growing trust in referral pathways and early positive outcomes. **All face funding ending in the next year (three by end June).**

The systemic issue we face is that even where there may be pockets of “innovation” or establishment funding, the pathways to continuity, scale and replication are haphazard at best.

There is much we could learn from the venture capital innovation framework⁵. Innovation funding or “venture” capital is best structured with clear gateways to a second and third stage of funding; initiatives meeting gateway criteria should have much stronger certainty about future funding.

Instead we think tens of millions of dollars are wasted each year with piecemeal “innovation” grant funding and a lack of clarity about objectives and success factors. Good ideas are not encouraged and go to waste. A consequence of this is communities’ distrust of newly established services resulting in a delay in engagement and therefore ability to demonstrate efficacy.

We recommend **developing a “learning system”** by:

- Developing a process framework for piloting service innovation with clear gateways for continuing to subsequent stages and mechanisms for scaled adoption.
- Overlaying a national framework for pilots that might be tested in different/relevant PHN/LHN regions so that there can be significant investment in key pilots with successful models adopted across PHNs/LHNs.

⁵Eg hbr.org/1998/11/how-venture-capital-works

Recommendations

To address **structural weaknesses**, our suggestions are:

- **Reduce overlap** between PHN (federal) and LHD/HHS etc (State) funding and responsibilities/ **increase clarity** about respective roles/better integrate these.
- Create **longer-term funding models** (for example, with minimum performance/outcomes criteria) and stronger certainty for service delivery agencies.
- Improve the **quality and consistency of commissioning processes** – develop national standards; conduct training for commissioning staff; provide clearer and more nationally uniform data/evidence where possible; implement a quality audit framework.
- Develop a “**learning system**” by:
 - Developing a process framework for piloting service innovation with clear gateways for continuing to subsequent stages and mechanisms for scaled adoption.
 - Overlaying a national framework for pilots that might be tested in different/relevant PHN/LHN regions so that there can be significant investment in key pilots with successful models adopted across PHNs/LHNs.
- Consideration be given to **overcoming the common mentality** in public health services that only the public system can provide high quality clinical service provision and governance.

Early Intervention

P16: QUESTIONS ON SPECIFIC HEALTH CONCERNS

- *Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?*

Increasing investment in early intervention is the most significant opportunity for improved social and economic outcomes we have, and yet this remains almost completely ignored in Australia today.

Unresolved infant and childhood trauma and developmental disadvantage are **causes of lifelong mental illness** and result in an enormous burden both for Australian families and for Australia’s health, education and social systems.

- Three in four **adult mental health conditions** emerge by age 24 and **half by age 14**⁶.
- **1 in 7 Australian children exposed to toxic levels of stress.** Triggers of childhood stress such as domestic violence, divorce, bullying and developmental conditions contribute to **54% of Australian children exhibiting psychological distress**. 17% of Australian children suffer from **abnormally high levels** of psychological distress⁷.

⁶Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR & Walters EE (2005). Lifetime prevalence and age of onset distributions of DSM-IV Disorders in the National Comorbidity Survey replication. Archives of General Psychiatry, 62, p 593. See also www.youthbeyondblue.com/footer/stats-and-facts.

⁷Department of Health, Canberra, 2015 (David Lawrence, Sarah Johnson, Jennifer Hafekost, Katrina Boterhoven de Haan, Michael Sawyer, John Ainley and Stephen R. Zubrick), The Mental Health of Children and Adolescents.

Aftercare Response

- A traumatic experience has a profoundly adverse impact on a child's developing brain - disrupting the development of neurological networks so severely that emotional, social, behavioural, cognitive and physical **functioning of a child can be permanently impaired**.
- **Access to quality psychological services is poor in low-socio economic areas**, which can "lead to doctors prescribing more antidepressants in areas where patients could not afford the gap payments for psychological therapy". The number of **Australian children on antidepressants has doubled** to more than 100,000 in the last six years.⁸
- As many as **13 out of every 30 students** in an average classroom will have toxic stress from 3 or more traumatic experiences. In communities with high poverty the figures are higher. Compared with children with no adverse childhood experiences these children are 3 times more likely to fail, 5 times more likely to have severe attendance problems, 6 times more likely to have severe behaviour problems and 4 times more likely to report poor health.⁹

There is overwhelming evidence that is (in our experience) widely accepted by researchers, policy-makers, bureaucrats and politicians alike that directs us towards early childhood, but **there is no systemic response ensuring quality early intervention**. This is especially true in high needs/low socio-economic areas.

Our Experience: Trying hard, but no systemic support

Aftercare has – with modest grant support and with its own funds – operated a pilot service focused on early childhood and family for about three years. Through **The Poppy Centre** we are piloting provision of clinical and related mental health early intervention and support services to hundreds of children aged 0-11 and their families.

"I just wanted to say thank-you. When I started Circle of Security I said I just wanted to be a better dad. Thanks to you I hope I can be. I have been struggling with depression for six months and one of the main causes was how poor a parent I felt I was being because I didn't know a better way. <You> helped ease one of the main causes of my depression." Father/Poppy Client 2018

"It wasn't until I started doing this playgroup that I felt like I'm not failing as a parent . . . We have 5 little girls under 5 & although I appear to keep it together, that's certainly not the case. The Poppy Centre validates me as a person and a mother. They understand that I'm not okay and they help me . . . be a better parent to my kids." Mother/Poppy Client 2018

"I know now if he is acting out, then there is a reason, not just because he wants to be naughty. He needs connection, not attention." Mother/Poppy Client 2018

We are also aware of at least one other small service with similar goals. **KidsXpress** is a specialist children's mental health organisation with primary focus on providing Expressive Therapy Programs and Trauma-Informed Training & Education Services. A registered charity, KidsXpress was established in 2005 to address the lack of services available to support children 4-14years who were living with the effects of childhood trauma.

