

Response to Draft Report

Part 2: Keys to System Reform

January 2020

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 nearly 650 staff providing community outreach, residential and integrated mental health services for over 17,000 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 primarily through NDIS with additional grant funding support from *Continuity of Support* and *National Psychosocial Measure* programs (formerly PHaMs and PIR programs) in particular. We also provide community services under several smaller State grant programs.
- **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 six “headspace” centres – Aftercare is the largest operator of headspace centres in Australia
 - For adults: we operate five integrated mental health services centres – two in NSW (under State funding for “LikeMind”) and three in Queensland (two under our own name “Floresco”).
 - For children and families: we operate a pilot mental health centre in Ipswich, called “Poppy”, and a second smaller centre in North Brisbane.

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 Draft Report dated October 2019.

In our initial submission (response to the Issues Paper) we stated that there were four keys to system reform (see page 4). These keys have, to varying degrees, been addressed in the Commission's *Draft Report*.

Our response to the draft report is in two parts:

Part 1: Early Intervention/Childhood Mental Health (separate paper).

Part 2: Keys to System Reform (this paper).

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Contact

Dr Andrew Young
Chief Executive Officer, Aftercare
andrew.young@aftercare.com.au
+61 2 8572 7721

Summary of our Views: Keys to System Reform

Introduction

This is the time of greatest change in the mental health service landscape in Aftercare's 113-year history. The Productivity Commission Inquiry (the Inquiry) is very timely and we welcome the systemic approach taken by the Commission to date.

In our *Initial Submission* made in response to the PC inquiry Issues Paper, we argued there are four keys to system reform. In summary, these were:

1. Invest in a national strategy for early intervention with at-risk/ disadvantaged children, families and young people.
2. Invest in models that provide integrated support.
3. Articulate the desired outcomes of mental health service delivery; create clear measurement frameworks underpinning these desired outcomes, and align funding mechanisms with these outcomes:
4. Reform funding to overcome structural weaknesses in the system and incentivise and support effective delivery of outcomes.

We have **dealt with the first of these keys to system reform in a separate response** to the Productivity Commission Inquiry's *Draft Report* (the Draft Report)– "Part 1. Early Intervention/ Childhood Mental Health". We believe significant investment in early childhood is the absolute key to improving long-term outcomes.

In this paper we will first **focus on the Draft Report's section 5 "Reforming the funding and commissioning of services and supports"**, which relates to keys 3-4 above.

We then **comment on selected other recommendations** from the Draft Report.

Summary

As we consider our key recommendations for system reform (above) and the Commission's *Draft Report*:

- We support the consideration of a **consolidated model for local mental health** strategy, funding and services (the RCA concept), but with some different views about model governance and pathway.
- The Draft Report considers **more innovative and outcomes-based funding**; we encourage the Commission to strengthen these concepts. We also recommend a stronger framework for our "learning system" from pilot to implementation.
- We encourage the Commission to **increase its focus on integrated service models**, which are essential for improving quality of support for service users and reducing confusion, fragmentation and inefficiency in the current system.
- We strongly disagree with the Commission's recommendation headspace funding not be hypothecated. We recommend that we **maintain hypothecation of funding for youth mental health**; there is room for more flexibility in/around the headspace model, but the core concept of the headspace brand should be protected.

A summary of our recommendations is given on the next two pages, followed by detailed responses to the Draft Report.

Summary of Recommendations

1. System Reform

- Create **Regional Commissioning Authorities** (similar to the Draft Report's "Option 2") but with an alternative governance model – either:
 - **Adapt the current PHN model** with improved integration with State services and Departments, or
 - Create RCAs with **independent Boards** and **reporting requirements to both State and Federal governments** (not controlled by either).
- In establishing RCAs, pursue **key principles** including:
 - **Independent, skills-based Boards** including consumer representation underpinned by strong development opportunities at a national level.
 - **Long-term funding models** (for example, with minimum performance/ outcomes criteria) and stronger certainty for service delivery agencies, rather than one-year contracts.
 - **Improve the quality and consistency of commissioning processes** – develop national standards; train commissioning staff; provide clearer and more nationally uniform data/evidence where possible; implement a quality audit framework.
 - **Create national benchmarks** (and definitions) for "overhead" and other provisions in funding. Current PHN contracts often seek overhead allowances at or well below 10% of other costs, and in some cases these allowances include direct costs (not overhead) like local office rent. These rates are unsustainable.
- Over time, **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 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.

