Evaluation of National Psychosocial Support Programs: Final Report

Prepared for the Australian Department of Health

2021

Nous Group respectfully acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians and the traditional custodians of the land.

We pay respect to Elders past, present and future in maintaining the culture, country and their spiritual connection to the land.

This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities

Acknowledgement of people with lived experience of mental illness:

We acknowledge those people with a lived experience of mental health issues, their families, friends and supporters who provided input into this report through direct consultation or other methods.

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Executive Summary

Evaluation overview

The National Psychosocial Support Measure (NPS-M) and Continuity of Support (CoS) programs were introduced by the Australian Government in 2019 to provide psychosocial support services to defined cohorts of people with living with severe mental illness. The two programs sit within a myriad of psychosocial support programs across Australia with similar aims but different funding streams via the Australian Government, the state and territory governments and the National Disability Insurance Scheme (NDIS).

The NPS-M program was introduced from 1 January 2019. NPS-M was intended to support people whose psychosocial support needs were not being met by the existing Commonwealth programs, the NDIS, or state and territory psychosocial support programs. It was primarily intended to provide time-limited, recovery-based support. NPS-M funding has supported just over 7,400 people over the period 1 July 2019 to 30 June 2020.

The CoS program was introduced from July 2019 to allow consumers of the Australian Government's ceased programs (Personal Helpers and Mentors (PHaMs), Partners in Recovery (PIR) and Day to Day Living (D2DL)) who were not eligible for NDIS services to continue accessing ongoing psychosocial support. Almost 5,000 consumers have received support through the CoS program over the same period (2019-2020).

The two programs are solely funded by the Australian Government (also referred to throughout this report as the Commonwealth). They provide broadly similar types of services to people living with severe mental illness with similar psychosocial support needs. Both programs were implemented through the 31 Primary Health Networks (PHNs) across Australia, which commissioned or contracted services from local non-government service providers.

The Nous Group (Nous) was engaged to conduct an independent evaluation of the NPS-M and CoS programs, to assess how appropriate, effective, efficient and impactful the programs have been. Nous partnered with the University of Sydney to engage consumers, their families, carers and support people in the evaluation.

The evaluation of the two programs was framed around key lines of enquiry (KLE) intended to draw out a range of aspects that will help build the evidence base on how governments can best deliver psychosocial supports to people with severe mental illness and to inform future directions. The most significant findings against each of the KLE are set out in the following pages, together with the associated recommendations for future consideration.

Overall, the evaluation found that the two programs provided valued psychosocial support for a cohort of people with severe mental illness who were not receiving support from either the NDIS or from state and territory-funded programs. The evaluation consulted with over 500 consumers, carers and family members, the majority of whom were overwhelmingly positive about the support provided through the programs, albeit with suggestions for improvement.

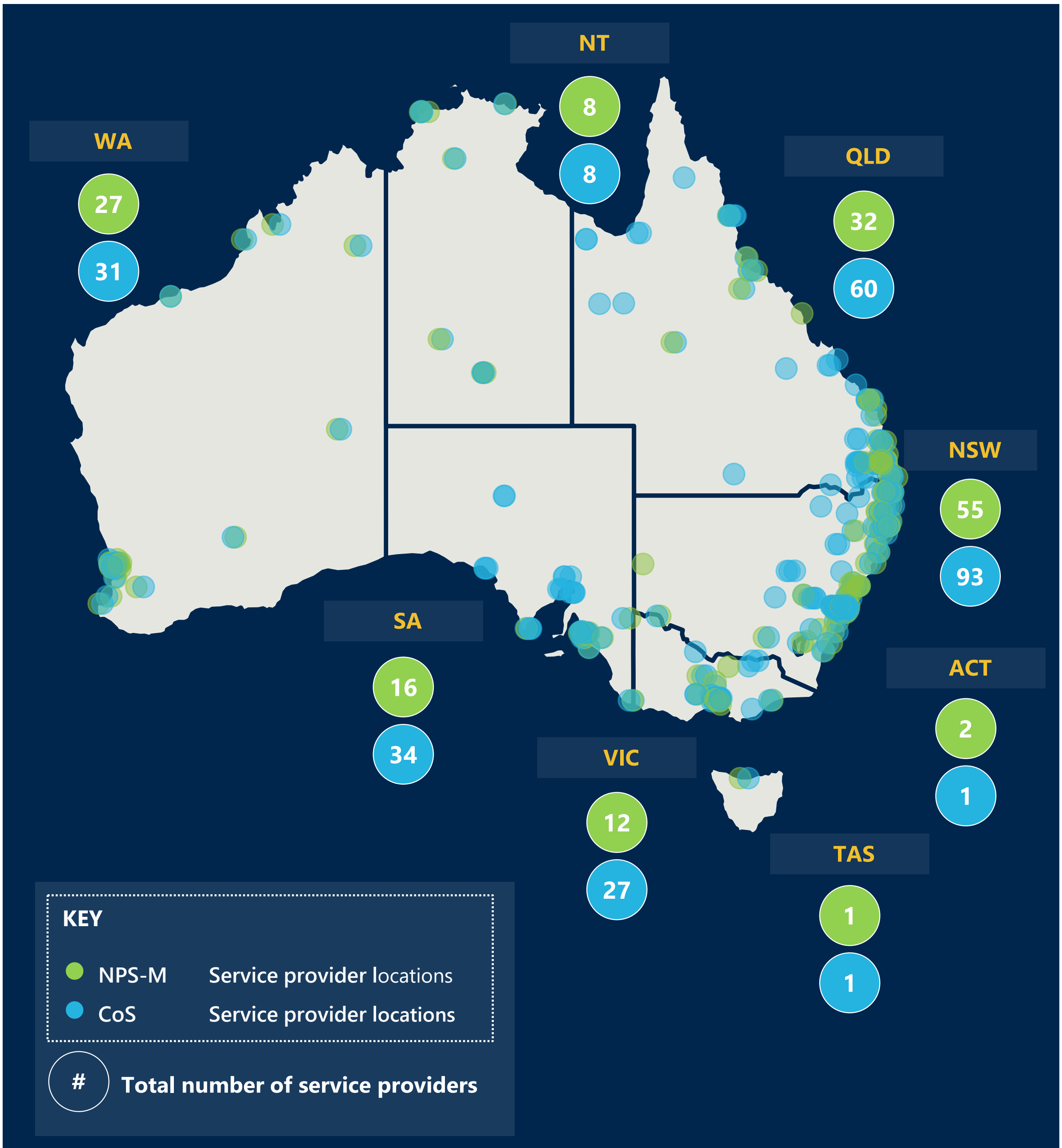
Implementation of the programs through the 31 PHNs was achieved in relatively tight timeframes with short funding cycles, which led to some limitations in program design and commissioning as well as challenges with maintaining a stable and qualified workforce. The maturity of the programs varies significantly across PHNs.

While tailoring of the programs to local needs is a key feature of the overarching approach, the result has increased the fragmentation of service delivery, adding to administrative costs and creating a level of complexity for service providers and consumers. A single funding stream, and a single nationally branded program, would streamline the provision of support in the future.

The evaluation drew on a range of data for the evaluation, including a Literature Review, extensive consultations with consumers and their family/support people, all 31 PHNs, all state and territory governments including their regional health networks, and many other sector stakeholders. Nous prepared individual service profiles of the NPS-M and CoS programs implemented by each of the 31 PHNs as well as summaries of the services provided in each jurisdiction by the PHNs and the state governments. Nous used administrative data including 12-month performance reports provided to the Commonwealth by PHNs. Data in the Primary Mental Health Care Minimum Data Set (PMHC-MDS) was not able to be used as planned and this limited the analyses conducted, outside of observations on aggregate information.

The intended outcomes of the NPS-M and CoS programs include that consumers avoid preventable hospitalisations, have increased social and economic participation, and improved quality of life, health and wellbeing. The NPS-M and CoS program funding has allowed the 31 PHNs to commission service providers across Australia as shown in Figure 1. The number of service providers in each jurisdiction and their geographical location is presented (as reported by PHNs for the evaluation in mid-2020).

Figure 1 | NPS-M and CoS service locations



Service location data collated by the Australian Government Department of Health based on information provided in the PHN profiles (Appendix A). Some locations represent head offices rather than service provision location. Location information represents one point in time as reported by each PHN and may have changed as service providers open and close locations, or establish or discontinue services.

Summary of findings and recommendations

The evaluation findings are summarised below, under each of the KLEs, noting KLE 7 summarises the key features for future psychosocial support and is presented in full in Section 9. The evaluation provides 18 recommendations, presented with the associated KLE findings.

For ease of reference, the evaluation KLEs are:

1 Have the NPS-M and CoS programs been implemented as planned and what are the lessons from the implementation?

2 To what extent have the NPS-M and CoS programs achieved their intended outcomes?

3 To what extent have the NPS-M and CoS services met the needs of consumers, their families and carers?

4 Has the approach to integration of NPS-M and CoS support with other clinical and non-clinical services assisted consumers to access effective care and reduce demand for acute health services?

5 How cost effective are the NPS-M and CoS programs?

6 How is evidence informing NPS-M and CoS service and program delivery?

7 What should psychosocial support look like in the future?

Towards the end of the conduct of this evaluation, the Productivity Commission's Report into Mental Health released its final report.[1] The Productivity Commission's data and findings have been referred to where relevant or appropriate in this evaluation report for context. The broad principles for reform in the Productivity Commission's report (e.g. a person-centred mental system, timely services and support, and care continuity and coordination) are aligned with the evaluation recommendations. This evaluation report presents findings and recommendations based on the data and evidence gathered for the specific purpose of the evaluation.

Have the NPS-M and CoS programs been implemented as planned and what are the lessons from the implementation? (KLE 1)

The NPS-M and CoS programs were each implemented through a commissioning process undertaken by the 31 PHNs across Australia. Both programs were implemented within the required time period across the majority of PHNs. While NPS-M funding announcements were made 12 months ahead of implementation, the timeframes between formal confirmation, receipt of funding and delivery of services were considered tight by stakeholders and created limitations for co-designed planning and effective commissioning. Some PHNs simply rolled over existing contracts for both NPS-M and CoS. Lead times for implementation, particularly for CoS, were condensed to prevent a gap in service delivery for consumers with the introduction of the NDIS and closure of PHaMs, PIR and D2DL. However, PHNs and service providers found that this contributed to market instability and prevented them from co-designing implementation and undertaking joint commissioning.

The Commonwealth's program guidance set out high-level parameters for the programs which allowed PHNs to tailor the implementation of both programs to meet local needs. As a result, there was substantial variability in the way the programs were commissioned and then implemented.

Nous prepared individual profiles of the programs put in place by all 31 PHNs, which reflect the national variability. The profiles (Appendix A) demonstrate that programs were branded differently across PHN areas and had differing intake and exit requirements. Some PHNs combined the two funding streams into a single program, offering tiered psychosocial support packages funded by both programs. Only one PHN joined with a state or territory to jointly commission a program.

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[1] Productivity Commission, Mental Health Inquiry Report, 2020. Accessed via: https://www.pc.gov.au/inquiries/completed/mental-health/report

The variety of service delivery models encountered by the evaluation was to some extent a deliberate feature of program design. There was no common branded program as, for example, with the PHaMs or PIR programs. While the variation reflects the aims of local commissioning, differences were also influenced by a range of additional factors, including differences in the capability and maturity of PHNs, affecting their capacity to plan, partner, monitor and shape service delivery. The local needs of each area differed, as did market and workforce capacity.

The high-level of program variability also resulted in fragmented service delivery and confusion for stakeholders including consumers about what support was available and to who. Some PHNs included additional eligibility criteria, for example, to reduce duplication with state and territory services. Larger service providers who operated across multiple PHNs found the variability increased their administrative burden and complicated communications.

As discussed in KLE 3, consumers valued flexibility within the program. Simpler administration without the loss of flexible support for consumers could likely be achieved (note recommendations below) without the creation of unnecessary variation.

Lessons learnt from implementation point to the need for longer lead times and funding cycles to support market capacity, increasing PHN capacity for joint commissioning, streamlining of funding and programs to increase flexibility for consumer-centred care, and improving data and governance arrangements.

RECOMMENDATIONS:

1. In the rollout of any future programs, longer lead-times (nine- to 12-months) for implementation would enable, meaningful co-design, joint-commissioning, increase opportunities for collaboration and integration, and thus increase effectiveness.
2. Commissioning programs for longer periods of time (five-year funding cycles) would allow for greater stability and certainty across the sector, positively impacting on collaborative arrangements, service provider workforce retention and skills, and consumer certainty.
3. Access to a funding pool to support innovative commissioning or communities of practice – would assist some PHNs with limited capacity to innovate.
4. Program funding that reflects the increased costs of service delivery in regional, rural and remote areas would help PHNs to incentivise a larger portion of the market to respond to procurement.
5. A standardised intake and assessment tool could enable service providers to identify target consumers and to understand when they can be stepped up or down.
6. Simplified and modified reporting (including revisions to outcomes measurement tools) would support increased oversight, create appropriate outcomes monitoring and enable more strategic decisions for future psychosocial support.
7. Clear and regular assessment points during program participation could support recovery, discourage dependence on services and inform better exit processes.

To what extent have the NPS-M and CoS programs achieved their intended outcomes? (KLE 2)

The intended policy outcome for the NPS-M and CoS programs was to enable delivery of psychosocial support services for the defined cohorts of consumers. As noted above, the intended consumer outcomes of the NPS-M and CoS programs include that consumers avoid preventable hospitalisations, have increased social and economic participation and improved quality of life, health and wellbeing.

NPS-M was put in place to provide funding to support people who had not previously received support, and who were not currently receiving support from the NDIS or from state or territory programs. Over the period 1 July 2019 to 30 June 2020 NPS-M has supported 7,412 people, which was close to double the number of consumers anticipated to receive services when modelling was conducted. NPS-M is intended to provide time-limited, short-to-medium term support which in part may explain the higher-than-expected numbers. Nevertheless, there remains unmet need and opportunities for improving the timeliness and appropriateness of the support provided.

The overall funding for CoS provided access to supports for nearly 5,000 consumers over the period 1 July 2019 to 30 June 2020, fewer than the anticipated 8,800 consumers. CoS provided many consumers who were previously accessing support through PIR, D2DL and PHaMs with continued psychosocial support. However, some consumers have disengaged and may have fallen through the cracks during the transition period.

Regional and remote areas have more consumers accessing psychosocial supports for their population compared with more metropolitan regions across both the NPS-M and CoS. Current funding for both programs appears to reflect this with higher levels of funding for regional and remote areas compared to metropolitan areas. However, there is some misalignment between the level of consumers and level of funding that could benefit from further modelling.

Analysis of the National Mental Health Service Planning Framework (NMSPF) suggests that despite psychosocial support being provided through the Australian and state and territory governments (including the NDIS) there is still a substantial number of consumers who are not able to access services.

Separate funding streams for NPS-M and CoS creates an apparent inequity of access with consumers who previously received support through PHaMs, D2DL and PIR accessing services more readily than those who did not (i.e. NPS-M consumers). In particular, some PHNs had substantial wait times for consumers to access NPS-M services which was not the case for CoS consumers. Many PHNs also provided time limited support for NPS-M consumers while CoS consumers could access ongoing support.

In the transition to the NDIS, separate arrangements may have been necessary to ensure that consumers who had been accessing the de-funded Commonwealth programs maintained ongoing access to support. In the post-transition context, the separate funding streams are no longer necessary. The cohorts of consumers are not distinct in their needs and can be accommodated by a single program.

The key distinction between NPS-M and CoS program design has been the exit arrangements. A single program with a standardised approach requiring clear exit timeframes with easy re-entry – as outlined above – has already been implemented by some PHNs.

Data from select PHNs with higher quality data provides evidence that the support provided through NPS-M led to decreased psychological distress. A similar pattern was seen in CoS, though the decrease was not statistically significant. PHNs and service providers noted that the current outcome measures for these programs (the K10+ and K5) may not be the most appropriate due to their language and focus on psychological distress rather than psychosocial function and instead used other assessment or outcome measures that were not recorded nationally.

The NPS-M and CoS programs achieved the intended policy outcome – valued psychosocial support was provided to consumers living with severe mental illness who were not receiving support from the NDIS or state and territory programs. In terms of consumer outcomes, it was not possible to assess reduction in avoidable hospitalisations due to limitations with the available data. Decreased psychological stress was noted for consumers in the programs, however, formal and specific measures of social and economic participation, quality of life, health and wellbeing were not available. Discussion of consumers' experiences relating to increased social and economic participation, improved quality of life, health and wellbeing is addressed in KLE 3.

RECOMMENDATIONS

8. A single funding stream and a single program that combines NPS-M and CoS would improve equity between consumers, decrease fragmentation and reduce administrative costs.

9. Future funding should consider the apparent unmet demand for NPS-M support and consider regional variation and need.
10. Adoption of a more fit-for-purpose outcomes assessment tool, in line with Recommendation 5, would assist service providers and PHNs to understand the extent to which outcomes are being met (and should be determined in consultation with the sector).

To what extent have the NPS-M and CoS services met the needs of consumers and their friends, families and other support people? (KLE 3)

Overall, most consumers who provided feedback for the evaluation indicated they had positive experiences and were very satisfied with the support provided through NPS-M and CoS. They outlined that these programs, when working well, provide unique supports, which can result in a range of positive and practical outcomes.

Consumers valued flexible supports that adapted to their individual and changing needs and included a mixture of individual one-to-one supports and group-based supports. They also wanted supports to be available when needed, person-centred and delivered by support workers who possessed positive characteristics including being respectful, authentic and positive. Consumers consulted for the evaluation outlined that some people need long-term support with soft re-entry points to cater to ongoing or fluctuating needs. Concerns and distress about having to exit the program after a certain time period were common.

Overall satisfaction expressed by consumers was high across all demographic groups. Those living in regional, rural and remote areas rated their overall experience with services more highly than those living in capital cities, other cities and metropolitan areas. One hypothesis is that people in regional, rural and remote areas were perhaps grateful to have received support at all due to general services shortages in their area, potentially influencing their experience. Notably, most consumers were not aware which of the two programs they were accessing.

When consumers felt their needs were not met, they identified contributing factors that included not enough one-to-one support or meaningful socialisation opportunities, high staff turnover or inadequately trained staff, poor transition support and poor coordination between supports. Some of those consulted said that they did not have frequent enough contact with the program. Not everyone received the same supports and opportunities, nor achieved the outcomes they wanted.

The evaluation has collated suggestions for improvement from consumers.

RECOMMENDATIONS:

Future programs would benefit from the following:

11. A single recovery-oriented program that is time-limited but with easy and rapid re-entry if needed.
12. Wider promotion of the programs, perhaps through a common branding and clear description of the services available.
13. Workforce incentives that help to attract a stable and well qualified workforce through competitive wages, conditions, training, support and job stability.
14. Greater attention to managing transitions in services to achieve smooth handovers without gaps in service. Exiting the service should be expected and agreed upon with consumers.
15. The provision of additional allocations of funding to cover the costs involved in NDIS testing for some consumers would avoid the need for a separate program and reduce the need for consumers to transition between programs and service providers.

Has the approach to integration of NPS-M and CoS with other clinical and non-clinical services assisted consumers to access effective care? (KLE 4)

Integration of the two programs with other services for this cohort of people was a stated goal for both programs, particularly NPS-M. The evaluation found many examples of integration mechanisms in place or in development across the 31 PHNs, which are detailed in the PHN profiles at Appendix A. Many PHNs established referral and care pathways.

Successful integration efforts were usually enabled by dedicated individuals or groups who generated shared motivation and strong relationships across stakeholders and clear governance structures to drive integration. Other enablers included the involvement of consumers in the integration process and the development of innovative ways around structural barriers to integration. The level of collaboration/interaction between the state or territory and Commonwealth funded programs varied by PHN: only the ACT jointly commissioned services with the local PHN.

Service boundaries and exclusions were in place between the state or territory and Commonwealth programs. States and territories largely provide psychosocial support for people accessing their clinical services. This prioritisation makes sense from the jurisdictional point of view as the jurisdictions run the clinical mental health services and need to maximise psychosocial support for those consumers in the community and prevent inpatient admissions. Opening state or territory-funded services up to other consumers who have not needed acute care would dilute the ability of the jurisdictions to achieve this outcome.

Because of the exclusion arrangements put in place by many jurisdictions, Commonwealth funded programs may provide a safety net that allows consumers who have not engaged with other mental health services to nevertheless access psychosocial support. This is in line with the Productivity Commission’s recommendation which suggests that access to psychosocial support should not require a mental health diagnosis (and eligibility should instead be based on a functional assessment).

States and territories continue to be the dominant funder of psychosocial support services in Australia and nearly all jurisdictions have program reviews or evaluations in place, which also represents a challenge to integrated arrangements. The potential for gaps and duplication remains.

The key barrier to integration was the fragmented service landscape with funding and governance split across all levels of government, resulting in dispersed accountability and poor incentives to cross-jurisdictional collaboration. Short implementation timeframes, uncertainty about the future of the programs and the pressured context generated by the roll-out of the NDIS impeded the development of the effective partnerships required for integration. Other barriers to integration included mixed understandings of what integration meant in a psychosocial context and a lack of experience, capability and guidance on how to commission for integration.

There are opportunities for further collaboration at all levels of the health system. The evaluation has developed a framework to assist in improving integration. The funding pool recommended at KLE 1, enabling PHNs to draw on support to establish collaborative interface mechanisms, would also assist.

RECOMMENDATION:

16. Strengthened cooperation and mechanisms for collaboration between the PHNs and the state or territory health services, particularly the state regional health networks, are needed to avoid gaps and duplication, and ensure broad coverage across Australia.

How cost effective are the programs? (KLE 5)

While full cost effectiveness analysis was not possible due to the data limitations, several key points can be drawn out from the analysis of available data.

The cost per consumer for NPS-M was lower than estimated when modelling the service ($3,248 vs $6,000) This is likely due to more consumers accessing the service for a shorter period than a full year. The cost per consumer for CoS was higher than expected ($7,385 vs $4,160) and likely reflects fewer consumers accessing the services either because they have not transitioned from NPS-T or did not pursue receiving support through CoS or have transitioned to the NDIS. The cost per consumer of the NPS-M program is on the low end of the range when compared with other psychosocial support services including PHaMs, PIR, D2DL and state or territory-funded programs. The cost per consumer for CoS is in the middle of the range compared with the same programs. The cost per consumer varies substantially between PHNs across both the NPS-M and CoS programs.

PHNs and service providers noted that service delivery is more costly in regional and remote areas (potentially up to double the cost of providing the same service in metropolitan areas) due to high travel costs and thin markets. Some PHNs noted that they cross-subsidised the NPS-M and CoS by commissioning services with other programs (often NPS-T and Interface funding) to increase access and provide appropriate support for consumers.

It is not possible to assess the cost-effectiveness of the current programs in terms of achieving outcomes for consumers and efficiencies across the broader health system due to limitations with data currently available. These limitations include a lack of consistent outcome data across psychosocial programs and the inability to link program usage data with other national datasets (e.g. national hospital morbidity database).

Administration costs used by PHNs and service providers reflected approximately 20% of total funding across both programs. Stakeholders noted that having two streams of funding and different reporting requirements across PHNs substantially increases administrative burden and costs.

The evidence on administrative costs supports the recommendation at KLE 2 above to combine the programs in future.

RECOMMENDATION

17. Future funding needs to continue to recognise the additional cost of service delivery in regional and remote areas.

How is evidence informing NPS-M and CoS service and program delivery? (KLE 6)

The evaluation found that the available evidence informs many aspects of the delivery of both NPS-M and CoS, including the focus on recovery and supports that build capacity. The types of support funded through the programs are also evidence-based to achieve positive consumer outcomes, although the level of evidence across these support types varies in volume and quality.

The evaluation drew on evidence and literature presented in the Literature Review and policy review – the *Evaluation of national psychosocial support programs NPS-M and CoS (the Literature Review)* which explored evidence from Australia as well as other comparable jurisdictions including New Zealand, the United Kingdom and Canada.

There are some areas where the evidence could be drawn on more heavily to improve the support outcomes. These include considering time-limited support with simple re-entry pathways, extending implementation time and introducing longer term funding cycles (e.g. five years) to better support workforce stability, consolidating and streamlining funding, increasing joint commissioning between PHNs and between PHNs and state or territory regional health services, further integrating clinical and non-clinical supports, and streamlining programs to create more flexible and consumer centred supports.

This finding supports all the recommendations presented above.

Overall, the lack of useful data created limitations to the evidence available for the evaluation. The data limitations resulted from inadequate governance and inconsistent consent arrangements leading to inaccurate and incomplete data, a lack of consistent outcome data across the programs and the inability to link program usage data with other national datasets.

RECOMMENDATION

18. The design and governance of the PMHC-MDS needs to be reviewed to ensure the data can be used for its intended purpose while considering the complex custodianship environment across the Australian Government and PHNs.

What should psychosocial support look like in future? (KLE 7)

KLE 7 summarises the insights across KLEs 1-6. The evaluation has documented several examples and case studies of good practice led by PHNs and service providers that can be shared and leveraged nationally where appropriate and tailored to regional need.

Future psychosocial support programs should be consumer-centred and codesigned with the sector (commissioners, providers, peaks), consumers, their support people, carers and family. The design of future programs should be focused on consumer outcomes and include the following key features:

- **Recovery-oriented programs:** goal based, time-limited support with easy and rapid re-entry as needed.
- **Flexible, tailored support:** services matched to the changing needs of individuals (either group and/or individual support across a range of support types).
- **Accessible and stable services:** streamlined referral and access to services with a stable workforce to support effective therapeutic relationships between consumers, carers and support workers.
- **Smooth transitions:** effective management of transitions in services to achieve smooth handovers without gaps in service or support – exiting the service should be expected and agreed upon with consumers.

The specific elements that should underpin a consumer-centred psychosocial support program are outlined in Section 9.

VOICES OF LIVED EXPERIENCE

Thomas' story

I'm a man in my 40s living in a remote area. I live alone but I am close with my family, particularly with mum. I have lived for most of my life with experiences of schizophrenia, but I've only recently started to come to understand and accept my diagnosis after I was brought into hospital by the police. I'm still dealing with court proceedings from what happened that day.

Through getting connected to psychosocial support, what I really want is to socialise. It's hard for me because of where I live and not having a licence. I was always pretty popular at school but when I started talking about what I believed because of my psychosis, my friends didn't take to that. I basically became a recluse because I couldn't understand why my friends were having their own lives and not focusing on me. I just became socially isolated.

Ideally, I really want to get connected with people to talk to, to have a cup of tea with and that sort of thing. I prefer to have interactions with women rather than men as men can be more aggressive.

I like that my support worker is female and has a lived experience. She's caring and has a motherly approach and shares how she deals with her son who experiences schizophrenia and similar beliefs to me, so it makes me feel less alone.

Paula's story (mother of Jenny)

I am now over 70 years old and a mother of four adult children. My youngest daughter Jenny is now 40 and has been living with and fighting the voices, nasty scary voices, in her head since she was a teenager. She has tried on and off over the years to move out and live on her own, but it has never worked out. Something always happens, she gets really distressed and unwell again and back home she comes.

I do almost everything for Jenny, I did even when she wasn't living here. I used to wash her clothes, clean up her flat and drive meals over when I visited her each day or two. I love Jenny but I am worn out, and I worry what is going to happen when I am not here anymore. Her brothers love her too, but they have their own families.

I spend my life trying to get help and services to support Jenny and trying to teach Jenny how to do things for herself. Services come and go – this is the problem, they never stay. Jenny gets settled into a new service or with a new person who is helping her, and then the worker ups and leaves – she has had so many different workers just in the last couple of years – or the government changes and the program stops.

I can't tell you how confused I am about all of the services and health programs stuff. Just when I think 'okay – now I understand what is what, and I can help Jenny apply for this or that', it all changes again and I'm confused and back to square one.

We are always starting all over again and I can't cope anymore. I'm getting old. I need Jenny to be helped to be independent and I want her to have friends – not just me. I need to know she will be okay when I am not here anymore.

1 Policy context and background

Psychosocial support services have long been funded by governments in Australia to support people with psychosocial disability to live well in the community. Such programs provide a range of services, both individually and in group settings, that help people to manage daily activities, including recovery in the community and participation in education and employment.[2]

Psychosocial support services work alongside clinical mental health services with varying degrees of integration to support individuals who are living with severe mental illness. Clinical mental health care services are provided across Australia by state and territory governments and comprise public acute and psychiatric hospital settings, community mental health care services and specialised residential mental health care services. The private sector also provides a range of clinical mental health services, including admitted patient care in a private psychiatric hospital and services provided by GPs, psychiatrists, psychologists and other allied health professionals.[3]

Since 2006 the state/territory and Commonwealth Governments have all had a role in providing psychosocial supports

Until 2006 psychosocial support was provided by states and territories as part of their responsibility for delivering mental health services and in line with the Commonwealth/State/Territory Disability Agreement.

State and territory services include residential services, non-residential accommodation support, community support and community access, in accordance with the National Disability Agreement.[4] The range and types of psychosocial support services offered varies between the different jurisdictions.

The Commonwealth entered the scene with the introduction of the PHaMs and the Support for D2DL programs in the 2006 budget. The PHaMs program was initially rolled out through a social services/ disability lens in the equivalent Department to the currently named Department of Social Services. The PIR program was introduced in the 2011 budget and was rolled out with a more health-focused lens through the Department of Health.

The two programs that are the subject of this evaluation, the NPS-M and CoS, build on this history of service provision within the Commonwealth.

The NPS-M, as rolled out through the PHNs, is funded by the Commonwealth. As part of the establishment of the NPS-M, high-level bilateral agreements were negotiated by the Commonwealth with each state and territory, committing the states and territories to maintain their effort in psychosocial support funding within their jurisdictions. The agreement for the NPS-M also commits the states and territories to collaborate in the evaluation of the NPS-M. All states and territories responded to an information request from Nous asking for information on jurisdictionally funded psychosocial support programs (discussed in Section 6), however agreement to publish this information was not received from all states and territories so the details have not been reported.

The CoS program is funded solely by the Commonwealth.

The introduction of the National Disability Insurance Scheme from 2016 has been the catalyst for significant change

The national roll out of the NDIS from 2016 and its provision of services to some people with psychosocial disabilities has led to significant changes in the mode of delivery of psychosocial support services by both

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[2] Productivity Commission, "Mental Health Draft Report Volume I", Productivity Commission, 2019.

[3] AIHW, Mental Health Services in Australia: Overview of mental health services in Australia, AIHW (Online), Canberra, 2019. Accessed via: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia

[4] AIHW, Mental Health Services in Australia: Psychiatric Disability Support Services, AIHW (Online), Canberra, 2019. Accessed via: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia

Commonwealth and state and territory governments. The NDIS provides support for as long as needed for eligible individuals with a permanent disability based on a legislative criteria and statutory intake scheme.

Although not originally part of the NDIS remit, the Scheme provides support for as long as needed to eligible individuals who experience a psychosocial disability as a result of a mental health condition. Its purpose is to provide long-term support via individualised packages to people for whom enduring disability majorly impacts their ability to carry out everyday tasks without support.[5]

The NDIS is not intended to meet the needs of all people with a severe mental and persistent illness. It has a relatively narrow eligibility criteria for access to the scheme, including requirements that a person's condition is likely to be permanent, and that a person has significantly reduced functional capacity across relevant domains.[6] Individuals who are deemed ineligible for access may have the decision reviewed or reapply in three months' time.

Some governments ceased to fund psychosocial support directly and transferred their funding to the NDIS

Although most governments continue to provide some level of funding for psychosocial support services, much of the existing funding for psychosocial support programs was re-directed to the NDIS.

The three existing Commonwealth programs (PHaMs, D2DL and PIR) each ceased on 30 June 2019, to coincide with the anticipated full operation of the NDIS. The funding for these three programs was transferred to the NDIS in anticipation that the people supported by these programs would be eligible for NDIS supports.

State and territory governments took different approaches to funding their own programs. While some jurisdictions retained all funding and program delivery, others transferred a portion or the entirety of this funding to the NDIS.

The NPS-M was introduced to cater for people whose needs are not met by other programs

The NPS-M was introduced from 1 January 2019 as a Commonwealth-funded program intended to support people with severe mental illness resulting in reduced psychosocial functional capacity who were not more appropriately supported through the NDIS, the existing Commonwealth programs or state/territory psychosocial support programs.

Participants who are receiving similar support services from state or territory-funded psychosocial programs are not eligible for NPS-M support.

The NPS-M provides eligible consumers with access to short- and medium-terms supports, intended to be time-limited. Ongoing support is not guaranteed by program guidance.

NPS-M funding is provided by the Commonwealth to the 31 PHNs, who commission the support services from local providers.

In the 2017-18 Budget, the Commonwealth Government committed $80 million over four years for the NPS-M, including $7.8 million in 2017-18 and approximately $24 million per annum for the following three years.[7]

The Commonwealth advised that funding for the NPS-M measure needed to remain a quarantined funding source, with a separate budget for reporting purposes. It couldn't be used as part of the Flexible Mental Health Funding Pool or be used in conjunction with funds held by PHNs for PIR and D2DL.[8]

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[5] NDIS, Access Snapshot 1, NDIS, 2020. Accessed via: https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis.

[6] National Disability Insurance Scheme Act 2013 (NDIS Act), s 24.

[7] Australian Government Department of Health, "PHN Psychosocial Support Guidance, Psychosocial Support for People with Severe Mental Illness", Australian Government, Canberra, 2019.

[8] The Flexible Mental Health Funding Pool was created in 2015-16 to provide a consolidated funding source from which PHNs could commission primary mental health care services to best meet regional needs.

As noted above, while the NPS-M is Commonwealth funded and administered, it was introduced under bilateral agreements between the Commonwealth and state and territory governments, that require ongoing effort and investment of states and territories to provide state or territory-funded psychosocial support.

In this context, the Commonwealth introduced the CoS to cater for people whose program funding ceased

The CoS program was introduced to cater for people who were receiving support through the PHaMs, D2DL and the PIR programs when they ceased on 30 June 2019 and who have been found ineligible for the NDIS.

CoS provides ongoing supports for as long as they are needed (i.e. the support is not time-limited).

Like the NPS-M, the funding is made available through the 31 PHNs across Australia, who then commission services from local service providers.

In the 2018-19 Federal Budget, the Australian Government announced $109.8 million from 1 July 2019 over three years for the CoS program.[9]

Both NPS-M and CoS have been implemented through the agency of PHNs

PHNs were introduced across Australia by the Commonwealth Government with the 'key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time'.

Prior to their introduction, service providers for the PHaMs, D2DL and PIR programs were contracted directly by the relevant Commonwealth Department, providing a relatively consistent implementation across Australia.

The distributed nature of the implementation model via PHNs has introduced a considerable degree of variability in the implementation, efficiency and impact of the services. This is attributable to a range of potential factors, including differences in the capability and maturity of PHNs, affecting their capacity to plan, partner, monitor and shape service delivery.

The two programs provide broadly similar services to similar cohorts of people

The type of supports provided and the needs of participants do not vary significantly between the two programs. They are best viewed as two different funding streams that cater for people whose program history is different. Table 1 draws out the differences and similarities.

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[9] Ibid.

Table 1 | Summary of NPS-M and CoS programs

Program	Purpose	Eligibility	Budget	Time period	Types of services
NPS-M	To provide psychosocial support services to people with severe mental illness resulting in reduced psychosocial functional capacity who have not been found eligible to receive psychosocial supports through the NDIS.	Consumers must: • live with a severe mental illness with an associated level of reduced psychosocial functional capacity • not be assisted by the NDIS. • Not be clients of CoS or transition support.	$80m (2017-18 budget): 17-18: $7.8m 18-19: $23.7m 19-20: $24.1m 20-21: $24.4m	Funded from 1 January 2019 to 30 June 2021	• Social skills and connections, including family connections. • Managing daily living needs. • Building broader life skills including confidence and resilience. • Financial management and budgeting. • Finding and maintaining a home. • Vocational skills and goals, (including volunteering for NPS-M). • Maintaining physical wellbeing, including exercise. • Education and training goals. • Managing drug and alcohol addictions including tobacco (CoS guidance mentions linking to these services instead of direct service provision).
CoS	To provide continued and similar support to clients of previous Commonwealth programs (PIR, D2DL, PHaMs) who have tested and/or deemed ineligible for the NDIS[10].	Consumers must: • be clients of PIR, D2DL and PHaMs on 30 June 2019 • be ineligible for NDIS • Not be receiving or entitled to receive similar community supports through state or territory government programs.	$109.8m (2018-19 budget): 19-20: $36.6m 20-21: $36.6m 21-22: $36.6m	Funded from 1 July 2019 to 30 June 2022	

Specific support is provided to assist people to test for and transition to the NDIS

The Commonwealth also funds transition support for people who had been participants in its three legacy programs on 30 June 2019 and who may be eligible for NDIS support but have not yet been tested for eligibility. This funding stream – *the National Psychosocial Support Measure – Transition (NPS-T)*, is out of scope for this evaluation, although it is an important aspect of the context. Once participants have received notification that they are either eligible or ineligible for the NDIS they are supported to transition to either the NDIS or CoS.

Funding levels for NPS-T include an allowance for the costs associated with supporting consumers to prepare an application to test eligibility for the NDIS and collecting the evidence required for an assessment.

Initially, the NPS-T program was funded for a period of one year and was due to cease on 30 June 2020. However, acceptance rates into the NDIS are much lower for consumers with primary psychosocial disability than the NDIS as a whole (67% vs 85%).[11,]

This relatively low level of access reflects in part the lack of focus on the complexity between severe and persistent mental illness and psychosocial disability in the early stages of the NDIS rollout and the acknowledged barriers to access for people with psychosocial disability.

The NDIA has published data which indicates that of the people with a primary psychosocial disability at 30 June 2019 who sought access to the NDIS, 67% had been found to meet the access requirements.[12] The

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[10] Some clients transitioned straight to CoS without testing as they did not meet the age or residency requirements for the NDIS

[11] NDIA, People with psychosocial disability in the NDIS report, National Disability Insurance Scheme, 2019

[12] NDIA, People with psychosocial disability in the NDIS report, National Disability Insurance Scheme, 2019.

rates of eligibility at 30 June 2019 vary according to jurisdiction, noting that a higher proportion of people have gained access in Victoria (77%) and Western Australia (70%).[13] The differential access levels between jurisdictions can largely be explained by the jurisdictional processes to support applicants, including the existence of 'defined schemes' in some jurisdictions as well as the different timeframes for the rollout.

As a result, the Commonwealth has now extended funding for the NPS-T program to 30 June 2021. It is anticipated that all clients will have transitioned to other ongoing support arrangements, such as the NDIS or CoS, by this time.[14] On 31 October 2020, there remained 1,607 consumers receiving support through NPS-T of the more than 15,000 who initially transitioned to NPS-T.[15]

From 1 July 2020 NPS-M and CoS clients requiring higher level and longer-term supports can be supported to test/retest eligibility for the NDIS.

The resulting web of psychosocial programs is complex and fluid

The NPS-M and CoS programs have been operating for a relatively short period of time and eligibility for CoS is contingent on not being found eligible for the NDIS, leading to a fragmented – and fluid – picture of program delivery in this space.

The relationship between the programs which are the subject of this evaluation, and other current and previous Commonwealth psychosocial support programs, is depicted in Figure 2 overleaf.

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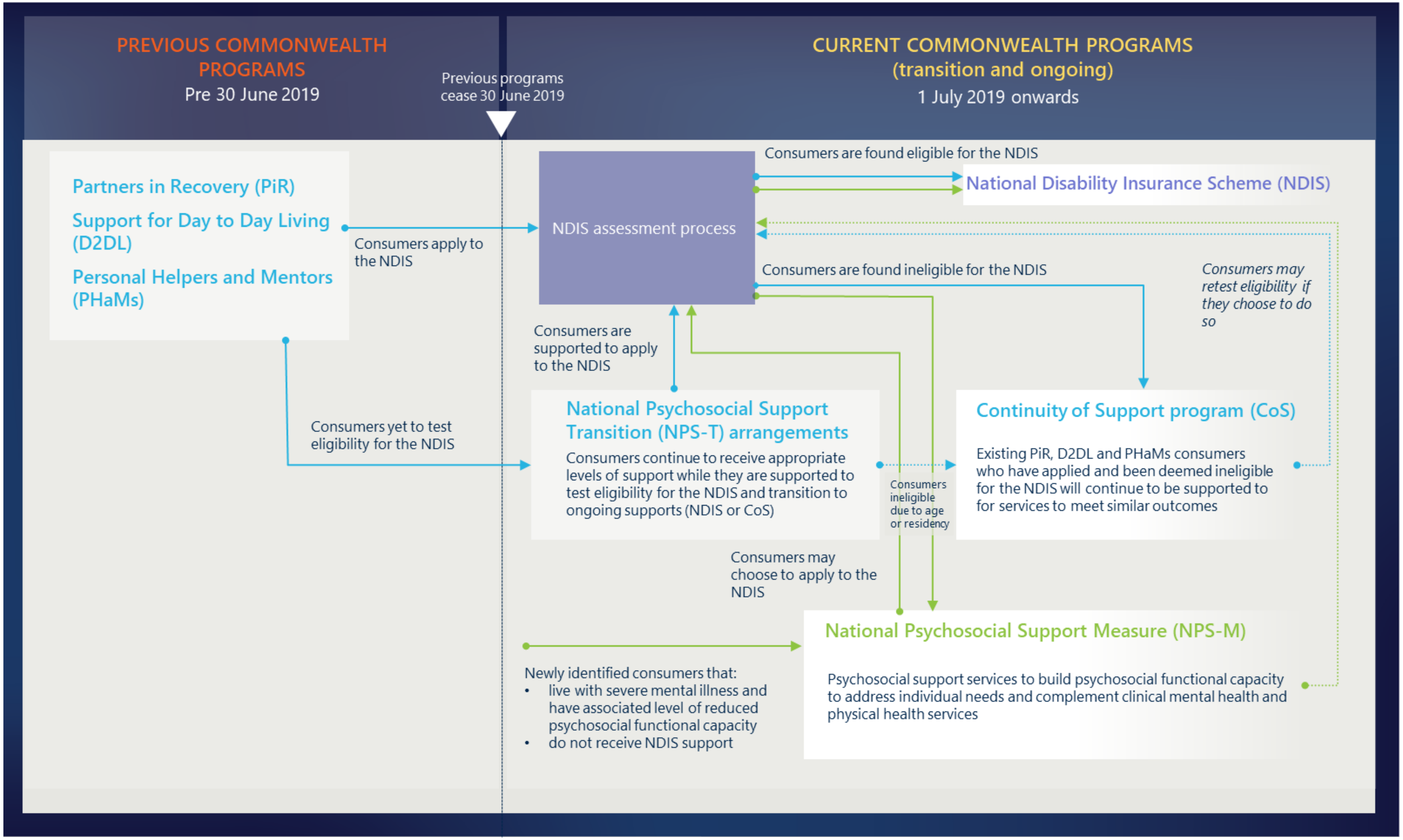
[13] Ibid.

[14] Australian Government Department of Health, Fact Sheet for Service Providers and Primary Health Networks Transition support arrangements for clients remaining in the National Psychosocial Support - Transition program on 1 July 2020, Australian Government, Canberra, 2020. Accessed via: https://www1.health.gov.au/internet/main/publishing.nsf/Content/national-psychosocial-support-transition.

[15] TRIS data for 1 July 2020 to 31 October 2020 provided by Australian Government Department of Health.

Figure 2 | Commonwealth funded programs, 2019 onwards



1.2 The nature of severe mental illness and associated psychosocial disability

The NPS-M and CoS programs are both intended to provide support to individuals who have psychosocial support needs associated with severe mental illness. In theory, the consumer cohort for the two programs is unlikely to be substantially different in needs – the difference is whether they were accessing the legacy Commonwealth programs on 30 June 2019.