Through the delivery of our nationally accredited and evidence-based therapy, KidsXpress has been recognised as a leading & innovative early-intervention service for children, families and communities. Their therapy programs are delivered centre based and via our outreach programs within schools across Sydney. They also provide Trauma-Informed Training and Education Services to metropolitan, regional and remote communities across Australia.

KidsXpress has been in operation for fourteen years and has relied heavily on philanthropic support to establish and maintain its programs.

⁸100,000 children on pills for depression, John Ferguson, The Australian Feb 23, 2019.

⁹Blodgett, C., Harrington, R., Lohan, J., Short, R., Turner, N., & Winikoff, J. (2013). Adverse Childhood Experience and Developmental Risk in Elementary Schoolchildren.

As we finalise this submission The Poppy Centre's future is in significant doubt; its "establishment" grant funding expires on June 30. KidsXpress has tried for the best part of 14 years to find avenues to scale its programs and impact, but remains heavily dependent on philanthropy.

These are just the kind of programs that can make a substantial difference to Australia's long term mental health burden, but there is no national or state funding program to incentivise early intervention mental health initiatives.

Recommendations

Invest in a national strategy for early intervention with at-risk/ disadvantaged children, families and young people.

- Over 3-5 years invest in action-research - pilot initiatives with rigorous evaluation to test the long-term benefits of early intervention and identify best models
- Over 5 years develop the business case for a national approach to improving childhood mental health with a particular focus on disadvantaged communities
- Build to scale using learnings from headspace/other national initiatives

P16: QUESTIONS ON SPECIFIC HEALTH CONCERNS

- *What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?*
- *What healthcare reforms do you propose to address other specific health concerns related to mental ill-health? What is the supporting evidence and what would be some of the benefits and costs?*

In our experience there is a significant gap for those with **Borderline Personality Disorder** (BPD) – this group falls in the gap between public (not severe enough) and community services (too complex). This is a disorder that most often emerges in adolescence and early intervention demonstrates a significant impact on the developing individual to engage in social and economic pathways. The Australian BPD Foundation and its State chapters (<https://www.bpdfoundation.org.au/>) outline current evidence based programs. Addressing this issue also requires broader community workforce upskilling.

Literature identifies the high proportion of individuals with a diagnosis of BPD who engage in suicidal or self-injurious activities. Dialectical Behaviour Therapy (DBT) has been internationally recognised as an empirically supported treatment for suicidal individuals¹⁰.

We recommend a national approach to supporting individuals with BPD.

¹⁰ Mechanisms of change in dialectical behaviour therapy and cognitive behaviour therapy for borderline personality disorder: a critical review of the literature, Journal of Mental Health, DOI: 10.1080/09638237.2017.1322185; JAMA Psychiatry. 2015;72(5):475-482. doi:10.1001/jamapsychiatry.2014.3039; Borderline Personality Disorder and Emotion Dysregulation 2019;6:3; <https://doi.org/10.1186/s40479-019-0100-9>

Aftercare Response

Health workforce and informal carers

P17: QUESTIONS ON HEALTH WORKFORCE AND INFORMAL CARERS

- *What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and tele-health services be suitable? What prevents greater remote provision of services to address the shortages?*
- *What could be done to reduce stress and turnover among mental health workers?*
- *How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?*

Rural and Regional Workforce

Recruitment and retention of quality mental health workforce in rural and regional areas is a critical challenge – in some cases this is true even reasonably short distances from the metropolitan area.

Aftercare operates integrated service centres in centres including Wagga Wagga and Orange in NSW and Ipswich and Toowoomba in Qld. In all of these, to varying degrees, we face challenges with staffing including attracting and retaining centre management roles and clinical staff (whether directly employed or private practitioners – mental health GPs and allied health - working within our services and billing MBS).

We don't believe there are simple solutions to these challenges. In our opinion we need to be able to provide financial and other incentives in these areas.

In some areas – for example, Ipswich, which is less than an hour from Brisbane – we think there is some potential to trial employment across multiple services/sites, where a practitioner may work 3 days in the metropolitan area and 1-2 days in Ipswich. This model if successful could be extended to more distant areas with an overnight stay.

There is also potential for student placement and graduate programs to focus on some of these communities.

Reducing Worker Stress & Turnover

Aftercare employs a wide variety of staff across community, residential and clinical services and centres. In our experience the key factors in worker stress and turnover include:

- Expectations for unreasonably high “productivity” or client-facing hours, especially under NDIS funding for Core Supports activities (but not limited to this). Modelling of the NDIS suggests expectations are that 85%-90% of worker hours are “billable”. When we construct an “ideal fortnight” our modelling suggests a maximum is in the mid-to-high 70s; this provides for team meetings, clinical supervision, professional development and administration.
- Risk of psychological injury. In Aftercare our Lost Time Injury (LTI) rate is low and we are proud of our overall WHS record; however, risk of psychological injury is now our highest prevalence risk. Factors involved in this risk increasing include:
 - Increasing complexity of clients including under NDIS funding
 - In some cases, lack of data provided by public health services about new clients (meaning we risk operating outside of a safe scope of practice)
 - High productivity expectations
 - Future funding uncertainty creating employment uncertainty (addressed in other sections in our response).
- Keys to reducing worker stress include creating reasonable productivity targets, increasing professional development and training, and providing quality clinical supervision.