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 RCA regions so that there can be significant investment in key pilots with successful models adopted across RCAs.

Over time, we recommend creating a **system-wide measurement framework** that builds a comprehensive picture of progress in improving mental health and wellbeing in communities, and also provides the framework for assessing effectiveness of individual programs and innovations.

2. Other 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 (reflecting the episodic nature of mental ill-health) 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.

Investment in the mental health of young people is core to the Productivity Commission’s objectives and critical to the future of our overall mental health system. We recommend:

- **Maintain hypothecation of funding for youth mental health.**
 - Overall, we believe it’s important to maintain the network of headspace centres and services.
 - Increase PHN understanding of options for flexible elements around headspace core (and, if necessary, review headspace model requirements to ensure sufficient flexibility for local customisation).

Finally, in our earlier *Response to the Issues Paper* we made several other specific recommendations and we are pleased to note that many of these recommendations are consistent with elements of the Draft Report. We have listed these on the last page of this submission and refer the Commission to our *Response to the Issues Paper* for more detail relating to these recommendations.

1. Reforming the Funding and Commissioning of Services and Supports

Discussion

As we argued in our initial submission (response to the Issues Paper), key objectives for system reform include:

- **Reducing overlap between PHN (federal) and LHD/HHS etc (State) funding** and responsibilities/ increase clarity about respective roles/better integrate these.
- **Creating longer-term funding models** (for example, with minimum performance/ outcomes criteria) and stronger certainty for service delivery agencies.
- **Improving the quality and consistency of commissioning processes** – developing national standards; building capacity and skills of commissioning staff; providing clearer and more nationally uniform data/evidence where possible; implementing a quality audit framework.
- **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.
- **Articulating the desired outcomes** of mental health service delivery for consumers and their carers; creating clear **measurement frameworks** underpinning these desired outcomes and **aligning funding mechanisms with these outcomes**.

The Draft Report correctly identifies the key issues in the current funding system, including:

- *To deliver seamless care and support for an individual as their mental health circumstances change requires improved coordination over funding and service delivery by all levels of Government. This includes greater clarity over who is taking responsibility for what. (p42)*
- *. . . funding for other supports such as psychosocial services is extremely fragmented and based on short contract cycles, which make it harder to deliver quality services on a continuous basis to people. Similarly, mental health interventions delivered in schools and other types of community services are funded through a very wide range of programs, which is leading to duplication, inefficiency and unnecessary red tape. (p44)*
- *The mental health system as a whole needs to move toward collecting data on the impacts of mental illness on the functional capacity of people and the outcomes of programs (rather than just activity data) where at all possible. (p48)*

Funding and Institutional Reform: the Two Options

Core to system reform is the need to address the fragmentation and confusion between PHN and LHD/HHS etc responsibilities for mental health funding, services and activities at a local level. The Draft Report suggests two options – in summary:

- **Option 1 Renovate model:** largely a **continuation of the current approach**, with some changes that would give more flexibility to PHNs by relaxing centrally imposed restrictions on their funding pools . . . public hospital and community mental health services would remain the responsibility of State and Territory Governments. Community mental health services (currently block funded) would be activity-funded . . . psychosocial supports (outside of the NDIS) and individual placement and support (IPS) employment services would become solely a State and Territory Government responsibility, with the Australian Government providing additional funding to support this.