Both NPS-M and CoS are intended to support people with psychosocial disability related to severe mental illness

Both programs help people with severe mental illness build skills to manage their mental illnesses, improve their relationships with family and others, and increase social and economic participation.[16] They promote personal recovery and quality of life. Services can be socially-based, capacity building group activities or targeted individual support for consumers at times of increased need.

These services can also improve the overall efficiency and effectiveness of mental health service delivery by reducing demand for more complex acute care.[17]

The experience of people with severe mental illness ranges from experiencing no impairments, few or minor impairments to experiencing significant impairments, resulting in psychosocial disability. Severe mental illness is characterised by a severe level of clinical symptoms and degree of disablement to social, personal, family and occupational functioning.[18] The definition of severe mental illness is discussed more fully in the accompanying *Literature Review and policy review – the Evaluation of national psychosocial support programs NPS-M and CoS* (the Literature Review).

A mental health condition or diagnosis is not itself a psychosocial disability – not everyone who has a mental health condition will experience psychosocial disability. Rather, a psychosocial disability relates to a person's experience of functional impairment associated with their mental health condition.

The types of impairments that may arise from mental health conditions include loss of or reduced ability to function (including both physical and cognitive functioning), think clearly, experience full physical health and manage the social and emotional aspects of living. Depending on the nature of the mental illness and the associated disability, some people will require continuous support, while others may require episodic, intermittent support. Some of the physical issues experienced by people living with severe mental illness are not only shaped by support, medication and treatment but also by the socio-economic impact mental illness can have. This can include for example poverty, homelessness, inadequate housing, loneliness and isolation, discrimination in general care. A range of activities can be provided as part of psychosocial support services these are presented in Figure 3.

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[16] Commonwealth Department of Health, "Psychosocial support for people with severe mental illness", 2020. Accessed via: https://www1.health.gov.au/internet/main/publishing.nsf/Content/psychosocial-support-mental-illness

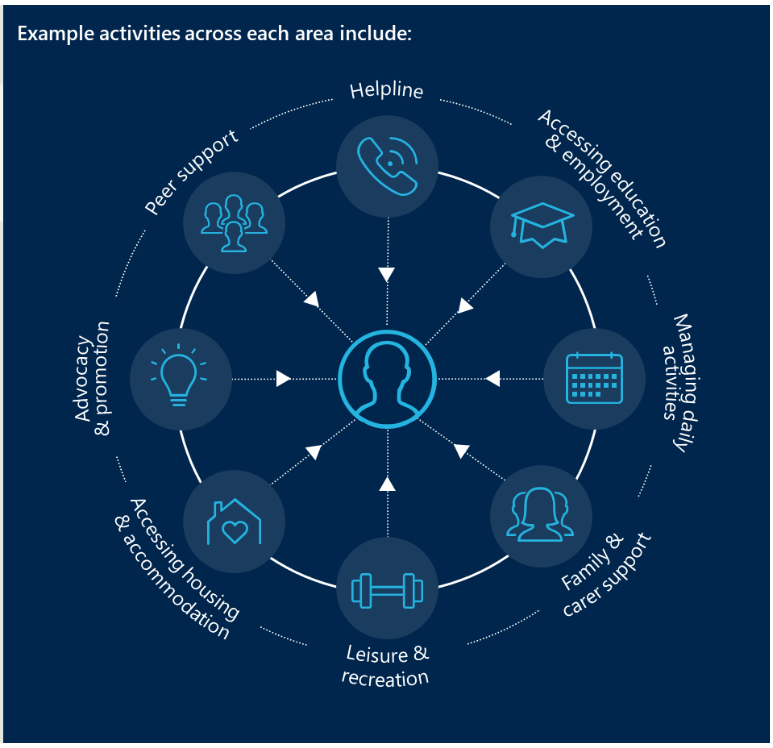
[17] Productivity Commission, "Inquiry Report – Mental Health", 2020, Volume 2, p.846. Accessed via: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume3.pdf

[18] Ibid.

Figure 3 | How do psychosocial supports provide help? [19,20,21]

Psychosocial support services are defined as services that focus on building capacity and stability in one or more of the following areas:

- social skills and friendships, family connections
- managing daily living needs
- financial management and budgeting
- finding and maintaining a home
- vocational skills and goals, including volunteering
- educational and training goals
- maintaining physical wellbeing, including exercise
- building broader life skills including confidence and resilience


Example activities across each area include:

Understanding the need for psychosocial support in Australia

A significant proportion of the Australian population will experience a mental illness at some point in their life. The Australian Government's Report of the National Inquiry into the Human Rights of People With Mental Illness published almost two decades ago was significant in raising awareness for the rights of Australians affected by mental illness and the need for improved psychosocial support (among other findings).[22] Now, the National Survey of Mental Health and Wellbeing estimates that 45% of the adult population will experience a mental illness in their lifetime.[23] However, the Productivity Commission estimates that only 3% of the adult Australian population experience a severe mental illness.[24] This group of people are more likely to experience a psychosocial disability and require short-term or sustained psychosocial support.

Figure 4 illustrates some key information and figures in relation to Australians living with severe mental illness, consumers of psychosocial disability supports and carers of people with mental illness.

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[19] Image adapted from the Productivity Commission Draft Report, Vol 1. Community Mental Health Australia (2012); North Western Melbourne PHN (2019). Community Mental Health Australia (2012); North Western Melbourne PHN (2019).

[20] Data dictionary for the Primary Mental Health Care Minimum Data Set, Strategic Data, 2020. Accessed via: https://strategic-data-pty-ltd-docspmhc-mdscom.readthedocs-hosted.com/projects/data-specification/en/latest/data-model-and-specifications.html?highlight=psychosocial%20support#definitions

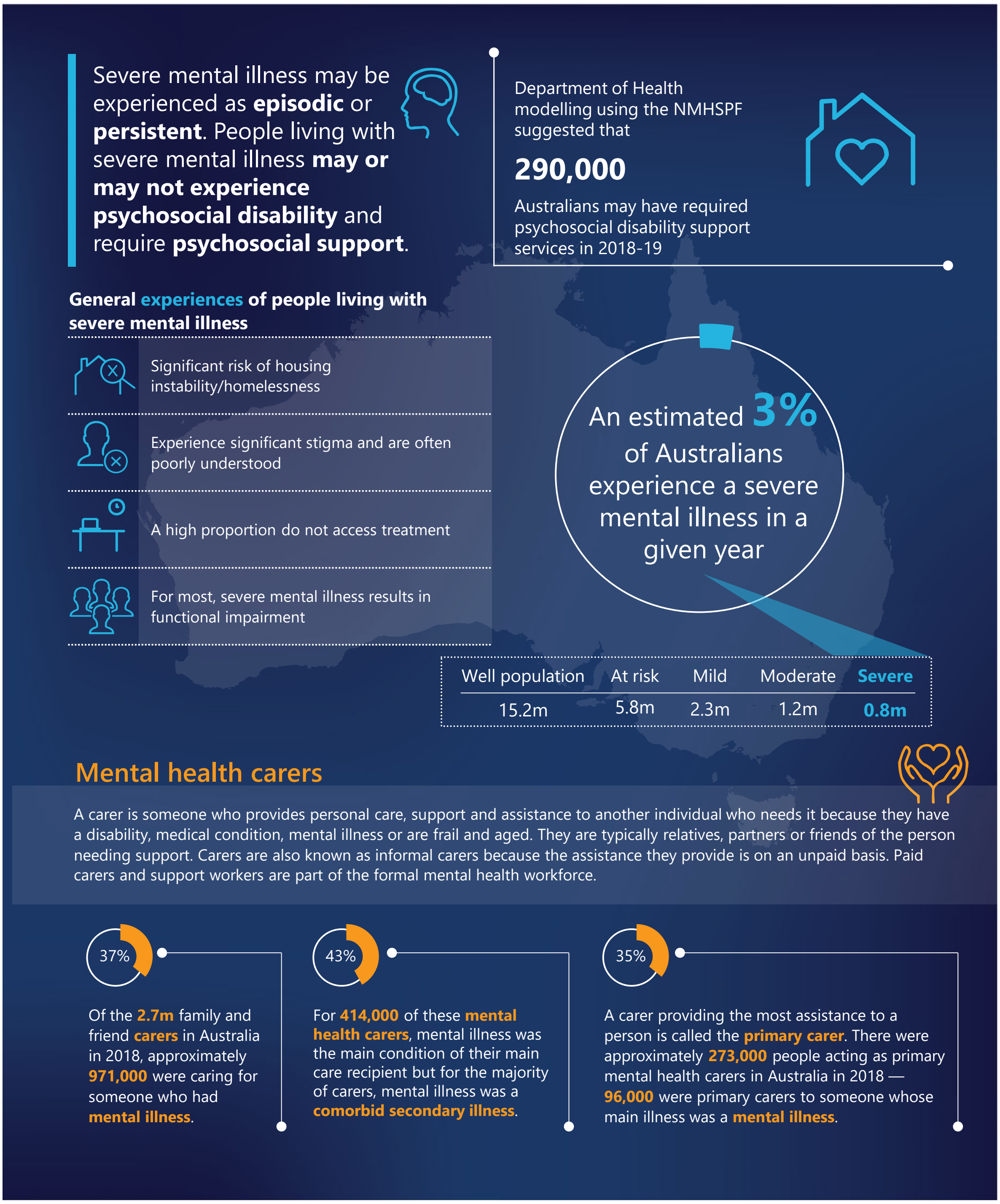
[21] Australian Government Department of Health, "PHN Psychosocial Support Guidance, Psychosocial Support for People with Severe Mental Illness", Australian Government, Canberra, 2019.

[22] Australian Government, " Report of the National Inquiry into the Human Rights of People With Mental Illness", 1993.

[23] Completed by the Australian Bureau of Statistics in 2007.

[24] Productivity Commission, "Mental Health Inquiry Report: Volume 2", 2020.

Figure 4 | Snapshot of severe mental illness and psychosocial disability in Australia[25]



Severe mental illness may be experienced as **episodic** or **persistent**. People living with severe mental illness **may or may not experience psychosocial disability** and require **psychosocial support**.

Department of Health modelling using the NMHSPF suggested that

290,000

Australians may have required psychosocial disability support services in 2018-19

General experiences of people living with severe mental illness

- Significant risk of housing instability/homelessness
- Experience significant stigma and are often poorly understood
- A high proportion do not access treatment
- For most, severe mental illness results in functional impairment

An estimated **3%** of Australians experience a severe mental illness in a given year

Well population	At risk	Mild	Moderate	**Severe**
15.2m	5.8m	2.3m	1.2m	**0.8m**

Mental health carers

A carer is someone who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition, mental illness or are frail and aged. They are typically relatives, partners or friends of the person needing support. Carers are also known as informal carers because the assistance they provide is on an unpaid basis. Paid carers and support workers are part of the formal mental health workforce.

37%

Of the **2.7m** family and friend **carers** in Australia in 2018, approximately **971,000** were caring for someone who had **mental illness**.

43%

For **414,000** of these **mental health carers**, mental illness was the main condition of their main care recipient but for the majority of carers, mental illness was a **comorbid secondary illness**.

35%

A carer providing the most assistance to a person is called the **primary carer**. There were approximately **273,000** people acting as primary mental health carers in Australia in 2018 — **96,000** were primary carers to someone whose main illness was a **mental illness**.

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[25] Ibid.

2 Methodology

Nous partnered with the University of Sydney to develop and apply a methodology to evaluate the implementation, impact and cost effectiveness of the NPS-M and CoS programs. The evaluation sought to produce evidence to inform the Commonwealth Government on potential reforms to psychosocial programs and inform decisions on future directions for psychosocial support services.

2.1 Key questions guiding the evaluation

Seven KLEs structured the evaluation and guided data collection and analysis:

1 Have the NPS-M and CoS programs been implemented as planned and what are the lessons from the implementation?

2 To what extent have the NPS-M and CoS programs achieved their intended outcomes?

3 To what extent have the NPS-M and CoS services met the needs of consumers, their families and carers?

4 Has the approach to integration of NPS-M and CoS support with other clinical and non-clinical services assisted consumers to access effective care and reduce demand for acute health services?

5 How cost effective are the NPS-M and CoS programs?

6 How is evidence informing NPS-M and CoS service and program delivery?

7 What should psychosocial support look like in the future?

2.2 Principles and standards

Nous and the University of Sydney maintained a set of overarching principles and external evaluation standards to provide a basis for guiding decision-making throughout the evaluation. The overarching principles (set at the outset of the evaluation) are detailed below.

OVERARCHING PRINCIPLES

- **Balanced** – the evaluation will balance feasibility, appropriateness and rigour to ensure the effectiveness of evaluation activities, whilst maintaining the validity of key findings and insights.
- **Robust** – the analysis will be methodologically robust and deliver valid insights.
- **Practical** – the insights of the evaluation will support future service delivery and policy development.
- **Collaborative** – the evaluation will leverage experiences of those directly participating, involved in and impacted by the programs to ensure evaluation activities reflect an understanding of day-to-day experience and practice.
- **Efficient** – the evaluation will make best use of existing data to optimise the efficiency of evaluation activities.
- **Respectful and empathetic** – the evaluation will design, conduct and report activities in a manner that respects the rights, privacy, dignity, entitlements and knowledge of different stakeholder groups.

STANDARDS

The evaluation was guided by external evaluation standards that provided direction as to best practice in the conduct of evaluations. These standards were developed based on extensive research and stakeholder consultation to provide a basis for guiding difficult decisions within the evaluation, as a heuristic device rather than formal rules for the conduct of the evaluation.

As part of Nous' commitment to these standards and principles, ethics approval was obtained from two Human Research Ethics Committees (HRECs). The University of Sydney provided ethical approval to conduct consumer and carer consultations, and the Australian Institute of Health and Welfare (AIHW) provided ethical approval to access and analyse relevant, deidentified program data; however, this program data analysis did not take place – see Section 2.4.3.

2.3 Theory of change and program logic

The evaluation was informed by a theory of change (TOC) and guided by a program logic model. The TOC provides a high-level summary of the how the program was intended to achieve its desired outcomes and is articulated in Figure 5.

The detailed program logic shown in Figure 6 expands on the TOC, articulating in more detail the relationship between desired outcomes, and the required inputs, activities and outputs. These relationships, and the underlying assumptions that support the TOC, were tested throughout the evaluation. While long-term goals are included in the program logic they were out-of-scope for the evaluation due to the need for longitudinal data.

Figure 5 | TOC for the NPS-M and CoS programs

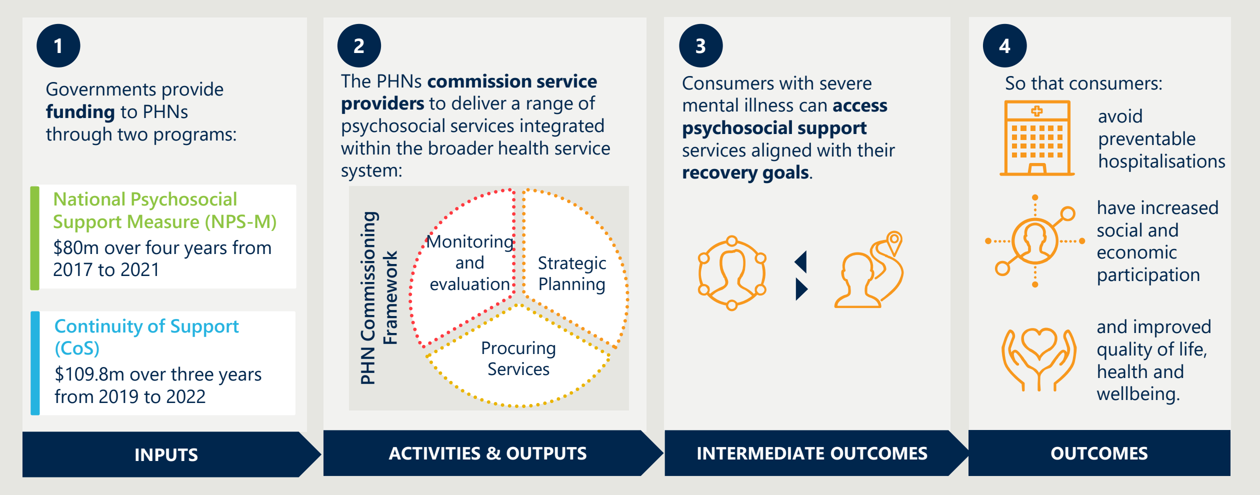
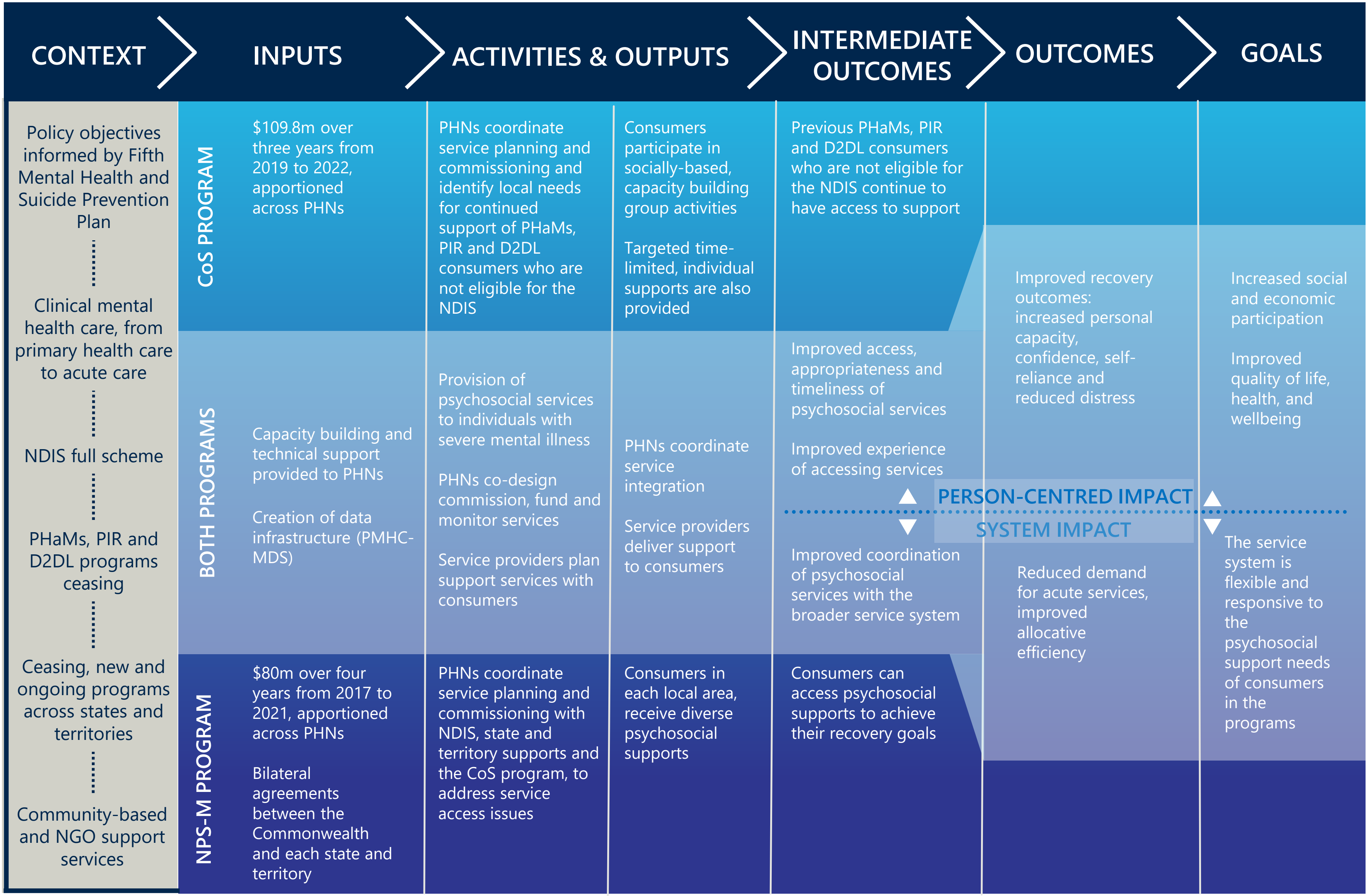


Figure 6 | Program logic for the evaluation



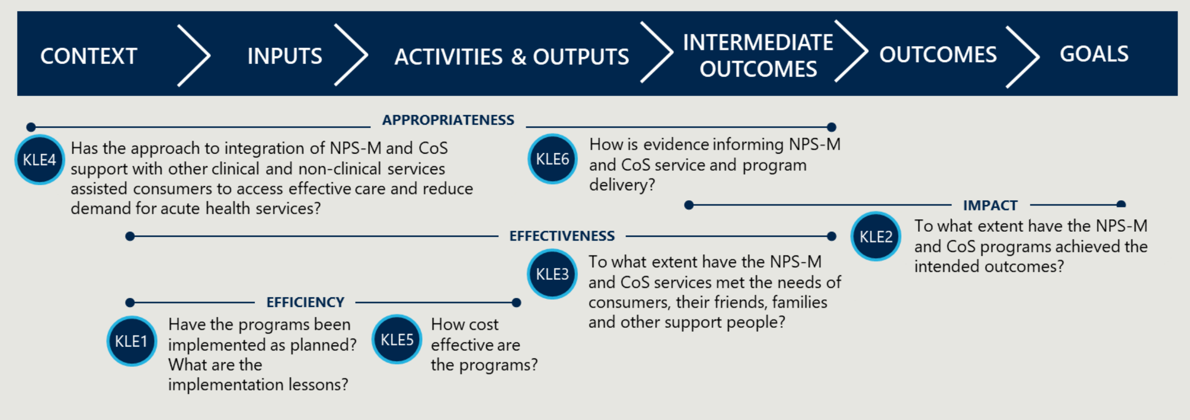
CONTEXT		INPUTS	ACTIVITIES & OUTPUTS		INTERMEDIATE OUTCOMES	OUTCOMES	GOALS
Policy objectives informed by Fifth Mental Health and Suicide Prevention Plan Clinical mental health care, from primary health care to acute care NDIS full scheme PHaMs, PIR and D2DL programs ceasing Ceasing, new and ongoing programs across states and territories Community-based and NGO support services	CoS PROGRAM	$109.8m over three years from 2019 to 2022, apportioned across PHNs	PHNs coordinate service planning and commissioning and identify local needs for continued support of PHaMs, PIR and D2DL consumers who are not eligible for the NDIS	Consumers participate in socially-based, capacity building group activities Targeted time-limited, individual supports are also provided	Previous PHaMs, PIR and D2DL consumers who are not eligible for the NDIS continue to have access to support	Improved recovery outcomes: increased personal capacity, confidence, self-reliance and reduced distress	Increased social and economic participation Improved quality of life, health, and wellbeing
	BOTH PROGRAMS	Capacity building and technical support provided to PHNs Creation of data infrastructure (PMHC-MDS)	Provision of psychosocial services to individuals with severe mental illness PHNs co-design commission, fund and monitor services Service providers plan support services with consumers	PHNs coordinate service integration Service providers deliver support to consumers	Improved access, appropriateness and timeliness of psychosocial services Improved experience of accessing services Improved coordination of psychosocial services with the broader service system	Reduced demand for acute services, improved allocative efficiency	The service system is flexible and responsive to the psychosocial support needs of consumers in the programs
	NPS-M PROGRAM	$80m over four years from 2017 to 2021, apportioned across PHNs Bilateral agreements between the Commonwealth and each state and territory	PHNs coordinate service planning and commissioning with NDIS, state and territory supports and the CoS program, to address service access issues	Consumers in each local area, receive diverse psychosocial supports	Consumers can access psychosocial supports to achieve their recovery goals		

PERSON-CENTRED IMPACT

SYSTEM IMPACT

As shown in Figure 7, the seven KLEs were targeted to the appropriateness, efficiency, effectiveness and impact of the program, encapsulating the components of the program logic, while KLE7 *(What should psychosocial support look like in future?)* was intended to synthesise learnings from across the evaluation to understand future opportunities.

Figure 7 | Program logic and core KLEs guiding the evaluation

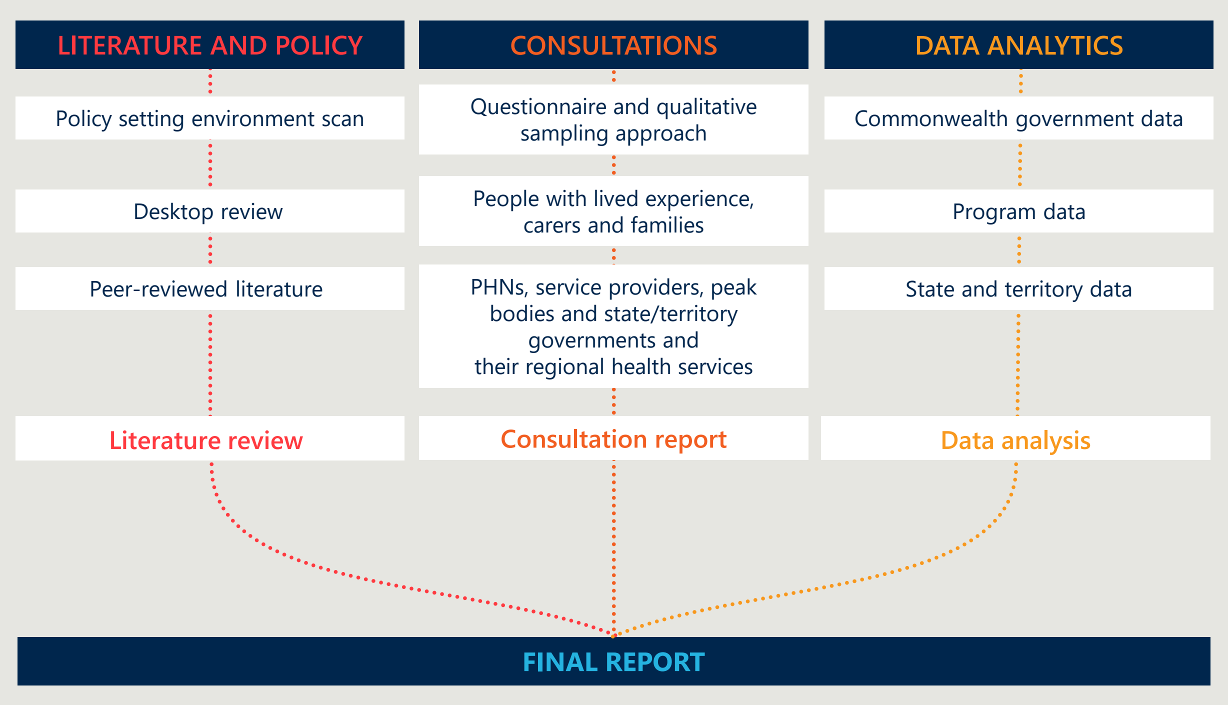


2.4 Overview of the methodology

The evaluation used three separate workstreams to capture a range of qualitative and quantitative data which were then synthesised to create a final report: literature and policy; consultations; and data analytics.

Figure 8 summarises the key inputs and deliverables for each stream, which are expanded in more detail in the subsequent sections.

Figure 8 | Evaluation workstream sources and deliverables



2.4.1 Literature and policy

The literature and policy workstream synthesised a range of qualitative data to develop a Literature Review and inform the final report. Key activities were as follows:

- **Policy setting environmental scan.** Nous examined specific policy documents developed by Commonwealth and state or territory governments, such as bilateral agreements and program guidance documents, and strategies or plans developed by PHNs.
- **Desktop review.** Nous reviewed a broad range of grey literature, media articles and other documents provided to Nous from a range of stakeholders.
- **Peer-reviewed literature.** Nous conducted research into relevant scholarly literature, such as support programs for psychosocial disabilities or severe mental health conditions.

Insights from these sources were summarised and drawn together to produce the Literature Review accompanying this report.

2.4.2 Consultations

Nous partnered with the University of Sydney to consult with over 800 stakeholders through individual interviews, group information sessions and a questionnaire.

- **Individual and group consultation.** Nous conducted interviews and group information sessions with more than 300 stakeholders, comprising of consumers and their friends, families and other support people, PHNs, service providers, peak bodies, state and territory governments and state or territory regional health services (e.g. Local health Districts, Hospital and Health Services).
- **Consumer questionnaire.** The University of Sydney administered a survey that received more than 500 responses from current or previous participants of the NPS-M and CoS programs.
- **Consumer and carer interviews.** The University of Sydney conducted 80 interviews with NPS-M and CoS consumers, carers, friend. Family or other support people.

Themes and findings from these stakeholders were drawn together into a Stakeholder Consultation Report, and have been incorporated into this report. Please see Appendix B for a full list of the type and number of consultations conducted.

2.4.3 Data analytics

Nous utilised existing datasets in conjunction with customised information requests to thoroughly examine all available evidence. Details of the program and customised datasets are provided below. Analysis was conducted using the R programming language, version controlled using a git repository.[26] All analysis was quality assured using Gitflow Workflow with analysts independently reviewing analysis.[27]

Program datasets

Nous originally planned to systematically and quantitatively evaluate the NPS-M and CoS programs through a combination of unit-level data from the PMHC-MDS in conjunction with the NMHSPF, TRIS NPS-T transition reports and PHN-reported activity data. However, data quality and availability issues limited Nous' use of some datasets, and the evaluation instead conducted analysis on the following data:

- **PMHC-MDS.** The PMHC-MDS is a database that captures mental health data from providers commissioned to provide mental health services by PHNs for both national and regional purposes. It includes information about the providers, clients, episodes, services contacts and outcomes, and is intended to support PHNs to benchmark, monitor and evaluate mental health programs. Nous was

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[26] R Core Team (2020). R: A language and environment for statistical ## computing. R Foundation for Statistical Computing, Vienna, Austria.

[27] https://www.atlassian.com/git/tutorials/comparing-workflows/gitflow-workflow

unable to access unit record data from the entire PMHC-MDS held by Strategic Data Pty Ltd. In place of direct access, two alternatives were used to conduct analysis of the data set:

  - Aggregate analysis was conducted of the PMHC-MDS by Strategic Data Pty Ltd based on a template provided by Nous. This analysis is included in Appendix C and contains details of the demographics of consumers, service use and referral pathways. This analysis needs to be treated with caution due to discrepancies between PMHC-MDS data on number of consumers compared with 12-month performance reports (see comparison in Appendix C).
  - Three PHNs provided unit record data as part of a case study analysis. These PHNs include remote, regional and metropolitan areas representing a cross-section of Australia's geography. The primary purpose of this data was to conduct the consumer flows and outcomes analysis presented in Section 4.3.1.

- **12-month performance reports.** As discussed in Section 3.4, PHNs were required to submit six- and 12-month performance reports to the Department that included consumer numbers, service capacity, waitlist information, length of service provision and average weekly hours of support. All analysis that involves consumer numbers is based on 12-month performance report data (e.g. total consumer numbers in Section 4.2.1 and cost per consumer in Section 7.2.2). Other analysis that used 12-month performance reports includes waitlist analysis presented in Section 4.2.2.
- **Transition Reporting Information System (TRIS) portal data.** The TRIS portal captures data related to consumers who are transitioning through the NPS-T either on to the NDIS or onto the CoS program. Data includes the number of individuals who are currently receiving support through the NPS-T programs and information on where consumers exit NPS-T including NDIS, CoS and other options. TRIS portal data has been used in the analysis of consumer transition from previous programs in Section 4.2.1.
- **NMHSPF.** The NMHSPF is a comprehensive model of the mental health services required to meet population needs in Australia.[28] The associated NMHSPF Planning Support Tool (NMHSPF-PST) allows users to estimate the need for mental health care including psychosocial support. The NMHSPF-PST has been used by the Australian Government and researchers at the University of Queensland to estimate the need for psychosocial support services across Australia.[29] These estimates have been included in Section 4.2.1 and compared with current service provisions across the Australian and state or territory governments. There are some limitations with the NMHSPF-PST including that it provides a national average model of need for delivering psychosocial support services and does not account for sociodemographic characteristics or regional and rural information. Regionality information is expected to be incorporated into a new version of the NMHSPF tool in 2021. The NMHSPF also estimates the total need for psychosocial support in the community and does not define the level of need which should be supported by different levels of government (Australian or state/territory).

PHN profiles

Nous developed a template that captured the approach each PHN used to implement the NPS-M and CoS programs. A series of questions were developed into a three page 'profile' that was populated by Nous and sent to each PHN to validate. After the final profile was received from all 31 PHNs, they were used to create a bespoke database that provided an overview of the implementation approach taken by PHNs and was used for the evaluation analysis. All 31 PHN profiles are provided in Appendix A.

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[28] The University of Queensland. 2019. Introduction to the National Mental Health Service Planning Framework – Commissioned by the Australian Government Department of Health. Version AUS V2.2. The University of Queensland, Brisbane.

[29]

Information from states/territories

To place the NPS-M and CoS programs in the context of the larger, state-funded, psychosocial programs and capture any interface or integration issues, a set of qualitative and quantitative questions were sent to all state and territory governments regarding their psychosocial support programs and initiatives. This information was collated and used in the evaluation analysis provided in Section 6. Not all states and territories agreed to publish the detail of their program information, so this report does not present any jurisdictional program information.

3 Have the NPS-M and CoS programs been implemented as planned and what are the lessons from the implementation? (KLE 1)

Summary of findings

The NPS-M and CoS programs were implemented through a commissioning process undertaken by the 31 PHNs across Australia. The two programs were implemented within the required time period; however, the timeframes (approximately six months) for the rollout created limitations for planning and effective commissioning. While the lead times to implementation were condensed to prevent a gap in service delivery for consumers with the introduction of the NDIS, PHNs and service providers found that it contributed to market instability and prevented them from co-designing implementation and undertaking joint commissioning.

The Commonwealth's program guidance set out high-level parameters for the programs which allowed PHNs to tailor the implementation of the programs to meet local needs. As a result, there was substantial variability in the way programs were commissioned and then implemented.

To capture the variation in implementation, Nous prepared individual service profiles of the NPS-M and CoS programs implemented by each of the 31 PHNs. These are included at Appendix A and demonstrate the variety of models implemented. For example, these profiles demonstrated that programs were branded differently across PHN areas and had differing intake and exit requirements. Some PHNs combined the two funding streams into a single program and only one joined with the territory service to commission a pooled program (ACT).

While the variation reflects the aims of local commissioning, differences were also influenced by a range of additional factors, including differences in the capability and maturity of PHNs, affecting their capacity to plan, partner, monitor and shape service delivery. The local needs of each area differed, as did market and workforce capacity.

Generally, the evaluation found that variation was intended and necessary to reflect these different contexts. However, it also resulted in fragmentated service delivery and confusion for stakeholders, including consumers, about what support was available and to whom. Some PHNs included additional eligibility criteria, for example, to reduce duplication with state or territory services. Larger service providers who operated across multiple PHNs found the variability increased their administrative burden, and complicated communications.

Lessons learnt from implementation are included throughout this section. Broadly they support longer lead times and funding cycles to support market capacity, increasing PHN capacity for joint commissioning, streamlining of funding and programs to increase flexibility for consumer centred care, and improving data and governance arrangements.

This section details implementation findings for five topics, captured in Figure 9.

Figure 9 | Five key implementation topics

The five topics are discussed in turn. The discussion for each topic explores three questions:

- What was planned?
- What happened during implementation and how did it vary nationally?
- What are the lessons learned?

The following sections draw from a range of data sources for the evaluation, including consultations and surveys from stakeholders (including consumers and their friends, families and other support people), program implementation profiles refined with all 31 PHNs, integration maps refined with several jurisdictions, and Commonwealth documentation such as bilateral agreements and program guidance.

3.1 Implementation process, timeframes and communication

What was the plan?

The Commonwealth communicated the programs' parameters through program guidance as well as agreements and contracts. The Commonwealth issued Psychosocial Program Guidance for the NPS-M and CoS, which were the key communication mechanisms for the high-level parameters of each program. This guidance contained a description of each program, its intentions, its target consumers, its providers, reporting requirements of PHNs and expectations for implementation process. More detailed implementation expectations were established through a series of agreements and contracts including funding schedules for the programs, and bilateral agreements for the NPS-M between the Commonwealth and states and territories. PHNs had approximately six months to design and implement the programs after the release of this documentation.

The Commonwealth expected PHNs to begin delivery of NPS-M by no later than 1 January 2019, and CoS by 1 July 2019. The NPS-M program was announced in the 2017-18 Federal Budget, with the Commonwealth committing $80 million including commissioning and establishment and two and a half years of delivery (until 30 June 2021). Funding was provided in June 2018 to support six months of commissioning and establishment, before service commencement on 1 January 2019. The CoS program was announced in the 2018-19 Federal Budget, with the Commonwealth committing $109.8 million including commissioning and establishment and three years of delivery (until 30 June 2022). The Commonwealth provided PHNs with formal confirmation of funding via Letters of Offer (NPS-M) and Deeds of Undertaking (CoS) for the programs and which were executed approximately six months prior to the deadline to establish services for NPS-M and executed approximately three months prior for CoS.[30]

PHNs were expected to implement the programs in two phases – a 'planning and establishment phase' and an 'implementation phase'. In the:

1. **Planning and establishment phase**, PHNs were expected to: consider the aims of the programs and local need to determine strategic priorities for the commissioned services; liaise with consumers, carers, service providers and Local Health Networks in the region to ensure complementary and flexible service delivery; put in place arrangements for referrals and communication about the programs.
2. **Implementation phase**, PHNs were expected to: fund and maintain sufficient commissioned services to provide adequate service delivery; monitor and assess progress reports and milestones attached to payment (including monitoring budgets and underspends); collect and report information including collection of data under the PMHC-MDS; and to maintain an issues register and take appropriate steps to resolve issues in collaboration with relevant parties.

The Commonwealth's implementation guidance was intended to be adapted by PHNs to reflect their local contexts. For example, guidance encouraged PHNs to consider the services that were currently provided locally (e.g. funded through state and territory programs) and ensure PHN-commissioned services complemented those services to best meet the needs of people in their region. This is discussed further in Section 3.2 and Section 6.

Implementation was supported by additional Psychosocial Support interface funding. This was intended to be used by PHNs to: assist Commonwealth community mental health clients to test for eligibility under the NDIS; fund service providers or commission new psychosocial support services targeted to support clients of the Commonwealth community mental health programs PIR, D2DL and PHaMs; ensure integration of supports and services through NPS and CoS; maintain funding arrangements for the Programs; and, complete reporting activities to report against outlined funding outcomes.[31]

What happened during implementation and how did it vary nationally?

Most PHNs rolled out NPS-M and CoS on time, and many noted the condensed timeframe created challenges

While many PHNs were able to meet the Commonwealth's timeframes for implementation, some PHNs did not. For NPS-M and CoS respectively:

- **NPS-M:** 18 (58%) PHNs commenced NPS-M service delivery in January 2019; five (16%) PHNs began delivery in the first half of 2019; and eight (26%) did not deliver NPS-M until July of 2019.
- **CoS:** 26 (84%) PHNs began CoS service delivery in July 2019 as mandated by Commonwealth guidance. Of the remaining five (16%) PHNs, three (10%) commenced two months later, and two (6%) PHNs did not commence until November. Consumers from these PHNs were supported under the NPS-T program and continued to receive services.

Most PHNs and service providers (including PHNs who met implementation deadlines) found timeframes for implementation too short. While they acknowledged the Commonwealth set timeframes that would ensure continuity of support for consumers, they outlined the short timeframes for implementation limited opportunities for meaningful co-design, integration planning and needs assessment activities. While announcements were made in preceding budgets, formal confirmation and transfer of funding provided six months lead time for NPS-M and three months for CoS. Some PHNs did not have capacity or capability to utilise the six months planning time for NPS-M. The three-month lead time for CoS was particularly tight and

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[30] **NPS-M:** The NPS-M Letters of Offer went out on 15 June 2018 and were all executed by 30 June 2018 with first payments going out on 1 July 2018. NPS-M services did not commence until 1 January 2019, however PHNs were given funding from 1 July 2018 to assist with the establishment of services (i.e. six months earlier). **CoS:** PHNs were provided with a Deed of Undertaking on 30 March 2019 for CoS, Interface and NPS-T funding. These were signed by PHNs, and countersigned by the Department for execution before caretaker period commenced on 11 April 2019. Following caretaker period, PHNs were offered Deeds of Variation to funding schedules in June 2019, which were executed by 30 June 2019 with first payments being released on 1 July 2019 to align with service commencement.

[31] NPS-T guidance

also confirmed the cessation of PIR, PHaMs and D2DL which was considered unexpected by some in the sector as the programs had been extended in the previous three years. The lead times have a cascading affect through the sector, from PHNs to service providers to service delivery and consumers. Some noted a key impact of the timeframes was workforce and market instability. Many service providers outlined that the transition period created deep uncertainty and they experienced higher staff turnover as a result. They also noted that there was existing fragmentation within the sector and increased uncertainty due in part from the shifting timeframes for the conclusion of PIR. However, other PHNs with more mature commissioning models and strong, stable, existing partnership networks were comparatively unphased by the condensed timelines.

Many PHNs would have valued more guidance from the Commonwealth to support implementation

Some PHNs noted the guidance varied substantially on the level of detail and directiveness in each section. While the Commonwealth's intention was to support flexibility to tailor programs to local contexts, many PHNs outlined that additional guidance and specificity would be welcomed in certain areas, such as eligibility or service models. They noted that further advice could have assisted with clearer integration points between the national programs and state or territory-based programs and services. Where PHNs had established relationships and partnerships more guidance was less important. The

The experience of transitioning to CoS from previous programs was variable for consumers

Some people experienced a very smooth transition and, in fact, had not even noticed that there had been a transition. Several people in the consumer questionnaire for this evaluation listed 'PIR' as their psychosocial support program, for example. When asked about whether their support had changed with the onset of CoS, many people who had formerly been involved with the block-funded services said it had not, and said for example 'The support I've been getting stayed the same, but I know that some programs, some names, have been changed'.

However, some program participants experienced gaps in service and peak representatives highlighted the issue of overall service gaps. Some consumers reported a difficult transition, with poor communication, periods of no support, lack of clarity over what was going on and considerable upheaval. See further detail on this in Section 5.

What are the lessons learned?

While short implementation timeframes were somewhat unavoidable, the impact of the timeframes have cascaded down through the sector – from PHNs, to service providers, to consumers. The key lessons learned that relate to NPS-M and CoS that relate to implementation process, timeframes and communication are:

- early communication and consultation with key stakeholders (including PHNs, service providers, consumers and carers) in the design of the program would increase program effectiveness
- longer lead-times (around 12 months) would enable meaningful co-design, increase opportunities to integrate supports and support workforce stability, and foster innovation. Longer lead-times between confirmation of funding and delivery of services will allow for PHN and service provider activities including needs/gap assessment, planning, joint-commissioning, program co-design including referral pathways and intake processes, recruitment and training of staff, promotion and awareness of programs.

3.2 Commissioning

What was the plan?

NPS-M and CoS guidance outlined that PHNs were expected to tailor their commissioning approaches based on:

- local needs (see Section 3.3 for examples on how this was done in regional, rural and remote areas including the Northern Territory for example)
- what services and supports were already available through state or territory programs
- ensure continuity of service for existing PIR, D2DL and PHaMs clients (via CoS).

The guidance emphasised the need for PHNs to consult with stakeholders to achieve this, and many PHNs complemented consumer engagement with broad information in their annual Needs Assessment to understand the health and service needs in their local areas.