Aftercare Response

Professional Development

High quality ongoing professional development and training is a key for high quality workforce attraction, retention and engagement, and critical for quality mental health service delivery.

We believe it's up to us to provide this quality professional development and we feel we are well incentivised to do so (it is a part of our employee value proposition). We may choose in some cases to collaborate with other organisations to create professional development programs at high quality and reasonable cost.

- Our main issue is again financial. In some funding sources there is room for us to invest in professional development and the investment fits within our grant funds and is acquittable. In many cases the grant funding margin over direct costs is insufficient to contribute to any professional development and this should be addressed.
- A second issue is the time needs for professional development – this is a hidden cost but can be significantly higher cost than the professional development or training program itself. Productivity targets set (whether implicitly or explicitly) in funding models must allow appropriate time for professional development.

In addition to our recommendations below, consideration should be given to improving access to established evidence-based resources such as Mental Health Professionals Online Development (MHPOD) for all sectors working in the mental health space.

Recommendations

Tailor funding models to provide service providers with the resources necessary to:

- Provide financial and other incentives for workers in rural and regional communities. Build into grant funding models a **loading for employment in regions** where employment and retention proves difficult.
- Provide appropriate **clinical supervision** to workers in mental health support roles.
- **Provide reasonable productivity (client-facing) hours**, allowing for supervision, professional development and administration; specifically, funding models must allow for *at least 20%* of hours to be non-client-facing (non "billable" under NDIS funding).
- In grant and NDIS funding models provide **2% of salaries and wages costs for professional development**; in grant funding this *could* be subject to an acquittal demonstrating the funds were spent accordingly.

P17: QUESTIONS ON HEALTH WORKFORCE AND INFORMAL CARERS

- *Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity?*
- *What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits?*
- *What changes should be made to how informal carers are supported (other than financially) to carry out their role? What would be some of the benefits and costs, including in terms of the mental health, participation and productivity of informal carers and the people they care for?*

Workforce restrictions

With the transition of the Mental Health Nurse Incentive Program (MHNIP) to PHN funded services, credentialed Mental Health Nurses (MHN) have lost their Medicare provider number. This has

Aftercare Response

significantly decreased the workforce options for skilled mental health clinicians to provide services within the scope of psychological therapies.

We recommend reinstating the right to hold a Medicare provider number to credentialed MHN.

Informal carers

Informal carers provide a strategy to support individuals living in the community with a stable, supportive connection. To enable carers to provide this essential function they require skilling in recognising symptomology, managing difficult behaviours and be supported through a network to reduce carer compassion fatigue. The benefits of this include a more engaged carer support system for individuals resulting in improved community supports reducing need for services for low intensity needs; improved relationships which impact social engagement; and reducing compassion fatigue on behalf of carer due to increased capability and capacity to fulfil role.

Housing, income support and social services

P19: QUESTIONS ON HOUSING AND HOMELESSNESS

- *What approaches can governments at all levels and non-government organisations adopt to improve:

 - support for people experiencing mental illness to prevent and respond to homelessness and accommodation instability?
 - integration between services for housing, homelessness and mental health?
 - housing support for people experiencing mental illness who are discharged from institutions, such as hospitals or correctional facilities?
 - flexibility of social housing to respond to the needs of people experiencing mental illness?
 - other areas of the housing system to improve mental health outcomes?*

P21: QUESTIONS ON SOCIAL SERVICES

- *How could non-clinical mental health support services be better coordinated with clinical mental health services?*
- *Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?*
- *What continuity of support are State and Territory Governments providing (or plan to provide) for people with a psychosocial disability who are ineligible for the NDIS?*

We have made **detailed comments in Section 4** describing the need for better wholistic views of mental health and non-health service provision and supports which apply in the case of people with a mental illness at in need of housing support and other social support services.

We have also commented elsewhere (in Section 4, and on page 11-12) about the need for greater coordination of clinical and non-clinical mental health services.

With regards to **housing**:

- There has been a very substantial lack of regulation and quality control in adult social housing (eg "boarding houses") for decades; these services house many people with complex mental health needs. Controls have tightened in recent years and some boarding houses have been forcibly closed as a result, but there are still many providers of social housing who are not qualified to support residents' needs.
- There is (as is widely recognised) a very substantial lack of social housing options.

Aftercare Response

Gaps around the NDIS

There are – or will be – enormous gaps for people with psychosocial disabilities not qualifying for the NDIS.