- **Option 2 Rebuild model:** most mental health funding held in **regional funding pools controlled by each State and Territory Government** and administered by **Regional Commissioning Authorities (RCAs)**. The purpose of RCAs is to create a seamless mental healthcare system that offers continuity of service for people with mental ill-health and fills gaps in service provision. RCAs would overcome unnecessary and inefficient care discontinuities, duplication and gaps that would otherwise persist at the interface between Australian Government and State and Territory Government responsibilities. These new bodies will be responsible for allocating all mental healthcare, psychosocial and carer supports (except for supports for people receiving NDIS funding).

The Draft Report recommends the second option.

Our view is:

- **Option 1 is not preferred.** In our opinion there are far too many issues (as well as fragmentation and confusion for consumers) with the current local funding/commissioning arrangements and overlaps between State and Federal responsibilities for this system to work, even with some improvements suggested in the Draft Report (see our response to the Interim Report for examples). In addition, since the introduction of the NDIS the magnitude of funding available for local primary/community services is too small to support parallel funding bureaucracies.
- **Option 2 has strengths but should be modified.**
 - We like: **a single local commissioning body** for mental health services in the community bridging the gap between State-funded hospital and other services and Federally-funded programs MBS, NDIS and others.
 - Issue: There are some risks in the proposed **State control** for the RCAs.
 - Historically our experience has been that state entities are very focused on their own “clinical” services and bed-based hospital services, and less interested in the role that community-based mental health services play. The experience of New Zealand establishing Regional Health Authorities and Crown Health Enterprises in the 1990s demonstrated this risk – the structures were disbanded in favour of Primary Health Organisations later.
 - State services are often unwilling to allow independent delivery of clinical service components. They’re often keen to focus community funding effort on reducing the burden on hospitals and other state-funded services (eg limiting referral pathways) and less interested in the wider community mental health view. This could put at risk high-performing community delivered clinical services. Community-based services must be promoted increasingly as a quality alternative to Emergency Department presentations and hospital admissions for mental health.
 - While integration with State-funded services is important, it’s also critical that local service provision integrates effectively with federal funded primary health services including GPs and other MBS-funded services, and with/around the NDIS.
 - Finally, the size and number of RCAs is an important issue. PHN geographic districts may be a better model than the State equivalent (in many cases States have smaller districts). We prefer larger districts as we already deal with 15 PHNs in three States / territories and fragmentation into smaller bodies complicates this. In addition, the smaller the districts the more bureaucratic overhead there is.
 - We note there may also be issues with RCAs being *Federally* controlled. A phase approach of transition would contribute towards mitigating some of this risk and potential loss of existing services, workforce and continuity of support while the model is modified.

- We suggest two alternatives:
 - a different governance model be considered in which the **RCAs are governed by independent, skill-based Boards¹ and not fully controlled by either State or Federal governments, but with reporting requirements for both**, under some form of COAG or similar agreement², or
 - **adaptation of the PHN model** with improved integration with State services and Departments.

Whichever Option and governance model are chosen, there are some **key principles** we believe should be a core part of the future model.

- **Independent, skills-based Boards** including **consumer and carer representation** underpinned by strong development opportunities at a national level.
- **Longer-term funding models** (for example, with minimum performance/ outcomes criteria) and stronger certainty for service delivery agencies, rather than one-year funding contracts, enabling community confidence in continuity of services.
- **Improve the quality and consistency of commissioning processes** – develop national standards; train commissioning staff; provide clearer and more nationally uniform data/evidence where possible; implement a quality audit framework³.
- **Create national benchmarks** (and definitions) for “overhead” and other provisions in funding. Current PHN contracts typically seek overhead allowances at or well below 10% of other costs, and in some cases these allowances include direct costs (not overhead) like local office rent. These rates are unsustainable and risk development of low-quality service models with low-quality management, increasing risks to workforce and service users.
- **Move beyond fixed grant funding contracts** to alternate funding models – see the next section (Outcomes vs Activity) for more.
- **Create a national learning and continuous improvement system** with pilots linked to outcomes (see following section).
- **Staged transition** that minimises disruption to services, providers and consumers.