The Commonwealth encouraged PHNs to leverage opportunities to integrate commissioning with state regional health services. The Commonwealth encouraged PHNs to 'consider opportunities to link the new funding to clinical services and care coordination commissioned by the PHN for people with severe mental illness to support integrated care as part of a multiagency care plan'.[32] The NPS-M guidance outlined that – subject to bilateral agreements – PHNs should explore the possibility of co-designing or co-commissioning services with their relevant state or territory government.[33]

What happened during implementation and how did it vary nationally?

PHNs used a variety of inputs to inform their planning and some leveraged existing data sources

PHNs used a range of local and national data as inputs to their planning processes and needs assessments. Some PHNs drew from local data, for example data from joint LHD and PHN regional mental health and suicide prevention plans.[34] Another data source leveraged by some PHNs (n=10, 31%) was national data, drawn from NMHSPF estimates. Many PHNs noted they experienced difficulty accessing the NMHSPF, due to the lack of training opportunities, which enable access to the tool.

PHNs often leveraged existing resources to inform their planning and commissioning of NPS-M and CoS. For example, some PHNs had recently conducted needs assessments in their areas for mental health services more broadly, and were able to lift out the insights that related to psychosocial support needs to inform their planning. This was an efficient approach, and many noted it was more achievable within the condensed timeframes for implementation (discussed earlier in Section 3.1).

Joint commissioning approaches were rare, but done well in some PHNs

PHNs rarely had a formal joint or integrated planning mechanism in place. PHNs had the opportunity to jointly commission services in partnership with other PHNs, and/or with state or territory regional health services, however many noted they required more time to do this, and/or had not previously participated in joint commissioned services. Some did not have strong existing relationships or collaboration forums in place that would have enabled a streamlined approach to joint commissioning. Overall 10 PHNs (32%) engaged with other stakeholders at least once to conduct a joint-planning exercise, but only two of these PHNs continued to involve the state and territory regional health services through an on-going basis. The ACT PHN provides an example of where joint commissioning was undertaken, captured in 'Case study 1 - Joint commissioning for integration' overleaf. As noted above, around 12 months lead-time would support effective joint-commissioning and integration efforts.

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[32] NPS-M Guidance

[33] NPS-M Guidance

[34] Department of Health, "Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services", 2018. Accessed via: https://www1.health.gov.au/internet/main/publishing.nsf/content/68EF6317847840E3CA25832E007FD5E2/$File/Regional%20Planning%20Guide%20-%20master%20at%2023%20October.pdf

CASE STUDY Joint commissioning for integration

AUSTRALIAN CAPITAL TERRITORY PHN | AUSTRALIAN CAPTIAL TERRITORY

KEY INSIGHTS

- ACT PHN worked in partnership with ACT Health to co-commission National Psychosocial Support (NPS) activities in the ACT across the commissioning cycle including identifying gaps, co-designing outcomes with stakeholders, and procuring and implementing services based on identified outcomes.
- This ensures psychosocial services are integrated with the NDIS, Canberra Health Services (for consumers coming in and out of mental health care), Medicare, as well as local charities (i.e. food banks, homelessness services).

ACT PHN and ACT Health joint commissioning approach

1 GAP ANALYSIS

ACT PHN and ACT Health undertook engagement with sectors to identify service gaps and areas of need related to psychosocial support in the ACT region.

2 CO-DESIGN

ACT PHN and ACT Health co-designed an outcomes framework with key stakeholders, based on areas of identified need, to inform the commissioning of psychosocial supports.

3 POOLED FUNDING

ACT PHN and ACT Health pooled funds, with ACT PHN being the fund holder for these activities.

4 CONTRACTING

ACT PHN contracted psychosocial support services, ensuring integration with the NDIS, Canberra Health Services, Medicare, as well as local charities (i.e. food banks, homelessness services).

5 DATA COLLECTION

ACT PHN developed streamlined data collection enabling contracted providers to monitor psychosocial support activities and service delivery quality.

Enablers

Psychosocial support working group

ACT PHN worked in collaboration with the ACT Health directorate and key stakeholders to establish a psychosocial support working group. This group has been tasked with identifying the target cohort, areas of needs and gaps, and developing an outcomes framework for the implementation of NPS measures in the ACT PHN region.

Joint governance arrangements

The ACT Mental Health and Suicide Prevention Plan 2019-2024 (the Plan), established joint governance arrangements. This formalised ACT PHN and ACT Health as the primary co-commissioners of mental health services along a stepped care continuum and established a Steering Committee responsible for championing implementation of the Plan. The Steering Committee includes representatives from consumer groups, service providers, mental health advocacy groups and the Aboriginal and Torres Strait Islander Elected Body.

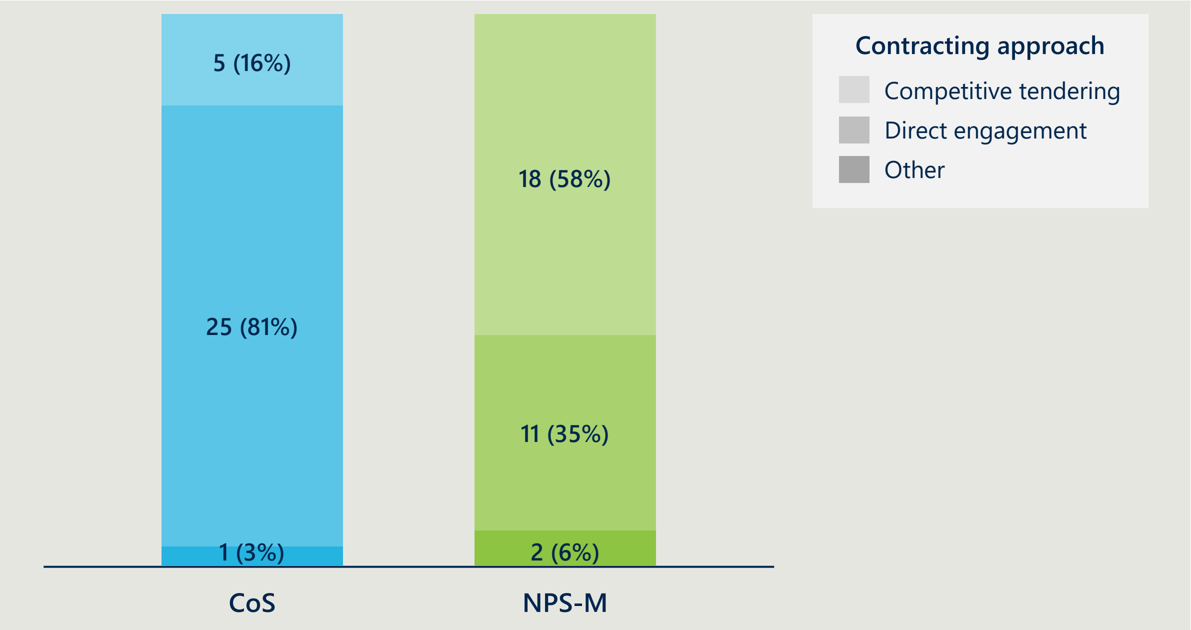
Some PHNs pointed to coordination mechanisms, such as alliances and taskforces, in lieu of joint-commissioning to support service interfaces. Some PHNs (n=7, 23%) incorporated NPS-M and CoS into discussions with state or territory regional health services around regional mental health and suicide prevention plans, in line with the Commonwealth's suggestion. Collaboration is explored further in Section 6.

PHNs' service provider choices were influenced by considerations beyond capability and capacity

PHNs considered a range of factors in their procurement decision making. This typically concerned providers' capability and capacity to deliver the required services, such as prior experience and workforce.

The timeframes discouraged some PHNs from testing the market for different service providers, making contract extension or direct re-engagement with existing providers a practical option to maintain support for consumers rather than a more lengthy competitive tender process. As shown in Figure 10, this was particularly true for the CoS program, whereas more than half of PHNs conducted a competitive tendering process for NPS-M. Some PHNs also outlined that the limited program funding and short-term contracts did not incentivise the market beyond this to respond.

Figure 10 | Initial commissioning approach taken by PHNs[35]



Other factors that influenced PHNs' decision making beyond capability and capacity included:

- opportunities for cross-program efficiencies and alignment (e.g. in some cases PHNs would look favourably on providers to whom they could award both NPS-M and CoS contracts)
- opportunities to improve interfaces with state and territory programs (i.e. where providers were also delivering psychosocial or relevant services through state and territory programs, PHNs would look favourably on the opportunity to award contracts to the same providers to support interfaces)
- the need to ensure regional coverage (i.e. in some cases PHNs would award contracts to a suite of providers based on their collective ability to ensure geographical coverage).

Most PHNs opted for standard approaches to contract and fund service providers

Most PHNs contracted service providers through individual service agreements, even where they procured multiple service providers. Based on a sample of NPS-M and CoS contracts (n= 20, 65%) the evaluation found this approach was more commonly taken by PHNs than contracting lead providers through consortium

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[35] Data self-reported by PHNs in their implementation profile.

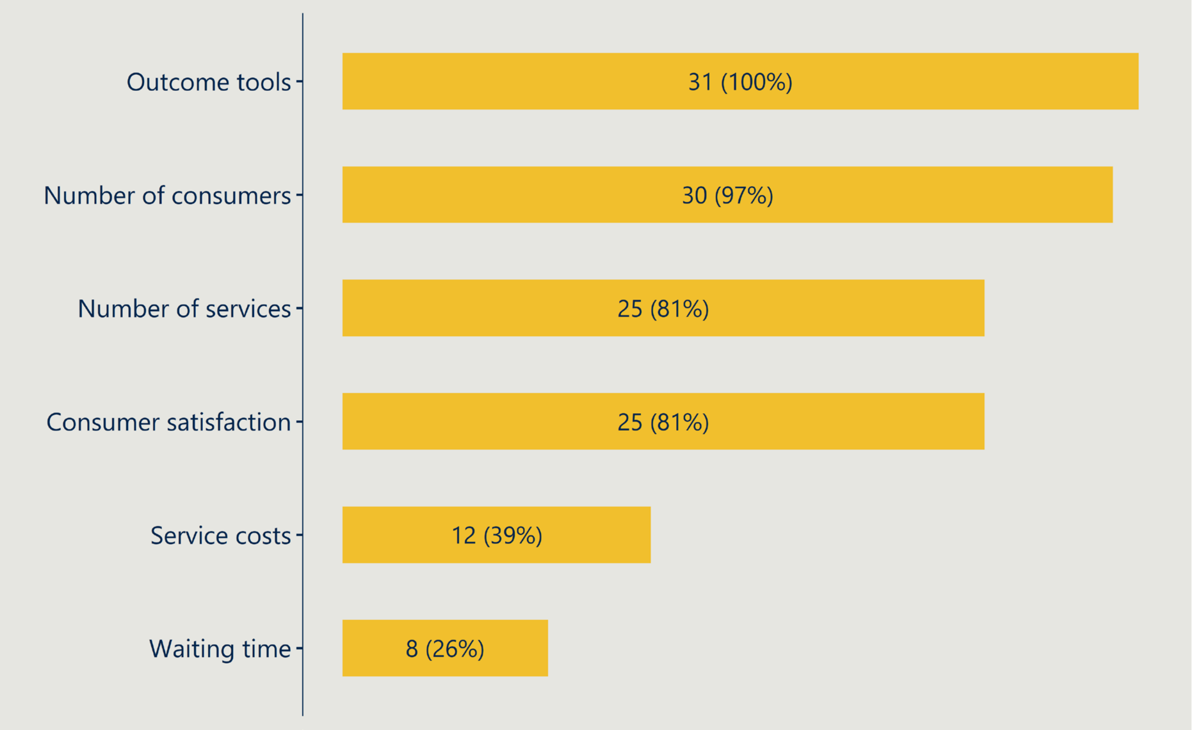
arrangements, for example. Some PHNs outlined this was a quick and efficient approach that was achievable within implementation timeframes.

Most PHNs (n= 25, 81%) used block funding to fund service providers, although some noted that they would like to move towards an outcomes-based funding approach in the future to better encourage high quality and innovative support provision.

Performance measures and evaluation timing varied across PHNs

The types of measures that PHNs required service providers to collect varied, although all incorporated some form of outcome measures. The performance measures that were used by PHNs included information from a range of sources including the PMHC-MDS. For example, the PMHC-MDS includes the K10+ and K5 outcome measures but many PHNs used other outcome measures alongside or instead of these measures (see 'Case study 6 - Outcome measures to assess psychosocial recovery' in Section 4.3.2). Other information like service costs, waiting time and consumer satisfaction is not captured in the PMHC-MDS. These performance measures are presented in Figure 11.

Figure 11 | Performance measures collected by PHNs[36]



Most PHNs had undertaken or planned a review of NPS-M and CoS service delivery. 23 (74%) PHNs had already reviewed (n=9, 29%) or had a plan to review in the next year (n=14, 45%). Only nine PHNs (29%) had not planned a review.

What are the lessons learned?

The key lessons learned that relate to the commissioning of NPS-M and CoS are:

- PHNs should prioritise development of regional networks and collaborative joint regional commissioning.

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[36] Data self-reported by PHNs in their PHN implementation profile.

- Some PHNs are not as progressed in their maturity and would benefit from additional support for commissioning and increased opportunities to build relationships for example through communities of practice.

As noted in Section 3.3, longer-term contracts with funding that reflects local challenges (e.g. funding that reflects increased costs of service delivery in regional/remote areas) would help PHNs to incentivise a larger portion of the market to respond to procurement opportunities.

3.3 Program structure and design

What was the plan?

The Commonwealth planned to fund psychosocial supports nationally through NPS-M and CoS, to complement NDIS and state-based programs (detailed earlier in Section 3.1). The programs were funded on an annual basis. The Commonwealth advised that funding for the NPS-M measure needed to remain a quarantined funding source, with a separate budget for reporting purposes as per agreement in the bilateral arrangements with states and territories. As outlined in Section 1, it could not be used as part of the Flexible Mental Health Funding Pool, or be used in conjunction with funds held by PHNs for PIR and D2DL.

> "The CoS measure will provide support for … clients with severe mental illness who may have an episodic rather than permanent psychosocial disability who are not best supported through the NDIS."
>
> **CoS program guidance**

Table 2 | Eligibility criteria of NPS-M and CoS

Eligibility criteria	NPS-M	CoS
People with severe mental illness who have an associated level of reduced psychosocial functional capacity	✓	✓
People who are not assisted by the NDIS	✓	✓
People who are not clients of other existing Commonwealth psychosocial support programs or state or territory government programs	✓	✓
People who have accessed supports under PIR, D2DL or PHaMs as at 30 June 2019 and are ineligible for the NDIS		✓
People who are not restricted in their ability to fully and actively participate in the community because of their residential settings (e.g. prison or a psychiatric facility)		✓
People who reside in the coverage area of the PHN where they are seeking support	✓	✓

Both NPS-M and CoS were intended to fund a range of psychosocial supports. Both programs offer group and individual supports. NPS-M guidance indicated that 'services may include individual as well as group-based activities'. CoS guidance was more prescriptive and indicated that 'services will provide group psychosocial support activities for clients… Additional targeted individual support can be provided at time of increased need if considered appropriate'. The image to the right shows the support categories for each program (minor difference highlighted in green or blue).

NPS-M SUPPORT CATEGORIES	CoS SUPPORT CATEGORIES
Social skills and friendships, including family connections	Social skills and friendships, including family connections
Managing daily living needs	Day to day living skills
Building broader life skills incl. confidence and resilience	Building broader life skills incl. confidence and resilience
Financial management and budgeting	Financial management and budgeting
Finding and maintaining a home	Finding and maintaining a home
Vocational skills and goals, including volunteering Educational and training goals	Vocational skills and goals Educational and training goals
Maintaining physical wellbeing, including exercise	Maintaining physical wellbeing, including exercise
Managing drug and alcohol addictions, including tobacco	Linking to services that manage drug and alcohol addictions, including tobacco

The duration of support offered through the two programs was intended to differ. NPS-M was designed as a short-term program where the 'focus should be on building capacity and connectedness at times when this is most needed, rather than providing ongoing support'.[37] Meanwhile, there was 'no time limit to how long a client can be supported under CoS'.[38]

The program guidance was not prescriptive about the intensity of supports. However, they indicated that NPS-M clients 'generally require less intensive support' than the NDIS whereas for CoS clients 'the intensity of support provided to clients is flexible and to be negotiated with each client based on their needs'.[39] The Commonwealth outlined two-tiers of support intensity within both programs: socially-based, capacity building group activities and targeted individual support for clients at times of increased need.

The NPS-M and CoS guidance indicated that psychosocial supports delivered through the NPS-M and CoS should align with various standards and principals. This included the National Standards for Mental Health Services 2010 and the National Practice Standards for the Mental Health Workforce 2013; and be recovery oriented, strengths based, client led, trauma informed, culturally appropriate, flexible in delivery, complementary to existing service systems, collaborative and clinically embedded. The guidance did not prescribe a model of care beyond these principles.

What happened during implementation and how did it vary nationally?

Many stakeholders desired longer funding cycles to support market stability and enable innovation

Most PHNs implemented 12-month contracts with their service providers, and providers struggled to retain and develop their workforce. Contract lengths are at the discretion of each PHN. As a result of the single-year contracts, service providers were unable to give their staff certainty or confirm roles in future years, leading to retention challenges and widespread uncertainty.

While all stakeholders appreciated the programs were necessary, many PHNs and service providers found the funding cycles and contracting periods challenging. Providers struggled to plan and provide long-term certainty for their workforces, often leading to retention challenges. Consumers observed instability within the sector and they seemed uncertain of its future.

Some stakeholders noted that longer term funding cycles (e.g. five years or more) from the Commonwealth and contract periods aligned with funding cycles from PHNs could enable more strategic

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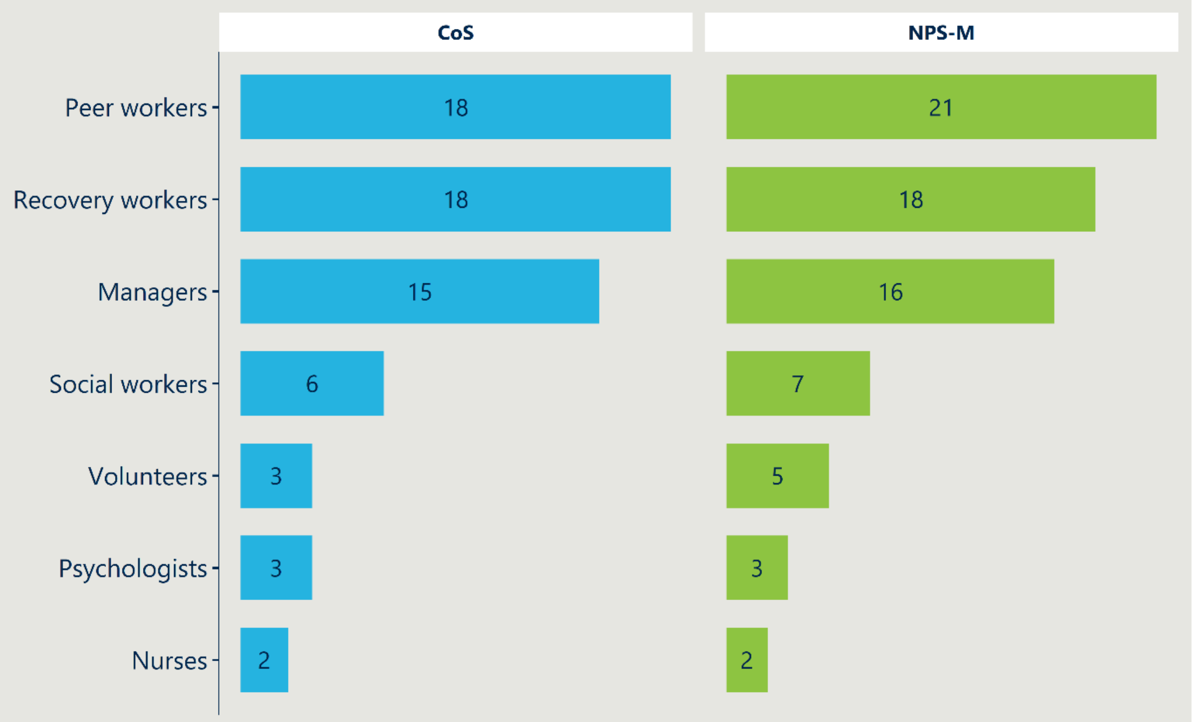
[37] NPS-M guidance
[38] CoS guidance
[39] NPS-M guidance

planning and innovation, as it would enable service providers to plan with certainty and reduce the burdens and distractions associated with regular funding applications.

PHNs outlined worker types to deliver services and many supported a peer workforce

Many PHNs included specific roles that service providers were required to include in service delivery, such as peer workers, recovery workers and managers or team leaders. As shown in Figure 12, most PHNs recognised the particular value of personal experience and mandated the use of a peer workforce in their contracts with service providers.

Figure 12 | Worker types prescribed in contracts by each PHN



Data self-reported by PHNs in their PHN profile.

This use of peer support workers was broadly very effective, with a number of participants in the personal interviews (n=13, 21%) and questionnaire (n=12, 2.4%) stating the use of a peer workforce was the most valuable component of the program. Other feedback, however, revealed that quality of peer workers was variable and highlighted the need for effective training and development of the peer workforce, with some consumers and support workers finding untrained peer support workers tended to 'overshare' and focus on their own needs rather than the consumers'.

Most PHNs used the Commonwealth's program eligibility criteria only, although some included additional criteria and targeted particular cohorts

Over 80% (NPS-M= 26, 84%; CoS= 27, 87%) of PHNs used the Commonwealth's suggested eligibility criteria for the programs provided in the guidance, captured in Table 2 of Section 3.3.[40] Some PHNs included additional eligibility criteria (self-reported in the PHN profiles in Appendix A), for example that consumers were not eligible if they accessed 'mental health clinical care from a public hospital within the last three months', or were previously 'involved in the justice system'. Some outlined consumers were only eligible if they were 'likely to require hospitalisation in future if not supported'. These PHNs outlined this was to reduce overlap with state or territory-funded programs and support.

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[40] PHN Implementation Profiles and NPS-M and CoS guidance.

Some consumer and carer peaks observed that differences in eligibility criteria across catchments created inequity for consumers, but that the programs remained relatively easy to access. Further discussion of the consumer assessment, entry and exit is captured in Section 3.5.

Half (n=16) of the PHNs also specified the programs should target specific cohorts. The main target cohorts reported in the PHN profiles were Aboriginal and/or Torres Strait Islander people (n=13, 42%), culturally and linguistically diverse people (n=7, 23%), elderly people (n=4, 13%), young people (n=3, 10%), and people living in rural and regional areas (n=3, 10%). 'Case study 2 - Integrated support for priority cohorts' (overleaf) showcases an example where Brisbane South PHN took a specific approach to meet the needs of its priority cohorts.

CASE STUDY

Integrated supports for priority cohorts

BRISBANE SOUTH PHN | QUEENSLAND

KEY INSIGHTS

- Regional governance structures improve connection and collaboration across providers, enabling integration.
- Commissioning specialist providers enables Brisbane South PHN to better meet the needs of priority cohort. Flexible contracting arrangements enables the PHN to adapt funding to meet emerging needs.
- Care coordination and service navigation are used to integrate supports for consumers with dual diagnoses.

BRISBANE SOUTH PHN DEMOGRAPHIC INFORMATION

- Over 100,000 adults (18+) were estimated to experience high/very high psychological distress in the PHN.
- Mental illness is the leading contributor to burden of disease in Aboriginal Torres Strait Islanders aged 15-29 in the PHN.
- 30% of people in the PHN are born overseas.

BRISBANE SOUTH PHN'S MODEL

- Brisbane South PHN takes a regional partnership approach to commissioning integrated services for people with severe mental illness, with a strong focus on meeting the needs of its diverse population.
- The key innovative features of its approach are introduced at a high-level below.

BRISBANE SOUTH PHN USES REGIONAL GOVERNANCE STRUCTURES TO PROMOTE INTEGRATION

Brisbane South PHN have fostered strong relationships between providers by establishing governance groups in the three local areas within the PHN.

- Regional governance groups aim to build strong relationships across providers and re-establish trust after the competitive tender process. They meet regularly to share insights, complete joint training and to establish referral pathways.
- Regional governance groups include representatives from PHNs, LHDs and service providers for clinical mental health supports, psychosocial supports and addiction treatment services.

EXAMPLE COORDINATION MECHANISMS

In 2019, Brisbane South PHN implemented a new service model, including specialist providers to respond to meet the needs of priority cohorts.

- Brisbane South PHN's priority populations are culturally and linguistically diverse people, lesbian, gay, bisexual, transgender, intersex and queer people, and Aboriginal and Torres Strait Islander people.
- Specialist providers deliver services directly to priority cohorts and work with generalist providers to improve their capability. Strong relationships between providers facilitates cross referrals where needed.
- Brisbane South PHN has developed an Inclusive Practice Reflection Tool, which is an annual self assessment tool aimed at supporting a service provider's continuous improvement in working with priority populations.

The decision to commission specialist services followed a co-design process with consumers and service providers.

In 2018, Brisbane South PHN undertook an in-depth co-design process which involved journey mapping with priority population groups and providers in the region to build a shared understanding of the challenges.

The provider bank commissioning approach enables Brisbane South PHN to flexibly address emerging needs.

Services commissioned to the provider bank are pre-vetted by the PHN and sign a flexible zero value contract. This flexible contract means that Brisbane South PHN can scale up or down the level of support provided by specialist providers based on the level of need at any time.

BRISBANE SOUTH PHN PROMOTES INTEGRATED SERVICES FOR CONSUMERS WITH DUAL DIAGNOSIS

Brisbane South PHN has taken a number of steps to promote integrated care for consumers with dual diagnoses including:

- Commissioning a dedicated resource to **coordinate care** and build mutual understanding between addiction treatment services and psychosocial supports. This aims to establish integrated care pathways and joint working across sectors.
- Building **service navigation** into all contracts to assist people with dual diagnoses in accessing services.

The distinction between the consumer cohorts created by NPS-M and CoS program eligibility was not necessary. Many PHN stakeholders noted that there is an artificial distinction between the consumer cohorts supported by NPS-M and CoS programs, based on consumers' history of engagement with previous programs, rather than their current needs. To demonstrate the variation in perspectives on the consumer cohorts across PHNs:

- Some PHN stakeholders noted that some CoS consumers have high needs and would benefit from individual supports, while many NPS-M clients could be supported through lower intensity group-based supports.
- Other PHNs, however, saw no great distinction in the level of need between the two cohorts. The evaluation found consumer needs to be similar for both cohorts and these are described in Section 5.2 and include, for example, the need to access a mixture of one-to-one and group support.
- Another group of PHN stakeholders reported they found some CoS consumers previously supported by PIR had lower support needs than most NPS-M consumers.
- Several PHN stakeholders interpreted the CoS program as being intended for primarily group-based support and noted that this did not align with the typical level of complexity and severity seen in this group.

> 'Some consumers needed exactly the support CoS was providing but were prevented by the eligibility requirements.'
>
> **PHN**

Most stakeholders outlined that supporting these two cohorts via separate programs was not necessary, and doing so provided no tangible benefits. They outlined that a single program structure could improve access to consumers (e.g. from simplified communications and reduced confusion), reduce the administrative burden on service providers who reported against the programs separately, and increase service providers' ability to be flexible and tailor support to consumer needs.

As a result, several PHNs engineered a single 'front door' to the programs

Most PHNs implemented NPS-M and CoS as separate programs. However, some PHNs treated the two as a 'single psychosocial support program' and leveraged benefits across both. Most PHNs (n=25, 85%) commissioned and procured providers to deliver NPS-M and CoS through separate processes and contracts, to align with the separate two-program structure designed by the Commonwealth. Some, however, identified that there would be benefits in terms of both efficiency (e.g. economies of scale) and effectiveness (e.g. simplified access and communications for consumers) to connect the implementation and delivery of the programs as much as possible. For example, Eastern Melbourne PHN developed a tiered care approach in partnership with a single provider, which created a single front-door to psychosocial support for consumers in its catchment area – see 'Case study 3 - PHN model of psychosocial support' overleaf. Additional detail on Eastern Melbourne PHN's communication approach and stepped care approach that accompanied its tiered packages is captured at Appendix D.

> 'Joining both programs together allowed for greater funding flexibility, lower admin costs and better therapeutic relationships'
>
> **PHN**

CASE STUDY

PHN Model of Psychosocial Support

EASTERN MELBOURNE PHN | VICTORIA

KEY INSIGHTS

- Eastern Melbourne PHN (EMPHN) has commissioned a single service provider, Neami National (Neami), to deliver person-centred psychosocial support to people with severe mental illness in its catchment area.
- Key innovative features of its approach include tiered care packages based on consumer needs and recovery goals, individual and group support, centre-based and outreach support, collaborative care and a strong approach to integration and stepped care.

EMPHN DEMOGRAPHIC INFORMATION

- ~247,600 residents experience mild to moderate mental illness.
- ~45,000 residents experience severe mental illness.
- 14% of residents are aged 65 years and older (expected to increase to 20% by 2031).
- 6,800 Aboriginal and Torres Strait Islander people are residents of EMPHN.

EMPHN'S MODEL

- EMPHN commissioned Neami to deliver the psychosocial support service, utilising funding from both NPS-M and CoS. The service provides time-limited interventions, and is recovery-focused and trauma-informed – focused on capacity building. It integrates with and complements clinical services, and aligns with EMPHN's Mental Health Stepped Care Model and Stepped Care service providers (see below).
- The key innovative features of its approach are introduced at a high-level below.

Tiered care packages of support are based on consumer need

- EMPHN and Neami collaborated to design the approach based on EMPHN's model, informed by consumer and carer engagement and insights. There is clear demand in the community for flexibility in terms of supports and intensity of service delivery.
- Neami delivers tiered levels of psychosocial support packages, funded using a combination of NPS-M and CoS funding:
  - intensive supports for up to 12 months
  - moderate supports for up to six months
  - low supports for four to eight weeks.
- This creates 'no-wrong door' to access psychosocial support where packages are based on consumer levels of need – a person-centred approach that caters to the fluctuating nature of mental illness.

Communication and branding is simplified to improve access

- EMPHN recognises that effective communications to its stakeholders are essential to create clarity about what 'psychosocial support' is and how it is delivered by service providers. Despite multiple psychosocial funding streams at state and Commonwealth levels, EMPHN's communications have avoided delineating funding stream names in favour of umbrella terms – 'psychosocial support' and 'psychosocial support services'.
- EMPHN has collaborated with other Victorian PHNs to develop accessible communications for all external stakeholders, including communication specifically for consumers and carers. *Please see examples below and full size versions overleaf.*

An access and referral team connects consumers to a range of supports

- EMPHN's Referral and Access Team helps health professionals and consumers to understand, navigate and access available mental health services in its area.
- The team includes mental health clinicians/practitioners who are able to assess clinical risk, triage as required and assist people to identify and access the service that best suits their needs. Referrals to EMPHN services can be made by anyone in the community with the consumer's consent.
- 60% of consumers receive intake through the Referral and Access Team and the remaining 40% access support directly via Neami.

Integration and collaboration underpins a stepped care approach

- The PHN collaborates with key organisations, programs and services through a range of forums to ensure integrated support, for example its psychosocial interface meetings with five Local Hospital Networks (LHNs).
- These meetings include: LHNs, NDIA/LACs, Psychosocial Support Service (NEAMI), Early Intervention Psychosocial Support Response (EIPSR), consumer, carer and EMPHN representatives.
- The meetings promote integration of psychosocial support services in EMPHN's catchment, information and updates, navigation pathways, referral, access, gaps and issues.

Almost half (n= 246, 49.5%) of consumers weren't aware of which program they were participants in. The evaluation hypothesises this is likely to be particularly true for consumers who were supported via services who had created a 'single front door', some of whom communicated the programs simply as 'psychosocial support'. Some service providers argued that it 'reduced the noise' and confusion for consumers, and this is therefore not considered detrimental. Consumer desire for a simplified and single program of psychosocial support is described further in Section 8.3.5.

PHN approaches to implementation varied significantly in line with the aims of the local commissioning model

Rather than national consistency, each PHN's implementation approach reflected their own experience and available options. The guidance intended for PHNs to tailor implementation to suit their local contexts and need. However, many PHNs reflected that their approach to implementation was only reflective of their capacity and capability during a time of flux within the sector – rather than what they would otherwise design and intend. For example, some PHNs suggested that they would have taken bolder approaches to commissioning, or worked more closely with service providers to design the models of care most appropriate for the need in their area had there been time to do so.

> 'We want to see national consistency with some local variation – not a thousand flowers blooming.'
>
> **PHN**

Some PHNs were able to coordinate consultation opportunities to support implementation in their area. For example, some PHNs were able to leverage existing mechanisms such as service provider forums and/or consumer/carer forums to gain their input into how supports should be implemented and delivered. Others noted however that the timeframes did not allow for consultation (or meaningful consultation), and some instead leveraged existing reports and materials to guide their implementation approaches. For example, some PHNs knew based on existing needs assessments in their area that particular providers, such as Aboriginal and/or Torres Strait Islander owned services, would be required to deliver effective supports in their area. Consumers noted that co-design is required to create truly impactful programs, and the need for this is described further in Section 5.4.

Most PHNs did not prescribe a model of care and required service delivery to be aligned with the guidance principles for care

Most PHNs outlined that the principles described in the guidance was enough to shape and guide care delivery in their area. Many of the sample of contracts provided to the evaluation outlined that services should be recovery-oriented, person-centric and provide individualised support that was effective within the broader mental health stepped-care approach.

Some PHNs, however, worked with service providers to identify models of care that would better meet the needs within their catchments. For example, in areas with a high proportion of regional and remote land, PHNs and providers identified a hub and spoke model would work best to ensure access and coverage.

Other PHNs worked with other stakeholders to integrate psychosocial support into stepped care models. This approach, as demonstrated by Eastern Melbourne PHN in 'Case study 3 - PHN model of psychosocial support' clearly outlined how consumers would be supported to step up and down between services of differing intensity as required on their journey to recovery.

Service providers in some PHN catchment areas benefitted from communities of practice

Some PHNs and service providers coordinated and participated in communities of practice. These forums typically included skills development activities and the opportunity for providers to understand the tools and processes used by their peers to improve service delivery and implementation in their area. For example, Tasmania PHN established monthly service provider meetings to serve this purpose. Some PHNs and service providers suggested it would be beneficial for PHNs across Australia to participate in a larger forum of knowledge and practice sharing to promote consistency, where sensible, more broadly. They suggested this could enable the Commonwealth to have more oversight of delivery lessons for psychosocial supports.

Service providers in some – particularly rural – PHN catchment areas noted they would have benefited from having a psychosocial support program-specific induction, conducted by their respective PHN. Some noted that additional information and staff training regarding the navigation of NDIS applications would have been beneficial.[41]

Program duration also differed between PHNs and programs

PHNs interpreted the Commonwealth's guidance for program duration differently. Many interpreted CoS to be an on-going support, and NPS-M to be a time limited (often to 12 months) support. However, some (n=5, 16%) PHNs put a time limit on the CoS program and 19% (n=6) provided ongoing support through the NPS-M program.

There were divergent views across PHNs about the value of time-limited support. Some PHNs noted that time limited support was in line with goal orientation and a recovery model, while others felt that it does not cater for the episodic yet ongoing nature of severe mental illness. Those who supported a time-limited program also stressed the importance of easy re-entry to the program if support was again required.

There was also a variation in whether PHNs required a goal-oriented focus from the programs. 26 (84%) PHNs reported their NPS-M programs were goal-oriented, but less than half (n= 13, 42%) said the same about the CoS programs. The evidence around goal oriented versus time limited supports is discussed in Section 8.3.1, and suggests that a goal-oriented approach is appropriate with easy re-entry into the program when needed.

Anecdotally, some PHNs reported that consumers in the programs generally don't have short-term support needs and this created challenges for providers trying to transition clients at the end of their NPS-M episode of support or trying to continue to support clients beyond the intended timeframes. Consumers experiences of exiting support are described further in Section 3.5.

Variability caused confusion for some consumers and additional administrative work for some service providers

Some consumers consulted for the evaluation outlined they were given inconsistent information about the programs including their purposes, the scope and level of supports they could offer, and the duration of access to the programs. Some of the challenges that people experienced stemmed from differences in expectations of the programs or inconsistencies in what was being delivered, including across PHN areas. Some consumers did not understand how they came to be engaged in the programs, why different people were getting different supports, or how they could benefit from the programs. It is not clear whether this was the result of variability across PHN areas, service providers and support people – but the evaluation contends it is likely to be a combination of all of the above based on consultations with these stakeholders.

Meanwhile, service providers outlined the variability in programs created additional and unnecessary administrative work. Some providers, particularly those who delivered NPS-M and CoS services across multiple PHN areas, noted the additional complexity this caused through data collection and reporting, as well as administration and program communications. Consumers and carer peaks on the other hand observed that, in comparison to the NDIS, NPS-M and CoS were seen as having less administrative weight and 'a fairly soft entry'.

> 'The data systems, reporting requirements and program specifics differ greatly between PHNs and add another layer of difficulty.'
>
> **Service provider**

Service providers found it challenging to adapt delivery of psychosocial supports to suit the need of some cohorts

Some service providers found it challenging to offer culturally appropriate support for Aboriginal and/or Torres Strait Islander consumers. Providers in several jurisdictions mentioned guidance was needed to supplement their limited experience in the area, such as a clear service delivery model or practical

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[41] In August 2020, the Australian Government announced an addition $3.5 million funding for PHNs to implement the Service Navigation measure under the Psychosocial Support Interface Activity. The funding is intended to support activities for 12 months from December 2020. Activities under the measure aim to improve the integration of local health services and make the health system more accessible for people with severe mental illness and associated psychosocial disorders. This includes working closely with NDIS Local Area Coordinators to gather and disseminate information on local services and identify service gaps. PHN Psychosocial Support Interface and Service Navigation Measure Guidance, Updated 10 November 2020, Australian Government Department of Health.

considerations like local language barriers. They also noted PHNs did not have the funds to invest in developing local teams to ensure effective support.

> **The Miwatj Health Aboriginal Corporation (Miwatj),** based in East Arnhem in the Northern Territory, provides psychosocial supports as part of a culturally safe and holistic model of care to Aboriginal consumers in its region. It provides clinical mental and physical health services (including acute care and longer-term preventative care) and runs a range of public health programs to address the underlying determinants of health. This gives Miwatj a full clinical picture of consumers and their communities, allowing them to integrate psychosocial supports into a broader care plan aligned with the holistic needs of the Aboriginal consumers and communities in East Arnhem land.

Further detail on Miwatj and examples from other PHN areas are outlined further in ‘Case study 4 - Aboriginal and Torres Strait Islander communities’ overleaf.

CASE STUDY Aboriginal and Torres Strait Islander Communities

NORTHERN TERRITORY PHN | BRISBANE SOUTH PHN

KEY INSIGHTS

- There is substantial need for psychosocial supports in Aboriginal and Torres Strait Islanders communities.
- A lack of funding and flexibility in program guidance makes it difficult to adapt delivery of psychosocial supports to be culturally safe for Aboriginal and Torres Strait Islander communities, particularly in remote areas.
- Northern Territory PHN and Brisbane South PHN have implemented culturally safe models of care (see below).

Service providers indicated a clear need for psychosocial supports in Aboriginal and Torres Strait Islander communities

- Service providers noted a high prevalence of complex mental health issues in Aboriginal and Torres Strait Islander communities, which warrant the use of psychosocial supports.
- Service providers reported that the Aboriginal and Torres Strait Islander communities they served were typically of low-socioeconomic status, located in isolated, remote areas and had poor access to education and health services. These markers of social disadvantage exacerbate the prevalence and complexity of mental health issues in these communities and make it more difficult to access supports.

Effective delivery of psychosocial support programs to Aboriginal and Torres Strait Islander communities under the current NPS-M and CoS program arrangements requires adequate funding and flexibility.

- Service providers noted investing significant time building the trust and cultural understanding required to deliver psychosocial supports in Aboriginal and Torres Strait Islander communities (see Northern Territory call out below).
  - – Before being able to provide support, some service providers reported investing significant time in learning about the country, culture, history and kinship structures within Aboriginal and Torres Strait Islander communities.
  - – To be effective, Aboriginal and Torres Strait Islander communities require long-term and sustained commitment from service providers once accepted into the community. Current short-term funding arrangements make it difficult for service providers to provide assurance and continuity of supports, risking broken trust and therapeutic relationships, and invested time and resources.
- Developing culturally safe service delivery models is complex, time intensive and expensive. Service providers reported high costs associated with travel to deliver services on country, the need to establish and train a local Aboriginal team, and cultural norms requiring holistic and inclusive support across the community, irrespective of eligibility for NPS-M and CoS.
- Service providers noted the need for flexibility to holistically address issues arising from social determinants of health (e.g. poor housing conditions and comorbid alcohol and drug issues) in order to be effective.

NORTHERN TERRITORY PHN

One service provider specialising in support for Aboriginal and Torres Strait Islander peoples has incurred significant and unsustainable out of pocket expenses associated with:

- **building trust and cultural understanding** – including immersion in the community and their cultural practices such as attending traditional ceremonies as well as hunting and fishing trips
- **developing culturally safe models of care** – including the need to establish and train a strong local Aboriginal team **from within the community**
- **integrating support into holistic community programs** – provide holistic, inclusive services or group supports to everyone in the community (regardless of their eligibility for NPS-M and CoS)
- **travelling to remote locations** – services needed to be delivered in person on country, which generates high transport and accommodation costs (although the services themselves are quite efficient to deliver).

Some Aboriginal and Torres Strait Islander communities within the Northern Territory PHN no longer have access to psychosocial supports with service providers opting out due to unsustainable financial arrangements for providers. For example service provision in the Tiwi Islands and Katherine ceased 30 June 2020 as the business model for the previous service provider was not viable with the available funding.

BRISBANE SOUTH PHN

- Brisbane South PHN has engaged a specialist provider for Aboriginal and Torres Strait Islander consumers, who are a priority cohort for the PHN.
- Brisbane South PHN has brokered partnerships between mild-moderate and severe and complex service providers with the Aboriginal and Torres Strait Islander provider to enable cross referrals.

Rural and remote service delivery often proved difficult

PHNs with areas featuring populations spread over rural and remote geographies found service delivery particularly challenging. This was due to the expense involved with travel which PHNs in these areas found challenging within the funding envelopes for the program, as well as these areas typically featuring a thin market and workforce coverage and retention challenges. Service providers estimate that costs for delivering services in rural and remote areas can be twice as high as in metropolitan areas, due in part to the cost and time associated with outreach services and support[42].

While as noted above, some worked with service providers to implement a hub and spoke model, some others developed innovative approaches to ensure service coverage. For example, some PHNs utilised telehealth as a cost-effective method to contact consumers in hard-to-reach areas, which also facilitated a quick transition during the COVID-19 pandemic. The use of telehealth delivery is well-evidenced, discussed further in Section 8. Further examples of how PHNs and service providers delivered services in regional, rural and remote areas is captured overleaf in 'Case study 5 - Regional, rural and remote service delivery' overleaf.

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[42] The Commonwealth announced additional funding in August 2020 which included regional loading for clients in Modified Monash regions 3 to 7. PHN CoS and NPSM/Transition Guidance, Updated 10 November 2020, Australian Government Department of Health.

CASE STUDY

Regional, Rural, and Remote Service Delivery

WESTERN QUEENSLAND PHN

KEY INSIGHTS

- Service delivery in regional, rural and remote areas is particularly challenging. Vast distances and difficult to access populations drive costs, meanwhile thin markets and workforce retention create added complexities for service coverage and delivery.
- PHNs with higher proportions of regional, rural and remote areas have developed innovative approaches to connect their distributed populations to psychosocial supports; however, the context remains complex.