- **Aftercare is a very significant Personal Helpers and Mentors Service (PHaMs) and Partners in Recovery (PIR) provider** with a total of about 25 service sites across these federal programs. We are now well advanced in NDIS transition for these service users.
- **Based on our progress and projections, we estimate:**
 - **30-40% of PHaMs clients will be ineligible or refused** for NDIS (including a small percentage declining to apply);
 - **Around 30% of PIR clients will be ineligible or refused.**
- The **total value of Continuity of Support (COS) funding** announced by the Federal Government is, on our calculation, **about 5% of the funding previously allocated** to PHaMs and PIR services¹¹.
- This means **there will be a gap of 25-35%** - this will diminish over time as service users exit COS services, but it will be a **very significant gap** emerging during the 2019-20 financial year¹².
- Similarly, the **National Psychosocial Support** measure (for “future” clients not eligible for NDIS) is also funded to about 5% (order of magnitude) of the previous federal measures¹³. We anticipate that this funding will prove greatly inadequate over time – in simple terms, 30%+ of community members that may have been supported in the past by PIR or PHaMs will be supported through 5% of the previous funding.

Recommendations

Review the psychosocial service resourcing for those who do not qualify for the NDIS.

- We recommend **the Inquiry seek to understand the assumptions and modelling** that has been used to determine the resource allocation quantum for NPS and COS measures – and **make this transparent** so others may also comment and so that service providers can better plan for continuity of client support.

¹¹Calculations also include Day 2 Day Living (for which Aftercare is not a service provider).

¹²The timing for the emergence of this gap is delayed because the recent announcement (March 2019) of an additional \$121m for ongoing transition of clients will effectively help fill the gap during 2019-20.

¹³We note that the NPS measure was to be “matched” by State funding – we believe that much of the “matching” is actually existing rather than new funding.

Aftercare Response

Child protection

P25: QUESTIONS ON CHILD SAFETY

- *What aspects of the child protection programs administered by the Australian, State and Territory Governments are the most effective in improving the mental health of people in contact with the child protection system?*
 - *What, if any, alternative approaches to child protection would achieve better mental health outcomes?*
-

Aftercare is a provider of 24-hour residential mental health support services for young people. In our experience there is a **drastic need for more specialist mental health residential services for young people in State care.**

We are aware of at least one State exploring increasing the provision of specialist mental health services like these. Such services are more expensive than “standard” out-of-home care but should be considered as a potential overlap of (collaboration of) mental health and child protection funding.

The long-term negative outcomes for people in and exiting State care are well documented. Many of these issues have mental health causes.

Recommendations

We urgently recommend investment in specialist residential mental health services for young people in State care.

Skills acquisition and employment

Education

P26: QUESTIONS ON EDUCATION AND TRAINING

- *What are the key barriers to children and young people with mental ill-health participating and engaging in education and training, and achieving good education outcomes?*
 - *Is there adequate support available for children and young people with mental ill-health to re-engage with education and training?*
 - *Do students in all levels of education and training have access to adequate mental health-related support and education? If not, what are the gaps?*
 - *Do teachers and other staff in schools and education facilities receive sufficient training on student mental health? Do they receive sufficient support and advice, including on the quality and suitability of different approaches, to adequately support students with mental ill-health?*
 - *What overseas practices for supporting mental health in education and training should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?*
-

Mental health issues have a **major impact on educational attainment**, for example¹⁴:

“A national survey led by The University of Western Australia has painted a bleak picture of the effect of mental disorders on Australia’s school students with the results revealing poorer academic outcomes, more absences from school and more likelihood of self-harm . . .

The survey found **mental disorders affected one in seven students** in the previous 12 months and students with mental disorders scored lower on average than students without mental disorders in every test domain and year level.

Students with a mental disorder in Year 3 were, on average, **seven to 11 months behind** students with no mental disorder but by Year 9 they were an average **1.5 to 2.8 years behind.**”

We know this impact has its **origins very early** and the **issues are widespread**.

Aftercare met recently with the CEO or a large provider of (hundreds) of early childhood education centres. We asked the CEO an open question (not in the context of a mental health discussion) “what are some of the biggest issues on your mind?”. The CEO’s response was “mental ill-health”. The company’s services – the great majority in disadvantaged communities and suburbs – are overwhelmed dealing with mental ill-health in their children. They cannot find services to which to refer students and they are desperately seeking additional training for their early childhood teachers. The issues impact the children with mental ill-health but also significantly disrupt classrooms for other students.

We have made strong recommendations relating to investment in early childhood earlier in this section. To these we would add the following:

Recommendations

To address the impact of mental ill-health on individual educational attainment and on classrooms, we recommend:

- Teacher education (from early childhood centres up) in mental health literacy
- Investment in childhood mental health services linking with schools in disadvantaged communities, particularly early childhood education centres and primary schools (as many headspace services already do for older young people)
- Consideration be given to additional mental health services provided within early childhood and school settings in specific cases.

¹⁴ <http://www.news.uwa.edu.au/2017121810236/study-links-mental-health-poor-school-results>

Employment

P27: QUESTIONS ON GOVERNMENT-FUNDED EMPLOYMENT SUPPORT

- *What alternative approaches would better support people with a mental illness (whether episodic or not) to find and keep a job?*
- *What will the transition to the NDIS mean for those receiving employment support?*
- *How could employment outcomes for people experiencing mental ill-health be further improved?*

“Employment is often an important element of recovery and rehabilitation, which should not and cannot be overlooked. It is widely recognised that mental illness is becoming a common and major disruptive factor in the lives of young Australians. Participation in mainstream education and employment embodies both the recovery and the social inclusion of people with mental ill-health. Extended periods of unemployment and underemployment have serious implications on a young person’s confidence and general mental wellbeing as they transition to adulthood. It has been argued that improving mental health can reduce unemployment and welfare dependency.”¹⁵

Productive employment (at different levels) is a **key factor in improved mental health outcomes** and can be circular – improved mental health is important for employment stability, and gainful employment contributes strongly to improved mental health. Aftercare provides support for people gaining and sustaining employment through a range of services including work with PHaMs/PIR/NDIS and residential service users.