Block Funding vs Activity vs Outcomes

Much of the discussion in the Draft Report about funding models centres on how RCAs might be funded. We encourage consideration also be given to innovative funding models for community mental health service providers centred on a performance measurement framework that incentivises outcomes.

In discussing funding options, the Draft Report acknowledges there is scope for greater innovation:

So far, this chapter has not taken an especially long-term view of development of innovative payment models for mental healthcare. This reflects the relatively paucity of research and data (both in Australian and abroad) about the relative merits of more sophisticated ways of paying providers of mental health services. But it is worth considering ways in which the healthcare system can support the development of innovative payment models. (p981)

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

¹We generally support the governance principles outlined on page 962 of the Draft Report.

²We note that the Draft Report considered this option and rejected it because “This avoids practical difficulties that have emerged when governments have tried collaborative funding.” We are not aware of the background to this comment. We are suggesting it may be better to overcome these “practical difficulties” than implement the model with solely State ownership.

³Importantly, this framework must replace multiple existing frameworks, not be in addition!

improving the productivity of the mental health system – a key objective of the Productivity Commission Inquiry.

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 in community settings. This gap remains.

Non-government organisations should be implementing measurement and reporting of outcomes, used to improve their own performance and demonstrate 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). A further benefit would be the ability to aggregate data to contribute towards system review and service comparisons, design and improvement – a process which is woefully lacking to date.

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) and collected for relatively short durations of time and not aggregated or shared in meaningful ways. This currently collected information can theoretically be used to understand and improve **service efficiency** but has limited use for improving **service effectiveness and the systems of care**. 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.

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 implements different 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 with minimal data sharing between 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) and a lack of trust on how the data will be applied for future funding decisions.

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 using different tools and different timeframes – the end result is that we use dozens of different measurement tools (probably relatively poorly) and have very little aggregated data sets. 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 and provider contracts
- Creating more integrated approaches – around individuals and/or communities. Both 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 cohort, scale, intensity and type of service being provided and that reflects participant goals and recovery journeys.

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 and replication of evidence-based service models.
- Improving tender and commissioning processes, where quality demonstration of outcomes is a key factor in determining the successful tender outcome.
- 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.

We recommend - in the mid-long term, **better articulation of the desired outcomes of mental health service delivery**; creating **clear measurement frameworks underpinning these desired outcomes**, and **aligning 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). This outcome framework should be developed in a co-design process with NGOs and service users.
- 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 and support meaningful data aggregation.
- 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.

Learning System – Pilots and Outcomes

The PC Inquiry Issues Paper included 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. In the past year we had many examples of services established effectively as pilots to address specific mental health issues in communities of high need. All have been operating three years or less, some operational for less time than the design and establishment phase of the service. Several can demonstrate successful growth in client numbers and occasions of service, strongly integrated services, growing trust in referral pathways and early positive outcomes for providers and consumers. **Funding for two has ended and services closed and one other facing closure by end June.**

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

There is much we could learn from the venture capital innovation framework⁴. 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, their continuity, resulting in a delay in engagement and therefore ability to demonstrate efficacy and contribution towards improving the community mental health system.

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 RCA regions so that there can be significant investment in key pilots with successful models adopted across RCAs.

⁴Eg hbr.org/1998/11/how-venture-capital-works

Recommendations

- Create **Regional Commissioning Authorities** (similar to the Draft Report's "Option 2") but with an alternative governance model – either:
 - **Adapt the current PHN model** with improved integration with State services and Departments, or
 - Create RCAs with **independent Boards** and **reporting requirements to both State and Federal governments** (not controlled by either).
- In establishing RCAs, pursue **key principles** including:
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- Overlaying a **national framework for pilots** that might be tested in different/relevant RCA regions so that there can be significant investment in key pilots with successful models adopted across RCAs.

Over time, we recommend creating a **system-wide measurement framework** that builds a comprehensive picture of progress in improving mental health and wellbeing in communities, and also provides the framework for assessing effectiveness of individual programs and innovations.