Context

- Delivery of psychosocial support services in regional, rural and remote areas is particularly expensive for service providers. Vast geographies with difficult to access terrain drives costs for service delivery where outreach is required. Meanwhile, the service provider market is thin and workforce challenges around recruitment and retention are amplified.
- Flexibility is critical in regional and remote areas due to the limited availability and capacity of mainstream and registered support providers, meaning providers may need to deliver integrated supports through more innovative, non-traditional mechanisms.

WESTERN QUEENSLAND PHN

- Western Queensland PHN has one of Australia's most remote catchment areas. It covers a land area of 956,438km.sq., which is 55% of the total land area in Queensland. There are twenty Local Government Areas (LGAs) and three Hospital and Health Services (HHS) within its area.
- Western Queensland has developed innovative approaches to connecting its distributed population to psychosocial supports. These are outlined in further detail below.

Out-of-area service providers fill market and workforce gaps

Western Queensland PHN recognised the market capacity within its catchment area was thin for service providers of quality psychosocial supports. As a result, the PHN has engaged service providers with the required skills and workforce capacity to deliver services remotely from other parts of Queensland. Consumers are connected to providers via GPs in their area. More on this below.

GPs are at the centre of care within Western Queensland PHN's healthcare home model of care

- Consumers in Western Queensland primarily access mental health care through GPs. As a result Western Queensland has invested time and resources to upskill and actively manage GPs in its area to make referral through to NPS-M and CoS providers.
- Western Queensland also allows funding to be used for brokerage through this model in recognition of the scarcity of local supports. If the client meets the eligibility criteria and it has also been established that there is no other way of funding these activities, an application can be made for this funding through the brokerage agency. The brokerage agency will work with the GP/service provider to source activities that have been identified as activities that will assist in the client's social recovery.

Online apps and electronic referrals increase access and support efficiencies

- Western Queensland PHN developed an app consumers could access on their smartphone, which provided education on psychosocial supports and links to psychosocial service providers.
- An electronic referral system supported the efficient referral of consumers from GPs to psychosocial support providers, enabling the relevant clinical information to be transmitted to coordinate care.

WA PRIMARY HEALTH ALLIANCE

WA PHNs have weighted the majority of their Commonwealth psychosocial support funding to regional, rural and remote parts of Western Australia. Meanwhile, state funded supports tend to be directed to metro areas.

NORTHERN TERRITORY PHN

The Northern Territory PHN's service provider market is thin. As a result, they take a direct engagement approach with providers and this supports the development of positive relationships where the PHN and providers can work together on solutions to complexities driven by their vast and remote geography.

What are the lessons learnt?

The key lessons learnt that relate to NPS-M and CoS **program structure and design** are:

- There is a clear need for a substantial program of psychosocial support for consumers who are not better supported by the NDIS. This aligns with the Productivity Commission Report's finding that there is a low intensity gap (i.e. a large gap in the utilisation of low cost, low risk and easy to access services). Of note, the Productivity Commission has concluded that the low intensity gap exists primarily because of under-provision of low cost, low risk and easy to access services, and because of a lack of information about these services.[43]
- Consumers, PHNs and service providers would benefit from a single program for psychosocial support that allows flexibility in the type and volume of support provided. This would allow supports to be better tailored to meet individual needs, remove the arbitrary distinction between cohorts and reduce the administrative burden on service providers who could report for one program instead of multiple.
- Funding cycles for future program(s) should be longer to increase market and workforce stability, and enable innovation, funding contracts with service providers should be longer than one year.
- There is a need to grow the specialised market and workforce to provide culturally safe and appropriate support for Aboriginal and Torres Strait Islander peoples and people of CALD backgrounds.
- A system for aggregating service delivery lessons within and across PHNs would be beneficial, for example establishing communities of practice.

3.4 Governance and reporting

What was the plan for NPS-M?

Implementation was overseen by the Commonwealth, in consultation with states and territories. The Commonwealth provided funding for the programs and established program and reporting requirements. PHNs were responsible for establishing reporting arrangements with commissioned service providers to meet reporting requirements.

States and territories agreed to work with the Commonwealth to implement, monitor, refine and evaluate the NPS-M through Bilateral Agreements. This included agreement to share information to assist with planning and policy development, subject to privacy requirements. The intended governance arrangements for NPS-M are captured in Figure 13.

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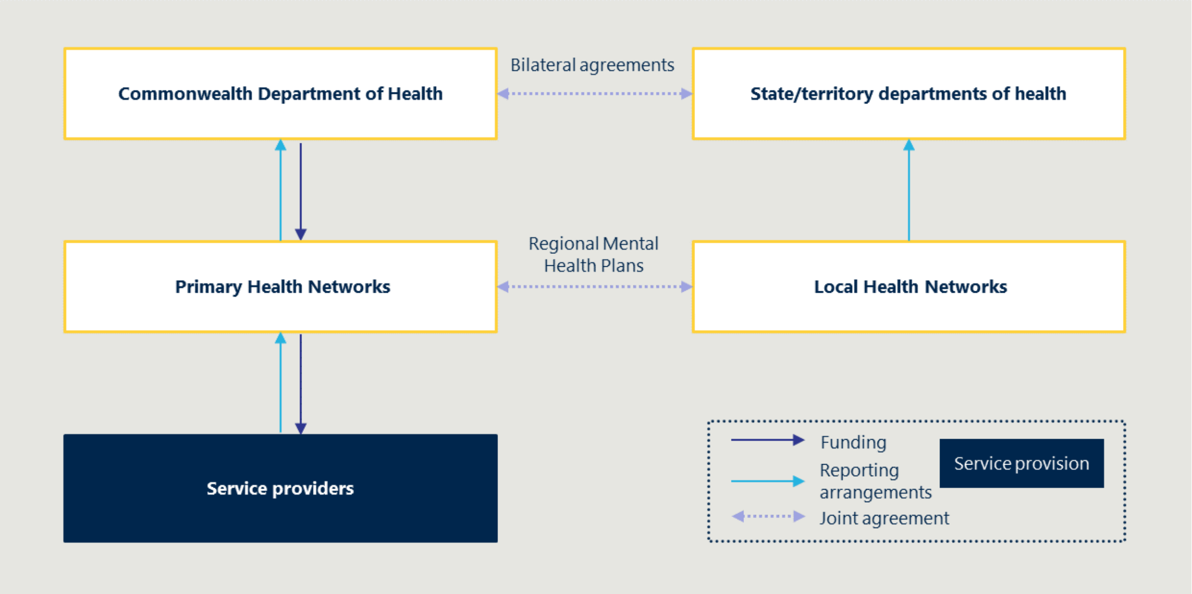
[43] Productivity Commission, Mental Health Inquiry Report – Volume 1, 2020, p30.

Figure 13 | Intended governance arrangements for NPS-M



The Commonwealth required PHNs to develop a suite of reports for both programs to describe and report against program implementation. These included an:

- **Activity Work Plan** to describe the implementation and delivery of NPS-M and CoS in their area, which comprised general information, planned processes and financials.[44,45,46]
- **Needs Assessment for their area to support implementation planning,** which were to comprise narrative, outcomes of their health needs analysis, outcomes of their service needs analysis, and opportunities, priorities and options.[47,48,49,50]

Following implementation, PHNs were then expected to submit six- and 12-monthly performance reports. The six- and 12-month performance reports were intended to cover the status of consumer metrics across the NPS-M and Cos programs, such as service capacity, participant numbers, waitlist details and average weekly hours of support.

PHNs were also required to submit financial reports including a submission of an annual budget for approval by the Department of Health, Financial Acquittal Reports and a Financial Declaration confirming proper use of funding.

PHNs were required to collect program data for commissioned activities through the PMHC-MDS. PHNs were required to ensure reporting and data processes were established with service providers to monitor NPS-M and CoS client numbers, service delivery, number of clients retesting/testing eligibility for the NDIS and number of clients successful in transitioning to the NDIS. PHNs were also expected to achieve 100% compliance with mandatory data submission to the PMHC-MDS within three months of each service delivery event within the reporting period.

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[44] Program description and aim, target population and geographic coverage
[45] Consultations planned, key milestones, commissioning method and approach, decommissioning plans
[46] Total expenditure and funding sources
[47] Outline of the region, as well as the process and any key issues in undertaking the Needs Assessment
[48] The Health status and needs of the population
[49] The region's services and health infrastructure
[50] A summary of the priorities identified in the Needs Assessment and how they will be addressed

What happened during implementation and how did it vary nationally?

The governance structure was variable in its ability to provide oversight and support coordination

Stakeholders considered that program governance arrangements were not generally conducive to integration and oversight of psychosocial supports between the Commonwealth and state and territory governments. The NPS-M bilateral agreements differed across states and territories to reflect different arrangements and commitments, and following this there was no clear mechanism or approach in place to continue oversight to enable Commonwealth and state or territory governments to understand which psychosocial support programs exist and where duplication may be. As a result, some stakeholders noted the duplication and gaps that exist for psychosocial support. This is discussed further in Section 6.

Regional Mental Health plans were in varying stages of development at the time of the evaluation. Some PHNs (n=7, 23%) utilised this process to plan the NPS-M and CoS programs. Further discussion on the integration and coordination across the programs and associated governance is captured in Section 6.

Reporting processes were complex and more burdensome than other programs

While key reporting by PHNs generally occurred as planned, on occasions there were delays attributed to complexity and validation issues. Some PHNs outlined the delays associated with six- and 12-month performance reporting was due to the need to create buy-in and upskill staff amongst service providers, as well as the format of the report templates. Some found the reporting across NPS-M, CoS and NPS-T in both the TRIS and the PMHC-MDS to be burdensome. Strategies to reduce the reporting burden included group training sessions, PHN-hosted databases and external tools to simplify data entry.

Some service providers also noted that administrative costs associated with NPS-M and CoS are high compared to other state programs or the previous Commonwealth-funded programs due to more onerous data collection and reporting requirements. Some outlined that multiple sources of reporting created inefficiencies that further exacerbated this cost. This is discussed further in Section 7.2.

Many stakeholders challenged the appropriateness and suitability of the data submitted via the PMHC-MDS

All parties involved in delivery of the programs have raised concerns regarding the data that is collected as part of the programs. These concerns include the completeness, appropriateness and quality of the data that has been collected as well as the governance, access, reporting and consent arrangements surrounding the data. Briefly, observations include:

- The structure and fields of the PMHC-MDS are not fit-for-purpose to capture data from NPS-M and CoS programs. This largely reflects the PMHC-MDS being built to hold data from the Primary Mental Health Care Flexible Funding Pool with minor changes being made to incorporate NPS-M and CoS.
- Some PHNs and service providers consider the outcome measures included in the PMHC-MDS (K10+ and K5) to be misaligned with the recovery approach of psychosocial support programs like NPS-M and CoS (see 'Case study 6 - Outcome measures to assess psychosocial recovery'). This has led to incomplete collection and reporting of outcome measurement data for these programs.
- PHNs and service providers have varying capacity to capture data and ensure its quality before it is reported to the Commonwealth. Some PHNs have high levels of capability and have developed sophisticated systems to provide high quality data. Other PHNs are not involved in data collection and quality assurance with service providers who provide data directly to the PMHC-MDS. Some service providers needed substantial support from PHNs to collect and report data for the NPS-M and CoS programs.
- There is confusion surrounding the governance and consent arrangements of the PMHC-MDS including a lack of clarity as to the ultimate data custodian for data held in the PMHC-MDS. This confusion has prevented use of the PMHC-MDS for legitimate evaluation purposes and a reticence to use the data for planning purposes.

What are the lessons learned?

The key lessons learned that relate to the governance and reporting arrangements for NPS-M and CoS are:

- The lack of useful and accessible data on which to evaluate the programs is a significant failing and requires urgent attention. Revisions to data reported to the PMHC-MDS (i.e. revisions to outcomes and their measurements) and a redesign of the governance for access to this data would support increased oversight and enable more strategic decisions for the future of psychosocial support.
- Governance arrangements could be strengthened to improve oversight and coordination of psychosocial support between the Commonwealth and state and territory governments. This aligns with the findings within the Productivity Commission report.[51]

3.5 Consumer assessment, entry and exit

What was the plan?

The assessment, entry and exit approaches for each program were intended to look different for NPS-M and CoS. This reflects the different support history for the consumers intended for each program (i.e. entry into CoS was only relevant for consumers previously supported by PIR, D2DL and PHaMs, who had been deemed ineligible for the NDIS), and the different intention for the programs in terms of length of support based on the anticipated level of need from consumers. The Commonwealth's guidance for assessment, entry and exit from the programs is captured in Table 3.

Table 3 | Commonwealth guidance for assessment, entry and exit for NPS-M and CoS

Stage	NPS-M	CoS
Assessment	**Guidance mandated a general assessment of consumer requirements**. The documentation did not provide a specific process or criteria for this assessment, but stated that PHNs should ensure consumers that need ongoing or higher levels of support were encouraged to test NDIS eligibility.	**Guidance mandated an initial assessment** with a support worker where the consumer is new to the service provider. This assessment includes a thorough assessment to identify the consumer's strengths, needs and recovery goals, as well as existing clinical and non-clinical supports to be referred to if needed.
Entry	**PHNs were expected to establish referral pathways into and out of the programs** by engaging with other commissioned services, NGOs providing other community support services and with NDIS Local Area Coordinators. Guidance suggested PHNs should use information in bilateral agreements or regional mental health plans to ensure arrangements were in place to support referrals to NPS-M services.	**Commonwealth also mandated an individualised support plan** should be developed together with the client from the needs assessment, outlining activities to be undertaken to achieve recovery goals and meet support needs, as well as a care/crisis plan in the event that the client becomes unwell or a crisis occurs. Guidance expected both PHNs and service providers to create and streamline referral pathways into the program from previous programs.
Exit	**The guidance did not clearly outline the intended duration of support and did not explicitly state that support must be time-limited.** The guidance noted that 'the cohort being targeted through this initiative would generally require less intensive and possibly shorter term psychosocial support than the service offer provided through programs transitioning to the NDIS'.	**Finally, guidance noted support plans and NDIS eligibility should be reviewed over regular time intervals** and following any significant events in the life of the client which may affect their support needs.

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[51] Productivity Commission, "Inquiry Report – Mental Health", 2020, Volume 1, p.58. Accessed via: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf

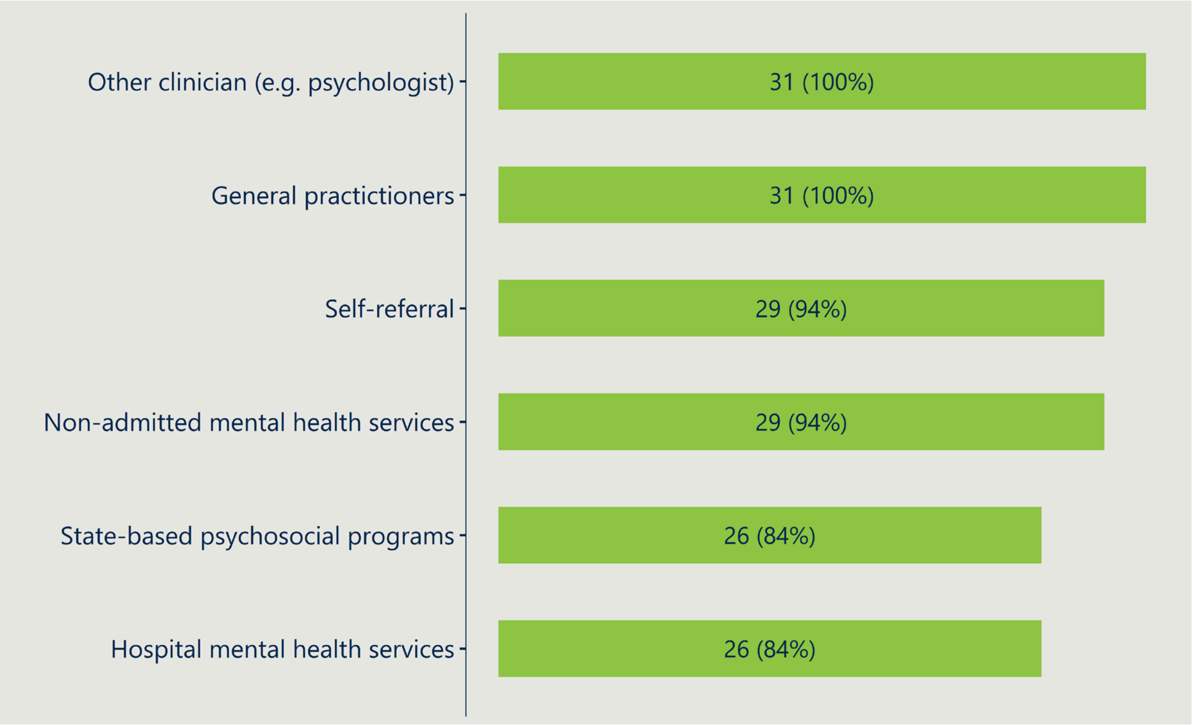
The process of setting and achieving recovery goals was also ambiguous. While recovery goals were included in Commonwealth guidance for the NPS-M program, there was no mandate or suggestion of processes that should be used to achieve these, unlike CoS guidance.

What happened during implementation and how did it vary nationally?

Referrals into the NPS-M program were based on existing relationships rather than formal pathways

Referral sources and numbers varied across PHNs as shown in Figure 14.

Figure 14 | Referral pathways specified by PHNs[52]



There was some confusion as to whether service providers could accept referrals from state-based clinical or psychosocial services. PHNs outlined that they attributed this to the guidance not being specific around mechanisms that could be used to link with clinical and non-clinical supports. Where PHNs were able to implement successful referral pathways, they often leveraged consortia models or pre-existing relationships to guide referrals or create new referral pathways. See 'Case study 8 - Examples of New South Wales integration efforts' for an example of this from NSW.

Consumer peaks outlined that their constituents' experiences were that referral processes varied greatly. For example, some allowed self-referral, others did not; some required the person have a clinical manager or otherwise specified who could refer; some required evidence of clinical diagnosis where others did not appear to do so.

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[52] Data self-reported by PHNs in their PHN implementation profiles.

Assessment processes varied between programs and providers

Service providers used a range of formal and informal tools to conduct initial assessments and gauge baseline outcomes. Some saw great success through clearly defined thresholds (e.g. the Life Skills Profile (LSP-16) or similar tools):

- Strengths and Difficulties Questionnaire (SDQ)
- Camberwell Assessment of Need Short Appraisal Schedule (CANSAS)
- Recovery Assessment Score – Domains and Scales (RAS-DS)
- Recovery Star
- Health of the National Outcome Scales (HoNOS)
- World Health Organisation Disability Assessment Schedule (WHODAS).

These measurement tools ranged greatly in their length and functional purpose, and PHNs assessment process varied according to the eligibility criteria set by the PHN. For more detail see 'Case study 6 - Outcome measures to assess psychosocial recovery'.

Consumers had mixed experiences of exiting programs and some processes were challenging

Some PHNs outlined it was difficult for service providers to smoothly transition consumers out of programs, stepping them down or up to a more appropriate service. Consumers who had exited NPS-M or CoS (n=9) varied in terms of whether they felt they no longer needed the support, but the management of the exit transition also varied. For some, the exit was well-managed, even if unwelcome. These people had always been aware of when the transition would occur and had been prepared for it.

In other cases, however, the exit was abrupt and sometimes traumatic. One consumer outlined they were 'cancelled out' of their program after six months, despite having been told that it was a 12-month program (the evaluation assumes therefore the program was NPS-M). Although the consumer and the support worker had a nice farewell afternoon tea together, the consumers found the exit very abrupt and thought that having been exited early had affected their progress toward their goals.

Others talked about the timing of their exit being poor, for example if they were going through a particularly bad time. For one consumer, the idea of exiting the service was put to her suddenly, at a very vulnerable moment, when she was crying on the phone. The support worker failed to check in on her after such an emotional phone call and the consumer felt so abandoned that she declined the offered final support call.

> 'If you've had an abusive background, which has been part of my history, when you go and engage with someone and then it's cut off it's a form of abuse in itself. It can hit you back. It's got to be really subtle how it's done.'
>
> **Consumer**

What are the lessons learned?

The key lessons learned that relate to NPS-M and CoS consumer assessment, entry and exit are:

- An ecosystem of referrals pathways in and out of the programs relies on strong relationships between commissioners and providers, and a mutual understanding of service offerings and consumer need.
- A standardised intake and assessment tool could enable service providers to identify target consumers and to understand when they can be stepped up or down (see 'Case study 6 - Outcome measures to assess psychosocial recovery' in Section 4.3.2).
- Clear and regular assessment points during program participation could support recovery, discourage dependence on services and inform better exiting processes.

4 To what extent have the NPS-M and CoS programs achieved their intended outcomes? (KLE 2)

Summary of findings

NPS-M was put in place to provide services for people who were not receiving psychosocial support from PIR, D2DL and PHaMs on 1 July 2019, and who were not currently receiving support from the NDIS or from state or territory programs. Over the period 1 July 2019 to 30 June 2020, NPS-M has supported 7,412 people. Nevertheless, there remains unmet need including substantial wait times to access support and opportunities for improving the appropriateness of the support provided.

The overall funding for CoS provided access to supports for nearly 5,000 consumers over the period 1 July 2019 to 30 June 2020, fewer than the anticipated 8,800 consumers. CoS provided many consumers who previously accessed support through PIR, D2DL and PHaMs and had been found ineligible for support through the NDIS with needed and continued psychosocial support. However, some consumers have disengaged and may have fallen through the cracks during the transition period.

Regional and remote areas have more consumers accessing psychosocial supports for their population compared with more metropolitan regions across both the NPS-M and CoS. Current funding for both programs appears to reflect this with higher levels of funding for regional and remote areas compared to metropolitan areas.

Separate funding streams for NPS-M and CoS creates an apparent inequity of access with consumers who previously received support through PHaMs, D2DL and PIR accessing services more readily than those who did not (i.e. NPS-M consumers). In particular, some PHNs had substantial wait times for consumers to access NPS-M services which was not the case for CoS consumers. Many PHNs also provided time limited support for NPS-M consumers while CoS consumers could access ongoing support.

Despite psychosocial support being provided through the Australian and state or territory governments (including the NDIS) there is still a substantial number of consumers who are not able to access services. The Productivity Commission estimates that up to 154,000 people would not be able access the psychosocial support services they need.[53]

A further policy objective of the NPS-M was contained in the bilateral agreements with each jurisdiction. Through these agreements all governments committed to maintenance of effort in psychosocial support programs, to foster integration and to contribute to this evaluation. Section 6 provides a discussion of the extent of integration achieved and the maintenance of effort. All states and territories provided information to the evaluation in relation to their funded psychosocial programs, although permission to publish this information was not provided by all states and territories, therefore no jurisdictional information is provided in this report.

Data from select PHNs provides evidence that the support provided through NPS-M led to decreased psychological distress. A similar pattern was seen in CoS, though the decrease was not statistically significant. PHNs and service providers noted that the current outcome measures for these programs may not be the most appropriate due to their language and focus on psychological distress rather than psychosocial function.

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[53] Productivity Commission, "Inquiry Report – Mental Health", 2020, Volume 3, p.862. Accessed via: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume3.pdf

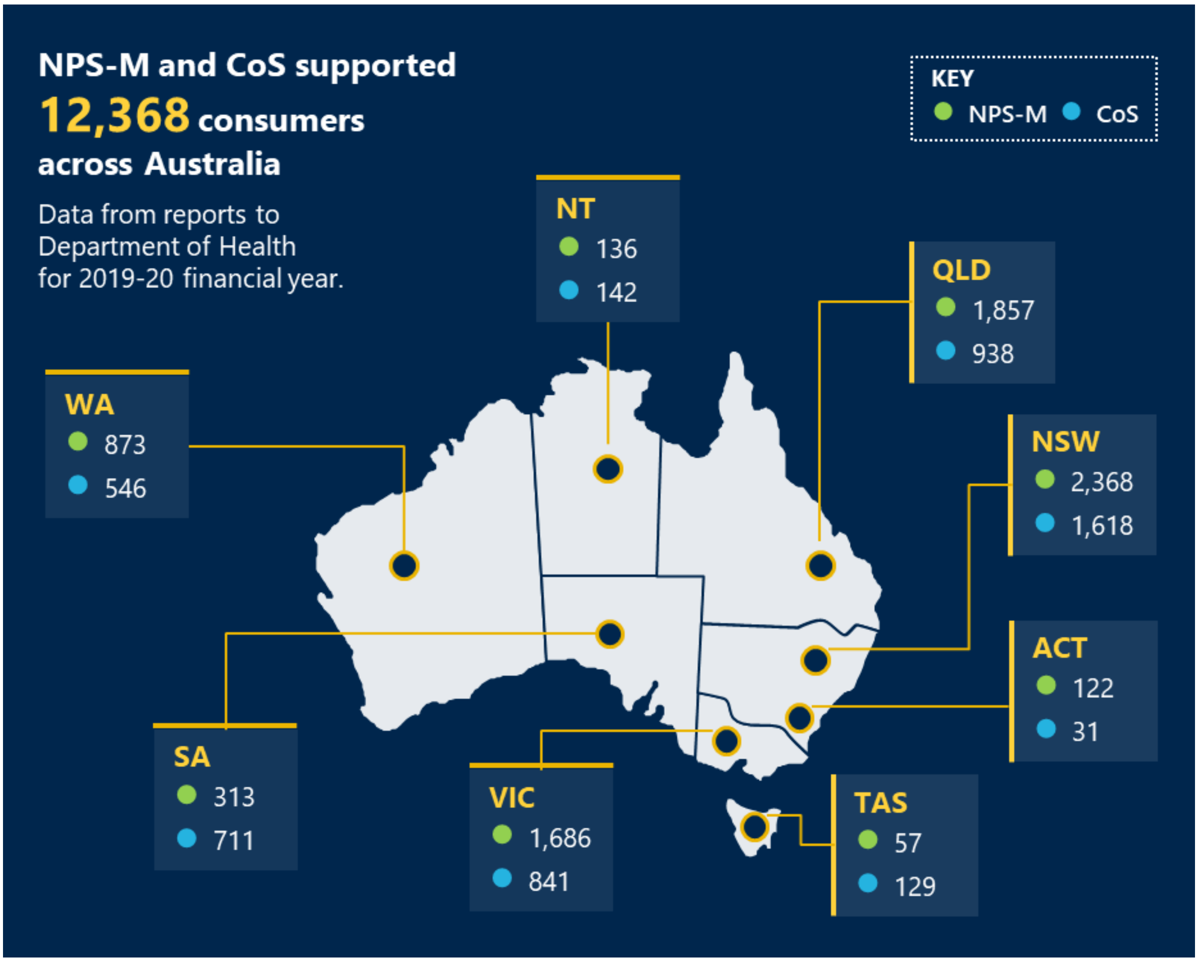
4.2 Did the NPS-M and CoS achieve the desired policy outcomes?

4.2.1 NPS-M and CoS allowed new and existing consumers to access psychosocial support but there remain unmet needs

A total of 12,368 consumers accessed support through NPS-M and CoS

NPS-M and CoS allowed consumers with severe mental illness to access psychosocial support that they otherwise would not have been able to access after PHaMs, D2DL and PIR ended. Together, the NPS-M and CoS programs supported 12,368 consumers in the period 1 July 2019 to 30 June 2020.[54] Figure 15 presents the number of consumers who received services through the NPS-M and CoS programs for each state and territory.

Figure 15 | NPS-M and CoS consumers across Australia from 1 July 2019 to 30 June 2020



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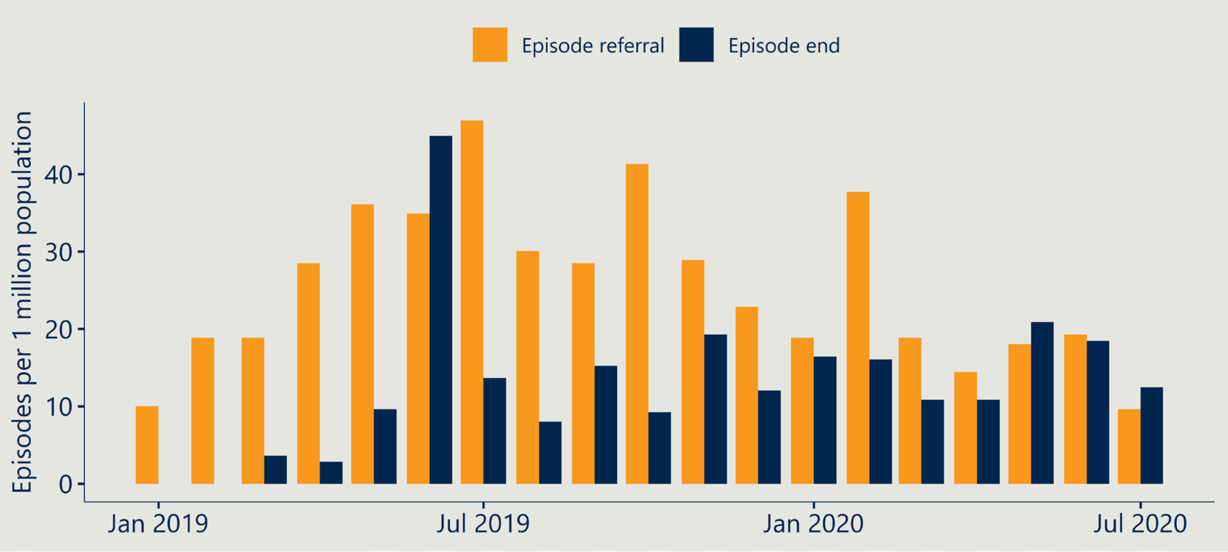
[54] Australian Government Department of Health, 12-month performance reports from Primary Health Networks. Separate data is available for the 1 January 2019 to 30 June 2019 period, but it is not possible to determine how many people carried over between this period and the 1 July 2019 to 30 June 2020 period. PMHC-MDS data does not provide an accurate reflection of consumer numbers (see Appendix C)

The NPS-M program provided psychosocial support to new consumers who were not accessing the NDIS to achieve their recovery goals. PHNs reported 7,412 consumers have received support through the NPS-M program over the period 1 July 2019 to 30 June 2020.[55] Modelling for the NPS-M program envisaged creating 3,800 consumer places that would be available throughout the program's existence.[56] Consumers were anticipated to access these places for a period and then exit NPS-M, making the place available for another consumer. The higher number of consumers accessing the program likely reflects this with consumers accessing the service for a period of time less than a year (either due to short-term need or time limited support). During consultations, PHNs noted that there was a tension between providing access for new consumers and ongoing long-term support for new program participants. Section 3.3 discusses NPS-M and CoS program design and the impact of this on the intensity and length of support typically provided. The high number of consumers accessing NPS-M also suggests the 3,800-figure used to model the service was an underestimate and that there is higher level of need in the community than anticipated. This is supported by modelling reported by the Productivity Commission which estimates that approximately 154,000 people in Australia with severe mental illness who are not able to access the psychosocial support they need (see 'Estimates suggest there is large unmet need for psychosocial support services', page 60)[57].

> 'I am, with their help, understanding who I am, developing new skills and a sense of peace.'
>
> **Consumer**

Access ramped up in the first six months of NPS-M service delivery. Figure 16 presents the number of NPS-M episodes per population that were referred and ended in each month across the PHNs that provided unit record data for case study analysis. Referrals increased between January and July 2019 as NPS-M programs came online and consumers began accessing services. Referrals then trend downwards while episode ends remain relatively constant, likely reflecting services reaching capacity. If the pattern observed in the PHNs presented here was reflected across the country, the peak number of consumers accessing services would reflect approximately 1,000 new episodes in any one month. Across the 18 months presented in Figure 16, only three months had more episode ending that being referred suggesting a high demand for services.

Figure 16 | NPS-M consumer flows in case study PHNs[58]



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[55] 12 monthly reports from PHNs to the Australia Department of Health. Data is not available during the first 6 months of the program from 1 January 2019 until 30 June 2019.

[56] Advice from the Department of Health, Mental Health Supports Branch.

[57] Productivity Commission, "Inquiry Report – Mental Health", 2020, Volume 3, p.862. Accessed via: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume3.pdf.

[58] Data from three PHNs which provided unit record PMHC-MDS data. Y axis represents the number of episodes per total population (in the 2016 ABS Census) across the three PHNs to account for differences in PHN size and make values applicable across Australia.

The CoS program allowed participants of PHaMs, PIR and D2DL who are not eligible for NDIS services to continue accessing psychosocial support. PHNs reported 4,956 consumers have received support through the CoS program over the period 1 July 2019 to 30 June 2020.[59] This is substantially lower than the 8,800 consumers who were anticipated to receive support through the program.[60] Some consumers in the previous programs immediately transitioned onto the CoS program if they had previously been found ineligible for support through the NDIS. Other consumers transitioned to NPS-T which was designed to provide support to consumers while they tested their eligibility for the NDIS. Over time, consumers would then either transition to the NDIS (if they are eligible) or transition to CoS (if they are ineligible for NDIS support).

On 1 July 2019, 15,484 participants transitioned into the NPS-T from the existing Commonwealth programs (PIR, D2DL and PHaMs). Table 4 presents a summary of the 13,479 participants who had exited from NPS-T by 30 June 2020.

Table 4 | Summary of exits from NPS-T to 31 December 2020

NPS-T status	Consumers	Proportion of NPS-T exits
Exited to CoS	4,560	29.5%
Exited for other reason	4,447	28.7%
Exited to NDIS	5,223	33.7%

Close to two thirds of consumers (66%) who have exited NPS-T are receiving ongoing psychosocial support through the NDIS or the CoS program. A further 34% of consumers have exited NPS-T for other reasons. Additional analysis conducted by Flinders University indicates that more than half the consumers who exited for other reasons over this period either disengaged, no longer wanted support or were not contactable.[61] This indicates CoS provided many consumers who were previously accessing support through PIR, D2DL and PHaMs with needed and continued psychosocial support. However, some consumers have disengaged and may have fallen through the cracks during the transition period. In some cases, consumers only attended a service once and did not continue seeking support.

Separate funding streams for NPS-M and CoS creates an apparent inequity of access with consumers who previously received support through PHaMs, D2DL and PIR accessing services more readily than those who did not (i.e. NPS-M consumers). Some providers observed that there are potential consumers who would benefit from CoS-level support but who are ineligible for access, given they were not consumers of previous Commonwealth-funded programs. These are typically consumers who would benefit from longer-term support and who are ineligible for the NDIS. These consumers were only able to access services funded under the NPS-M program which had a lower level of average funding per consumer place than the average funding per consumer available for the CoS program (see Section 7.2.4).

> ‘Keeping CoS shut to new consumers means the program is quite stagnant. We have participants in other programs who would mix well with the CoS program and services and derive a lot of benefit from this.’
>
> **Service provider**

Regional and remote areas had more consumers per population and higher levels of funding

PHNs in regional and remote areas had more consumers relative to their population compared with PHNs in metropolitan areas. Figure 17 presents the number of consumers per 100,000 population compared with an estimate of the regionality of each PHN based on the Modified Monash Model (MMM) value of its

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[59] 12 monthly reports from PHNs to the Australia Department of Health.

[60] Advice from the Department of Health, Mental Health Supports Branch.

[61] Exit to Other Analysis, 1 July 2019 to 30 June 2020, Flinders University provided by Department of Health

constituent postcodes (see Appendix E for PHN MMM values).[62] There is a positive relationship between the number of consumers per population and estimated MMM regionality with higher values of regionality (more regional areas) having more consumers per population. This relationship is present and statistically significant in both the NPS-M and CoS program but is more prominent in the NPS-M program.[63] Table 5 presents the estimated number of consumers for each level of MMM regionality based on the regression analysis[64] conducted. This modelling suggests regions with the highest level of MMM regionality have more than five times the number of NPS-M consumers per population than regions with the lowest level of MMM regionality. A similar pattern is seen with CoS where regions with higher MMM regionality have more than three times the number of consumers per population compared with less rural areas. This may be caused by the relative paucity of supports of other services in regional and remote areas making these services proportionately more important. Further analysis with more detailed data than is currently available is needed to investigate this further. As noted below, regions with higher number of consumers per population also had higher levels of funding and this may have driven the number of consumers who access the services.

Funding is proportionately higher in regional and remote areas likely reflecting regional loadings. Figure 17 also presents the amount of funding per 100,000 population compared with an estimate of the regionality of each PHN based on the MMM value of its constituent postcodes. There is a similar pattern to the number of consumers per population where PHNs with higher estimated MMM regionality have higher levels of funding per population.[65] This likely reflects regional loadings used to distribute funding across PHNs. Table 5 presents the estimated total funding for each level of MMM regionality based on the regression analysis conducted. Regions with the highest level of MMM regionality are expected to have more than three times the amount of NPS-M funding per population than regions with the lowest level of MMM regionality. The relationship is stronger for the CoS program where regions with higher MMM regionality have more than four and a half times the amount of funding per population compared with less rural areas.

There appears to be some misalignment between the number of consumers and funding per population across the two programs. The increase in funding (per population) for each unit of MMM regionality is higher in CoS compared to NPS-M. In contrast, the increase in consumers (per population) for each unit of MMM regionality is higher in NPS-M than CoS. This suggests the average level of funding per consumer in regional and remote areas is higher for the CoS program than the NPS-M program. CoS has also received additional regional loading which may have increased this discrepancy.[66]

This analysis highlights the need to consider funding allocations for regional and remote areas due to consumer need. Separate consideration should be given to the additional cost for providing equivalent services in regional and remote areas, outlined further in Section 7.

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[62] The Modified Monash Model (MMM) is how the Australian Government Department of Health defines whether a location is a city, rural, remote or very remote. It measures remoteness on a scale of 1 to 7 with 1 being a major city and 7 being very remote. Accessed via: https://www.health.gov.au/health-workforce/health-workforce-classifications/modified-monash-model

[63] Linear model across PHNs with consumers per 100,000 population as the outcome variable and estimated MMM regionality as the predictor variable. Coefficient for estimated MMM regionality was 13.4 (p = 4.6e-5) for NPS-M and 5.5 (p = 8.2e-4) for CoS.

[64] Regression analysis is the process for estimating relationships between a dependent variable and one or more independent variables. This analysis involved linear regression with the number of consumers per 100,000 population and the amount of funding per 100,000 population used as dependent variables (in separate models) and the estimated of regionality of each PHN based on the MMM value of its constituent postcodes as the independent variable (in all models).

[65] Linear model across PHNs with total funding per 100,000 population as the outcome variable and estimated MMM regionality as the predictor variable. Coefficient for estimated MMM regionality was $91,705 ($p$ =1.88e-10) for NPS-M and $188,189 ($p$ =3.71e- 5) for CoS.

[66] The Commonwealth announced additional funding in August 2020 which included regional loading for clients in Modified Monash regions 3 to 7. PHN CoS and NPSM/Transition Guidance, Updated 10 November 2020, Australian Government Department of Health.

Figure 17 | PHN consumers and funding per population across regionality[67]

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[67] Consumer numbers from 12-month performance reports (2019-20) from PHNs to Australian Department of Health. Population values from the ABS Census (2016). Estimated Modified Monash Model (MMM) regionality represents a mean of the MMM of postcodes in each PHN weighted according to postcode population from the ABS Census (2016).

Table 5 | Estimated consumers and funding per 100,000 population based on MMM regionality

	NPS-M		CoS	
MMM regionality	**Estimated consumers per 100,000 population**	**Estimated $'000 funding per 100,000**	**Estimated consumers per 100,000 population**	**Estimated $'000 funding per 100,000**
1	19	$251	17	$308
2	32	$343	22	$497
3	45	$434	28	$685
4	59	$526	33	$873
5	72	$618	39	$1,061
6	86	$710	44	$1,249
7	99	$801	50	$1,437

Estimates suggest there is large unmet need for psychosocial support services

The Productivity Commission estimates that there are approximately 154,000 people with severe mental illness who are unable to access the psychosocial support they require.[68] This estimate of unmet need is based on an estimate from the NMHSPF which indicates there are approximately 290,000 people with severe and persistent mental illness who are most in need of psychosocial support.[69] The Productivity Commission estimated that approximately 110,000 people in Australia received government funded psychosocial supports in 2019-20 including through NPS-M, CoS, NPS-T, NDIS and state/territory-funded supports.[70]As the NDIS continues to rollout, an additional 30,000 people are estimated to be receiving support for a psychosocial disability through the NDIS and 3,000 will transition from other psychosocial support services to the NDIS. The remaining gap in psychosocial support services is expected to be approximately 154,000 people.

The Productivity Commission estimates that expanding the provision of psychosocial support to provide support for all 290,000 people including those who currently miss out could cost approximately $610 million (2019-20 dollars) per year.[71]

Further specific modelling for psychosocial support can inform regional planning processes. The Productivity Commission has recommended that each regional grouping of PHNs and their Local Health Networks estimate the shortfall in the provision of psychosocial supports outside of the NDIS in their region, relative to benchmarks from the NMHSPF. Conducting modelling at the regional level will allow for important factors such as at-risk people, groups and geography to be considered that may not be captured at the national level. Currently, conducting gap analysis for small geographic areas (e.g. local government areas (LGAs)) for all regions in Australia is difficult due to the limitations of data in the PMHC-MDS (see Section 3.4).

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[68] Productivity Commission, "Inquiry Report – Mental Health", 2020, Volume 3, p.862. Accessed via: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume3.pdf

[69] Productivity Commission, "Inquiry Report – Mental Health", 2020, Volume 3, p.862. Accessed via: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume3.pdf

[70] Productivity Commission, "Inquiry Report – Mental Health", 2020, Volume 3, p.862. Accessed via: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume3.pdf. This figure includes 34,200 people with psychosocial disability receiving services through the NDIS and 75,000 people the Commission estimates is receiving support from Australian, State and Territory-funded programs outside of the NDIS. The 75,000 consumers estimate includes participants from NPS-M, CoS and NPS-T programs.

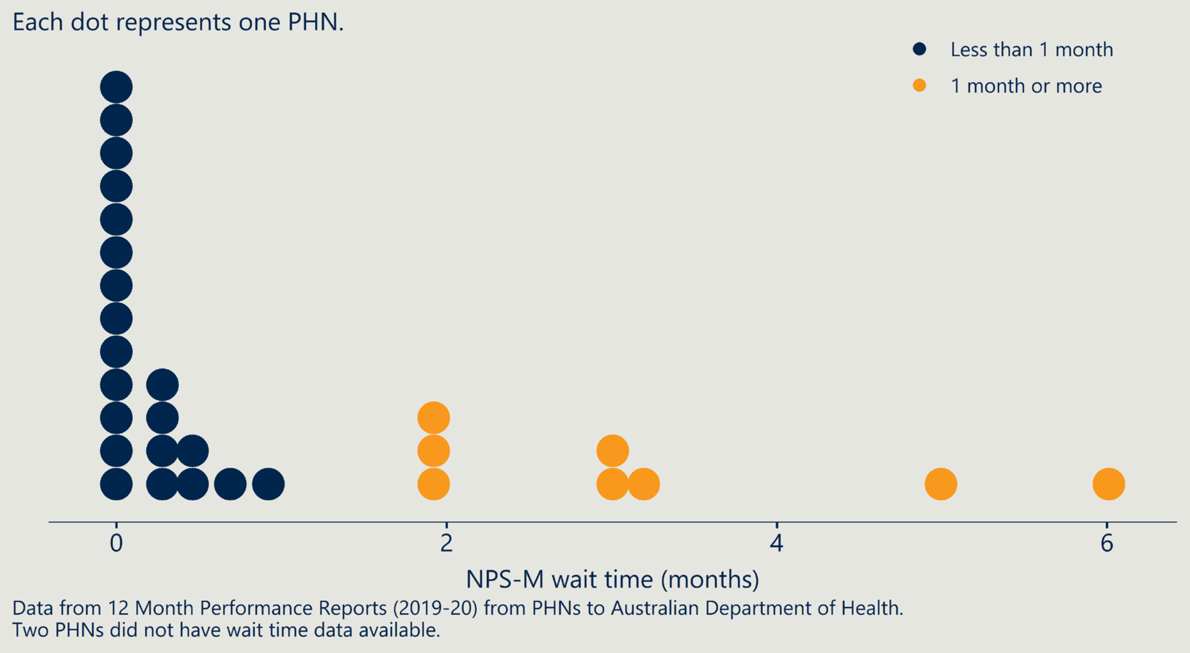
[71] Productivity Commission, "Inquiry Report – Mental Health", 2020, Volume 3, p.862. Accessed via: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume3.pdf

4.2.2 CoS consumers experienced timely support, while NPS-M consumers waited up to six months to receive service

Consumers involved in previous programs were able to rapidly access support through the CoS or NPS-T programs. Some consumers of previous programs (PHaMs, D2DL and PIR) were able to immediately access CoS if they had tested their eligibility for the NDIS and been found ineligible. Other consumers were transitioned to NPS-T which provided support for them to test or retest their eligibility for the NDIS before exiting to CoS if they were ineligible.