One specific service we provide with a focus on employment outcomes is our Individual Placement & Support (IPS) program – an adjunct to headspace. A 2018 Fidelity review found that we have an **85% placement rate** which is considerably higher than DES programs average –this is attributed to our integrated support stabilising and enabling engagement with work (and education) activities.

We believe there are significant opportunities to improve employment outcomes with well-designed integrated mental health support services.

NDIS and Employment

We think that adjustments will need to be made to effectively promote this goal for **participants supported through the NDIS**; we understand that the NDIA is particularly interested in employment outcomes.

Currently the NDIS payment structure emphasises hours of service over outcomes. There is little (visible to us) definition of desired outcomes or measurement or incentivising of these outcomes.

We believe that the NDIA has some ability to track some outcome indicators – employment is an example – and can see relative performance by provider or by geography and other factors.

We are very interested in exploring with Inquiry (and with the NDIA) how specific outcomes might be progressed for targeted NDIS participants either within current NDIS pricing models and/or with some different funding mechanisms alongside NDIS payment-by-activity structures.

Recommendations

To support engagement with employment, we recommend that funding agencies be more transparent with employment objectives, be more open with performance data and consider alignment of funding with employment outcomes.

¹⁵*Tell them they're dreaming* - Work, Education and Young People with Mental Illness in Australia, Orygen Youth Health Research Centre 2014

4. Framework to enhance mental health and improve participation and workforce contribution

Coordinated care and a fully integrated system

P32: QUESTIONS ON COORDINATION AND INTEGRATION

- To what extent do current governance and institutional arrangements promote coordination and integration of mental health services and supports across health and non-health sectors and different levels of government?
- What are the barriers to achieving closer coordination of health, mental health and non-health services and how might these be overcome?
- Are there aspects of mental health governance where roles and responsibilities are unclear or absent? Are the mechanisms for holding government decision-makers accountable for system performance sufficiently well-defined?

Mental health services in context: The social-ecological model

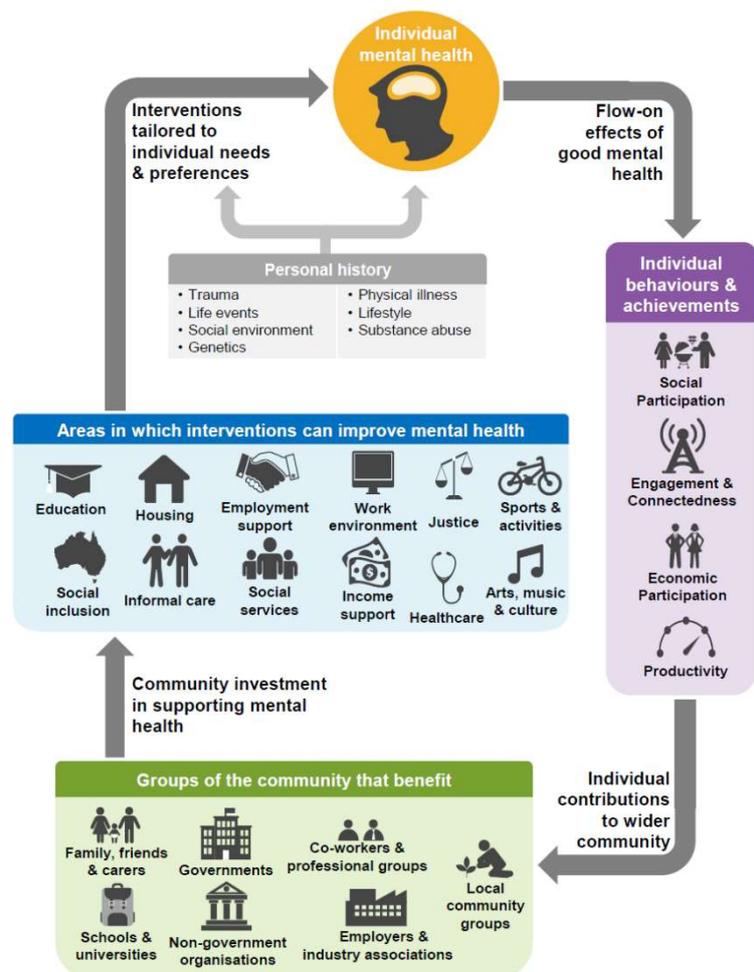
Figure 1 in the Issues Paper (see right) acknowledges a range of institutions and communities benefit from improved mental health, and that a range of institutional and community interventions can contribute to improved mental health.

All of the elements depicted in Figure 1 (and more) are important and relevant context for improved mental health. These elements re-drawn make up the concentric circles of the Social-Ecological model conceptualised by Bronfenbrenner¹⁶ in 1977; this model has been widely referenced and adapted for different purposes since. One version of the Social Ecological Model is illustrated on the following page.

The point of Bronfenbrenner’s model is that an individual exists at the centre of a **complex and interrelated** set of systems ranging from family, friends and local community to more formal supports (health and social) to macrosystems.