2. Responses to Other Recommendations from the Draft Report

Integrated Services

Mental health services in context: The social-ecological model

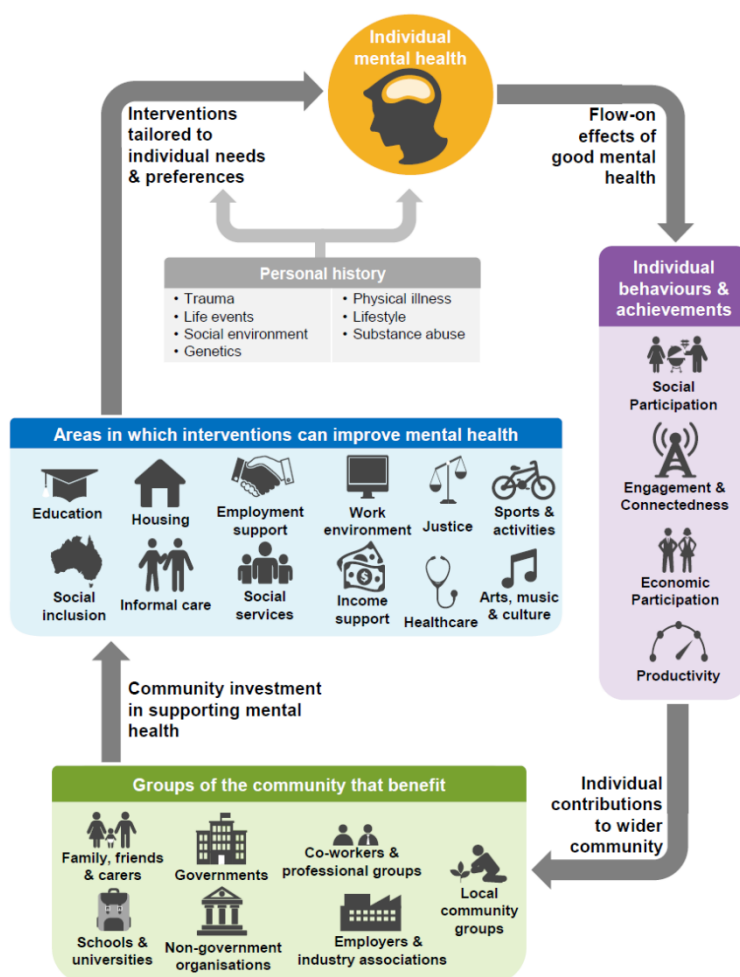
Figure 1 in the Issues Paper (see right) acknowledges a range of institutions and communities benefit from improved mental health, and that a range of institutional and community interventions can contribute to improved mental health.

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 Bronfenbrenner⁵ 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 (at right) 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.

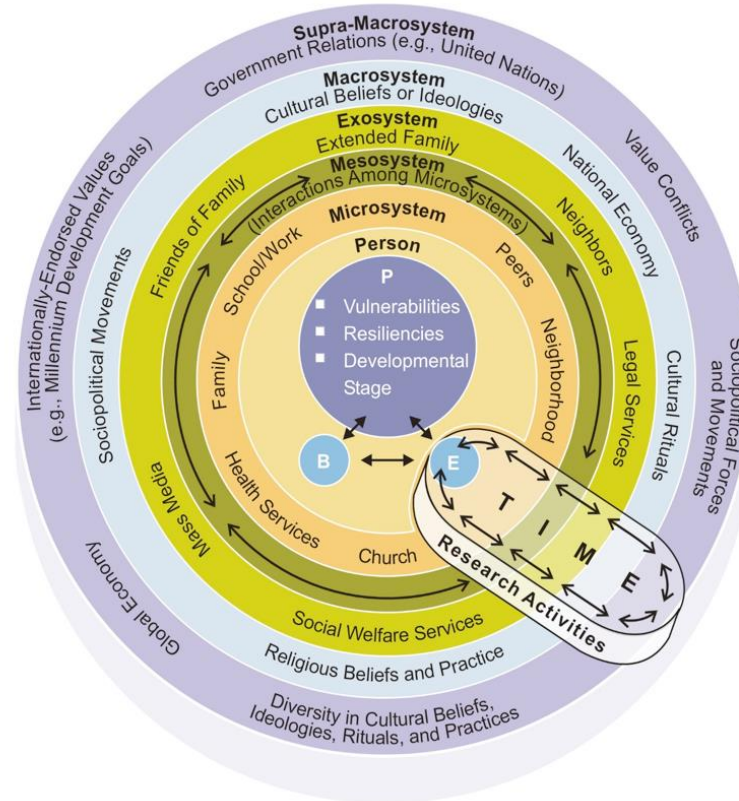
Figure 1 Improvements in mental health can benefit both individuals and the wider community