Consumers who did not participate in previous programs waited months to access NPS-M services in some regions. Figure 18 presents the wait times reported for consumers to access services in each PHN. Of the 31 PHNs, 21 either had no wait time or a wait time of less than one month. Eight PHNs had a wait time of longer than one month including two PHNs that had a wait time of more than four months. This may have been driven by PHNs actively promoting their services leading to greater community awareness. Several PHNs and service providers conducted weekly telephone calls or light touch in-person check-ins to ensure consumers did not feel neglected and monitor for deteriorating mental health, but these wait times were substantial and potentially had a material impact on the wellbeing of consumers.

Figure 18 | Wait time to access NPS-M program



Data from 12 Month Performance Reports (2019-20) from PHNs to Australian Department of Health.
Two PHNs did not have wait time data available.

> ‘We didn’t need to promote NPS-M program as there was very high uptake and additional demand from the beginning. We are working with [Service provider] to adjust funding to meet this emerging need.’
>
> **PHN**

Delays were due to an unexpected demand at the outset of the program, limited funding and short funding cycles. Unlike the clear visibility on CoS cohort, some PHNs had limited access to the demand estimates in the NMHSPF and were caught unaware by the immediate consumer demand for NPS-M. The level of funding was not sufficient to meet this demand with service providers reporting the number of staff that were hired under the measure was not enough for consumer demand leading to long waitlists. While PHNs developed short-term workforce plans, short contracts and funding cycles meant they did not have the stability to refine and plan long-term. Evidence suggests this is critical, as explored in Section 8.3.3.

4.2.3 Supports provided under the programs were appropriate but additional funding and more flexible use of funds by consumers would allow them to better meet needs

In general, psychosocial services funded through NPS-M and CoS were appropriate and met the needs of consumers. Stakeholders with lived experience of NPS-M and CoS reported that these programs provided unique supports which resulted in positive outcomes. Service users reported that they benefitted from help and support with:

- advocacy and navigating health and social service systems
- practical issues, such as transport to appointments
- planning, goal setting and problem solving
- linking with other needed services.

> 'She was the only person I've ever experienced up till then who gave me unwavering, consistent, non-judgemental, trustworthy support that helped build safety.'
>
> **Consumer**

Service users highly valued individual support workers and these workers are considered critical to consumers' experience of services. Many service providers noted that the supports funded through the programs and the models of care used to deliver them were highly appropriate for the recovery potential of consumers.

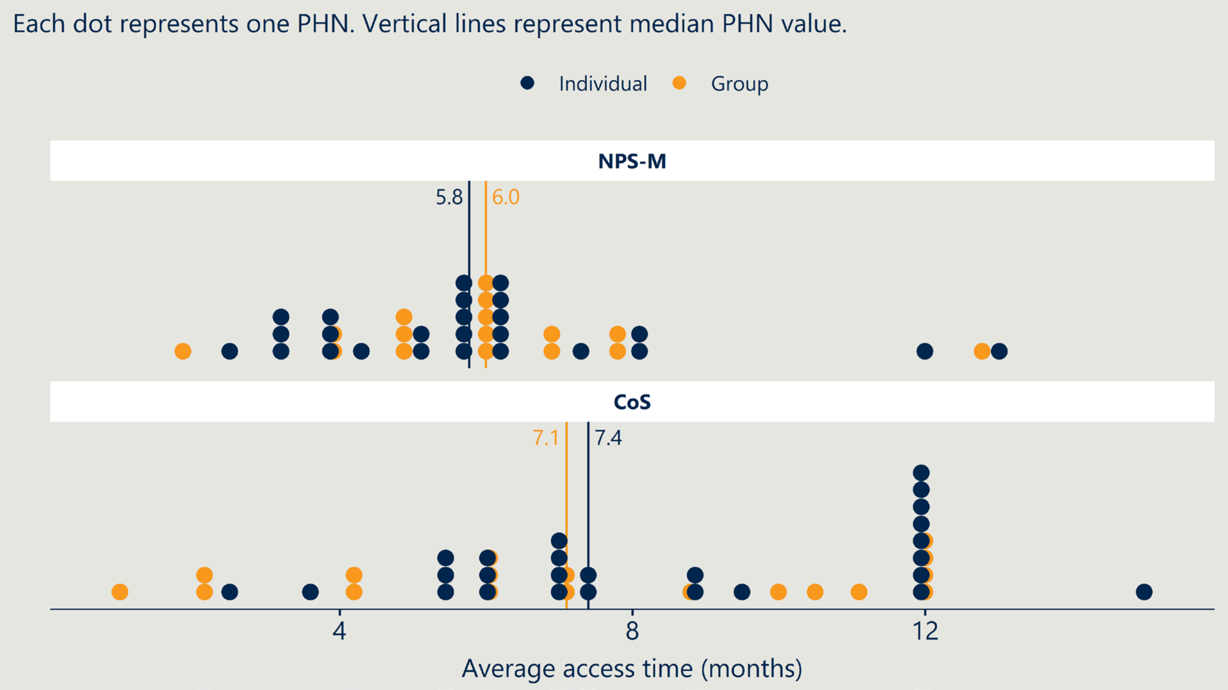
> 'Group services are not possible with such a distributed cohort, [but] funding does not cover delivery of individual services.'
>
> **PHN**

Group-based supports were not appropriate for all consumers. As discussed in Section 3.3, most service providers offered group-based supports. Some consumers found this approach effective: one consumer stated that *'if you're around people that have a mental health problem… they can relate to you and you bounce ideas off each other'*. However, many service providers found that group supports, at least in the form in which they were delivered, were not appropriate for many consumers. Service providers particularly noted that group supports are not an appropriate replacement for individual supports which are crucial for some consumers. Similarly, one regional PHN found that *'group services are not possible with such a distributed cohort'*, however, they also acknowledged that the limited funding allocated is insufficient to *'cover delivery of individual services'*.

Time-limited supports were often ineffective for people with severe mental illness. Some PHNs require that access to the NPS-M program is time-limited (ranging from six weeks to 12 months), as discussed in Section 3.3. Whilst these PHNs found this to be in line with a goal-oriented and recovery-centred model, other PHNs felt that time-limited supports did not cater for the episodic and ongoing nature of some consumers' illness. Some PHNs reported that consumers in the programs generally do not have short-term support needs and time-limited supports created challenges for providers trying to transition consumers at the end of their NPS-M episode or trying to continue to support consumers beyond intended timeframes. PHNs who supported a time-limited program did stress the importance of easy re-entry to the program if support was needed again.

Figure 19 presents the average time consumers accessed the NPS-M or CoS programs for each PHN where data was provided in 12-month performance reports. The median access time across PHNs that provided data is close to six months for the NPS-M program and close to seven months for the CoS program. The median length of access was slightly shorter for NPS-M consumers who accessed individual support compared with those who only accessed group support (5.8 vs 6.0 months). The median length of access was slightly longer for CoS consumers who access individual support compared with those who only accessed group support (7.4 vs 7.1 months). These values need to be treated with caution because only a subset of PHNs provided data for this field in the 12-month performance reports.

Figure 19 | Average consumer access time for NPS-M and CoS programs[72]



Many PHN stakeholders reported that differing funding levels between NPS-M and CoS did not reflect the respective needs of consumers of the programs. PHNs had a range of views regarding the relative needs of the NPS-M and CoS cohorts. For example, some PHN stakeholders noted that CoS consumers generally have high needs, and thus would benefit from individuals supports, while many NPS-M clients could be supported – from their perspective – through lower intensity, group-based supports. While another group of PHNs reported that CoS consumers previously supported by PIR had largely lower support needs than most NPS-M consumers, others saw no distinction in the level of need between the two cohorts.

Many PHNs observed that the rationale for current funding levels on NPS-M and CoS appears to be the by-product of the funding allocated to previous programs, rather than a reflection of current consumer need. The funding levels for the NPS-T program, which is out of scope for this evaluation, were generally considered much more generous, to the extent that some cross-subsidisation was occurring between NPS-T and the other programs. Some PHNs also commissioned the same service provider using several funding streams including the Primary Mental Health Care Flexible Funding Pool and this enabled the provider to use funds more flexibly. PHNs suggested that combining NPS-M and CoS into one funding stream with greater flexibility in how funding could be spent would mean more consumers received appropriate services.

Many stakeholders consulted noted that the capacity to use funding more flexibly would greatly benefit consumers through tailoring their support. Many PHNs and service providers outlined that a distinct difference between the current programs and previous programs was the ability to use funding flexibly (see Section 3.3 for further information). The current programs were often compared with PIR, which had a higher funding level than the current program but also allowed for more flexible use of funding which were valued by services providers and consumers.

Examples of flexible funding that PHNs and services providers noted would be helpful for consumers included:

- paying the bond on a rental property so that a consumer would no longer be homeless
- paying costs to see a private health practitioner (e.g. psychologist) where there are often significant out of pocket expenses

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[72] Australian Government Department of Health, 12-month performance reports from Primary Health Networks. 2020. PHNs that reported an average access time of zero have been excluded from the graph as has one PHN with average access times substantially longer than the period of time the programs have been running.

- paying for an assessment by an Occupational Therapist to support an application for the NDIS.[73]

4.3 Did the NPS-M and CoS improve consumer outcomes?

This section provides evidence that the NPS-M and CoS programs improved outcomes for consumers. The NPS-M and CoS programs were intended to allow consumers of psychosocial supports to achieve their recovery goals including increased personal capacity, confidence and self-reliance.[74,75] Data includes a questionnaire of consumers, consultation with consumers and peak bodies and case study analysis of PMHC-MDS data from select PHNs.

Evidence from other programs and peer-reviewed literature suggests psychosocial support programs improve consumer outcomes. The critical role psychosocial supports play in improving outcomes for consumers living with psychosocial disability associated with severe mental illness is discussed in detail in Section 8 and the Literature Review.

4.3.1 Consumers reported improved outcomes through consultation and survey responses

One of the key sources of data on consumer outcomes was the questionnaire and consultations conducted by the evaluation team based at the University of Sydney. Responses were collected through a questionnaire (n =500) and in-depth interviews with consumers, their friends, families and other support people and peak bodies (n=89). For further detail on participants and methodology see Section 2 and Appendix A.

Programs increased participants' capacity, confidence and self-reliance

Many consumers mentioned how the programs had helped them become more independent through understanding and building their skills and strengths. Three main themes emerged from in-depth interviews with consumers (n=63):

- increased engagement in daily activities, relationships and the community (n=38, 60%)
- improved self-confidence and self-concept (n=31, 49%)
- increased knowledge and skills (n=21, 33%).

Consumers also provided specific examples of new skills and activities directly resulting from program participation, such as enrolling in educational courses and obtaining driver licenses.

> 'It's just shown me, I guess, that I can do all of the things that I set my mind to. Often I think "*I can't do this, I can't do this*". But it shows me that I can, with enough planning and preparation.'
>
> **Consumer**

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[73] PHN Psychosocial Support Interface funding can be used to assist clients with gathering evidence required for establishing functional/permanent disability for their NDIS application. Australian Government Department of Health, "PHN Psychosocial Support Interface and Service Navigation Measure Guidance", Australian Government, Canberra, 2020.

[74] Australian Government Department of Health, "PHN Psychosocial Support Guidance, Psychosocial Support for People with Severe Mental Illness", Australian Government, Canberra, 2019.

[75] Australian Government Department of Health, "PHN Continuity of Support Guidance, Psychosocial Support for People with Severe Mental Illness", Australian Government, Canberra, 2019.

More generally, consumers reported that the programs led to positive outcomes

> ‘She has gone from being, you know, at one stage of being so down, you know, I didn't want to leave her for five seconds … now she feels like she's got a chance … I don't know if that's the right word, a chance.’
>
> **Carer**

Almost all (n=460, 92%) of consumers surveyed said their life had improved from using the service, with most (n=340, 68%) selecting it had improved their lives ‘Quite a bit’ or ‘A great deal’. When explored further in the interviews, consumers said the program had resulted in:

- connection and a sense of not being alone (n=33, 52%)
- hope and reassurance for the future (n=31, 49%)
- improved or stabilised mental health and well-being (n=31, 49%)
- regular positive experiences and something to look forward to (n=22, 35%).

4.3.2 While the outcome data collected has limitations, indicative analysis suggests NPS-M and CoS reduce psychological distress

NPS-M and CoS programs used the K10+ and K5 to measure consumer outcomes. PHNs were required to report data related to the NPS-M and CoS programs into the PMHC-MDS. The PMHC-MDS existed prior to the establishment of the NPS-M and CoS programs and used the Kessler-10 (K10+ version) and K5 which could be used for Aboriginal and Torres Strait Islander clients as outcome measurement tools for adults.[76] The K10 is a measure of non-specific psychological distress based on questions about the level of nervousness, agitation, psychological fatigue and depression.[77] The K10+ includes additional items to assess functioning and related factors (e.g. ‘In the last four weeks, how many days were you totally unable to work, study or manage your day-to-day activities because of these feelings [reported above]?’).[78] The K5 is a measure of psychological distress that has been designed for use with Aboriginal and Torres Strait Islander clients which includes a subset of five questions taken from the K10 scale. Minor changes have been made to the language of some questions (e.g. replacing ‘hopeless’ to ‘without hope’).[79] The K5 does not include any items that refer to functioning or related factors.

Some PHNs do not complete the mandatory outcome measures and there are concerns about the quality of data in the PMHC-MDS.

A subset of PHNs and service providers who raised concerns about the K10+ and K5 noted that they did not use these measures for consumers of the NPS-M and CoS programs. This means for some consumers of these programs the PMHC-MDS is not capturing any outcome information.

Data from select PHNs with high quality data provides evidence that outcome measures have improved. Figure 20 provides the mean K10+ scores for records in the case study subset of PMHC-MDS where episodes have more than one K10+ measurement. Across both the NPS-M and CoS programs K10+ scores decreased between K10+ measurements throughout the program, reflecting a decrease in psychological distress. In episodes of the NPS-M program, there was a statistically significant mean change in K10+ score of 4.8 units which represents a decrease of 14.6% from the first K10+ score.[80] In episodes of the CoS program, the mean change was 2.5 which represents a decrease of 7.7% from the first K10+ score. This difference in the CoS program was not statistically significant.[81] The smaller decrease in K10+ scores for CoS consumers may reflect differences in consumers who receive support through this program and the ongoing nature of the support provided.

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[76] Kessler RC, Andrews G, Colpe LJ, Hiripi E, Mroczek DK, Normand SL, Walters EE, Zaslavsky AM. Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychological medicine. 2002 Aug;32(6):959-76.

[77] Kessler RC, Andrews G, Colpe LJ, Hiripi E, Mroczek DK, Normand SL, Walters EE, Zaslavsky AM. Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychological medicine. 2002 Aug;32(6):959-76.

[78] Australian Government Department of Health, Mental Health National Outcomes and Casemix Collection, 2003.

[79] Australian Government Department of Health, Mental Health National Outcomes and Casemix Collection, 2003.

[80] Student’s t-test on difference in K10+ scores within each episode, T statistics is -6.64, df = 110 and p = 1.3e-10.

[81] Student’s t-test on difference in K10+ scores within each episode, T statistics is -1.44, df = 32 and p = 0.16.

Figure 20 | Change in K10+ score between first and last measurement within episode of support[82]

Caution is needed when interpreting these results due to the relatively small sample (n=110 for NPS-M and 33 for CoS) and potential that decreases in K10+ scores reflect reversion to the mean rather than changes caused by the programs. Further analysis which examines which individuals within the cohort are most likely to have reductions in K10+ scores associated with psychosocial support need larger sample sizes.

The K10+ and K5 outcome measures are problematic for the NPS-M and CoS programs, as they are potentially misaligned with recovery and capacity building models of support.

PHNs and service providers appreciated the need for a consistent scale to measure the impact of programs nationally. At the same time, many PHNs and service providers raised concerns about the use of the K10+ and K5 outcome measures for psychosocial support programs throughout our evaluation including:

- Measures that assess psychological distress are not appropriate to capture the desired outcomes of the programs (i.e. improved psychosocial function). Stakeholders noted that improved psychosocial function can occur without reduced psychological distress.
- Clients can respond negatively to the K10+ and K5 because these tools use deficit-based language which is inconsistent with the recovery-oriented nature of the psychosocial support being delivered through the NPS-M and CoS programs. For example, questions in the K10+ like 'In the last four weeks, about how often did you feel so nervous that nothing could calm you down?' can be at odds with the recovery and capacity building models of supports being provided.

Many service providers use other outcome measures that directly measure psychosocial function.

Service providers and PHNs have noted a range of measures that they use to support service delivery and measure consumer outcomes which are not captured in the PMHC-MDS. These include:

- CANSAS
- RAS-DS
- LSP-16

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[82] Data from a subset of two PHNs who provided unit record outcome data to the evaluation. Data only includes episodes that included more than one K10+ measurement. Average number of days between K10+ measurements is 102 for NPS-M and 203 for CoS. Error bars reflect standard deviations.

- Recovery Star
- HoNOS
- WHODAS.

These outcomes vary in their language, length and whether they are rated by a consumer or a clinician. 'Case study 6 - Outcome measures to assess psychosocial recovery' overleaf compares the different outcome measures used by services providers for these programs. The evaluation did not assess suitability or effectiveness of the range of outcome assessment tools that are being used.

Some stakeholders consulted for the evaluation noted a more appropriate outcome measurement tool could be developed in consultation with PHNs and service providers or an existing outcome measurement tool chosen to replace the K10+ and K5. An alternate outcome measure would need to assess the scientific validity of the outcome tool, the length and associated burden when completing the tool, the appropriateness of the tool including recovery oriented-language and the ability to use across Indigenous and CALD groups.

CASE STUDY

Outcome measures to assess psychosocial recovery

MULTIPLE PHNS

KEY INSIGHTS

- The current K10+/K5 outcome assessment tools used for NPS-M and CoS consumers measures psychological distress, rather than psychosocial function.
- PHNs are using a range of outcome measures for their NPS-M programs (alongside or instead of K10+/K5).
- Validated recovery-oriented outcome measures like the Recovery Assessment Score – Domains and Stages are specifically designed to assess psychosocial recovery.

Outcome assessment tools for NPS-M and CoS (via the PMHC-MDS)

Kessler 10+ (K10+)[1]

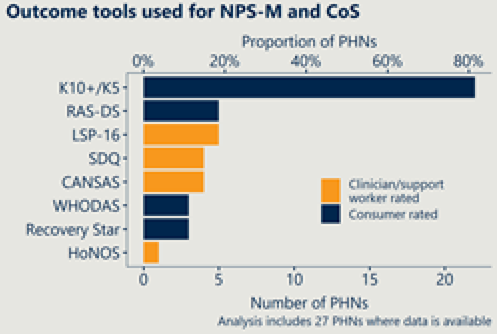
The K10 is a measure of non-specific psychological distress based on questions about the level of nervousness, agitation, psychological fatigue and depression. The K10+ includes additional items to assess functioning and related factors.

Kessler 5 (K5)

A measure of psychological distress that has been designed for use with Aboriginal and Torres Strait Islander consumers which includes a subset of five questions taken from the K10 scale. Minor changes have been made to the language of some questions.

What we've heard

- The K10+/K5 can be inappropriate for measuring the outcomes of psychosocial support programs because they primarily measure psychological distress rather than psychosocial function.
- The clinical and psychological language of the K10/K5+ can create barriers to consumers completing these assessments, and in some cases, can be a distressing process for consumers on a recovery journey.
- Service providers and PHNs are using a range of outcome measures either alongside or instead of the K10+ and K5 to assess consumers' psychosocial function and recovery (outlined below).


Outcome tools used for NPS-M and CoS

Analysis includes 27 PHNs where data is available

Alternate outcome tools

Camberwell Assessment of Need Short Appraisal Schedule (CANSAS)[2]

- A measure of met and unmet needs across 22 health and social areas widely used in mental health services.
- Areas include accommodation, physical health, intimate relationships and psychological distress.
- Completed by clinician/support worker with consumer.

Recovery Assessment Score – Domains and Scales (RAS-DS)[3]

- A measure of consumer defined **recovery** across four domains (Doing things I value, Looking forward, Mastering my illness, and Connecting and belonging).
- Items include statements like 'I can handle it if I get unwell again'.
- Consumer rated.

Life Skills Profile (LSP-16)[4]

- Assesses consumer's basic life skill abilities focusing on general functioning and disability rather than clinical symptoms.
- Items include 'Does this person generally have any difficulty with initiating and responding to conversation?'.
- Clinician/support worker rated.

Health of the National Outcome Scales (HoNOS)[5]

- A measure of behaviour, impairment, symptoms and social functioning in people with severe mental illness.
- Items include 'Problems with activities of daily living' and 'Problems associated with hallucinations and delusions'.
- Clinician/support worker rated.

Recovery Star[6]

- A recovery-oriented outcome measure which enables consumers to measure their progress. The Recovery Star can be integrated into service delivery including goal-setting with consumers and monitoring recovery.
- A total of 10 areas are measured including living skills, relationships, work and identity, and self-esteem.
- Consumer rated.

World Health Organisation Disability Assessment Schedule (WHODAS)[7]

- A measure of health and disability across six domains: Cognition, Mobility, Self-care, Getting along, Life activities and Participation.
- Items include 'How much difficulty did you have in concentrating on doing something for ten minutes?'.
- Consumer rated.

1. Kessler RC, Andrews G, Colpe LJ, Hiripi E, Mroczek DK, Normand SL, Walters EE, Zaslavsky AM. Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychological medicine. 2002 Aug;32(6):959-76.
2. Phelan M, Slade M, Thornicroft G, Dunn G, Holloway F, Wykes T, Strathdee G, Loftus L, McCrone P & Hayward P (1995) The Camberwell Assessment of Need: the validity and reliability of an instrument to assess the needs of people with severe mental illness, British Journal of Psychiatry, 167, 589-95.
3. Scanlan, J.N., Hancock, N., & Honey, A. (2018). The Recovery Assessment Scale – Domains and Stages (RAS-DS): Sensitivity to change over time and convergent validity with level of unmet need. Psychiatry Research, 216, 560-564.
4. Rosen A, Hadzi-Pavlovic D, Parker G, Trauer T. The Life Skills Profile: Background, Items and Scoring for the LSP-39, LSP-20 and the LSP-16. Randwick, NSW, Australia: Black Dog Institute.
5. Wing JK, Beevor AS, Curtis RH, Park SG, Hadden J, Burns A. Health of the nation outcome scales (HoNOS). The British Journal of Psychiatry. 1998;172(1):11-8.
6. Dickens G, Weleminsky J, Onifade Y, Sugarman P. Recovery star: validating user recovery. The Psychiatrist. 2012 Feb;36(2):45-50.
7. Üstün TB, Kostanjsek N, Chatterji S, Rehm J, editors. Measuring health and disability: Manual for WHO disability assessment schedule WHODAS 2.0. World Health Organization; 2010.

5 To what extent have the NPS-M and CoS services met the needs of consumers and their friends, families and other support people? (KLE 3)

Summary of findings

The evaluation drew on insights from consultations with NPS-M and CoS consumers, their friends, families and other support people, and consumer and carer peaks to understand the extent to which the programs are meeting the needs of consumers.

While the needs of each individual varied to reflect their own unique context and lived experience, the evaluation was able to identify general themes surrounding psychosocial support needs based on responses to the questionnaire and interviews with consumers, friends, families and support people.

Many of those consulted were not aware which of the two programs they were accessing. The only discernible difference potentially attributable to a particular program was the time limited nature of support on NPS-M, where some consumers needed longer term support but were required to exit the program.

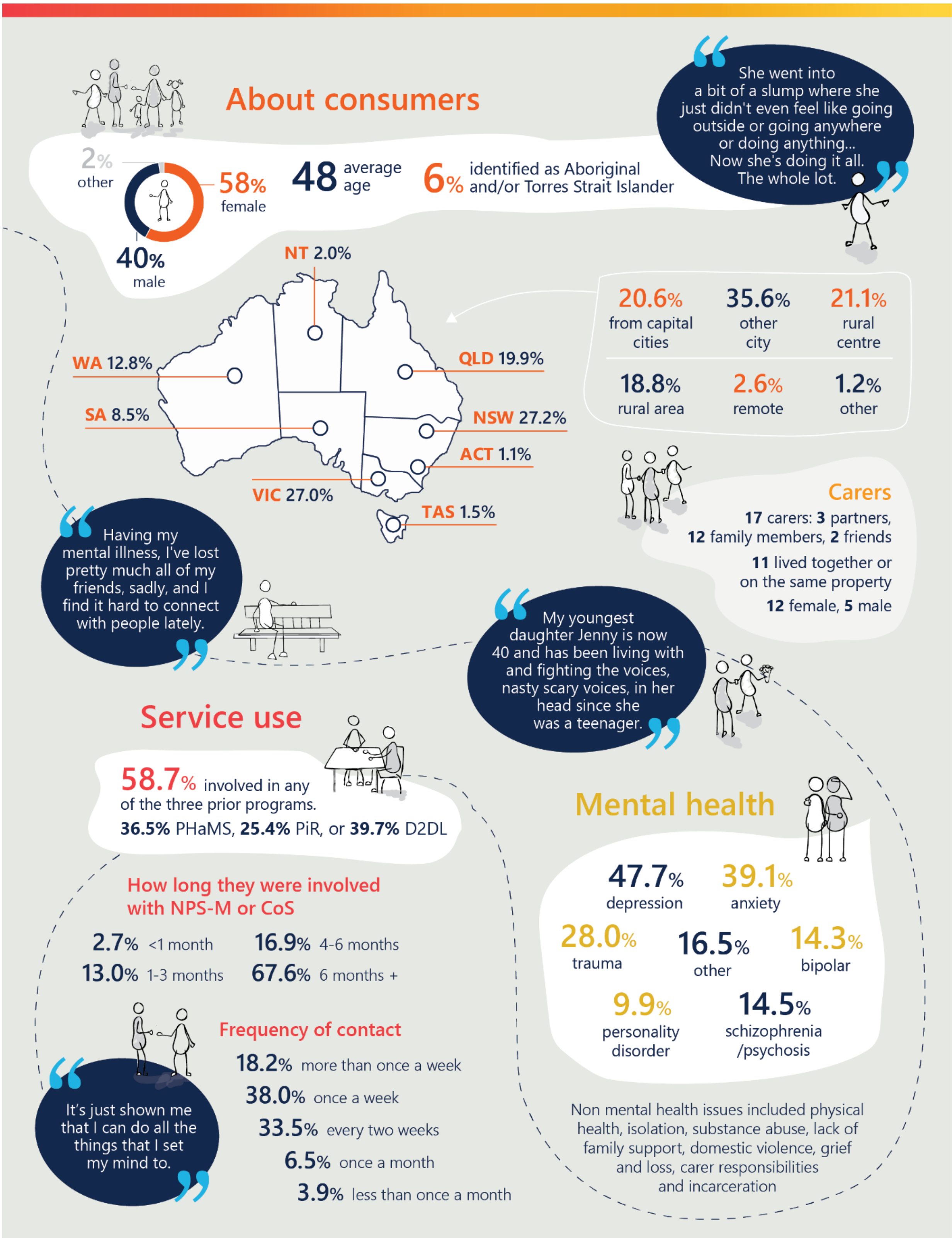
Peoples' experiences of the programs also varied. Overall, most consumers reported that they were very satisfied with NPS-M and CoS programs. They outlined that these programs, when working well, provide unique supports, which can result in a range of positive and practical outcomes. They valued flexibility and being able to access a mixture of individual and group supports. Consumers also outlined that how support was provided was very important and they described the qualities they valued in support provision – for example, available when needed, regular and reliable, proactive support.

However, some said that they did not have frequent enough contact with the program. Not everyone received the same supports and opportunities, nor achieved the outcomes they wanted. Their suggestions on how the programs could be improved are collated at the end of this chapter.

Friends, families and other support people generally noted that they valued the programs; however, they would appreciate the opportunity to be more involved in the programs, in instances where it was what they and the consumers would like. Some also found that their need to see consumers progress towards independence was not well met. They attributed this to support workers' focus on companionship in some cases, where there were opportunities for them to focus more on supporting the consumer in building their capacity.

Key characteristics about the consumers and their friends, families and other support people involved in the evaluation are captured in Figure 21 overleaf.

Figure 21 | Overview of the NPS-M and CoS consumers and their friends, families and other support people consulted for the evaluation



About consumers

2% other

58% female

40% male

48 average age

6% identified as Aboriginal and/or Torres Strait Islander

"She went into a bit of a slump where she just didn't even feel like going outside or going anywhere or doing anything... Now she's doing it all. The whole lot."

NT 2.0%
WA 12.8%
SA 8.5%
QLD 19.9%
NSW 27.2%
ACT 1.1%
VIC 27.0%
TAS 1.5%

20.6% from capital cities	35.6% other city	21.1% rural centre
18.8% rural area	2.6% remote	1.2% other

Carers

17 carers: **3** partners, **12** family members, **2** friends

11 lived together or on the same property

12 female, **5** male

"Having my mental illness, I've lost pretty much all of my friends, sadly, and I find it hard to connect with people lately."

"My youngest daughter Jenny is now 40 and has been living with and fighting the voices, nasty scary voices, in her head since she was a teenager."

Service use

58.7% involved in any of the three prior programs.
36.5% PHaMS, **25.4%** PiR, or **39.7%** D2DL

How long they were involved with NPS-M or CoS

2.7% <1 month
16.9% 4-6 months
13.0% 1-3 months
67.6% 6 months +

Frequency of contact

18.2% more than once a week
38.0% once a week
33.5% every two weeks
6.5% once a month
3.9% less than once a month

"It's just shown me that I can do all the things that I set my mind to."

Mental health

47.7% depression
39.1% anxiety
28.0% trauma
16.5% other
14.3% bipolar
9.9% personality disorder
14.5% schizophrenia /psychosis

Non mental health issues included physical health, isolation, substance abuse, lack of family support, domestic violence, grief and loss, carer responsibilities and incarceration

See Section 2 for further detail on the methodology for consulting these stakeholder groups.

5.2 The psychosocial support needs of NPS-M and CoS consumers and their friends, families and other support people

Importantly, **more than half of the consumers who participated in the evaluation did not know which program they were accessing**.[83] As a result, a caveat is applied to discussion of any differences in needs between NPS-M and CoS that in some cases assumptions about the program they are accessing have been drawn based on their history of previous programs, or other logical reference points.

5.2.1 Support needs of NPS-M and CoS consumers

This section outlines the **needs of consumers** who are participants in the NPS-M and CoS programs. It introduces their **needs** including:

A	Flexible and consumer-focused supports
B	One-to-one support
C	Opportunities to interact with other people and to 'give back'
D	High quality support provision and communication
E	Longer term support and soft re-entry points (NPS-M consumers)

These are discussed in turn below.

A Flexible and consumer-focused supports

NPS-M and CoS consumers who were interviewed for this evaluation reported they needed supports to be flexible to adapt to their individual needs as they arose and changed over time. They outlined that a 'one size fits all' approach failed to meet their unique needs. For example, some people felt that rules and regulations about what support workers could and could not do limited their ability to provide services that addressed consumers' needs. Others talked about support workers pushing their own agenda, pressing for what they thought would be good for the NPS-M/CoS consumer, rather than supporting the person to do what they wanted to do.

The types of supports that consumers described in interviews or reported finding the 'best or most helpful thing' about NPS-M or CoS in the questionnaire are captured in Table 6. They include a mixture of individual one-to-one supports and group-based supports. Consumers outlined that their needs can encompass a broad spectrum, from practical supports with minimal involvement from the consumer e.g. where a support worker went shopping on behalf of a consumer) which typically resulted in less skill-building for the consumer – through to primarily capacity building supports (e.g. where the consumer was coached in problem solving).

> '[What I value in a support worker is] someone who is there for you without putting a lot of pressure on… someone who gives you options but doesn't say that you have to do it. That would be my main thing.'
>
> **Consumer**

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[83] NPS-M consumers: questionnaire: n=104, interviews: n=13. NPS-M consumers: questionnaire: n=104, interviews: n=13. Unknown: questionnaire: n=246, interviews: n=33.

Table 6 | Frequency of positive mentions of supports and opportunities

Activity	Questionnaire (n=355)	Interviews (n=63)
Support with:		
Social and emotional support	113	44
Advocacy and navigating health and social services	44	30
Planning, goal setting and problem solving	38	32
Practical assistance	37	21
Linking with other needed services	26	25
Opportunities to:		
Meet and interact with other people	54	11
Participate in activities, both within and outside the centre	32	42
Accept challenges, with support	6	9
Contribute and give to others	4	11

Consumers outlined the supports above are typically delivered through either one-to-one or in a group setting, although the evaluation notes that this can depend on the activities – for example, it is possible for consumers to also receive social and emotional support through a group setting; however, consumers referenced this as a need that was typically met through one-to-one support from their worker. The needs associated with these support categories are explored further in the following sections ‘one-to-one support’ and ‘opportunities to interact with other people’.

B One-to-one support

Consumers identified a range of needs that are typically best met through one-to-one support. These needs included:

- advocacy, navigating health and social services
- linking with other needed services
- planning, goal setting and problem solving
- practical assistance
- social and emotional support
- accept challenges with support.

These needs are described briefly below.

Advocacy, navigating health and social services

Consumers frequently identified advocacy and assistance in navigating and managing health and social service systems as a need, and this was also identified as highly valued by friends, families and other support people. Advocacy and navigation support mostly related to other services/programs such as NDIA, government housing services, Centrelink, councils, and physical and mental health services.

It became apparent from consumer interviews that transition support and testing for the NDIS was a particular advocacy need shared by many consumers. Consumers who previously participated in other psychosocial support programs (including PHaMs, D2DL, PIR) and consumers who were testing eligibility for the NDIS outlined the need for support to navigate these transitions (or potential transitions). Consumers also need this support where services are changing or ceasing due to COVID-19 and where their support workers are leaving the service.[84]

Linking with other needed services

Consumers valued support that would link them with other services and supports in the community, for example Recovery College and TAFE, counselling and psychology, drug and alcohol support, shopping and cleaning services, accommodation services, support groups and disability services. See Section 6 for further discussion on integration of supports.

> '[My support worker] has good resources and networks and knows where to find things. So, she used her network a few times and helped me find a few things and one was she found a women's group.'
>
> **Consumer**

Planning, goal setting and problem solving

Consumers valued support to identify and articulate what they wanted and needed, either informally or through a goal setting process. This included planning or scheduling to help people achieve what they wanted or a support worker acting as a 'sounding board' to help consumers work through problems or issues and consider their options.

Practical assistance

Many consumers indicated they needed practical assistance support such as transport, help with shopping or acquiring household items. Financial assistance was also identified as a need for some, as a result of limited or lost opportunities for employment and inadequate fiscal support structures.

Social and emotional support

One of the most critical supports consumers described being provided by support workers was one-to-one social and emotional support. This was not just about goal setting and problem solving. Rather, people valued the opportunity for human contact, to vent and be heard, and to hear a different and helpful perspective. For some, just being able to talk about problems and difficulties was important. Others talked about the impact of the understanding and helpful ways in which support workers responded, for example by providing emotional support or suggesting different interpretations and ways of thinking, for example, reminding people of their successes and positive qualities.

> '[What I value is] more day-to-day. How to cope with stuff day-to-day.'
>
> **Consumer**

Sometimes people talked about working through specific psychological or mental health issues with their support worker; however, most saw their interactions with the support worker as very different to a counsellor or psychologist and valued that difference. People tended to appreciate the less clinical, formal and structured approach and the ability to talk about what they wanted to talk about.

Accept challenges, with support

Consumers appreciated when support workers encouraged and supported them to accept challenges and try things that were outside their comfort zones – such as communicating by phone or taking a leadership role in the organisation. Some consumers valued when support workers coached people to do the things they needed to do, such as housework, and held them accountable. These were rewarding experiences and showed people what they are capable of.

> '[What I appreciated from my support worker was they] challenged what I can and can't do... Because when you actually get sick you feel useless and hopeless, whereas they never made you feel like that.'
>
> **Consumer**

---

[84] In recognition of this the Department announced additional funding on August 6 which included funding to support consumers assessed as requiring ongoing and higher levels of support to test eligibility for the NDIS. PHN CoS and NPSM/Transition Guidance, Updated 10 November 2020, Australian Government Department of Health.

C Opportunities to interact with other people and to 'give back'

Many consumers outlined that it was important to have the opportunity to meet and interact with other people apart from support workers. For most people interviewed, this meant interacting with other people with lived experience. While this was not desired by everyone, it often helped people feel less alone, provided social interactions, and was a source of learning and support. Opportunities to make social connections was a major priority for families, who celebrated them when they were available.

> 'She [my support worker] encouraged me to actually run a couple of sessions…when I was there, I was helping people a bit and I found that it was a really rewarding experience.'
>
> **Consumer**

An opportunity that was highly valued by consumers was also the opportunity to give and make a contribution to other people or the organisation. These opportunities ranged from formal roles within organisations, to providing informal and reciprocal assistance to support workers and other consumers. Some people talked about running groups, becoming peer workers, and sitting on committees and panels. These roles are not part of service provision but exist to serve the organisation, or benefit others within it, representing a genuine contribution for consumers. The benefits of a peer workforce and need for effective training pathways are discussed in Section 5.

D High quality support provision and communication

How the supports and opportunities were provided was critical to consumers' experiences. Consumers found the qualities and behaviours of individual support workers critical to achieving positive outcomes. Consumers needed support workers who were:

- available when needed
- regular and reliable
- proactive
- genuinely understanding of them as an individual
- respectful, authentic and positive
- flexible and person-centred
- friendly and comfortable
- professional, competent and efficient
- clear and transparent.

Consumers also outlined that simple, streamlined communication increased the quality of their experience.

E Longer term support and soft re-entry points (NPS-M consumers)

Consumers consulted for the evaluation outlined that some people need long-term support with soft re-entry points to cater to ongoing or fluctuating needs. Concerns and distress about having to exit the program after a certain time period were common.

Note: The evaluation assumes the need for longer term support and soft re-entry for support was raised predominantly by NPS-M consumers; however, not all consumers were aware which program supported them.

> 'I believe you need ongoing… because it's not like flicking a switch, oh it's all better, it's all fixed, it's all done. A lot has got to happen in my life before that kind of thing can happen.'
>
> **Carer**

5.2.2 Needs of friends, families and other support people of NPS-M and CoS consumers

This section outlines what friends, families and support people of consumers using the NPS-M and CoS programs **valued most** from psychosocial support, including:

A	Reducing the support load
B	Support and advice
C	Positive family relationships
D	Seeing the consumer happy
E	Seeing the consumer progress towards independence

These are discussed in turn below.

A Reducing the support load

Families and support people outlined supporting consumers in a variety of ways, including:

- Advocating including researching options, contacting, organising and coordinating services.
- Financially supporting consumers either directly or indirectly, for example paying medical expenses and buying groceries.
- Providing practical assistance. For some this was intensive and daily practical assistance with self-care and everyday tasks. For others, the assistance was routine but not daily.
- Encouraging and prompting people to do things for themselves, such as personal care, housework, taking medications, engaging with services (including psychosocial support programs), and participating in passions or hobbies such as sport or music.
- Emotionally supporting them, loving and being there for them.

> 'In the past, prior to [this service], I've turned around and said I don't know if I can go the distance.... And now I'm not feeling [like this].'
>
> **Support person**

Families, friends and support people described how they valued a service providing some of this assistance, which reduced the emotional and physical load on families.

B Support and advice

Families and support people valued support and advice for them in their supporting role. Many families described, to varying degrees, feeling exhausted, overwhelmed by their sense of the complexity and ever-changing nature of the mental health system, and desperate for more support for their son, daughter, niece, partner, parent or friend, as well as more support for themselves.

C Positive family relationships

Families and support people valued opportunities to 'interact again as a family' and appreciated support to reduce their more formal caring responsibilities to regain this aspect of their relationship with their loved one. In some cases, this can help to return to engaging with the consumer as a family member rather than always as a 'carer'.

> 'Before, it [my role] was 100 per cent carer, whereas now I just visit her [consumer]. She is just my mum. We just talk about mum/daughter stuff, not just things that she needs.'
>
> **Support person**

D Seeing the consumer happy

Families and support people described how they benefited from seeing the person they cared about as happier, more mentally well or more hopeful.

E Seeing the consumer progress towards independence

Families and support people wanted consumers building independence, working towards and achieving their goals, making social connections, and linking in with services and opportunities in the community such as employment programs.

5.3 The extent to which NPS-M and CoS met the needs of consumers and their friends, families and support people

Overall, consumers reported they were satisfied and valued the support provided through the NPS-M and CoS programs. This section discusses where the needs of consumers, their friends, families and other support people needs were met and not met by the NPS-M and CoS programs.

5.3.1 Where consumer needs were met

Many consumers who took part in the evaluation indicated that they had positive experiences and were satisfied with the support provided through NPS-M and CoS. How the supports were provided were critical to peoples' experiences and getting their needs met. Where support met the needs of consumers it resulted in a range of positive outcomes. These findings are explored further in the passages below.

Many consumers had positive experiences and were satisfied with the support provided through NPS-M and CoS

> 'It's just shown me, I guess, that I can do all of the things that I set my mind to.'
>
> **Consumer**

Consumers outlined that psychosocial support provided through NPS-M and CoS includes a range of unique supports not available within other mental health service models. Overall satisfaction expressed by consumers was high across all demographic groups. Results from consumers' responses to key experience and satisfaction questions in the evaluation's questionnaire are captured in Figure 22.

Figure 22 | Consumers' experience and satisfaction with NPS-M and CoS programs[85]

Experience

In the questionnaire, respondents were asked to rate, on a scale of one to 10, their experience with their service. One was described as 'terrible – nothing good about it', while 10 was 'fantastic – all I'd hoped for'. The ratings were heavily skewed to the high end of the rating scale, with a median score of eight (interquartile range: six to nine). Results are displayed in Figure A.

Satisfaction with frequency of contact

Respondents were asked to rate their satisfaction with the frequency of contact they were receiving from the service. Again, responses were generally very positive, though a significant minority (21.4%) felt that they did not have frequent enough contact with the services. Results are displayed in Figure B.