We would suggest Figure 1 is partly right and partly misleading. It’s right in that it depicts a circular relationship between elements – for example, improved mental health can lead to stronger participation in employment which can in turn benefit mental health. It’s perhaps less useful in that it separates benefits of improved mental health from interventions – in practice these are much more interrelated.

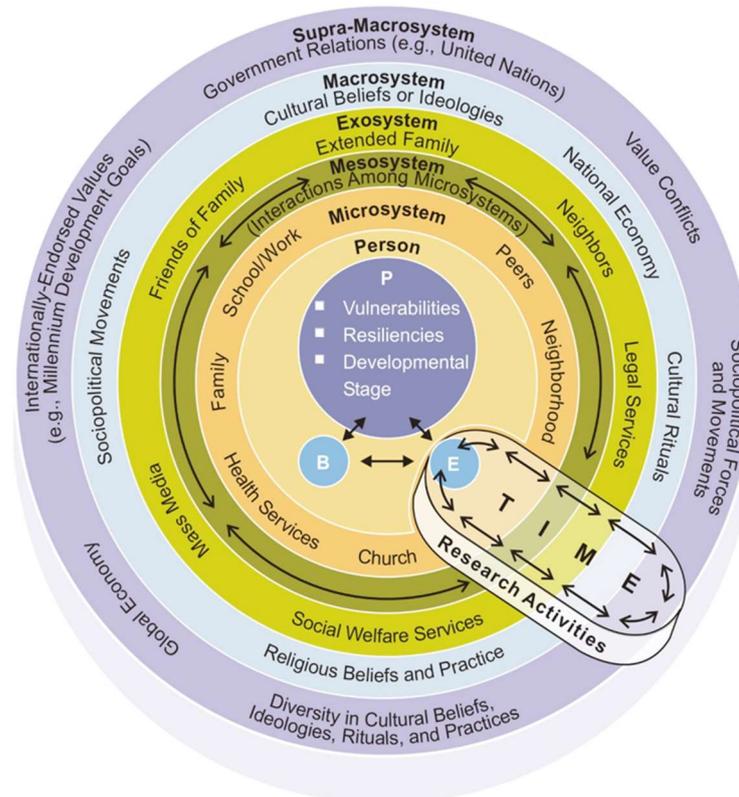
Figure 1 Improvements in mental health can benefit both individuals and the wider community



¹⁶Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. American Psychologist, 32(7), 513-531.

Social-Ecological Model¹⁷

Understanding the person at the centre of a complex web of systems



Integrated Service Provision

What are the implications of the social-ecological model for mental health services, funding and structures?

1. Working with Individuals

- To be effective – *especially* when dealing with complex mental health issues – service providers need to understand the social-ecological context of their service users and be **effective at influencing key aspects of this context** (with the service user and their informal support/s).
- **It's not just "healthcare" services that must be influenced**, but a wide range of informal community elements, non-healthcare services (social services) and others.

Example: Aftercare works with a 50 year-old male with long-term complex mental health needs in a regional community. He has had a long term career in hospital orderly roles, but a recent history of unemployment. After a year or more of clinical support he was ready to return to the workforce and – with our support – was the favoured candidate for an orderly role in the town public hospital. When the hospital conducted its background checks it found a minor element in the man's criminal history that precluded his appointment under their standard rules. We were well placed to provide assurance to the hospital that the man did not pose a risk and could be employed; however, the hospital declined to engage and the man was not employed. The long-term benefit of gainful employment for improved mental health in this case (and many others) cannot be understated – it is this kind of connection that can make the difference in many cases.

¹⁷This version from Psycho-Ecological Systems Model: A Systems Approach to Planning and Gauging the Community Impact of Community-Engaged Scholarship, Reeb et al 2017.

Aftercare Response

- **Fragmentation of service funding** (commented on in “healthcare” in Section 3) **is a critical barrier** to providing stronger integration of services around complex individuals’ needs, especially for those falling outside of the NDIS.
- In addition, **while NDIS funding generally represents an increase in funding support** for those gaining access, we understand that “Support Coordination” NDIS schedule items are not intended to replicate coordination of support activities undertaken in the mental health sector and are not necessarily expected to be sustained or ongoing parts of a Participant’s funding packages over time. Ongoing care coordination of support coordination is essential to help ensure integrated support for mental health Participants.