⁵Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32(7), 513-531.

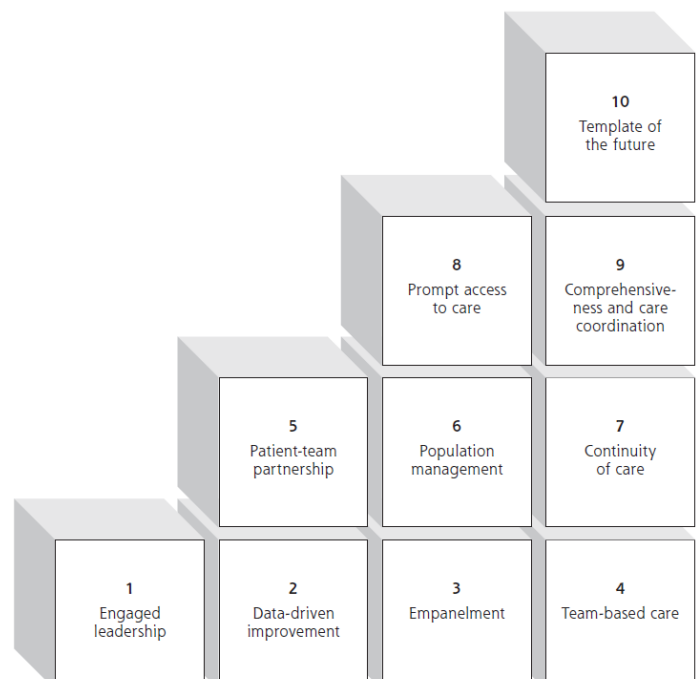
Social-Ecological Model⁶

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



The 10 Building Blocks of High Performing Healthcare (Bodenheimer et al⁷) presents a practical conceptual model towards providing high performing and person-centred services.

The Ten Building Blocks of High Performing Healthcare



⁶This version from Psycho-Ecological Systems Model: A Systems Approach to Planning and Gauging the Community Impact of Community-Engaged Scholarship, Reeb et al 2017.

⁷Bodenheimer, Ghorob, Willard-Grace and Grumbach, Ten Building Blocks of High Performing Healthcare, Annals of Family Medicine March/April 2014.

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 users⁸ 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 and education 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.

- **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. Navigation of health services is identified as one of the greatest barriers to accessing services. 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) than 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 operated two centres in Qld under the name "Floresco" – one in Toowoomba and one in Ipswich. We have recently opened a similar service in North Brisbane.
 - We currently operate two in NSW under the State brand "LikeMind" – one in Wagga Wagga and one in Orange.
- **All 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;

⁸And that each service user has their own recovery journey.

- 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 and reducing cost to secondary services e.g. emergency department presentations;
 - 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 NPS, CoS, 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 simplify consumer access and can 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 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 and psychosocial 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 (reflecting the episodic nature of mental ill-health) 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.

Youth Mental Health services/headspace

The Draft Report recommends that:

The Department of Health should cease directing PHNs to fund headspace centres, including the headspace Youth Early Psychosis Program, and other specific service providers. PHNs should be able to continue funding headspace services or redirect this funding to better meet the needs of their local areas as they see fit.