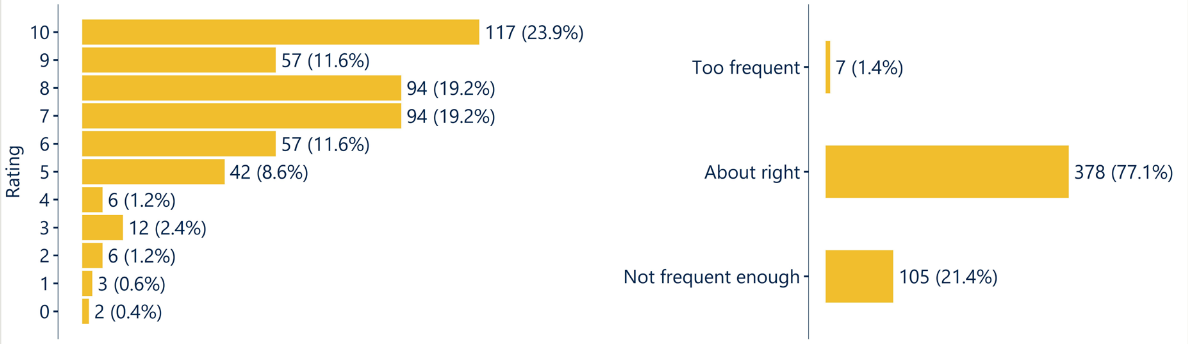

Figure A. Overall experience with service

Figure B. Frequency of contact with service

Satisfaction with support

Respondents were also asked to indicate whether they were getting what they wanted from using the service and whether their lives were improving from using the service. Again, the ratings were heavily skewed toward the positive end of the rating scale. Results are displayed in Figures C and D.

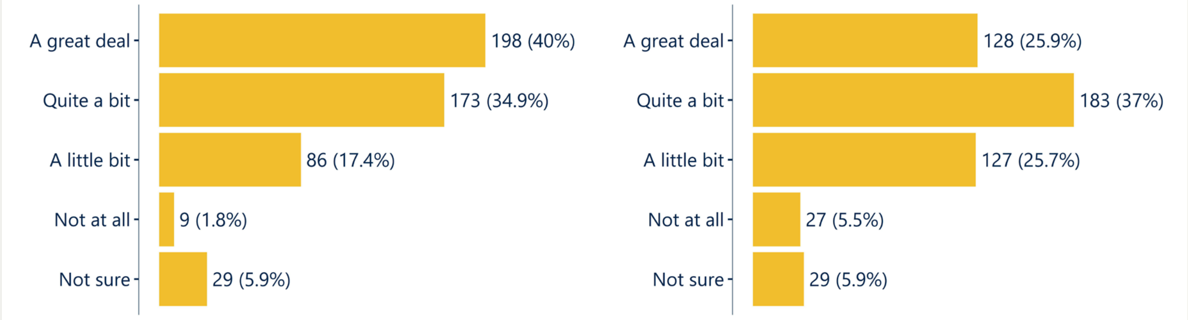

Figure C. Are you getting what you wanted from using the service?

Figure D. Has your life improved from using the service?

Another indicator of satisfaction was that when asked about 'the worst or least helpful thing about the service' 32% of questionnaire respondents (n=159) wrote 'nothing', or otherwise indicated that they had no criticisms. In the interviews, consumers were asked what could improve the services and 25% (n=16) of respondents said that they could not think of any improvements needed.

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[85] NPS-M and CoS Evaluation – consumer questionnaire data.

> 'It's 10 hours away from us, where they're based. So [we're] very lucky that they considered our town. They just didn't keep it to the city.'
>
> **Consumer**

Those living in regional, rural and remote areas rated their overall experience with services more highly than those living in capital cities, other cities and metropolitan areas. One hypothesis is that people in regional, rural and remote areas were perhaps grateful to have received support at all due to general services shortages in their area, potentially influencing their experience. As noted in Section 4.2.1, regional and remote areas had more consumers per population compared with metropolitan regions, which may also reflect a paucity of other services in regional and remote areas.

Perhaps unsurprisingly, those in contact with services once a week or more were more likely to say that they were getting 'quite a bit' or 'a great deal' of what they wanted from the service than those who had contact fortnightly or less. People who reported that the frequency of contact with services was 'about right' rated their overall experience of the service significantly more highly than those for who contact was 'too frequent' or 'not frequent enough'.

Supports met the needs of consumers when they were available at the right time, flexibly delivered, and delivered with care and skill

When services met the needs of consumers, they were:

> 'She'll [support worker] sit there no matter how many times you block her or have walls up she'll just sit there and go, "**eventually you've got to open up to me, I'm not going anywhere, I'm here to listen**" and, you know, one month down the track I'm great friends with her.'
>
> **Consumer**

- **Available when needed.** This was achieved when consumers were able to contact a support worker when they were feeling distressed without having to wait for an appointment, and when they received enough support, for as long as they needed, in a timely way. This was particularly important to consumers, being the most frequently mentioned service characteristic in both the questionnaire (n=86, 17%) and consumer interviews (n=45, 71%).
- **Flexible and person-centred.** This was achieved when consumers felt that supports addressed issues that were most important to them, rather than being provided with 'one size fits all' support. This was also frequently discussed by consumers as a key contributing factor influencing their experience in the questionnaire (n=72, 14%) and interviews (n=60, 95%).
- **Delivered by support workers who possessed positive characteristics.** These characteristics are captured in D of Section 5.2.1. While all these characteristics were outlined as important by consumers, the most frequently discussed characteristic in questionnaire responses (n=46, 9%) and interviews (n=39, 46%) was the impact of regular and reliable support.
- **Integrated with other services.** Consumers wanted a minimum of basic integration for advocacy reasons, with some desiring full integration across services. Almost all consumers mentioned a need for surface-level integration so staff could provide advocacy across other health or social care systems. Other consumers desired full integration between services, with staff collaborating to avoid duplication and best meet the needs of the consumer. This support was highly regarded by participants who experienced it, but most consumers reported that this level of collaboration only occurred when bringing together NDIS applications, in a crisis, or not at all.

Some consumers acknowledged that they played an active part in benefiting from the services. They actively managed their relationships with the support workers and the services both overtly, by asking for what they needed, and more subtly, by taking action to maintain a good relationship with the support worker.

> 'I tend to – I've taken the stance that I need to befriend them. So they need to hear a little bit about me. I need to hear a little bit about them. I find that's important, just to break the ice.'
>
> **Consumer**

Where programs met the needs of consumers it resulted in a range of positive outcomes

> ‘We've [consumer and support worker] started completing some of the goals… I've enrolled in a course now and I'm getting my licence. I'm going for the licence drivers test next month.’
>
> **Consumer**

Outcomes from the NPS-M and CoS programs based on a range of data are discussed in detail in Section 4. Where programs met the needs of consumers, consumers outlined they:

- experienced a sense of connection with other people and not being alone
- were able to focus on life goals and move towards achieving these
- had regular positive experiences and something to look forward to
- had opportunities to acquire knowledge and skills
- developed new and helpful ways of thinking and looking at the world
- increased their engagement in daily activities, relationships and the community
- experienced improvement/stabilisation of mental health and well-being, and improvement in self-confidence or self-concept, felt hope, fulfilment and reassurance about the future.

5.3.2 Where consumer needs were not met

Where consumer needs were not met, consumers indicated that contributing factors included:

- consumers did not receive enough (or varied enough) one-to-one support
- there were not enough meaningful socialisation opportunities and opportunities to ‘give back’
- staff turnover was high
- staff received inadequate training
- transition support was poor
- there was poor communication and coordination between supports, and/or
- barriers to consumers’ engagement with supports existed (e.g. personal readiness, limited resources and geographical challenges).[86]

These factors, where they occurred, are discussed below. This section draws from consumer data from the questionnaire (n=500 respondents) and consumer interviews (n=63 interviewees).

Consumers did not receive enough (or varied enough) one-to-one support

As noted in Figure 22, most consumers who responded to the questionnaire outlined that they got what they needed from using their service; however, some indicated that they only got what they needed ‘a little bit’ or ‘not at all’. [87,88] Out of the 63 consumers who were interviewed, 35 (56%) consumers discussed services that were not available but that they would like. Several consumers (n=4, 6%) for whom only group-based support was available wanted more one-to-one support.

Others were disappointed that the support they received was limited to talking and listening, and they did not receive enough of the other types of one-to-one support. Additional one-to-one support needed by this group included: practical assistance (n=11, 17%), advocacy (n=6, 10%), opportunities to be linked to and participate in the wider community (n=5, 8%), linking with other needed services and supports (n=4, 6%), and planning, problem solving and goal setting (n=4, 6%).

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[86] Note that consumer attributed difficulties to themselves; however, difficulties were not necessarily about them.

[87] Questionnaire data: out of the 495 consumers who responded to the question ‘are you getting what you wanted from using the service?’, n=173 consumers (34.9%) responded ‘quite a bit’, and n=198 (40%) responded ‘a great deal’.

[88] Questionnaire data: out of the 495 consumers who responded to the question ‘are you getting what you wanted from using the service?’, n=86 consumers (17.4%) responded ‘a little bit’, and n=9 (1.8%) responded ‘not at all’. n=29 consumers (5.9%) responded they were ‘not sure’.

There were not enough opportunities for meaningful activity, socialisation and ‘giving back’

For many consumers, (n=14, 22%) additional supports needed were activities to help them occupy their time in a meaningful way, including activities that would ‘get them out of the house’, help them to socialise and develop a friendship network.

Some consumers mentioned that the groups offered by their service provider or available in the local community did not meet their needs (n=8, 13%), either because they were not interested in the content of the groups, or because they were not able to get to the groups because of other commitments. Others reported looking forward to groups which had not gone ahead because of low numbers. Some existing groups were considered irregular and inconsistent, and some were seen as more formal or formulaic, rather than focused on people’s social needs.

Other meaningful opportunities sought by consumers included activities that would help consumers to ‘give back’. Two consumers talked about how they would like the opportunity to be more involved in and contribute to the running of the supports, or work toward becoming peer support workers, but did not feel that this opportunity was offered, or did not know how to go about finding it.

Barriers to consumers’ engagement with supports existed (e.g. personal readiness, limited resources and geographical challenges)

Some consumers expressed the belief that they were responsible for their own lack of engagement with supports. Some looked back on their engagement with services and felt that lack of progress was affected by their being unready to commit or being unable to put enough time and effort into their engagement with the service to achieve more positive outcomes. Some people reported not knowing what they wanted or needed from the service, especially when they first started with it. Some consumers partially attributed issues with their relationship with their support workers to their (the consumer’s) own personality, foibles, symptoms or patterns of behaviour, such as being ’renowned for not being a nice person’ or being someone who ‘sabotaged’ relationships. While these consumers attributed their lack of progress or engagement to themselves, their reasons could be expected within the client group. Instead, challenges may well have been addressed by more flexible, tailored, person-centred and proactive services.

Others explained their engagement with support workers or their progress as being limited by where they lived and/or resource constraints. Some, especially those living in rural areas, said that they were not able to meet their goals because of a lack of community resources for the support worker to refer them to. Others had difficulty attending programs because they lived a long way from the service in an area with poor public transport and did not drive a car.

Staff turnover was high

While people understood that support workers sometimes left, they appreciated a constant support worker who could get to know them, rather than continually changing personnel. Out of the 500 respondents to the questionnaire, 18 (3.6%) listed turnover of support workers as the least helpful thing about the service and 11 (17%) consumers who were interviewed discussed either being happy to have had a consistent support worker for a long time or frustrated by rapidly changing support workers. Continuity in support workers enabled people to develop trust and rapport and allowed the support worker to really get to know them, both of which contributed to positive outcomes. Peak bodies also identified this as a challenge and concern.

> ‘We also had feedback from people who were engaged in the Continuity of Supports program where, because the staff delivering the support process were very insecure in their job continuity with all the changes, there was a lot of turnover. It didn’t feel like continuity of support as the level of support and the same staff were not able to be there.’
>
> **Peak body representative**

Staff received inadequate training

Some consumers mentioned a need for better staff training in specific areas, including ‘psychological training and just being aware of how to facilitate open discussion’, ways to start conversations with clients about issues of diverse identities and trauma informed care.

Out of the 63 consumer interviews, 13 (21%) consumers expressed positive opinions of peer workers. Meanwhile out of 500 consumer respondents to the questionnaire, 12 (2.4%) listed the lived experience of the worker as the best feature of the program. Two peak representatives noted, however, that the peer workforce rarely included carer peer workers, and that this was a major oversight. Further, a couple of consumers had had negative experiences with peer workers who they described as over-sharing or not being focused on the needs and experiences of the consumer. These issues were also noted with some other support workers and this speaks to the need for appropriate training for both peer and other support workers.

Transition support was poor

Problems with services frequently arose at points of transition. It was critical that these transitions were managed efficiently and sensitively. The transition to CoS from previous block-funded programs had been variable. Some consumers experienced no change in support; however, some experienced gaps in service and peak representatives highlighted the issue of overall service gaps.

> 'I had all these different names, and I didn't know who I was meant to call or ask any questions about anything really. I was still waiting for the next thing to happen.'
>
> **Consumer**

Several consumers talked about transitioning between different organisations, whether due to their relocation, NDIS-related funding restructures or other reasons. Because of how critical individual support workers were to people's experience and the outcomes they achieved, often the hardest aspect of transitioning between services was changing support workers.

A smooth and well-managed transition made the process more tolerable. A smooth and well-managed transition meant that: the process was explained clearly; it was not sudden or rushed; where possible there was a meeting between the consumer and both the former and new support workers; there was no gap in support; and the former support worker checked in with the person to ensure that the transition had been successful.

There was poor communication and coordination between supports

Consumers varied considerably in the extent to which they experienced or indeed wanted communication and coordination between supports. Many wanted and needed advocacy support – the support worker representing their interests and helping them to represent their own interests in dealing with health and social care systems. However, closer coordination, where different service providers collaborated to ensure coherent supports and avoiding double-ups and gaps, was less common. Those who described this sort of collaboration spoke positively about it.

Most consumers, when asked about whether the support worker communicated with other mental health supports, such as psychologists or GPs, tended to report that this occurred only when bringing together NDIS applications, in times of difficulty, or not at all. Several said that they believed that the support worker would communicate with other supports if necessary and none expressed a desire for more communication or collaboration between them.

5.3.3 Where the needs of friends, family and other support people were met and not met

Many of the friends, families and other support people interviewed generally found the programs:

- reduced their support load
- supported positive family relationships
- improved the wellbeing of consumers they supported.

Almost all friends, families and other support people described the positive relationships consumers had developed with their support workers. They valued the person having a support worker who was there for them, that they could talk to and could trust.

Most friends, families and support people noted, however, that their own needs were often not met when it came to receiving support and advice for their caring role. They attributed this to the focus and purpose of the programs being to support the consumer as an individual. Some noted that they would appreciate the opportunity to be more involved in the programs, in instances where it was what they and the consumers would like.

> ‘She [consumer] has gone from being, you know, at one stage of being so down, you know, I didn't want to leave her for five seconds… now she feels like she's got a chance.’
>
> **Support person**

Some friends, family and support people also found that their need to see consumers progress towards independence was not well met. They attributed this to support workers’ focus on companionship in some cases, where there were opportunities for them to focus more on supporting the consumer in building their capacity.

5.4 What would work in a new program and what could be improved

As discussed in Section 5.3, not all consumers were happy with their services and even those who were happy often had suggestions on how they could be improved. The most common suggestions from consumers and their friends, families and other support people included the need to:

- **Promote programs more widely** to the public and within the health and social service system, and make it clear what services are available, who they are available to and how people can access them. This would help to make programs more accessible.
- **Make programs available for as long as people need them** because time-limited support does not meet the needs of people who have ongoing or fluctuating needs.
- **Build a stable and well-qualified workforce** by providing competitive wages, conditions, training, support and job stability. This way, services can attract the best people and keep them, and consumers are able to engage with a highly competent and consistent support worker over time.
- **Improve how transitions in services are managed** so that when consumers need to change support workers, organisations, or when consumers are moving into or out of programs, the change is not abrupt, there is a smooth handover and there are no gaps where consumers get no support. Exiting the service should be expected and agreed upon with consumers.

> ‘Probably advertise more in places like [mental health hospitals]. I've been in [hospital] about three times and I had no idea of these places, so a bit more advertising on the walls of those places so people do know they exist.’
>
> **Consumer**

- **Involve friends, families and other support people in programs where appropriate opportunities arise,** if that is what they and consumers would like.
- **Provide more funding to psychosocial support programs** to better enable services meet consumers' needs and help them to be available when consumers need them. This is particularly needed for people living in regional, rural and remote areas.
- **Improve communication within the sector to provide greater clarity about the place of psychosocial support services within the broader mental health system and stability around their future funding.** Short-term funding, defunding and refunding of programs, and frequent changes in program names and language have led to a sense of confusion and perception of a fragmented mental health system amongst consumers and service providers alike.
- **Use human centred design and co-design services to ensure programs best meet consumer needs.** Initiatives that aim to improve or reform programs and systems should be guided by the wisdom of consumers and their friends, families and other support people. They are best placed to know and have ideas on how to deliver psychosocial supports that are: (i) innovative: (ii) desirable to people who need them, (iii) feasible, and (iv) viable to operate and sustain. PHNs and services need time in the service development phase to achieve this.

> 'It [the mental health system] is so fragmented – CoS is a classic example of that because it's not clear about eligibility, how you access it, what's the difference between the kind of packages that are supported through those and the NDIS.'
>
> **Peak body representative**

6 Has the approach to integration of NPS-M and CoS with other clinical and non-clinical services assisted consumers to access effective care? (KLE 4)

Summary of findings

Integration of the two programs with other services for this cohort of people was a stated goal for both programs, particularly NPS-M. The evaluation found many examples of integration mechanisms in place or in development across the 31 PHNs, which are detailed in the PHN profiles at Appendix A

Integration efforts showed marked variation in the service types, and aspects of care being integrated with psychosocial supports, as well as the stakeholders and levers involved in enabling integration. Many PHNs established referral and care pathways. Only one example of pooled funding to enable joint commissioning was encountered.

Successful integration efforts were usually enabled by dedicated individuals or groups who generated shared motivation and strong relationships across stakeholders and clear governance structures to drive integration. Other enablers included the involvement of consumers in the integration process and the development of innovative ways around structural barriers to integration.

The level of collaboration/interaction between the state or territory and Commonwealth programs varied by PHN: only the ACT jointly commissioned services with the local PHN. Service boundaries and exclusions were in place between the state or territory and Commonwealth programs, but they were not always clear.

States and territories continue to be the dominant funder of psychosocial support services in Australia and nearly all jurisdictions have program reviews or evaluations in place, which also represents a challenge to integrated arrangements. The potential for gaps and duplication remains.

The key barrier to integration was the fragmented service landscape with funding and governance split across all levels of government, resulting in dispersed accountability and poor incentives for cross-jurisdictional collaboration. Short implementation timeframes, uncertainty about the future of the programs and the pressured context generated by the roll-out of the NDIS impeded the development of the effective partnerships required for integration. Other barriers to integration included mixed understandings on what integration meant in a psychosocial context and a lack of experience, capability and guidance on how to commission for integration.

There are opportunities for further collaboration at all levels of the health system. Some of these opportunities are outlined at the end of this chapter, based on a framework the evaluation has developed to assist in improving integration.

6.1 Integration was a central goal of the NPS-M and CoS programs

In designing the funding arrangements for both NPS-M and CoS, the Commonwealth recognised the importance of integrating both programs with other clinical and non-clinical services to ensure a coordinated approach that meets consumer needs. As discussed in Section 8, evidence has demonstrated that effective care enables consumers to experience seamless continuity of care. This means that programs need to have established links or referral arrangements in place to avoid consumers having to access multiple separate programs. It also means that consumers should be able to transition smoothly between services and locations as their needs change.

There were two key aspects targeted for integration. The first was joint planning and coordination with the state or territory clinical mental health and psychosocial services. The second was integration with broader social/human services to allow a more holistic approach to care – for example for consumers with alcohol and other drug issues in addition to their psychosocial needs.

The importance of integration was demonstrated to PHNs through the program guidance. It was also a feature of the NPS-M bilateral agreements with each jurisdiction, which were shared with PHNs. The addition of the Commonwealth's Service Navigation funding to PHNs from late 2020 (outlined below) was further recognition of the importance of facilitating integration between services for the consumer.

Detailed NPS-M and CoS guidance clearly outlined the need for and potential approaches to integration

Both NPS-M and CoS guidance set out the need to link programs with clinical and non-clinical programs to support a coordinated team approach to meeting the needs of people with severe mental illness, and form part of a multiagency care plan. The guidance noted integration could take place across many systems such as primary care (health and mental health); state and territory specialist mental health systems; the mental health and broader non-government sector; disability services; alcohol and other drug treatment services; and income support services and education, employment and housing supports.

PHNs were expected to implement this through contracting of services that facilitated client care activities to enable the appropriate delivery of psychosocial support services (e.g. through communication and sharing of relevant information; processes to support team-based approaches, such as care plans, case conferences; and by facilitating access to other health and social support services).

Key differences between the two programs' guidance include:

- NPS-M guidance emphasises the importance of PHN and state or territory regional health service coordination and shared planning, with proposed Regional Mental Health and Suicide Prevention plans a key vehicle for this.
- CoS guidance specifies service providers are to build strong linkages and partnerships with local clinical and social/human services to increase service access and streamline referral pathways.

Implementation plans contained in the bilateral agreements supported integration of NPS-M with state-based programs to varying degrees.

Bilateral agreements between the Commonwealth and each jurisdiction included an 'implementation plan' schedule. This schedule detailed the amount of funding committed per year by each jurisdiction as well as details of programs that would be created or supplemented through this funding.

Some implementation plans also summarised planned integration or clarified the distinction between Commonwealth and State-funded programs, but this varied greatly between jurisdictions, with several states or territories providing very little detail. PHNs received copies of these agreements to support their integration efforts.

The NPS Service Navigation Measure was developed to enhance integration efforts

In August 2020, the Australian Government announced new funding for PHNs to undertake Service Navigation activities for 12 months from December 2020.[89] This can be used to fund new or existing initiatives that:

- Improve consumer understanding of the services available to them and result in better access to supports which promote recovery; or
- Enable PHNs, state regional health services and the Local Area Coordination services (LACs) established by the NDIS to develop a joint understanding of psychosocial referral pathways, available supports as well as service and capacity gaps.

Flinders University has been commissioned to provide implementation support to PHNs for the Service Navigation Measure including the development of online training modules and a community of practice.

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[89] PHN Psychosocial Support Interface and Service Navigation Measure Guidance, updated 10 November 2020

6.2 PHNs employed a range of strategies to encourage integration

Most PHNs considered the collaborative development of mechanisms that would facilitate more integrated service delivery for the consumer. In some cases, these efforts were significant and produced effective arrangements. Other PHNs were at earlier stages of development and noted that they had started establishing foundational enablers for integration, which have yet to translate into meaningful integration for the consumers.

Collaboration or joint planning or joint commissioning between PHNs and state or territory services was seen in pockets across the country.

Areas where examples of integration strategies or mechanisms were noted included needs assessment and planning, contract specifications, referral and care pathways, intake processes, care coordination and navigation initiatives, program coordination mechanisms, joint skill and capability improvement initiatives, commissioning the same provider to deliver multiple service types, partnerships.

Needs assessment and planning

Many PHNs used needs assessment and planning activities as an opportunity to engage with other stakeholders and develop integration across the sector. The most prominent example of this is the development of Joint Regional Plans for Integrated Mental Health and Suicide Prevention Services by PHNs and state regional health networks that are a requirement under the Fifth National Mental Health Plan.[90] These plans were being developed while the NPS-M and CoS were being implemented with different regions at various stages of completion. During the evaluation the Commonwealth extended expected finalisation of joint regional plans until 30 December 2020 due to COVID-19.[91] In some areas where the plans were more developed, they provided a useful input for planning NPS-M and CoS services including identifying areas gaps in service delivery as well as duplication.

Many PHNs also held open consultations or workshops where consumers, service providers, state regional health services and other stakeholders could provide input before services were being commissioned. More details on the processes undertaken by PHNs to implement NPS-M and CoS services are provided in Section 3.2.

PHN contracts with service providers

All PHN contracts reviewed by the evaluation included requirements for service providers to create relationships and linkages across providers and sectors.[92]

Integration inclusions in contracts ranged in specificity, for example:

- **inclusion of high-level principles**: 'Service needs to be in line with an integrated, person-centred, recovery-based approach, with optimal use of available resources, including workforce and infrastructure.'[93]
- **detailed specification of required integration objectives**: 'Supplier must work towards reducing intense and acute health service intervention, by working closely with the LHD and primary care providers. Supplier must proactively facilitate a stepped approach as required, to meet the individual's needs that offset the need for client to present in crisis and mitigate the need for acute and intense service responses.'[94]

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[90] Australian Government Department of Health, Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: A Guide for Local Health Networks (LHNs) and Primary Health Networks (PHNs), 2018. Accessed via: https://www1.health.gov.au/internet/main/publishing.nsf/content/68EF6317847840E3CA25832E007FD5E2/$File/Regional%20Planning%20Guide%20-%20master%20at%2023%20October.pdf

[91] Primary Health Exchange, COVID-19 deadline extension to Joint Regional Plans. Accessed via: https://phexchange.wapha.org.au/joint-regional-mental-health-plan/news_feed/deadline-extension-to-joint-regional-plans-due-to-covid-19

[92] The evaluation received de-identified contracts from 20 (65%) PHNs

[93] Deidentified Western New South Wales PHN NPS-M, CoS and Interface Service Schedule

[94] Deidentified Nepean Blue Mountain PHN Service Provider Grant Agreement

- **inclusion of specific integration deliverables**: a requirement for service providers to develop an Integration and Coordination plan.[95]
- **requirement for service providers to implement a specific integrated model of care:** (see 'Case study 7 - Integrated service hub model' for more detail).[96]

Referral and care pathways

Referral and care pathways varied in scope, format and focus across PHNs, for example:

- **A focus on pathways into the NPS-M and CoS programs:**
  - Western Queensland PHN invested in upskilling GPs to refer into NPS-M and CoS as part of their brokerage model of care which places the GP at the centre of consumer care (see 'Case study 5 - Regional, rural and remote service delivery').
  - Western Victoria PHN developed Referral Point which is a single point of entry to enable patients to access psychological therapy services via their treating health practitioners.
- **Development of cross sector integrated care pathways:** Western Sydney PHN has developed care pathways for youth and adults with low-, medium- and high- intensity needs. These pathways include a range of services including NPS-M and CoS, state-funded psychosocial supports, Aboriginal mental health services, drug and alcohol services as well as primary and acute mental health care services.

Care coordination and navigation initiatives

Some PHNs focused on empowering consumers to connect with the complex service system (service navigation initiatives) whereas others focused on ensuring service providers work together for integration. For example:

- **Care coordination:** The Gold Coast Psychosocial Alliance assists integration across psychosocial programs primarily at the point of intake and assessment as well referral and care pathways beyond NPS-M and CoS (see 'Case study 9 - Program coordination mechanisms' for more detail).
- **Service navigation:** Central and Eastern Sydney PHN provides a free Information Line to assist consumers in connecting with mental health services and supports in line with their needs (see 'Case study 8 - Examples of New South Wales integration efforts' for more detail).
- **Care coordination and service navigation:** This is seen in Eastern Melbourne PHN and Brisbane South PHN:
  - Eastern Melbourne PHN established a Referral and Access Team which assists consumers and health professionals to understand, navigate and access available mental health services in its area (see 'Case study 3 - PHN model of psychosocial support' for more detail).
  - Brisbane South PHN has a dedicated resource to coordinate care and build mutual understanding between addiction treatment services and psychosocial supports. Brisbane South also builds service navigation into all contracts (see 'Case study 2 - Integrated support for priority cohorts' for more detail).

Centralised intake processes

A small number of PHNs implemented centralised intake processes that provide single points of entry and assessment services across a range of services. Examples include:

- East Melbourne PHN's Referral and Access Team which includes mental health clinicians and practitioners who can assess clinical risk, triage as required and assist people to access the service that best suits their needs (see 'Case study 3 - PHN model of psychosocial support' for more detail).
- North Coast PHN has also commissioned (using separate funding) a centralised assessment and referral service which provides a single point of contact for consumers, carers, GPs, allied health

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[95] Deidentified Murray PHN Psychosocial Recovery Services Schedule

[96] Deidentified Brisbane South NPSM Services Agreements

professionals and NDIS support services (see 'Case study 8 - Examples of New South Wales integration efforts' for more detail).

- Brisbane North's service hubs which provide a single point of entry for both clinical and non-clinical supports commissioned by the PHN (see 'Case study 7 - Integrated service hub model' for more detail).

Further information regarding consumer entry, assessment and exit is available in Section 3.5.

Program coordination mechanisms

Many PHNs lead or are involved in program or service coordination mechanisms that meet regularly to improve access and continuity of care for consumers. Program or service coordination mechanisms (often known as alliances, networks or taskforces) connect stakeholders across psychosocial programs within a PHN or across multiple PHNs within a state or across multiple states. Examples the evaluation encountered included representatives from psychosocial commissioners (PHNs, the NDIS and state government) and service providers across the NPS-M and CoS, the NDIS and state-government funded programs.

Coordination mechanisms vary in structure and are organised at PHN-level, regional government level and at times between neighbouring states. These forums allow members to:

- develop a common understanding of the distinct roles and target cohorts of psychosocial programs and commissioned services in the region
- seamlessly refer consumers into appropriate programs, advancing a 'no wrong door' approach
- establish the relationships and clear referral pathways required to ensure continuity of care between clinical services and psychosocial supports
- discuss local challenges, share ideas and best practice and provide a forum for collaboration and consistency.

Examples such as the Murrumbidgee Mental Health, Drug & Alcohol Alliance are described in more detail in 'Case study 8 - Examples of New South Wales integration efforts'.

Consumers valued collaborative approaches

Consumers' experiences of integration and coordination across services varied and where it occurred was driven by their support worker. Consumers varied considerably in the extent to which they experienced or indeed wanted coordination between supports to happen. Many wanted and needed advocacy support – the support worker representing their interests and helping them to represent their own interests in dealing with health and social care systems. However, closer coordination, where different service providers collaborate to ensure coherent supports, avoiding double-ups and gaps, was a less common experience. Those who described this sort of collaboration spoke positively about it.

Most consumers, when asked about whether the psychosocial program communicated with other mental health supports, such as psychologists or GPs, tended to report that this occurred only in bringing together NDIS applications, in times of difficulty, or not at all. Several said that they believed that the support worker would communicate with other supports if necessary and none expressed a desire for more communication or collaboration between them.

Joint skill and capability improvement initiatives

Examples of capability improvement initiatives ranged in structure and format including:

- **workshops:** Northern Sydney PHN ran a series of stepped care workshops with the service providers to upskill them in integration. Western New South Wales PHN ran a collaborative workshop including the PHN, LHD, Ministry of Health and NDIA.
- **ongoing learning forums:** Brisbane South PHN has a regional governance structure which includes structured opportunities for providers to share lessons as well as formal training opportunities. Tasmania PHN runs monthly meetings with service providers which allows for learning across PHNs (see 'Case study 2 - Integrated support for priority cohorts' for more detail).

Commissioning the same provider to deliver multiple services

Examples of PHNs commissioning multiple services from the same provider allowed efficiencies and streamlined processes for consumers and administration or reporting. For example:

- Darling Downs and West Moreton PHN commissioned the same provider for Mental Health Nurse Care (MHNC), NPSM and CoS.
- Brisbane North PHN commissioned NPS-M and CoS and clinical mental health supports by pooling CoS, NPS-M and Primary Mental Health Flexible Funding (see 'Case study 7 - Integrated service hub model' overleaf)
- East Melbourne PHN commissioned a single provider only to deliver both NPS-M and CoS funded supports for their entire region.

CASE STUDY

Integrated Service Hub Model

BRISBANE NORTH PHN | QUEENSLAND

KEY INSIGHTS

- Integration is encouraged via pooled funding across multiple Commonwealth programs, contracting psychosocial supports and clinical supports through a single contract with a lead provider.
- Longer term contracting arrangements (three years) enable a deep partnership and collaboration between PHNs and service providers.

Brisbane North PHN uses an Integrated Service Hub model to deliver integrated clinical NPS-M and CoS supports

- Brisbane North PHN co-designed the integrated service model with consumers, carers, service providers and other stakeholders through targeted reviews of its mental health services.
- The key aims of Integrated Service Hubs (the Hubs) are to improve mental health and suicide prevention planning, commissioning and integration of services at a regional level to improve outcomes for people with or at risk of mental illness and/or suicide.

Brisbane North PHN commissioned the Hubs using integrated approaches such as pooled funds and prime contracting

The program pools funding from multiple Commonwealth programs to commission integrated and coordinated primary mental health care including psychosocial supports for a wide range of cohorts:

- Primary mental health care services, clinical care coordination and psychosocial supports for people with severe mental illness and associated psychosocial functional impairment.
- Low-intensity mental health services and psychological interventions for people with mild to moderate mental illness.
- Early intervention and integrated primary mental health care services for children and young people (including those with severe mental illness being managed in primary care).

The PHN has contracted one service hub covering each Metro North Mental Health Service (MNMHS) catchment area (Redcliffe/Caboolture, The Prince Charles Hospital, The Royal Brisbane and Women's Hospital).

This reflects a prime contracting model in which a lead organisation (the service hub) is required to either deliver or contract out services, remaining accountable for the provision of quality, integrated care.

There are six essential elements of Integrated Service Hubs

1. Integration of clinical and non-clinical services in a hub and spokes model.
2. Use of a stepped care approach matching care with the level of need for people with severe mental illness.
3. Physical colocation of psychological therapies, mental health nursing and psychosocial supports in the hub.
4. Provision of outreach to ensure maximum geographical reach in the catchment area.
5. Establishment of formalised agreements with external providers to ensure access to services, strong referral pathways and smooth transitions.
6. Maintenance of a diverse workforce, including people with a lived experience of mental illness, which have the requisite skills and experience to accommodate varying types of presentations, needs and supports.

KEY FEATURES OF INTEGRATED SERVICE HUB MODEL

Pooled funding from multiple Commonwealth funding streams:

- NPS-M
- CoS
- Primary Mental Health Care flexible funding.

Integrated contracting:

- Commission integrated psychosocial supports and clinical supports through a single contract
- Prime Contracting model in which a provider (the service hub) is responsible for delivering or contracting all services.

Functions of service hubs:

- Assessment, triage/intake
- Service navigation – linking to other services at the hub or in the community as appropriate
- Provision of psychosocial supports, mental health nursing/physical health support, psychological therapy services
- Care coordination, ongoing review, and exit and follow-up.

Joint commissioning

ACT PHN worked in partnership with ACT Health to co-commission National Psychosocial Support (NPS) activities in the ACT across the commissioning cycle including identifying gaps, co-designing outcomes with stakeholders and procuring and implementing services based on identified outcomes.

This ensures psychosocial services are integrated with the NDIS, Canberra Health Services, Medicare as well as local charities including food banks and homelessness services. For more detail see 'Case study 4 - Aboriginal and Torres Strait Islander communities'.

Partnerships

The North Coast Collective is a partnership between North Coast PHN, Mid North Coast LHD and Northern NSW LHD to promote integrated approach to planning, funding and delivering mental health and drug and alcohol services. For more detail see 'Case study 8 - Examples of New South Wales integration efforts' overleaf.

CASE STUDY

Examples of New South Wales integration efforts

WESTERN SYDNEY PHN, MURRUMBIDGEE PHN, NORTH COAST PHN, HUNTER NEW ENGLAND PHN

KEY INSIGHTS

NSW PHNs have adopted a range of strategies to promote integration of NPS-M and CoS programs with other psychosocial, mental health, other health, and broader social, housing and NDIS services. Strategies include:

- Commissioning care coordination and service navigation through NPS-M and CoS contracts or other dedicated resources.
- Developing centralised referral and assessment bodies and integrated care pathways.
- Creating formal partnerships to move towards the integrated planning, funding and delivery of services.

North Coast PHN

North Coast PHN aims to improve integration by hiring a dedicated care coordinator, requiring integration of NPS-M and CoS contracts, funding a central assessment and referral service, as well as the North Coast Collective.

- NPS-M and CoS contracts stipulate that service providers must build and maintain strong linkages and partnerships with local clinical services to streamline referral pathways.
- Through the NPS-M interface funding, North Coast PHN has hired a worker dedicated to enhancing sector coordination and communication (including relationships with the Local Health Districts (LHDs)), identifying service gaps and preventing duplication of supports.
- North Coast PHN has commissioned Neami as a centralised assessment and referral service. This promotes a 'no wrong door approach' through a flexible response and single point of contact for consumers, carers, GPs, allied health professionals and NDIS support services.
- The North Coast Collective is a partnership between North Coast PHN, Mid North Coast LHD and Northern NSW LHD to promote integrated approach to planning, funding and delivering mental health and drug and alcohol services.

Murrumbidgee PHN

Murrumbidgee Mental Health, Drug and Alcohol Alliance (the Alliance) is a formal arrangement between leading partners for services with mental health and drug and alcohol problems in Murrumbidgee. The Alliance includes Murrumbidgee PHN, Murrumbidgee LHD, all service providers, consumers and carers.

The Alliance's key objectives are to:

- develop and articulate a shared vision for mental health, and drug and alcohol services that meet the needs of the Murrumbidgee population
- develop innovative models and ways of working together across human services that reflect a shared purpose and purposeful collaboration
- promote recovery as the highest goal for service users, recognising that this involves the whole person with a lived experience journey.

Integration initiatives completed to date include the development of a common referral form, an online service directory, diagnoses and carer support groups, and person-held digital care plans ('Jimba').

Western Sydney PHN

Western Sydney PHN encourages integration through the development of integrated mental health care pathways.

- Western Sydney HealthPathways is a partnership initiative between Western Sydney PHN, Western Sydney LHD and the Sydney Children's Hospitals Network.
- Mental health care pathways have been developed for youth and adults with low-, medium- and high-intensity needs. Care pathways include a range of services including NPS-M and CoS, state-funded psychosocial supports, Aboriginal mental health services, drug and alcohol services, as well as primary and acute mental health care services.
- NPS-M and CoS contracts require providers to shape the development of referral pathways by engaging with other commissioned service providers, clinical care, NGOs providing other community support services and with NDIS Local Area Coordinators.

Central and Eastern Sydney PHN

Central and Eastern Sydney PHN has adopted a service navigation approach to promoting integration empowering the consumer to connect with services.

- Central and Eastern Sydney PHN's Information Line is a referral service available for people within the community with severe mental illness, who wish to access psychosocial supports, including the NDIS. It is accessible to consumers and providers. The Information Line is available to provide information and offer referral pathways to mental health services and supports that will best suit a person's needs.
- Consumers are assisted to link in with other health and mental health services (for example hospitals, psychologists and primary health care) as well as social services (for example Centrelink, housing and human services) based on identified needs; however, there is no formal integration arrangements between the organsiations.

6.3 The level of collaboration or interaction between the state or territory and Commonwealth programs varied

As evidenced in the mechanisms described above, the evaluation found various levels of collaboration or interaction between jurisdictions in the delivery of NPS-M and CoS. Some state regional health services are working closely with PHNs to ensure there is cross-referral and avoidance of gaps and duplication. The most successful of these have a regional coordinating mechanism (alliance/taskforce/committee) to manage the interface between state or territory and Commonwealth programs. The maturity and effectiveness of these initiatives is variable, with some working effectively and others being recently established. The evaluation found that some PHNs would benefit from a greater capacity to innovate and reach out to other parties.

> 'Our service doesn't have a lot of interaction with the Commonwealth programs. On the ground, there has only been awareness about those programs in the past few months…
> …We have had a lot of collaboration with PHNs, they're great collaborators. We shared info about providing supports in this space'
>
> **Service provider**

Service boundaries and exclusions are not always clear

Eligibility for the NPS-M and CoS programs requires that consumers must not be receiving similar supports from state or territory psychosocial programs.

Analysis of PHN information indicated that nearly half of PHNs (n=14, 45%) had clear processes in place to ensure no duplication of service between NPS-M and CoS and state or territory-funded psychosocial support, while others did not.

Information provided to the evaluation from states and territories indicated that only one of 75 reported state/territory-funded psychosocial programs explicitly excluded consumers of the Commonwealth funded psychosocial support programs from receiving state or territory services.

The exclusion requirements were at times a point of confusion, with differing views about whether state clinical mental health service clients could access Commonwealth psychosocial programs. Some PHNs have overcome any confusion by developing structured processes that facilitate referral pathways from clinical services to psychosocial programs. In other cases there was a lack of clarity about the eligibility across the Commonwealth and state or territory divide.

Information provided to the evaluation by State and Territory Governments indicated that many (n=28, 38%) state/territory-funded psychosocial programs require consumers to have received support from a state-funded clinical mental health service in order to access psychosocial support. This means that the states/territories largely provide psychosocial support only for people within their clinical services. This prioritisation makes sense from the jurisdictional point of view as the jurisdictions run the clinical mental health services and need to maximise the support for those consumers to be able to manage them in the community and prevent inpatient admissions. Opening state/territory-funded services up to other consumers who haven't needed acute care would dilute the ability of the jurisdictions to achieve this outcome.

Because of the exclusion arrangements put in place by many jurisdictions, Commonwealth funded programs may provide a safety net that allows consumers who have not engaged with other mental health services to nevertheless access psychosocial support. This is in line with the Productivity Commission's key recommendation which suggests that access to psychosocial support should not require a mental health diagnosis (and eligibility should instead be based on a functional assessment).

The potential for gaps and duplication remains

States and territories continue to be the dominant funder of psychosocial support services in Australia. While a number of jurisdictions cashed out some of their psychosocial programs to the NDIS, they all continue to provide significant levels of funding for these programs. Moreover, these programs continue to be modified: there are ongoing evaluations or reviews of psychosocial programs in six jurisdictions. The levels of funding or program design are not static and may change at any time, independent of the Commonwealth psychosocial program arrangements.

States and territories provided information to the evaluation outlining the psychosocial programs they fund. All jurisdictions stressed that these figures represent a point in time only and may vary in the future, particularly given the extent of review currently underway.

States and territories used a combination of large state-wide programs and small location-based programs to make psychosocial support accessible. Programs varied from large state-wide programs delivered by multiple service providers to small, location-based programs (e.g. a drop-in centre).

6.4 Enablers and barriers to integrating psychosocial supports

The evaluation found a number of common enablers and barriers of successful efforts to integrate psychosocial supports. These are described below.

6.4.1 Enablers

- **Strong, established relationships between service providers and PHNs** enable clear communication, open knowledge-sharing and a willingness to solve cross-cutting problems (e.g. integrated referral pathways between providers).
- **Establishing clear governance arrangements** are essential to the smooth functioning and ongoing collaboration across stakeholders by establishing a clear purpose to the group, roles and responsibilities and decision making processes. These are usually formalised in a terms of reference or through service provider contracts.
- **Including the voice of consumers in the planning, implementation and evaluation of integration efforts.** This ensures that integration efforts are targeted to consumer's needs.
- **Developing innovative ways of addressing structural barriers to integration while remaining compliant with program and funding requirements.** = The case studies on Brisbane North PHN, Eastern Melbourne PHN and ACT PHN are examples of such innovative solutions (see 'Case study 7 - Integrated service hub model', 'Case study 3 - PHN model of psychosocial support', and 'Case study 1 - Joint commissioning for integration').
- **A dedicated individual or group who generates shared motivation across stakeholders** to overcome challenges to integrating and delivering accessible psychosocial supports was a key reason for establishing formal coordination mechanisms. This ranged from the leadership of existing PHN employees (as seen in 'Case study 9 - Program coordination mechanisms' overleaf, to the establishment of a dedicated role (as seen in 'Case study 8 - Examples of New South Wales integration efforts').