2. Working in Communities

- There are many advocates for **more wholistic “integrated services” models** of mental health service delivery, particularly in disadvantaged communities where the prevalence of mental ill-health can be double (or worse) elsewhere.
- Aftercare has deep experience in recent years operating **four pilot services** that attempt to provide **integrated mental health services** (one-stop-shop) – all in regional centres.
 - We operate two centres in Qld under the name “Floresco” – one in Toowoomba and one in Ipswich.
 - We also operate two in NSW under the State brand “LikeMind” – one in Wagga Wagga and one in Orange.
- **All of these services:**
 - Operate out of a common premises with street frontage (a walk-in centre);
 - Incorporate a small grant-funded core staff and rely on private practitioners (GPs and allied health) billing MBS for clinical service delivery;
 - Incorporate co-location of collaborative services – for example, employment support services.
 - Provide:
 - A one-stop shop where a range of health (mental health, physical, sexual and drug and alcohol) and wellbeing (social, employment, housing) needs can be addressed seamlessly;
 - A service which initiates social engagement to build confidence and capability followed by warm referrals to community activities;
 - A walk-in centre that accepts self-referral reducing barriers to service access;
 - An identified place to seek support without the associated stigma of being a ‘mental health service’.
- Among these, our work in the **Ipswich community** is relatively unique. In Ipswich:
 - We operate co-located services for all ages:
 - In the “**Floresco**” site, Aftercare operates an integrated service centre (Floresco); we also operate Partners In Recovery (PIR), Personal Helpers and Mentors (PHaMs), NDIS services and other services for adults with persistent mental ill-health and complex needs;
 - Directly across the same road we operate the **Poppy** child and family mental health centre;
 - In the same building we operate the Ipswich **headspace** service for young people.
 - As a result, **we are able to address a wide range of needs** and provide for **service and relationship continuity** – well-known keys to successful service provision and long-term outcomes, for example:

We first met a young woman through our headspace service a few years ago. She became a young mother. Today, her daughter (with mental health needs of her own) is

Aftercare Response

a client of The Poppy Centre; the mother participates in support programs there and also receives support through our Floresco centre services across the road.

- Our integrated services are still relatively new (Ipswich, the oldest, has been operating for about three years). **Learnings include:**
 - A coordinated focus on non-health areas can improve mental health and wellbeing (education, housing, employment support, work, justice, recreation activities, social inclusion, utilisation of informal supports, social services, health care).
 - Evaluations of integrated services like headspace & Floresco highlight the merits of integrated care to address the broader issues that often create the barriers to accessing help and achieving outcomes.
 - It is unlikely that the current model of attracting independent MBS funded private practitioners is sustainable on its own; a different funding model and/or top-up is needed to engage and retain private practitioners particularly in regional centres. Aftercare is trialling direct employment of private practitioners with some improved success but even this model places a financial risk or burden on the service provider that is not recognised in funding.
 - Stronger definition of a minimum data set and sharing of clinical data with public services is needed.

Recommendations

Recognising that people with mental ill-health live in layered context of family/friends/informal carers, formal supports, community and other systems; **invest in models that provide integrated support.**

- **Invest in integration of services/coordination of services for Individuals:**
 - In the NDIS; by ensuring there is a schedule item designed for long-term coordination of support for mental health Participants and that Participants with mental health needs have sufficient funding for this activity
 - For service users not accessing NDIS funding but with complex mental health needs, ensuring there is sufficient funding for care coordination.
- **Invest in developing the service model for “adult integrated services” for Disadvantaged Communities** based on LikeMind, Floresco and similar experience to date:
 - Establish a pilot program pathway with clear objectives and decision “gateways” to test and advance service model/s;
 - Ensure there is sufficient resourcing for the “core” staffing for these services and a funding model allowing sustainable engagement and retention of clinical service providers (GPs and allied health);
 - Invest in an overall evaluation framework for these services;
 - Improve data sharing and collaboration between public health services and integrated service centres.

Funding Arrangements

P36: QUESTIONS ON FUNDING ARRANGEMENTS

- Can you provide specific examples of sub-optimal policy outcomes that result from any problems with existing funding arrangements?
- How could funding arrangements be reformed to better incentivise service providers to deliver good outcomes, and facilitate coordination between government agencies and across tiers of government?
- Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved?
- How does the way the Medicare Benefits Scheme operate impact on the delivery of mental health services? What changes might deliver improved mental health outcomes?
- What government services and payments beyond those directly targeted at mental health should this inquiry seek to quantify, and how should this be done?

We have **commented extensively on recommendations for improved funding arrangements** under the section on **“Structural Weaknesses”** from **page 9**. Our recommendations in that section included:

- **Reduce overlap** between PHN (federal) and LHD/HHS etc (State) funding and responsibilities/**increase clarity** about respective roles/better integrate these.
- Create **longer-term funding models** (for example, with minimum performance/outcomes criteria) and stronger certainty for service delivery agencies.
- Improve the **quality and consistency of commissioning processes** – develop national standards; conduct training for commissioning staff; provide clearer and more nationally uniform data/evidence where possible; implement a quality audit framework.
- Develop a **“learning system”** by:
 - Developing a process framework for piloting service innovation with clear gateways for continuing to subsequent stages and mechanisms for scaled adoption.
 - Overlaying a national framework for pilots that might be tested in different/relevant PHN/LHN regions so that there can be significant investment in key pilots with successful models adopted across PHNs/LHNs.
- Consideration be given to **overcoming the common mentality** in public health services that only the public system can provide high quality clinical service provision and governance.

We would **add some additional responses to the Issues Paper questions** here:

- In our opinion current arrangements for commissioning and funding mental health services are not delivering the best outcomes for consumers, for example:
 - Significant fragmentation and short commissioning time frames affect the ability of service providers to design evidence-based, integrated services that meet the needs of consumers.
 - Lack of certainty in the funding environment leads to service providers making decisions that put consumer outcomes at risk (e.g. service providers “pulling out” of NDIS Core Supports).
 - Lack of certainty puts consumers in tenuous positions, risking exacerbating mental health conditions.