Aftercare is the (equal) largest provider of headspace services in Australia. **We do not support this recommendation.**

We understand from the Draft Report that the rationale for the recommendation is that:

- At present, about 32% of PHNs’ Mental Health Flexible Funding Pool is devoted to headspace (including the headspace youth early psychosis program) (page 977).
- The Commission believes that PHNs are equally well-placed to determine the use of these funds as the Australian Government (page 978).

The Draft Report also argues that, for at least some issues, PHNs may NOT be well placed to determine the use of funding:

The Australian Government may be justifiably concerned that some PHNs would lack adequate cultural understanding and awareness to commission these programs were they not required to do so. For this reason, the Commission sees merit in maintaining the hypothecation of funding for mental health programs for Aboriginal and Torres Strait Islander people (page 979).

In short, the current situation is that a disproportionate amount of mental health funding is hypothecated to headspace/to youth mental health. We believe there is a very clear case for this allocation of funding – as outlined in the Draft Report:

Mental illness affects people of all ages, but it tends to first emerge in younger Australians – 75% of those who develop mental illness, first experience mental ill-health before the age of 25 years (Page 4).

We believe that it is **imperative that the funding allocated to headspace services be quarantined and protected for addressing youth mental health**. This is critical both for young people and also for the future of mental health in adults. We believe, if anything, there is a very strong case for increasing expenditure in children and young people.

In our view there are many drivers determining the use of funding at a local level – as we have argued elsewhere, one example is that State mental health funding and services are often disproportionately interested in programs that reduce hospitalisation, hospital costs and waiting lists. Yet in that consideration headspace provides the early intervention foundation for reducing young peoples needs on tertiary services in their adult years.

We believe the **Australian Government/the Department of Health must be in a position – at the right time – to implement national policy priorities**. It must be able to – at the right time – direct the use of funds. Our belief is that improving the mental health of Australia's young people is an example of the right policy priority that sits equally alongside protecting the investment in mental health of Aboriginal and Torres Strait Islander people.

If the Commission accepts that a 32% of PHN funding should be quarantined for youth mental health, then **the question that remains is whether this should be directed to headspace, or could equally well be dedicated to other youth mental health services or service models**.

On this issue, we argue that⁹:

- There is **significant value in the national brand of headspace** and the consistent understanding/expectation of young people.
- There are **many elements of the headspace model**, including empowerment of young people in co-design and governance, **that are valuable**.
- **headspace is a core model with significant flexibility** for local context and service implementation.

Recommendation

Investment in the mental health of young people is core to the Productivity Commission's objectives and critical to the future of our overall mental health system.

▪ **Maintain hypothecation of funding for youth mental health.**

- Overall, we also believe it's important to maintain the network of headspace centres and services.
- Increase PHN understanding of options for flexible elements around headspace core (and, if necessary, review headspace model requirements to ensure sufficient flexibility for local customisation).

⁹We support the position of headspace National.

Addendum: Aftercare Additional Recommendations

In addition to the systemic reforms discussed in this paper, in our *Initial Submission* we also made six additional recommendations:

From Aftercare's Initial Submission (April 2019):
Additional Recommendations

1. **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)?
2. 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.
3. **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.
4. We urgently recommend **investment in specialist residential mental health services for young people in State care.**
5. 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.
6. **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.

We are pleased to note that many of these recommendations are consistent with elements of the Draft Report and refer the Commission to our *Response to the Issues Paper* for more detail relating to the above.

While the Draft Report does address the need for growth in mental health residential services in the community, one issue not yet substantially addressed in the Draft Report is the issue of **children and young people in State care** and the **urgent need for mental-health-focussed residential services** for a significant proportion of these (recommendation 4 above). Outcomes for people in and leaving State care without adequate specialist mental health services are appalling; this is a significant issue that should be considered. See our response to the Issues Paper for more information.