CASE STUDY

Program Coordination Mechanisms

GOLD COAST | NORTH COAST | SOUTH AUSTRALIA | VICTORIA AND TASMANIA

KEY INSIGHTS

- Program or service coordination mechanisms connect commissioners and service providers across psychosocial programs, improving access and continuity of care for consumers.
- Key enablers of coordination mechanisms include shared motivation, strong relationships, clear governance processes.

Formal coordination groups connect commissioners and service providers across psychosocial programs

- Coordination mechanisms tend to include representatives from psychosocial commissioners (PHNs, NDIA and state government) and service providers across the NPS-M and CoS, the NDIS and state-government funded programs.
- Coordination mechanisms vary in structure and are organised at PHN-level, state-level and the interstate-level. Examples of coordination mechanism at these levels are detailed at the bottom of the page.

Key enablers of coordination mechanisms include shared motivation, strong relationships, clear governance processes

- A **shared motivation** to overcome challenges to integrating and delivering accessible psychosocial supports was a key reason for establishing formal coordination mechanisms.
- **Strong, established relationships** between service providers and commissioners enable clear communication, open knowledge-sharing and a willingness to solve cross-cutting problems (e.g. integrated referral pathways between providers).
- **Clear governance processes** are essential to the smooth functioning and ongoing collaboration across stakeholders by establishing a clear purpose to the group, roles and responsibilities, and decision making processes. These are usually formalised in a terms of reference or through service provider contracts.

Coordination mechanisms overcome key challenges to integrating and delivering accessible psychosocial supports

CHALLENGES

- Multiple programs with complex eligibility criteria can create uncertainty about the best funding source of support and delays access. Stakeholders report that this uncertainty at times leads to overlapping and duplicative services.
- Continuity of care for people with severe mental illness is often disrupted when stepping up or down between psychosocial, clinical or disability supports.
- Each PHN faces local challenges in delivering integrated psychosocial supports shaped by their unique geography, demographics and policy landscape.

BENEFITS OF COORDINATION MECHANISMS

Coordination mechanisms provide a forum for providers and commissioners between providers to:

- Develop a common understanding of the distinct roles, target and cohorts of psychosocial programs and commissioned services in the region.
- Seamlessly refer consumers into appropriate programs, advancing a 'no wrong door' approach.
- Establish the relationships and clear referral pathways required to ensure continuity of care.
- Discuss local challenges, share ideas and best practice, and provide a forum for collaboration and consistency.

EXAMPLE COORDINATION MECHANISMS

PHN-level

Gold Coast Psychosocial Alliance

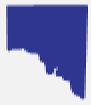
- Coordinates the delivery of psychosocial supports across NPS-M, CoS, NDIS and, Queensland Health and Gold Coast Health programs.
- Aims to facilitate information sharing as well as access to psychosocial supports and continuity of care for consumers.

PHN-level

North Coast Collective

- Comprised of representatives from the PHN and LHDs, as well as local council planners.
- Aims to facilitate strategic planning and the pooling of resources, address challenges regarding commissioning, reduce duplication and develop a predictive model.

State-level



South Australian NDIS Taskforce

- Comprised of representatives from the South Australian Department of Health, the NDIA, PHNs, NGOs and lived-experience representatives.
- Aims to address barriers South Australians face in gaining access to the NDIS, via a collaborative approach to planning.

Interstate-level

Victoria/Tasmania PHN Psychosocial and Interface Network

- Comprised of the psychosocial program managers from Victorian and Tasmanian PHNs, the Department of Health and Human Services (Victoria), and the NDIA.
- Aims to coordinate commissioning approaches across psychosocial services, preventing service gaps or duplications.

Australian Capital Territory PHN and Murrumbidgee PHN also have program coordination mechanisms which are detailed in other case studies.

6.4.2 Barriers

Stakeholders noted several barriers to integrating psychosocial supports, as summarised below.

A key barrier to integration was the fragmented service landscape with funding and governance split across all levels of government.

- Split funding and governance models across Commonwealth and State or Territory Governments disperse accountability and do not encourage collaboration across jurisdictions. This aligns with broader Mental Health reform opportunities discussed in the Productivity Commission's report. The report's recommendation was a focus on greater collaboration between PHNs and LHNs, potentially through the use of Regional Commissioning Authorities[97].
- Some service providers held contracts with both PHNs and the relevant State or Territory Government for similar services which increased their administrative burden. Many service providers with contracts across PHNs noted that reporting and contractual arrangements differed between PHNs and programs.

Condensed timeframes and insufficient consultation made integration difficult.

> "Due to timing, we couldn't communicate with the LHDs properly about what was happening … Really these programs were implemented as solo programs and entirely separate from existing opportunities."
>
> **Primary Health Network**

- Short timeframes for implementation and uncertainty about the future of the programs was seen as a barrier to integration with other services as effective partnerships require time to develop and evolve. PHNs consistently said that, even where they had good working relationships with other service providers, the timeframes prevented them from undertaking joint planning and commissioning of services, including with neighbouring PHNs, and/or in some cases State/Territory Governments.
- Consultation took place over the bilateral funding agreements between the Commonwealth and State or Territory Governments that accompanied the introduction of the NPS-M; however, in nearly every case, the state or territory contribution to the NPS-M was a commitment to a separate (state-based) program. Subsequent interaction at the implementation stage between state or territory mental health services and the PHNs was generally very limited. Stakeholders felt that an opportunity for better integration had been missed, as there was insufficient time for meaningful discussion.

The roll-out of the NDIS created a pressured context in the states/territories that inhibited interaction with the PHNs.

The decision to include people with psychosocial disability in the NDIS and the subsequent introduction of the NPS-M and CoS created a flow-on effect to the funding and organisation of state-based psychosocial programs. This pressured context made consultation and collaboration more difficult.

Mixed understandings of integration in a psychosocial context created barriers to integration.

PHNs and service providers knew they should be integrating but were unclear on what this meant for psychosocial supports. There was varied understanding of what types of integration were possible within the PHN remit and desirable for consumers, including those from Aboriginal and Torres Strait Islander backgrounds, see 'Case study 4 - Aboriginal and Torres Strait Islander communities'.

Some PHNs noted they lacked the experience, capability and guidance on how to commission for integration and manage the associated risk.

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[97] Productivity Commission, "Inquiry Report - Mental Health", 2020. Volume 3, p.1134. Accessed via: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume3.pdf

Key skill gaps included leveraging joint commissioning approaches and co-designing integrated service models and pathways. PHNs noted a desire for the Commonwealth to provide more support, materials and guidance on how to integrate services as seen in the NHS.[98]

There are legal ambiguities about who owns accountability for clinical governance and quality assurance in integrated services over multiple organisations. Service providers and PHNs noted this as a key barrier to implementing more integrated service delivery models.

6.5 A Psychosocial Support Integration Framework to guide future integration efforts

The Psychosocial Support Integration Framework summarised in Figure 23 (overleaf) provides a conceptual framework, informed by the evaluation, to understand the various aspects of integration efforts in the NPS-M and CoS programs to date.

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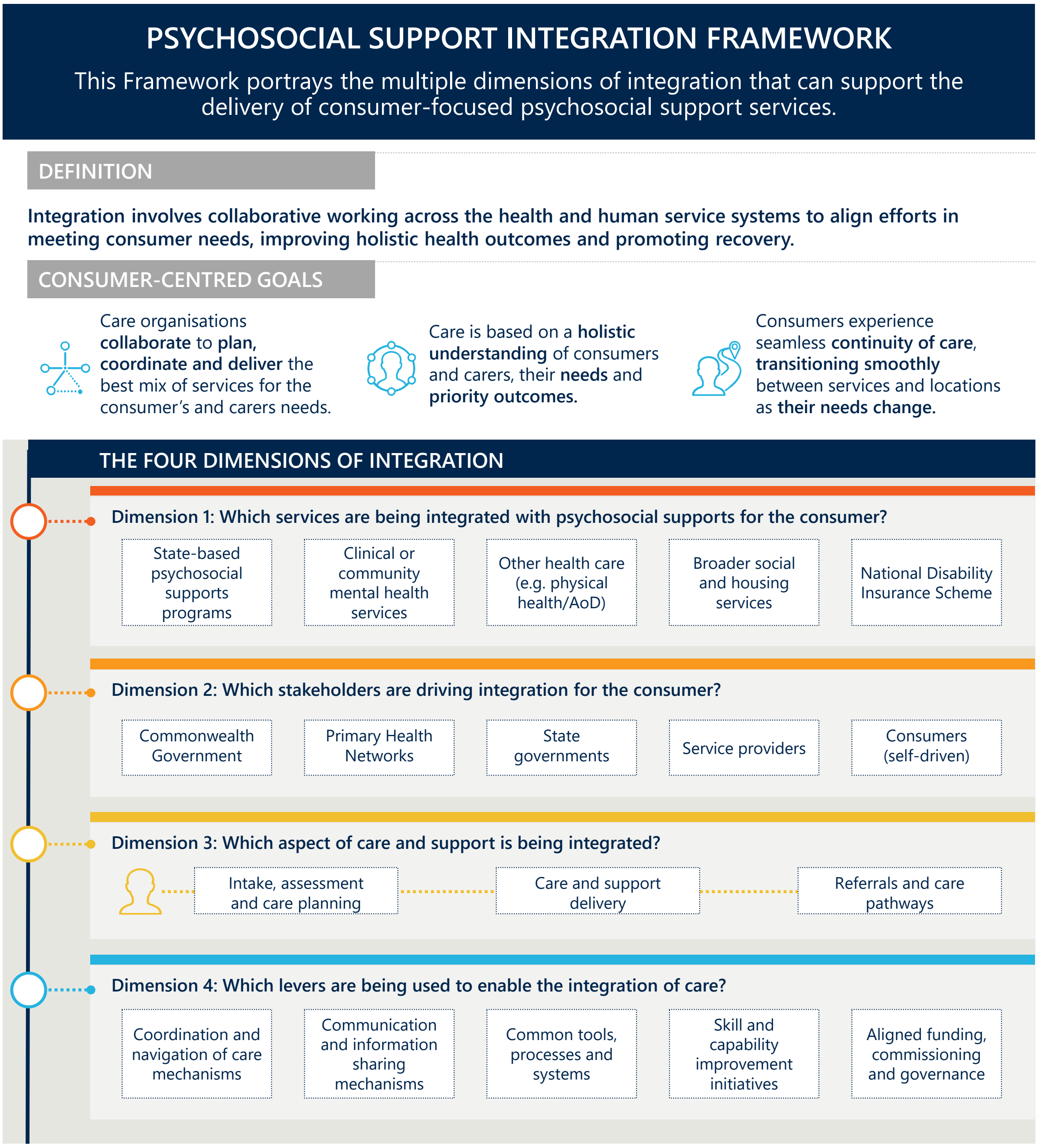
[98] NHS Improvement, "Valued care in mental health: Improving for excellence", 2018. Accessed via: https://improvement.nhs.uk/documents/3453/NHS_Mental_Health_Improvement_web.pdf

Figure 23 | Psychosocial Support Integration Framework



PSYCHOSOCIAL SUPPORT INTEGRATION FRAMEWORK

This Framework portrays the multiple dimensions of integration that can support the delivery of consumer-focused psychosocial support services.

DEFINITION

Integration involves collaborative working across the health and human service systems to align efforts in meeting consumer needs, improving holistic health outcomes and promoting recovery.

CONSUMER-CENTRED GOALS

Care organisations **collaborate** to **plan, coordinate and deliver** the best mix of services for the consumer's and carers needs.

Care is based on a **holistic understanding** of consumers and carers, their **needs** and **priority outcomes.**

Consumers experience seamless **continuity of care, transitioning smoothly** between services and locations as **their needs change.**

THE FOUR DIMENSIONS OF INTEGRATION

Dimension 1: Which services are being integrated with psychosocial supports for the consumer?

- State-based psychosocial supports programs
- Clinical or community mental health services
- Other health care (e.g. physical health/AoD)
- Broader social and housing services
- National Disability Insurance Scheme

Dimension 2: Which stakeholders are driving integration for the consumer?

- Commonwealth Government
- Primary Health Networks
- State governments
- Service providers
- Consumers (self-driven)

Dimension 3: Which aspect of care and support is being integrated?

- Intake, assessment and care planning
- Care and support delivery
- Referrals and care pathways

Dimension 4: Which levers are being used to enable the integration of care?

- Coordination and navigation of care mechanisms
- Communication and information sharing mechanisms
- Common tools, processes and systems
- Skill and capability improvement initiatives
- Aligned funding, commissioning and governance

The four dimensions of the Framework are described below.

Dimension 1 asks 'Which service types are being integrated with psychosocial supports for the consumer?'. Five levels of this dimension reflect the complexity of integrating psychosocial supports with service types that may have different objectives, contexts and vocabulary.

Dimension 2 asks 'Which stakeholders are driving integration for the consumer?'. Integration can be promoted by all levels of the health system including the Commonwealth Government, Primary Health Networks, service providers and consumers.

Dimension 3 asks 'Which aspect of care is being integrated?'. The elements in this dimension relate directly to a consumer's care pathway:

- intake, assessment and care planning refers to the initial processes involved in assessing the consumer's needs to understand the services that will best support them, plan their care and support their recovery goals.

- care and support delivery refers to integration at the point of delivering psychosocial supports to consumers.
- referrals and care pathways refers to the processes undertaken to ensure consumers access the right services at the right time, by identifying the appropriate next steps for a consumer in their recovery journey.

Dimension 4 asks 'Which levers are being used to support the integration of care?'. This dimension refers to the practical mechanisms or levers being used to promote and enable integration. There are five elements within Dimension 4:

- coordination and navigation of care mechanisms refers to efforts aimed at empowering consumers to connect with the complex service system (service navigation) whereas others focused on ensuring service providers work together for integration (care coordination). Stakeholders in the evaluation noted ambiguities about the definitions of service navigation and care coordination. The evaluation proposes the following definitions:
    - service navigation refers to efforts to support consumers in understanding and connecting with a complex service and funding system to meet their needs. It is an approach based in empowering the consumer to have choice and control over their care by enabling them to effectively access the services they need.[99]
    - care coordination refers to the deliberate organisation of consumer care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of healthcare services.[100]
- communication and information sharing mechanisms refers to formalised and established bodies or forums to facilitate communication, exchange learnings or lessons or relevant consumer information across governments, commissioners and service providers.
- common tools, processes and systems refers to establishing standardised tools (e.g. assessment and intake screening tools), processes (e.g. care pathways) or systems (e.g. data and information management systems). Service co-location is frequently used to maximise the commonalities between tools, process and systems.
- skill building and capability uplift refers to initiatives aiming to increase governments, commissioners and service providers knowledge and ability to integrate psychosocial support services.
- aligned funding, commissioning and governance refers to the use of joint commissioning or governance structures to incentivise, monitor and create accountability for integration efforts.

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[99] Carter N, Valaitis RK, Lam A, Feather J, Nicholl J, Cleghorn L. Navigation delivery models and roles of navigators in primary care: a scoping literature review. BMC health services research. 2018 Dec 1;18(1):96.

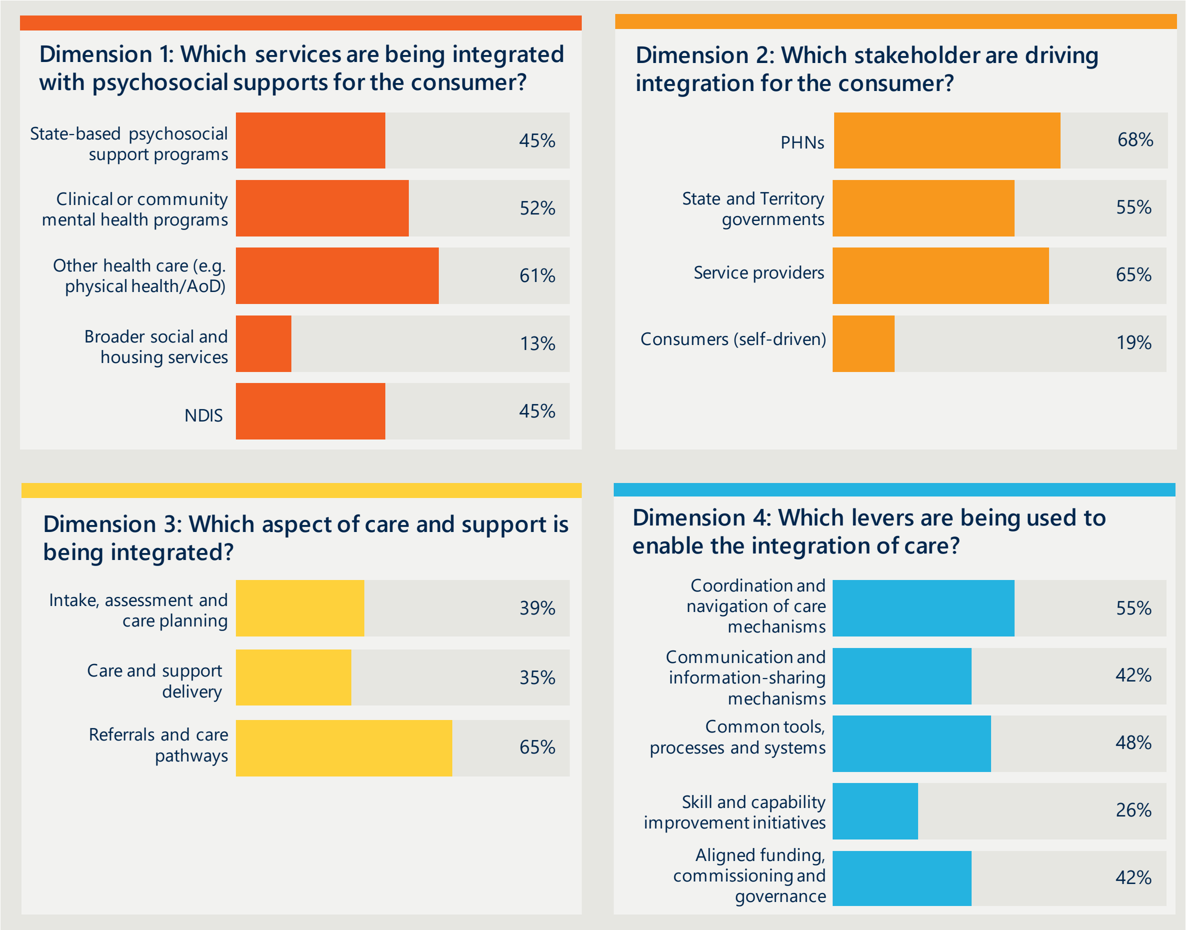
[100] McDonald KM, Sundaram V, Bravata DM, Lewis R, Lin N, Kraft SA, McKinnon M, Paguntalan H, Owens DK. Closing the quality gap: a critical analysis of quality improvement strategies (Vol. 7: Care Coordination). 2007.

6.5.1 Using the Psychosocial Support Integration Framework to quantify the nature and extent of integration efforts in psychosocial support programs

The Framework provides a typology to quantify the nature and extent of integration efforts in psychosocial support programs. This has applications in the monitoring and evaluation of future psychosocial support programs. Some key insights from applying the Framework to the NPS-M and CoS in this way are:

- Most (n=21, 68%) PHNs applied at least one form of integration across the four dimensions.
- The most common service type integrated with was other healthcare (e.g. physical health/AoD), while the least common service type was broader social and housing services (see Figure 24, Dimension 1).
- Stakeholders driving integration were mostly PHNs (n=21, 68%), service providers (n=20, 65%) and State or Territory Governments (n=16, 55%) (See Figure 24, Dimension 2).
- Most common aspect of care and support integrated was referral and care pathways (n=20, 65%), which may reflect the increased difficulty and coordination required to integrate intake, assessment and planning processes as well as the care and support delivery (see Figure 24, Dimension 3).
- Only a quarter (n=8, 26%) of PHNs used skill and capability improvement initiatives as an integration lever, which may have contributed to the mixed quality of some service provider staff (see Figure 24, Dimension 4).

Figure 24 | PHN integration framework



6.5.2 Using the Psychosocial Support Integration Framework to guide future action

Collaboration at all levels of the health system is needed to support integration across the dimensions of the Framework. The Framework may provide a common language for the Commonwealth, PHNs and service providers to agree on respective roles and responsibilities in promoting integration.

The Commonwealth can build integration into program design and share best practice. The Commonwealth can enable integration by:

- Articulating a clear and specific vision for integration of psychosocial supports across all four dimensions of Figure 23 and building this vision into program design and structure. This may include moving toward fewer programs which fund multiple service types (i.e. a broader scope) and providing increased flexibility in the use of funds to promote integration and delivery of the services needed by consumers.
- Negotiating for integration at a national level. This includes working with state and territory governments and the NDIS to develop a coherent vision for how relevant programs, funding and services should integrate, and translating these into clear agreements.
- Providing guidance and support to PHNs on integration. This includes collecting and aggregating intelligence from all PHNs, sharing best practice and facilitating communities of practice.

States and territories can further collaborate with the Commonwealth and PHNs. States and territories can enable integration by:

- Participating in regional governance structures to coordinate or integrate psychosocial supports. This may include joining up psychosocial programs or establishing clear distinctions in the aims and roles of Commonwealth and state psychosocial funding.

PHNs can use levers across the commissioning cycle and their role as a regional leader to enable integration. PHNs can enable integration by:

- Co-designing evidence-based local care pathways for different cohorts (e.g. dual diagnoses, Aboriginal and Torres Strait Islanders and people from culturally and linguistically diverse backgrounds).
- Bringing together states/territories, NDIS and service providers under regional governance structures to coordinate or integrate the planning, delivery and evaluation of psychosocial supports.
- Facilitating the establishment of common tools and processes such as centralised intake and assessment processes, a standardised monitoring and evaluation framework for psychosocial support integration (including metrics for tracking progress towards integration).
- Considering the use of joint commissioning (including budgeting, contracting and payment) approaches to incentivise integration.

Service providers can work collaboratively with consumers and other service providers to ensure consumer-centric, continuous care. Service providers can enable integration by:

- Understanding what's important to the consumer, their friends, families and other support people.
- Working with other service providers to ensure transitions between care settings are smooth.
- Innovating and sharing integrated models of care.
- Adapting organisational practices to adhere to common tools, systems and processes (e.g. using common assessment and planning tools and interoperable information sharing systems).

7 How cost effective are the programs? (KLE 5)

Summary of findings

The average funding per consumer for NPS-M was lower than estimated when modelling the service ($3,248 vs $6,345) This is likely due to more consumers accessing the service for a shorter period than a full year. The average funding per consumer for CoS was higher than expected ($7,385 vs $4,160) and likely reflects fewer consumers accessing the services either because they have not transitioned from NPS-T or did not pursue receiving support through CoS. The funding per consumer of the NPS-M program is on the low end of the range when compared with other psychosocial support services including PHaMs, PIR, D2DL and state or territory-funded programs. The funding per consumer for CoS is in the middle of the range compared with the same programs. The funding per consumer varies substantially between PHNs across both the NPS-M and CoS programs.

PHNs and service providers noted that service delivery is more costly in regional and remote areas (potentially up to double the cost of providing the same service in metropolitan areas) due to high travel costs and thin markets. Some PHNs noted that they cross-subsidised the NPS-M and CoS by commissioning services with other programs (often NPS-T and Interface funding) to increase access and provide appropriate support for consumers.

It is not possible to assess the cost-effectiveness of the current programs in terms of achieving outcomes for consumers and efficiencies across the broader health system due to limitations with data that is currently available. These limitations include a lack of consistent outcome data across psychosocial programs and the inability to link program usage data with other national datasets (e.g. national hospital morbidity database).

Administration costs used by PHNs and service providers reflected approximately 20% of total funding across both programs. Stakeholders noted that having two streams of funding and different reporting requirements across PHNs substantially increases administrative burden and costs. There are opportunities to streamline funding streams and support service providers to find economies of scale.

7.2 Cost of national psychosocial support programs compared with other psychosocial supports

This section provides a description of the modelled funding for the NPS-M and CoS programs, the actual cost per consumer and a comparison with other psychosocial supports funded by the Australian and state or territory governments.

7.2.1 Modelled funding for the NPS-M and CoS programs

NPS-M was expected to provide 3,800 consumer places and cost $24.11 million (2019-20) resulting in average funding of $6,345 per consumer place. Each of the intended 3,800 places was funded for 12 months but the Department has advised that the funding did not anticipate that individual consumers would use the place for the full 12-month period. The guidance to PHNs for the NPS-M program noted that 'the cohort being targeted through this initiative would generally require less intensive and possibly shorter term psychosocial support than the service offer provided through programs transitioning to the NDIS. The focus should be on building capacity and connectedness at times this is most needed, rather than providing ongoing support.' [101] The Department has advised that, because of this, the number of individual consumers who accessed support through NPS-M was expected to be higher than the 3,800

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figure as consumers moved in and out of available consumer places. If all 7,412 consumers who accessed the NPS-M program did so for 5.9 months (see Section 4.2.3)[102] this is equivalent to 3,644 consumers using the program for a full 12 months. This figure needs to be treated with caution as there is a broad range of average access times across PHNs and some PHNs have not provided data.

CoS was expected to support 8,800 consumers and cost $36.6 million per year resulting in an average funding per client per year of $4,160. Unlike NPS-M, CoS consumers were expected to receive ongoing support. CoS funding was based on the current numbers of clients who were receiving support through the PHaMs, PIR and D2DL programs.[103] The Department advised that adjustments were made to these consumer numbers to account for an estimated likelihood that a consumer would be eligible for the NDIS (only for individuals under 65 years of age). Each of the three programs had different costs per consumer per year that were used to estimate funding. PIR consumers were modelled to require support costing $3,000 per consumer per year. D2DL consumers were modelled to require support costing $1,685. PHaMs modelled funding varied depending on the region with the average cost per consumer per year being $5,900 in metropolitan areas, $6,700 in regional areas and $15,000 in remote areas.

7.2.2 Cost per consumer of the national psychosocial support programs

On average, the cost per consumer of delivering NPS-M was $3,248 and CoS was $7,385 over the period 1 July 2019 to 30 June 2020. Table 7 provides the number of consumers, funding and cost per consumer of the NPS-M and CoS program over the period 1 July to 31 December 2019.

Table 7 | National 2019-20 NPS-M and CoS cost per consumer

Program	Consumers	Funding	Average funding per consumer†
NPS-M	7,412	$24,073,986	$3,248
CoS	4,956	$36,600,000	$7,385

†NPS-M consumers were expected to access supports for a shorter period compared with CoS consumers. Because of this the difference in cost per consumer between the two programs may not reflect different support intensity.

The actual funding per consumer for NPS-M was lower than the $6,345 estimated average funding per consumer place. This reflects more consumers using the program than consumer places, potentially for a shorter period than a year leading to lower actual funding per consumer. The actual funding per consumer for the CoS program was higher than the average derived from the estimated number of consumers and total cost of the program. This likely reflects fewer consumers accessing the CoS service as they are still being supported by the NPS-T program while they test their eligibility for the NDIS or disengaging during the transition from previous programs through NPS-T. Lower funding per consumer for the NPS-M program compared with the CoS program does not necessarily reflect reduced intensity of support for NPS-M consumers because more consumers have accessed the service for short term periods.

The funding per consumer of the NPS-M and CoS varies substantially across PHNs. Figure 25 presents the funding per consumer for the NPS-M and CoS in each PHN. In most PHNs, the funding per consumer was between $1,000 and $5,000. There is a wide range above this amount with one PHN having a funding per consumer of $12,390. The CoS program had a higher funding per consumer across PHNs with most

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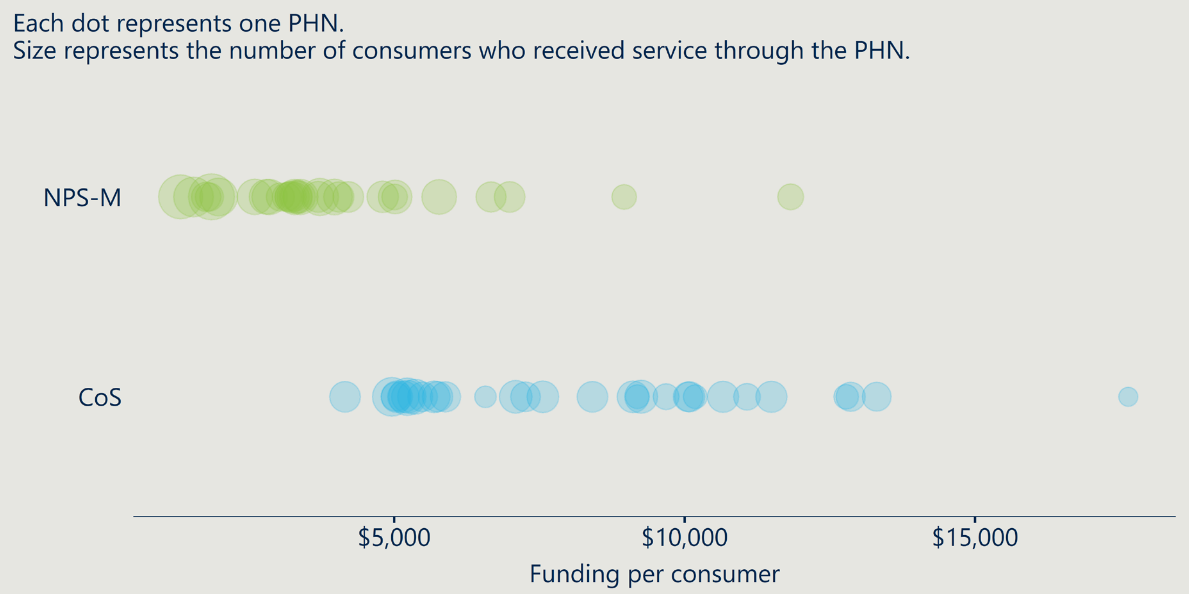
[102] 5.9 months reflects the average across individuals who accessed individual support and those who only access group support for the NPS-M. Data was only available for a subset of PHNs and there was a substantial range of average access times across those that did provide data.

[103] Advice from the Australian Government Department of Health Mental Health Supports Branch

ranging from $5,000 to $7,500. Again, there were several PHNs that had substantially higher funding per consumers for the CoS program.

Figure 25 | NPS-M and CoS cost per consumer across PHNs[104]



7.2.3 Increased service delivery costs in regional and remote areas.

Stakeholders including PHNs and service providers noted that service delivery costs more in regional and remote areas. Both PHNs and service providers estimated the cost of providing services in regional and remote areas was almost double the cost of service provision in metropolitan areas. This is largely driven by lower population densities that increase the cost of outreach service provision including additional travel and accommodation costs. As noted in Section 4.2.1, regional and remote areas tended to have higher numbers of consumers per population. This increased need should be considered separate to the increased cost of service provision described here.[105]

PHNs and service providers also noted that current funding levels were not sufficient and compromised their ability to create program efficiencies. This was exacerbated by having two funding streams (NPS-M and CoS) that needed to be commissioned separately. PHNs in regional and remote areas took steps to increase the funding available for these programs including cross-subsidising with other programs to make up for what they believed was a shortfall (see Section 7.2.5, below).

Thin markets may increase the costs of services in regional and remote areas. Many regional and remote PHNs noted their service provider market and workforce was thin. Some PHNs reported that going through a commissioning process for service providers was not feasible because in some locations there was only one provider servicing that region. This may reduce competition between service providers and increase costs for services. There were also reports of service providers pulling out of regional and remote areas as the cost of providing support was not financially viable for the fragmented business model.

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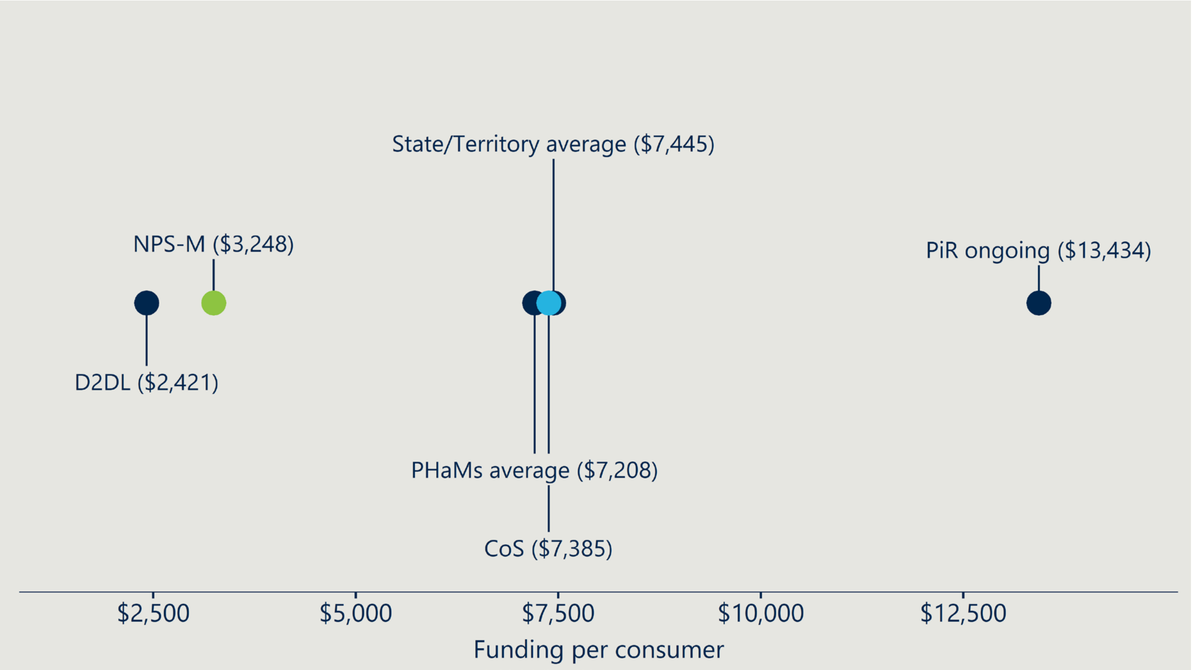
[104] Data from 12-month performance reports (2019-20) from PHNs to Australian Department of Health.

[105] The Commonwealth announced additional funding in August 2020 which included regional loading for clients in Modified Monash regions 3 to 7. PHN CoS and NPSM/Transition Guidance, Updated 10 November 2020, Australian Government Department of Health.

7.2.4 The funding per consumer for NPS-M and CoS is similar to other psychosocial support services.

A range of psychosocial support programs funded by the Australian Government and state or territory either are in place currently or have been in place in recent years. These include NPS-M, CoS, PHaMs, D2DL and PIR funded by the Australian Government and a range of small and large programs funded by state and territory governments. Figure 26 presents a comparison of the different funding per consumer for these programs. Both NPS-M and CoS are within the range of previous supports. The funding per consumer for NPS-M is towards the lower end and likely reflects more consumer accessing the service for a shorter period (see Section 7.2.2). CoS is in the middle of the range and has a similar funding per consumer as the PHaMs program (across all regions) and state or territory-funded programs.

Figure 26 | Cost per consumer comparison across psychosocial support programs[106]



The following sections describe relevant information to determine the funding per consumer for each of the programs in Figure 26.

- **D2DL** ran from 2011 to 2019 and aimed to improve the quality of life for people with severe and persistent mental illness by creating 60 locations nationally where consumers could access 100 hours of low or medium level support. The Productivity Commission reports that the average cost per client of the D2DL program was $2,421 (inflated to 2019 dollars).[107]
- **PHaMs** was a program designed to help people with severe mental illness to live independently through an Individual Recovery Plan and personal helper/mentor. The program ran from 2007 to 2019 and was supporting approximately 9,200 consumers when the program ceased on 30 June 2019.[108] PHaMs service providers were commissioned directly by the equivalent Australian Government Department to that currently named the Department of Social Services. The average cost per participant in PHaMs per year was $6,750 in 2015-16 ($7,208 inflated to 2019 dollars).[109] This varied

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[106] Details for relevant data presented in text below.

[107] Productivity Commission, "Inquiry Report – Mental Health", 2020, Appendix K, p.238. Accessed via: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-appendices.pdf.

[108] Data from Australian Government Department of Health

[109] PHaMs average cost comparisons provided by the Australian Government Department of Social Services (D16 7859333)

between $5,960 in metropolitan areas, $6,270 in regional areas and $15,260 in remote areas ($6,365, $6,696 and 16,296 respectively, inflated to 2019 dollars).[110]

- **PIR** was designed to improve coordination and provide wrap-around support for people with complex needs, their friends, families and other support people. PIR was initially commissioned through Medicare Locals and then PHNs when these were established. Service provides employed support facilitators to drive collaboration between relevant sectors, services and supports within the region and ensure that all relevant needs of people in the target group were identified and met. The program ran from 2012 to 2019 and supported approximately 7,200 consumers when the program ceased on 30 June 2019.[111]. The total cost of providing the service for a consumer per year (set-up and ongoing) was estimated to be $15,755 and the ongoing cost per year was estimated to be $13,434.[112]
- **State and Territory-funded psychosocial supports**: States and territories provided information to the evaluation including funding numbers and consumers. Of the 35 programs for which funding and consumer numbers were provided for the 2019-20 financial year, the average funding per consumer was $7,445. This totalled $229 million dollars of funding that supported 30,727 consumers.

Two psychosocial support programs have not been included in Figure 26 because the nature of supports is substantially different to those provided through NPS-M:

- NDIS support is more intensive than the national psychosocial support programs. Over the same 12 monthly period as the above programs, participants with psychosocial disability as their primary disability under the NDIS had an average committed support budget of $74,000[113]. There is a wide range of committed support budgets provided under the NDIS. Consumers who have 'Supported Independent Living' included (approximately 5% of consumers) have average budgets over $300,000 while consumers who do not (approximately 95% of consumers) have average budgets of $60,000. NDIS supports have not been included in the graph above because of the substantial difference in the intended intensity of support compared with other psychosocial support programs.
- NPS-T was established in July 2019 to support participants in PHaMs, PIR and D2DL as they transitioned to NDIS or CoS program. Initially, 15,484 consumers were listed as clients of the NPS-T program on 1 July 2019.[114] This number steadily reduced as consumers exited to the NDIS, CoS or left NPS-T for other reasons (see Section 4.2.1). On 31 October 2020, there were 1,607 consumers receiving support through NPS-T.[115] It is not possible to conduct a like-for-like comparison between the NPS-T and other psychosocial support programs due to the transitional nature of NPS-T support and the short period of time which some consumers receive support.

7.2.5 PHNs took steps to maximise access across consumers by cross-subsidising and limiting the level of support provided

Many PHNs needed to cross-subsidise between funding streams. Many PHNs stated that the distribution of funding across NPS-M and CoS created challenges in ensuring the right mix and intensity of supports for consumers. Some PHNs found that funding for NPS-M was relatively small compared to the volume of consumers and/or the extent of their need. PHNs also noted that CoS was, for some, generous in its funding. As a solution, some PHNs used pooled budgeting for NPS-M (n=9, 29%) and CoS (n=11, 35%) with other programs (typically with NPS-T or Interface programs).[116] Examples of these approaches are provided in Case Studies.

Commissioning more group supports than individual supports allowed more consumers to access services, but these were not always appropriate. Some PHNs (particularly in regional and remote areas)

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[110] PHaMs average cost comparisons provided by the Australian Government Department of Social Services (D16 7859333)

[111] Data from Australian Government Department of Health

[112] Isaacs A, Beauchamp A, Sutton K. The outcomes and cost effectiveness of Australia's Partners in Recovery Initiative. Workshop on Costs and Assessment in Psychiatry: The Value of Mental Health Services 2019.

[113] National Disability Insurance Agency, "Report to disability ministers for Q1 of Y8 Full report", 2020. Accessed via https://www.ndis.gov.au/about-us/publications/quarterly-reports

[114] TRIS data for 1 July 2019 to 30 June 2020 provided by Australian Government Department of Health.

[115] TRIS data for 1 July 2020 to 31 October 2020 provided by Australian Government Department of Health.

[116] Data from PHN profiles self-reported by PHNs.

suggested that insufficient funding levels have compromised their ability to create program efficiencies, and in some cases, have limited the programs' effectiveness particularly for consumers with higher levels of support needs. PHNs noted that they were able to make limited funding 'go further' by restricting the amount of individual support provided under both programs and increasing the amount of group support. Group supports costs less per consumers but may not be appropriate for all consumers (see Section 4.2.3).

7.3 Administration costs compared with service delivery

This section outlines the administration costs of the NPS-M and CoS program and describes the impact of fragmentation and multiple funding streams on the administration needed to deliver psychosocial supports.

PHN and service provider administration costs means that for each dollar invested in the national psychosocial support programs approximately 80 cents are directly used to provide services to consumers.

The national psychosocial support programs (NPS-M and CoS) are commissioned through PHNs which creates two layers of administration and associated costs for the services to be delivered to consumers – one at the PHN and one for the service providers commissioned by the PHN. Schedules between the Australian Government Department of Health and the PHN allow for a proportion of funds provided to the PHNs under the measure to be used for administration by the PHN (8% for NPS-M[117] and 6% for CoS[118]). This equates to $6.4 million of the $80 million provided for the NPS-M program and $6.6 million of the $110 million for the CoS program.

PHNs have separate schedules with service providers to provide services under the NPS-M and CoS programs and some of these schedules specify a proportion of funds that can be used by service providers to administer the service separate from direct service delivery. These administration costs are in addition to administration costs taken by PHNs. Figure 27 presents the proportion of funding used by service providers for administration of the NPS-M and CoS programs rather than service delivery across PHNs. There is a range of funds allocated to administration across PHNs from 10% to 36% for one NPS-M program. The median proportion for both programs is 15%. As a comparison, the median overhead for NDIS service providers across all services was 23.4% in 2017-18.[119] If all service providers used the median value of 15% for administration this would equate to $11 million for the NPS-M and $15.4 million for the CoS program being used for administration separate to service delivery across the country.[120]

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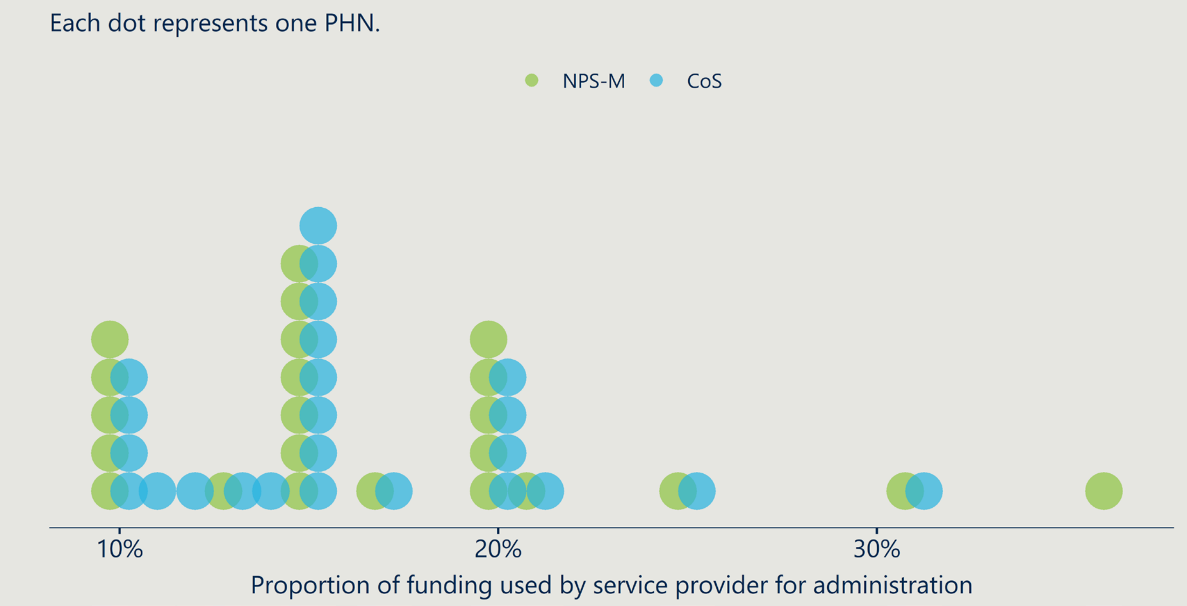
[117] Schedule between Australia Government Department of Health and PHNs for NPS-M and NPS-T program provided by Department of Health.