Aftercare Response

- **MBS:** As has been commented by others, the current MBS allowance for up to ten sessions through the MBS does not have a strong evidence base¹⁸. For many, ten sessions is insufficient.
- **NDIS:** There is currently a wide range of issues facing Participants with NDIS funding, for example, organisations and mental health workers engaged in NDIS delivery are driven by the need to increase productivity over other goals. Service providers must have flexibility to respond to the episodic nature of complex mental ill-health.

Measurement and reporting of outcomes

P37: QUESTIONS ON MONITORING AND REPORTING OUTCOMES

- *Are decision-making forums for mental health receiving high quality and timely information on which to base strategic decisions?*
 - *Is there sufficient independence given to monitoring, reporting and analysing the performance of mental health services?*
 - *What does improved participation, productivity and economic growth mean for consumers and carers? What outcomes should be measured and reported on?*
 - *To what extent is currently collected information used to improve service efficiency and effectiveness?*
-

The creation of clear outcome measurement frameworks and tools for mental health service delivery is the holy grail of systemic improvement.

An earlier version of the National Mental Health Strategy stated that “In the mental health sector, explicit measures should be developed to assess service quality and track progress against desired outcomes”.

The Nous Group 2018 report for NMHC demonstrated some progress, but the outcomes defined are skewed towards system and population level outcomes; the framework does not naturally form the basis of an outcomes measurement approach for service providers (particularly non-government organisations) supporting individuals. This gap still remains.

Non-government organisations should be implementing measurement and reporting of outcomes, used to improve their own performance and prove achievement of outcomes to stakeholders. This includes reporting of individual and aggregated outcomes to consumers, their natural supports, funders and other relevant stakeholders (where appropriate).

Currently, a key mechanism for enabling outcomes measurement is through funding contracts. However, measures in funding contracts are typically input, activity or output-related (e.g. occasions of service; staff numbers). This currently collected information can theoretically be used to understand and improve **service efficiency** but has limited use for improving **service effectiveness**. This needs to be resolved.

In addition there is little consistency across the community mental health sector. This results in an infinite number of measures being used and no effective way to compare efficacy across services or regions to effectively evaluate models of service.

¹⁸Medicare-funded mental healthcare needs major re-think, health experts say, ABC News, www.abc.net.au/news/health/2019-04-01/mental-healthcare-needs-major-re-think-experts-say/10957812, 1 April 2019

Aftercare Response

Barriers

There are **many barriers** to creating an effective system of outcome measurement, including:

- Lack of definition and articulation of the intended outcomes of services (from funders and from policymakers).
- Fragmentation of services and of funding bodies (as described earlier in this response) – with two key impacts:
 - Each funder has a different view about measurement tools and processes
 - Each service has different aims and objectives (and therefore requires different measurement approaches).
 - Fragmentation of services also means an individual sees multiple services and service providers. This makes evaluation more and more difficult as attribution of the impact of any individual becomes less and less possible.
- Lack of funding available to design, implement and operate outcome measurement approaches.
- Lack of data capability in service providers (a funding and capability issue).

The outcome measurement challenge for organisations like Aftercare is enormous. In a range of fragmented funding contracts for different funders and different programs we are asked to collect a myriad of data and report in different timeframes – the end result is that we use dozens of different measurement tools (probably relatively poorly). We receive almost no feedback about the data we submit. We also know that at least some of the funding bodies have access to large amounts of comparative data that might help inform our service delivery – but we can't access it.

Solutions

In the context of these barriers, some of the **keys to enabling better outcome measurement** have been described earlier in this response – they include:

- Rationalisation of mental health funding bodies
- Creating more integrated approaches – around individuals and/or around communities. Both of these approaches are more amenable to outcome definition and measurement than fragmented service delivery models.

More broadly, we don't believe the solution is to implement a common, standardised outcome measurement tool across all services/service providers. **Good service providers need the flexibility to create quality measurement frameworks** and report on outcomes in a manner that is appropriate to the scale, intensity and type of service being provided.

This approach would mean funders will need to be adept at reading and comparing different outcome measurement results.

One potential middle ground would be for a collaborative, evidence-based process to **identify a range of "best in class" or high quality outcome measurement tools**, so that service providers can retain flexibility to design their own outcomes measurement approach but selecting at least some tools from the range identified.

Outcome measurement/demonstration of outcomes should be a key determinant of future funding. As described earlier in this response, quality definition and measurement of outcomes can help us solve most key structural issues in our sector including:

- Creating pilot – to – scale pathways, where outcomes help define gateways for access to next stage funding

Aftercare Response

- Improving tender and commissioning processes, where quality demonstration of outcomes determines success
- Providing security for ongoing organisation funding (rather than services being re-tendered every few years, longer term contracts are offered subject to a quality of outcome).

This vision may be years away from our current state – hence “holy grail” – but it is one we must continue to pursue.

Recommendations

In the mid-long term, **better articulate the desired outcomes of mental health service delivery**; create **clear measurement frameworks underpinning these desired outcomes**, and **align funding mechanisms**.

- Funding agencies should better articulate the *desired outcomes* of mental health service delivery (whether at national, State or regional planning levels and in individual commissioning processes).
- Provide in funding contracts for the cost of quality outcomes measurement and, where appropriate, program-level evaluations.
- Improve access to government data sources that may better inform service providers’ outcome measurements.
- Potentially – identify a range of outcome measurement tools and approaches that are considered “best in class”; allow service providers to design measurement of desired outcomes using a subset of these tools.