[118] Advice from the Australian Government Department of Health Mental Health Supports Branch.

[119] Sector Summary Report – National Disability Service Providers, Benchmarking Survey – Collection 3 2017/2018. (2019).

[120] Values reflect additional administration costs after PHNs have taken the proportion of funds allocated to them for administration. The median value has been used as representative because data is only available for a limited set of PHNs.

Figure 27 | Service provider administration costs across PHNs[121]



The cumulative impact of administration costs between both PHNs and service providers is estimated to be $17.4 million of the $80 million provided for the NPS-M program (22%) and $22 million of the $110 million provided for the CoS program (20%).

> 'We have six different reporting requirements with three PHNs for the same two programs.'
>
> **Service provider**

Service providers reported that multiple funding streams and reporting requirements meant that NPS-M and CoS have comparatively high administrative costs. During consultations with service providers, some noted that the administrative costs associated with NPS-M and CoS are high compared with other state programs or the previous Commonwealth-funded programs due to more onerous data collection and reporting requirements. Service providers who have been engaged to deliver both NPS-M and CoS with the same PHN noted that they have two sets of reporting requirements increasing the administrative burden particularly when the reporting requirements for the two programs differ.

Service providers who provided the same program (NPS-M or CoS) across multiple PHNs also reported higher administration costs due to inconsistent reporting requirements between PHNs. A national service provider noted in their submission to the Productivity Commission that they operate in 16 PHNs, each with different strategies, tender processes, reporting requirements and stakeholder complexities that need to be addressed.[122]

The distinct reporting requirements for different programs and PHNs frustrates the ability of service providers to create economies of scale and deliver programs efficiently.

Fragmentation within the psychosocial support sector means that service providers are not taking advantage of potential economies of scale. The Productivity Commission noted that psychosocial supports sector is dominated by a few large service providers operating nationwide and many small providers. Throughout this evaluation there was little evidence that small providers were finding efficiencies by either amalgamating or sharing administrative functions. Some PHNs drove efficiencies by commissioning service providers to provide multiple programs or encouraging collaboration (see Case Studies PHN Model of Psychosocial Support and Integrated Service Hub) but this was the exception rather than common place. Fragmentation adds to the overall administrative burden with each service provider

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[121] Data self-reported by PHNs through PHN profiles. Where PHNs reported a range across service providers the middle has been used as representative.

[122] Aftercare, Submission 480 to Productivity Commission Mental Health Inquiry. 2019, Accessed via: https://www.pc.gov.au/__data/assets/pdf_file/0016/241261/sub480-mental-health.pdf

needing to spend resources developing systems and hiring and training staff to meet the obligations of the various reporting requirements.

Psychosocial support service providers have multiple funding streams with separate reporting requirements creating excessive administrative burden. This evaluation examined two psychosocial support programs funded by the Australian Government: the NPS-M and CoS. More broadly, the Productivity Commission notes that ‘there are too many funding channels’ for psychosocial support in Australia and that this creates an excessive administrative burden. Funding channels include:

- Funding from different levels of government for psychosocial support programs (e.g. Australian and State or Territory-funded programs) (see Figure 28 below)
- Funding from different psychosocial support programs from the same level of Government (e.g. NPS-M, CoS and NDIS all funded by the Australian Government)
- Funding from different commissioning bodies for the same program (e.g. PHNs with different processes and contracts to deliver the NPS-M program)

In one submission to the Productivity Commission a service provided observed that one of its regional offices that focused on providing psychosocial support had four different contracts with three separate funders, with each contract having its own administrative requirements[123]. These inconsistent compliance obligations result in significant red tape and draw resources away from front-line services.[124]

Many service providers receive funds from both Australian and state or territory-funded programs. Figure 20 presents the proportion of service providers in each jurisdiction that are funded by the Australian Government for NPS-M and CoS, State or Territory Government or both. All jurisdictions had some level of overlap in their use of service providers, ranging from 17% in the Northern Territory to nearly 60% in NSW. While consistent service providers are useful in promoting integration and referrals, the differing reporting requirements of PHNs and LHNs (or equivalent) result in unnecessary costs and time spent on administration (see Section 8.3). There are likely efficiencies to be gained, particularly where services are similar.

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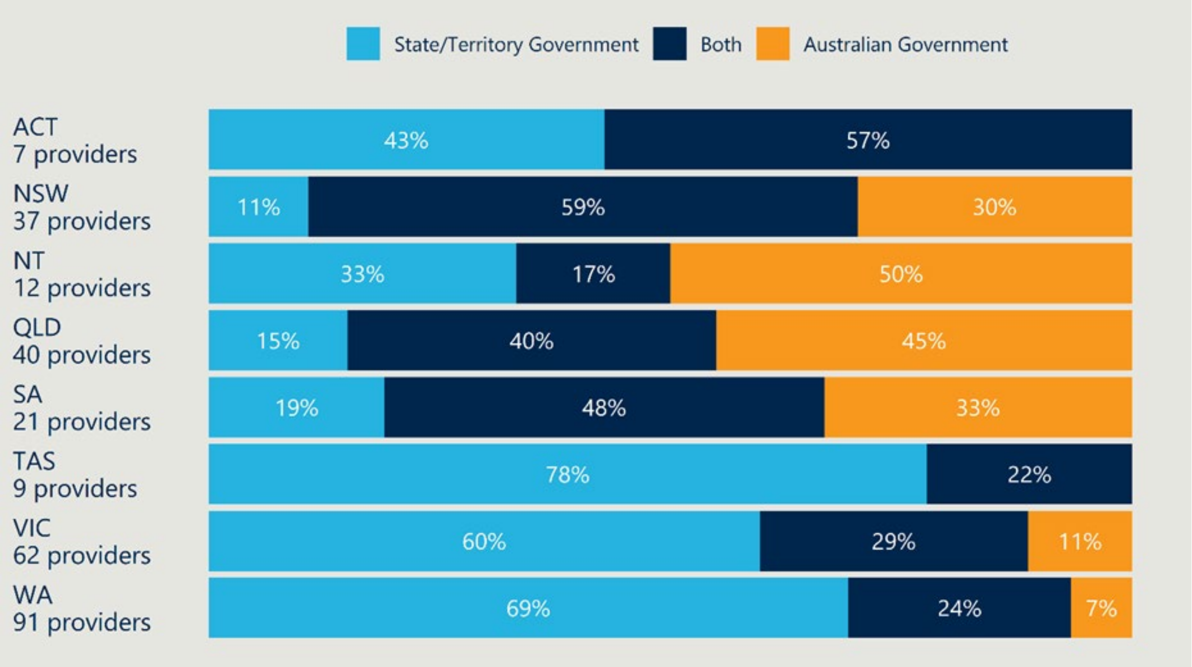
[123] Wellways, Submission 396 to Productivity Commission Mental Health Inquiry, 2019. Accessed via: https://www.pc.gov.au/__data/assets/pdf_file/0013/241015/sub396-mental-health.pdf

[124] National Mental Health Commission, Contributing Lives Thriving Communities: Report of the National Review of Mental Health Programmes and Services -Summary, 2014

Figure 28 | Service provider overlap[125]



7.4 Cost impact of not providing national psychosocial programs

With the PIR, D2DL and PHaMs ending, consumers needed NPS-M and CoS services to access psychosocial support.

It is important to consider the context that existed prior to the introduction of the national psychosocial social support programs NPS-M and CoS when assessing the cost impact of not providing these services. Both programs were implemented as part of changes to psychosocial support services, catalysed by the introduction of the NDIS, to provide services for consumers who were already accessing support from the Australian Government (CoS) or for those who were not accessing support elsewhere (NPS-M) (see Section 1). If these services were not provided, these consumers would have been left without psychosocial support and this may have led to substantial negative outcomes include mental health deterioration and potentially the need for comparatively expensive acute care.

Evidence from similar programs suggests psychosocial supports reduce the use of more expensive acute services. There is limited direct evidence on the cost impact of not providing the national psychosocial support programs due to the inability to link program data with other data from the health system (see below). Psychosocial supports' role in preventing mental health deterioration has been shown to reduce the demand for more expensive clinical or hospital interventions. For example, an evaluation of a South Australian Government-funded psychosocial support service found a 39% reduction in mental health-related hospital admissions and a 16% reduction in the length of stay in hospital.[126] Further information on literature that examines cost-effectiveness is available in the Literature Review.

Measurement of the impact these programs have had on the broader health system was not possible due to data issues encountered by the evaluation. National psychosocial supports including the NPS-M and CoS aim to have system-wide outcomes including reducing the demand for acute service and improving allocative efficiency within the health system.[127] The most direct and statistically powerful

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[125] Providers were confirmed through information requests with PHNs and State or Territory Government representatives. Subsidiaries of service providers in the same jurisdiction were considered the same service provider (e.g. "CentaCare New England North West" and "CentaCare South West NSW" were both treated as "CentaCare" in NSW).

[126] Uniting SA, "Submission in response to the Draft Report of the Productivity Commission Inquiry into Mental Health", 2020. Accessed via https://www.pc.gov.au/__data/assets/pdf_file/0004/250951/sub807-mental-health.pdf

[127] Bilateral agreements between the Commonwealth and each jurisdiction for the National Psychosocial Support Measure.

method for measuring outcomes beyond individual consumer outcomes is to link program data with other data sets like the National Hospital Morbidity Database which holds admitted patient data. During this evaluation, Nous was advised by the Department that the PMHC-MDS is not able to be linked with other data sets, citing that the foundational governance parameters prevent such linkage. The prohibition on linkage of the PMHC-MDS with other datasets limited the ability of the evaluation to assess the impact of the NPS-M and CoS programs on the broader health system. The scope of outcomes that can be measured using unlinked PMHC-MDS data is limited to those which the data contains. In this case, it was not possible to identify whether psychosocial support programs have reduced the demand for acute service or improved allocative efficiency within the health system.

8 How is evidence informing NPS-M and CoS service and program delivery? (KLE 6)

Summary of findings

The following section draws on evidence and literature presented in the *Literature Review and policy review – the Evaluation of national psychosocial support programs NPS-M and CoS* (the Literature Review) which explored evidence from Australia as well as other comparable jurisdictions including New Zealand, the United Kingdom and Canada. Additional evidence was identified throughout the course of consultations, and further research and analysis was conducted. The evidence is relevant to both NPS-M and CoS programs, and the only section where there was a difference between how evidence was applied between NPS-M and CoS is discussed in Section 8.3.1.

The evaluation found that the available evidence informs many aspects of the delivery of both NPS-M and CoS, including the focus on recovery and supports that build capacity. The types of support funded through the programs are also evidence-based to achieve positive consumer outcomes, but the level of evidence across these support types varies in volume and quality.

There are some areas where the evidence could be drawn on more heavily to improve the support outcomes. These include considering time-limited support with simple re-entry pathways, extending implementation time and introducing longer-term funding cycles (e.g. five years) to better support workforce stability, consolidating and streamlining funding, increasing joint commissioning between PHNs and between PHNs and state or territory regional health services, further integrating clinical and non-clinical supports, and streamlining programs to create more flexible and consumer-centred supports. The lack of useful data on which to evaluate the programs was a significant impediment to the conduct of the evaluation.

8.2 How evidence has informed aspects of NPS-M and CoS service and program delivery

This section discusses how evidence informed aspects of NPS-M and CoS service and program delivery.

8.2.1 Recovery focused and capacity building supports

Both the NPS-M and CoS guidance for implementation note that psychosocial support services should be undertaken with a recovery focus and supports should assist with capacity building.[128] Recovery oriented mental health practice recognises that recovery is about having opportunities for choice, living a meaningful, satisfying and purposeful life, and being a valued member of the community. Building capacity enables this pathway to recovery by empowering consumers to engage independently and reducing their dependence on support.

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[128] The NPS-M guidance notes that 'key areas of activity could focus on building capacity and stability', and that 'the cohort being targeted through this initiative would generally require less intensive and possibly shorter term psychosocial support than the service offer provided through programs transitioning to the NDIS. The focus should be on building capacity and connectedness at times this is most needed, rather than providing ongoing support.'p4 and 5; CoS guidance notes on p4 'services will operate under a recovery framework by increasing choices and opportunities for clients to live a meaningful, satisfying and purposeful life'.

The evaluation of NPS-M and CoS program delivery has found:

- **Evidence indicates the mixture of support categories funded through NPS-M and CoS aligns with recovery principles and capacity-building.**[129] The NPS-M and CoS guidance outlines a suite of support categories (captured in Section 3.3) for PHNs to commission from service providers.
- **Literature is clear on the benefits of taking a recovery-focused approach to severe mental illness, with participants seeing benefits in hopefulness, self-perceived recovery, symptom scores and quality of life.**[130,131] Many PHNs requested their service providers deliver services using recovery-oriented frameworks and practices. For example, many PHNs communicated the importance of recovery-focused support to their service providers via contracts, and through additional messaging and implementation guidance documentation. Consultation data for the evaluation indicated service providers implemented recovery-based practices to varying degrees.
- **Tensions exist in the evidence concerning time limitations for psychosocial support and whether this supports a recovery focus or causes undue distress to consumers.** On the one hand, time limitations on support convey the expectation that consumers will experience improved outcomes surrounding self-sufficiency. However, consumers interviewed for this evaluation indicated programs should be available for as long as people need them, and time limited programs were seen as inappropriate for many people who have ongoing or fluctuating needs. As a result, some PHNs and service providers set time limitations for NPS-M funded support (often 12 months), and others did not. This is discussed further in Section 8.3 as an opportunity to draw further on the evidence base.
- **The evidence base prosecuted in the Literature Review (Chapter 4) confirms that the psychosocial supports typically associated with the NPS-M and CoS support categories can result in capacity building for people with severe mental illness.** The level and quality of evidence varied across support categories and generally all support categories had either emerging evidence base or established evidence bases underpinning them.[132] See further detail about the evidence base underpinning NPS-M and CoS supports more broadly in Section 8.2.2. Consultation data indicated that many service providers reported that the mixture of services funded through the programs are appropriate for supporting the recovery of consumers.

8.2.2 Types of psychosocial support

NPS-M and CoS guidance for implementation outlined categories of psychosocial support that could be provided by each PHN (see Section 3). Literature and evidence confirm that psychosocial support is critical to the recovery and improved outcomes for people living with psychosocial disability associated with severe mental illness.[133,134]

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[129] See analysis in Section 4 of the NPS-M and CoS Literature Review.

[130] Slade et al., "Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems", *World Psychiatry,* 2014, vol. 1, pages 12-20. Doi:/10.1002/wps.20084

[131] AHURI, "Trajectories: the interplay between housing and mental health pathways", 2020. Accessed via https://www.ahuri.edu.au/__data/assets/pdf_file/0021/58260/Executive-summary-Trajectories-the-interplay-between-housing-and-mental-health-pathways.pdf

[132] Generally, all eight categories of support have some evidence to indicate that they improve outcomes for people living with psychosocial disability. Evidence quality is stronger for supports that focus on vocational goals, physical wellbeing and exercise, and drug and alcohol addiction. Moderate quality evidence was found for supports that focus on housing, social skills and connections, and those building confidence and resilience. Weaker evidence quality was found for supports focusing on day-to-day living skills and financial budget and management.

[133] Hayes, L., et al. "Effective, evidence-based psychosocial interventions suitable for early intervention in the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery." Melbourne: The Centre for Mental Health, Melbourne School of Population Health & Mind Australia, 2016.

[134] The National Mental Health Commission, "Contributing Lives, Thriving Communities", 2014. Accessed via: https://www.mentalhealthcommission.gov.au/getmedia/6b8143f9-3841-47a9-8941-3a3cdf4d7c26/Monitoring/Contributing-Lives-Thriving-Communities-Summary.PDF

The evaluation of NPS-M and CoS program delivery has found:

- **Evidence indicates the support categories prescribed in NPS-M and CoS guidance is underpinned by mixed but compelling evidence.** While a lack of directly comparable studies limited the strength of conclusions that could be drawn, there was a compelling evidence base for programs that supported vocational goals, physical wellbeing and support, drug and alcohol addiction. Broad life skills, housing, and social skills and connections had a moderate evidence base in comparison, and there was a sparse evidence base for day-to-day living programs and financial budgeting programs. Common outcomes associated with these supports are greater community engagement, improved social skills and reduced symptoms. A summary of the evidence underpinning these support categories is captured in Table 8.

Table 8 | Summary of evidence for psychosocial support categories

Categories of support	Evidence of effectiveness for psychosocial supports		Evidence of cost effectiveness of psychosocial supports	
	Effective?	Quality and volume of evidence	Cost effective?[135]	Quality and volume of evidence
Social skills and connections, including family connections	Yes	🟠	Potentially	🟠
Day-to-day living skills	Yes	🟠	Potentially	None found
Building broader life skills, including confidence and resilience	Yes	🟠	Yes	🔴
Financial management and budgeting	Yes	🔴	None found	None found
Finding and maintaining a home	Yes	🟠	Potentially	🔴
Maintaining physical wellbeing, including exercise	Yes	🟢	Potentially	🟠
Managing drugs and alcohol addictions, including tobacco	Yes	🟢	Potentially	🔴

Key:

🔴 = varied quality and volume of evidence for supports in this category, overall weak strength to evidence base for supports across this category (e.g. evidence base comprises case studies and grey literature; however, limited to no systematic reviews and high quality randomised controlled trials)

🟠 = varied quality and volume of evidence for supports in this category, overall moderate strength to evidence base for supports across this category (e.g. evidence base comprises quasi-experiments, meta-analysis of natural experiments, before-after studies, case studies and grey literature; however, limited to no systematic reviews and high quality randomised controlled trials)

🟢 = varied quality and volume of evidence for supports in this category, overall high strength to evidence base for supports across this category (e.g. evidence base comprises systematic reviews and high quality randomised controlled trials)

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[135] While evidence that has been identified that suggests some categories of support are cost effective, this evidence is often limited and based on single studies in countries other than Australia.

- **The evidence supports that psychosocial services must be individualised and delivered in a way that helps consumers achieve their goals.** The evidence demonstrates that while some consumers' goals can be met through one-to-one support, group activities play an important role in fulfilling other goals that can only be developed in a group setting.[136,137] The NPS-M and CoS guidance suggests offering group and individual based supports, which is aligned with the evidence on how to achieve outcomes and best cater for different levels of need. PHNs cascaded the guidance from NPS-M and CoS to service providers through the inclusion of the categories of support and mixture of group versus individual supports in contracts with service providers. Consumers, PHNs and service providers suggested there is not sufficient individual support offered through the programs, discussed further in Section 8.3.6.
- **Evaluation consultation data suggests that more flexibility in the types of supports (especially individual versus group support) is required in order to align with best practice.** Rural and regional service delivery in particular was constrained by PHN specified ratios of group versus individual support, which PHNs indicated was in most cases driven by a lack of funding. In some cases, the dispersion of participants meant group programs were difficult or impossible. This will be explored in more detail in Section 8.3.6.
- **Telehealth also featured in the implementation of NPS-M and CoS in some locations, which is supported by an emerging evidence base.** Telehealth was used as both a mechanism to reach consumers who were more challenging to access – either due to residing in rural or remote locations, or due to social distancing requirements in the COVID-19 pandemic context. Research shows telehealth and eHealth measures are feasible and accepted by consumers with severe mental illness, but the evidence base is not yet large enough to evaluate their effectiveness in improving psychosocial outcomes.[138,139] The Productivity Commission has recommended for example that 'the Australian Government should make permanent the changes to expand access to psychological therapy and psychiatric treatment by videoconference and telephone introduced during the COVID-19 crisis' as a way to 'ensure that more people can access the services they need, as well as reducing the time, effort and cost involved.'[140,141]

8.2.3 Coordination and collaboration mechanisms

As outlined in Section 6, guidance from the Commonwealth and PHNs clearly mentioned the need for coordination between psychosocial supports and other health services. Coordination can take many forms, from loose collaborative arrangements to formal referral pathways and handovers, as needed by the consumer. Coordination and collaboration across PHNs and NPS-M and CoS service providers has in some cases reduced service duplication and allowed consumers to more easily transition between supports on their journey to recovery.

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[136] Routasalo, P.E., Tilvis, R.S., Kautiainen, H. and Pitkala, K.H. (2009), Effects of psychosocial group rehabilitation on social functioning, loneliness and well-being of lonely, older people: randomized controlled trial. *Journal of Advanced Nursing*, vol 65: p297-305. doi:10.1111/j.1365-2648.2008.04837.x

[137] Savikko, N., Routasalo, P., Tilvis, R. and Pitkälä, K., Psychosocial group rehabilitation for lonely older people: favourable processes and mediating factors of the intervention leading to alleviated loneliness. *International Journal of Older People Nursing*, 2010, vol 5: p.16-24. doi:10.1111/j.1748-3743.2009.00191.x

[138] Pratt, S. I., Bartels, S. J., Mueser, K. T., Naslund, J. A., Wolfe, R., Pixley, H. S., & Josephson, L. "Feasibility and effectiveness of an automated telehealth intervention to improve illness self-management in people with serious psychiatric and medical disorders", *Psychiatric rehabilitation journal*, 2013, vol.36, no.4, p.297-305.

[139] Naslund, J. A., Marsch, L. A., McHugo, G. J., & Bartels, S. J. , "Emerging mHealth and eHealth interventions for serious mental illness: a review of the literature", Journal of mental health, 2015, vol.24. no.5, pp.321–332. doi: 10.3109/09638237.2015.1019054

[140] Productivity Commission, *Inquiry Report – Mental Health*, June 2020, Volume 2, p.846

[141] Productivity Commission, *Inquiry Report – Mental Health*, June 2020, Volume 1, p.71.

The evaluation of NPS-M and CoS program delivery has found:

- **The evidence outlines the benefits of integration across multiple stakeholders and settings, including from clinical care settings and other types of care such as physical or more holistic care.** Coordination and collaboration are critical to effective integrated care, as they enable integration 'players' to work together to provide holistic and person-centred support that can step consumers up or down in care depending on the extent of their needs which can change over time. A number of PHNs, service providers, clinical and other services have developed effective coordination and collaboration mechanisms. For example, psychosocial support forums with multiple neighbouring PHNs present opportunities to draw from one another's practice and align communications is discussed.
- **Evidence in the literature highlighted the critical role of coordination and collaboration particularly where it comes to simplifying communications and messaging for consumers**. It can also create efficiencies, for example through leveraging the practice and learnings of others, and through resource and training sharing.[142]

8.3 Opportunities to further draw on evidence

This section discusses where and how the evidence was not effectively leveraged to inform NPS-M and CoS service and program delivery. It also includes opportunities to improve the application of evidence.

8.3.1 Recovery focused – time limits and re-entry

As outlined in Section 8.2.1, recovery-focused support has been a feature in the service and program delivery of NPS-M and CoS. However, opportunities exist to further draw on the evidence base surrounding the recovery paradigm. These are captured below.

The evaluation of NPS-M and CoS program delivery has found:

- **Some PHNs and providers struggled to balance goal-oriented support within NPS-M as a time-limited program.** However, the evidence indicates that the achievement of these goals can take many years, and pushing consumers to achieve goals by limiting support to short time frames can cause anxiety and disengagement.[143] The result of this tension can be seen through program delivery – while 27 (87%) PHNs say transition out of NPS-M support is 'goal-oriented' (i.e. will occur on the achievement of an agreed upon set of goals), 18 (67%) of these PHNs also put a time limit on program length (many chose 12 months).
- **Both goal-oriented and/or time limited programs have been shown to be effective.** For example, goal-oriented programs such as the Boston Psychiatric Rehabilitation approach (BPR), and time-limited supports such as Critical Time Interventions (CTI) have both been shown to have substantial impacts on consumer outcomes such as distress and transition to lower intensity support or the

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[142] Evert Schot, Lars Tummers, Mirko Noordegraaf, "Working on working together. A systematic review on how healthcare professionals contribute to interprofessional collaboration", *Journal of Interprofessional Care,* 2020, vol.34:3, pages 332-342. Shiney Franz, Jürgen Muser, Ulrike Thielhorn, Claus W. Wallesch, Johann Behrens, "Inter-professional communication and interaction in the neurological rehabilitation team: a literature review", *Disability and Rehabilitation,* 2020, vol.42:11, pages 1607-1615.

[143] Clarke et al. Do goal-setting interventions improve the quality of goals in mental health services? Psychiatric Rehabilitation Journal, 2009, vol. 32(4), p292–299. doi:10.2975/32.4.2009.292.299

community.[144,145,146] However, few studies to-date have compared the two approaches in the severe mental health context or judged one to be more effective than the other.

- **Evidence suggests time-limited support with simple re-entry pathways could be an appropriate program structure.**[147] Time-limited support with simple re-entry pathways suits the needs of consumers with episodic disability as a result of severe mental illness. These consumers are likely to need multiple transitions on their journey to recovery. Re-entry needs to be simple and timely so consumers experiencing a severe episode can access support rapidly when their need is greatest. Consumers noted that this could reduce negative experiences and trauma that some had experienced from exiting programs, as they would know that they can access support again if they need it.

8.3.2 Workforce

NPS-M and CoS encourage PHNs to include a range of professionals in the delivery of services, including peer workers. Psychosocial programs need a strong workforce with broad skillsets that enable them to support and connect effectively with consumers. This typically includes a mixture of professional staff and staff with lived experience. The opportunities to improve workforce stability and appropriately use peer workers are captured below.

The evaluation of NPS-M and CoS program delivery has found:

- **Best-practice literature on workforce stability and talent retention contrasted with the short time frames and uncertainty created by the implementation approach of the NPS-M and CoS programs**. The evaluation found that workforce stability was impacted due to the condensed timeframes for the transition (see more in Section 3). Market and workforce coverage was found to be particularly thin in regional, rural and remote areas. The evidence suggests longer funding cycles, funding certainty and longer program implementation transition times can support market capacity and workforce retention/stability (see more in Section 8.3.3).

> *'Workers can find themselves on a short-term contract 'merry-go-round,' moving from one contract to another, trying to secure sustainable work. This undermines both organisational capacity and worker morale. It can also disturb trusting therapeutic relationships built with vulnerable people – the foundation of quality, person-centred services'* – Victorian Council of Social Service[148]

- **The evidence for lived experience in the mental health workforce is emerging but encouraging.**[149,150] In addition, there is strong sectoral support for the use of a peer workforce, evidenced by the establishment of various Australian organisations to advocate for the implementation of peer workforces in the provision of mental health care, such as the Centre of Excellence in Peer Support in Victoria and the Peer Work Hub in New South Wales.

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[144] Sanches et al., The Role of Working Alliance in Attainment of Personal Goals and Improvement in Quality of Life During Psychiatric Rehabilitation, 2018. *Psychiatric services*, vol 69, p903-909. doi: 10.1176/appi.ps.201700438

[145] Sanches et al., Effectiveness of the Boston University Approach to Psychiatric Rehabilitation in Improving Social Participation in People With Severe Mental Illnesses: A Randomized Controlled Trial. 2020. *Frontiers in Psychology,* vol 11, p970. doi:10.3389/fpsyt.2020.571640

[146] Jormfeldt H, Svensson B, Hansson L, Svedberg P. Clients' experiences of the Boston Psychiatric Rehabilitation Approach: a qualitative study. *Int J Qual Stud Health Well-being*, 2014. doi:10.3402/qhw.v9.22916

[147] Slade et al. Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. 2014. *World Psychiatry*, vol 13, p12-20. doi:10.1002/wps.20084

[148] Victorian Council of Social Service, 'Delivering Fairness: Victorian Budget Submission 2019-20', 2019. Accessed at https://vcoss.org.au/wp-content/uploads/2019/03/DF_Online.pdf

[149] Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S. and Whitley, R. (2014), Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13: 12-20. doi:10.1002/wps.20084

[150] Julie Repper & Tim Carter (2011) A review of the literature on peer support in mental health services, *Journal of Mental Health*, 20:4, 392-411, DOI: 10.3109/09638237.2011.583947

- **PHNs recognised the value of staff with lived experience; however, some struggled with a small talent pool**. While many PHNs requested peer workers be involved in the delivery of NPS-M and CoS in their service provider contracts (see Section 3.3), consultation data suggests that some service providers found it challenging to recruit suitably skilled peer workers.

8.3.3 Streamlined funding

NPS-M and CoS are separate funding streams. Literature from other countries reveals that psychosocial support can be funded through multiple standalone programs, or a more streamlined approach where programs are combined into a single program. Multiple individual programs are often a result of organic growth over time and can lead to inefficient uses of funding and confusion, while streamlined and broad programs allow flexible coordination and leveraging of resources.

The evaluation of NPS-M and CoS program delivery has found:

> '[Multiple short contracts] are a big pressure in the sector with payment schedules and reporting requirements… It takes a while to get the program up and running and short contracts only just get to touch the surface.'
>
> **Service provider**

- **Literature highlights how a more consolidated funding stream can create efficiencies and economies of scale for service providers and PHNs.**[151,152] Delivery involved multiple fragmented funding streams and Australian psychosocial supports are delivered in discrete, individual programs at the national and state or territory level. The latest iteration of Commonwealth guidance did, however, allow PHNs greater flexibility in moving funding between streams (with the exception of the NPS-M funding is this is subject to bilateral agreements).
- **The evidence suggests that longer term funding cycles (e.g. five years)** creates stability, enables strategic commissioning and innovation in service delivery, and leads to better consumer outcomes.[153,154]

8.3.4 Commissioning

NPS-T guidance encouraged direct commissioning of existing providers (e.g. D2DL, PIR, PHaMs). The NPS-M and CoS guidance suggests PHNs could directly commission existing providers from previous psychosocial programs as an option, and suggests joint commissioning where possible. Meanwhile, PHNs can contract service providers through a range of approaches and models. The underpinning evidence base to their commissioning approaches outline the benefits and risks associated with each. Opportunities to improve the commissioning of NPS-M and CoS based on the evidence are captured below.

The evaluation of NPS-M and CoS program delivery has found:

- **The evidence indicates a strategic commissioning approach is suitable for psychosocial programs and can improve system outcomes.** Strategic commissioning typically involves active planning, relationship management, program analysis and review in order to ensure the commissioned program is aligning to deliver desired outcomes. Robust data capture and analysis, as well as effective contract and performance management are key enablers to effective commissioning of psychosocial services. Strategic commissioning is notoriously complex and challenging to implement effectively, and the

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[151] Wellways Australia, "Submission to the Productivity Commission into Mental Health", 2019. Accessed via https://www.pc.gov.au/__data/assets/pdf_file/0013/241015/sub396-mental-health.pdf

[152] Neami National, "Submission in Response to the Productivity Commission Issues Paper *The Social and Economic Benefits of Improving Mental Health*", 2019. Accessed via https://www.pc.gov.au/__data/assets/pdf_file/0006/240729/sub254-mental-health.pdf

[153] The National Mental Health Commission, "Contributing Lives, Thriving Communities", 2014. Accessed via: https://www.mentalhealthcommission.gov.au/getmedia/6b8143f9-3841-47a9-8941-3a3cdf4d7c26/Monitoring/Contributing-Lives-Thriving-Communities-Summary.PDF

[154] Productivity Commission, "Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services", 2017. Accessed via: https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/human-services-reforms-overview.pdf

literature suggests this is mainly due to the capacity of the commissioners. As outlined in Section 3.2, commissioning approaches for NPS-M and CoS varied across the 31 PHNs and strategic commissioning was rare.

- **Joint commissioning approaches are appropriate to support the integration of supports across various settings including psychosocial supports.** Joint commissioning is a type of strategic commissioning that involves collaboration between commissioners, and the literature confirms it can be effective in removing barriers to integration between psychosocial services and broader health and social care. Joint commissioning of psychosocial services between PHNs (and between PHNs and state or territory governments or regional health networks) could improve access and continuity of support for consumers – particularly in metro areas, where they may move across catchments on a daily basis. For joint commissioning to be an effective and appropriate choice, the evidence base outlines that deep collaboration between consumers, service providers and regional commissioning bodies needs to be present. Joint commissioning can be challenging, and strong investment in building commissioner skills and knowledge will allow organisations to reap the benefits and manage the risk of joint commissioning approaches. As outlined in Section 3.2, joint commissioning by PHNs was rare.

8.3.5 Service integration and coordination

NPS-M and CoS guidance requires that PHNs integrate psychosocial programs where possible with existing services and supports. As discussed earlier in Section 6, service integration and coordination between different health services is essential to reduce duplication and allow consumers to transition between clinical and non-clinical supports on their journey to recovery. Opportunities to draw on the evidence to improve service integration and coordination are outlined below.

The evaluation of NPS-M and CoS program delivery has found:

- **The literature indicates integration and coordination of psychosocial support with clinical and other non-clinical supports (i.e. Dimension 1 of the Integration Framework captured earlier in Figure 21, Section 6) is critical to achieve consumer outcomes.** These processes deliver a better experience and better outcomes for consumers of mental health services, who often experience diverse health and social needs simultaneously. The literature suggests that effective integration is enabled primarily by effective coordination and collaboration mechanisms (which, as outlined in Section 8.2.2, happens inconsistently across PHN catchment areas) and strategic commissioning approaches, particularly joint-commissioning (see Section 8.3.4).
- **PHNs’ attempts at service integration and coordination had varying levels of success.** As discussed in Sections 3 and 6, service integration and coordination varied across the implementation of NPS-M and CoS. In particular, consultation data for the evaluation highlighted the following intersections as opportunities for improved integration and coordination: clinical; non-clinical; and other supports (e.g. drug and alcohol).
- **Integration and coordination also underpin effective stepped care models.** Stepped care models (discussed earlier in Section 6) are evidence-based, staged approaches to the delivery of mental health services, comprising a hierarchy of interventions – from the least to the most intensive – matched to the individual's needs. The literature indicates stepped care models are important for people with severe mental illness, as it allows consumers to step up or step down their care based on fluctuating needs – particularly those with episodic illness, including many consumers in the NPS-M cohort. Consultation data for the evaluation revealed that some PHNs work closely with clinical and non-clinical services to establish workable stepped care models; however, this is rare.

8.3.6 Flexible and consumer centred supports

NPS-M and CoS guidance requires that each consumer receives an initial assessment and individual support plan. For services to be individualised and targeted to the consumer, PHNs and service providers must have the flexibility to meet individual consumer needs. A key enabler to this is the streamlining of supports where possible, which is discussed further in Section 8.3.3. Other opportunities to increase flexibility and consumer centredness are outlined below.

The evaluation of NPS-M and CoS program delivery has found:

- **Flexible and consumer centred supports are important so that people with severe mental illnesses can access the help they value and actively shape their recovery.**[155] The current psychosocial support landscape of multiple programs with strict eligibility criteria does not allow consumers to access support flexibly (see Section 3.3 for more detail on this). The literature identifies other countries are moving towards a single and flexible program approach (discussed further in Section 8.3.3).
- **The literature demonstrated how other countries are moving towards a single program approach supported by a single corresponding funding stream.** Psychosocial support services in other jurisdictions, including New Zealand and the UK, have shifted to single funding streams that allow long-term planning and flexibility to use funds where needed to support consumers. See Appendix E for profiles of the psychosocial support landscape of these countries. Efforts to streamline psychosocial programs and funding is linked to improved flexibility and consumer centred support (see Section 3.6.2).
- **Support design (including streamlining of supports) are most effective when they leverage consumer insights in the design process.** Consumer consultation was not fully embedded in NPS-M and CoS service design, as outlined in Section 5.4. Consumer participation is critical in the planning, delivery, implementation and evaluation of mental health care services to ensure the development of services that are responsive to the needs of consumers and the broader community. Genuine involvement is key, whereby the perspectives of consumers, their friends, families, other support people and communities are not only heard, but integrated and included in decision-making processes. There is increasing evidence for the efficacy of co-design in enabling healthcare providers to achieve this; however, it can be costly and lengthy, and has limitations.
- **Based on the literature there are additional measures that can improve the flexibility of supports**. For example, simplifying eligibility for psychosocial supports increases understanding and improves access for consumers – see Appendix E for examples from other countries where this has been done. Giving consumers a central role in deciding the types of services they want to access through shared decision making can also improve the consumer focus of supports and improve consumer outcomes.[156,157,158]

8.3.7 Data, evidence, monitoring and evaluation

The development of robust and consistent datasets and quality measures is crucial for monitoring and evaluating psychosocial services. It is important to have a 'single version of the truth', with all relevant partners and stakeholders having access to the same information. This information can be used by stakeholders at all levels (including the public) to develop quality measures which can be used in monitoring and managing the performance of national government, regional commissioning bodies and service providers in delivering psychosocial supports to people with severe mental illness.

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[155] Yarborough, B. J. H., Yarborough, M. T., Janoff, S. L., & Green, C. A. Getting by, getting back, and getting on: Matching mental health services to consumers' recovery goals. *Psychiatric Rehabilitation Journal*, 2016, 39(2), p97–104. https://doi.org/10.1037/prj0000160

[156] National Collaborating Centre for Mental Health & National Health Service (NHS), "The Community Mental Health Framework for Adults and Older Adults", NHS England, 2019. Accessed via: https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

[157] Ministry of Health NZ, Disability support system transformation. Accessed via: https://www.health.govt.nz/our-work/disability-services/disability-projects/disability-support-system-transformation

[158] Cranwell, K., McCann, T. V., & Polacsek, M., "Evaluating the effectiveness of experience-based codesign in improving the client experience of mental health transition across health sector interfaces", Australian Primary Health Care Research Institute, 2015.

The evaluation of NPS-M and CoS program delivery has found:

- **The literature supports the importance of collecting data – particularly relating to activity, quality and cost.**[159,160,161,162] These types of data are critical to collect in order to build the evidence base on quality and cost effectiveness of psychosocial interventions for people with severe mental illnesses, to better understand service capacity quality and gaps, and to better understand the psychosocial needs of people with severe mental illnesses.
- **Mechanisms outlined in the literature, such as the UK's MHSDS, demonstrate the potential of frequent reporting.** The NHS mandates monthly reporting on their minimum dataset and make this information publicly available so stakeholders at all levels of the system are able to inform their own views and evaluate the performance of services and individual service providers.[163] This allows for informed consumer decision-making as well as strategic planning.
- As outlined in Section 3.4, there were significant challenges and limitations regarding access to and quality of data which impacted on this evaluation and the implementation of NPS-M and CoS more broadly.

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[159] England, M. J., Butler, A. S., & Gonzalez, M. L., (eds.), "Psychosocial Interventions for Mental and Substance Use Disorders: A Framework for Establishing Evidence-Based Standards", *National Academies Press (US),* 2015, Sep 18.

[160] Fisher, C. E., Spaeth-Rublee, B., & Pincus, H. A., "Developing mental health-care quality indicators: Toward a common framework", *International Journal for Quality in Health Care,* 2013, vol.25, no.1, pp.75–80.

[161] Kilbourne, A., Keyser, D., & Pincus, H. A., "Challenges and opportunities in measuring the quality of mental health care", *Canadian Journal of Psychiatry,* 2010, vol.55, no.9, pp.549–555.

[162] Pincus, H. A., Spaeth-Rublee, B., & Watkins, K. E., "Analysis & commentary: The case for measuring quality in mental health and substance abuse care", *Health Affairs (Millwood),* 2011, vol.30, no.4, pp.730-736.

[163] NHS UK, "*Mental Health Services Monthly Statistics*", 2020. Accessed via https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/mental-health-data-hub/mental-health-services-monthly-statistics

9 What should psychosocial support look like in future? (KLE 7)

The evaluation of the NPS-M and CoS programs was framed around KLEs intended to draw out a range of aspects that will help build the evidence base on how governments can best deliver psychosocial supports to people with severe mental illness and to inform future directions for psychosocial support programs.

The evaluation has made a series of specific recommendations linked to the core KLEs outlined in the Executive Summary. In addition, this section addressing the future of psychosocial support (KLE 7), provides a summary of the key features of future psychosocial programs, based on the learnings from this evaluation.

The evaluation has also documented several examples and case studies of good practice led by PHNs and service providers that can be shared and leveraged nationally where appropriate and tailored to regional need.

Future psychosocial support programs should be consumer-centred and codesigned with the sector (commissioners, providers, peaks), consumers, their support people, carers and family. The design of future programs should be focused on consumer outcomes should include the following key features:

- **Recovery-oriented programs:** goal based, time-limited support with easy and rapid re-entry as needed.
- **Flexible, tailored support:** services matched to the changing needs of individuals (either group and/or individual support across a range of support types).
- **Accessible and stable services:** streamlined referral and access to services with a stable workforce to support effective therapeutic relationships between consumers, carers and support workers.
- **Smooth transitions:** effective management of transitions in services to achieve smooth handovers without gaps in service or support – exiting the service should be expected and agreed upon with consumers.

The specific elements that should underpin a consumer-centred psychosocial support program include:

Funding

- Streamline the multiple existing programs and funding streams into a single program – this will improve equity between consumers currently accessing different funding streams, decrease fragmentation across the sector and reduce administration costs at the Department, PHN and provider level.
- Ensure funding reflects the increased costs of service delivery in regional, rural and remote areas, and in Aboriginal and Torres Strait Islander communities. Future funding should consider regional variation and priority population need.
- Confirm funding for five years – this would allow longer commissioning periods to encourage greater stability and certainty throughout the sector and workforce, and allow for more strategic design of services and integration where appropriate.
- Make available additional funding allocations for consumers in the program who need to test their eligibility for the NDIS – this will avoid the need for a separate program and therefore avoid the need for consumers to transition between programs and service providers.

Implementation

- Increase the lead times from funding confirmation to delivery of services – adequate time for PHNs to prepare, co-design and joint-commission where appropriate, and for service providers to recruit and train their workforce, requires a period of at least nine- to 12-months. Time constraints from when funding is promised until it is delivered produce a cascading effect throughout the sector on quality of support and services provided.

- Promote the program more widely, using a common, national branding and clear description of the services available. This should not conflict with local tailoring.

Integration

- Strengthen cooperation and provide specific incentives to enhance mechanisms for collaboration between the PHNs and the state or territory health services, particularly the state regional health networks, to avoid gaps and duplication in support and ensure broad coverage across Australia. Consider application of the integration framework presented in Section 6.5.
- Encourage PHNs to undertake joint commissioning through building capacity in PHNs. Ideally, joint commissioning with state and territory governments would be commonplace, additionally neighbouring PHNs could jointly commission regional service providers.

Workforce

- Provide incentives that help to attract a stable and well qualified workforce through competitive wages, conditions, training, support and job stability. Provide training opportunities that target workers with lived experience.

Intake and assessment

- Develop a standardised intake and outcomes assessment tool, with simple indicators for a stepped care approach for when consumers can step up/down in their support provision, aligned with a recovery-oriented program (measuring psychosocial function). The fit-for-purpose tool could be used for assessment and outcome measurement, whereby the intake assessment offers a baseline for future assessments, to replace the current recommended tool (K10+/K5). The preferred tool should be determined and agreed in partnership with PHNs, service providers and appropriate expertise.
- Standardise regular assessment points during program participation to support recovery and easy exit for consumers.

Data collection and governance

- Improve program data design, monitoring, quality and governance for the PMHC-MDS to ensure the program data can be used for its intended purpose.[164]

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[164] Australian Government Department of Health, PMHC-MDS. Accessed via:: https://pmhc-mds.com/index.html Intended purpose of the PMHC-MDS: "The Primary Mental Health Care Minimum Data Set (PMHC-MDS) will provide the basis for PHNs and the Department of Health to monitor and report on the quantity and quality of service delivery, and to inform future improvements in the planning and funding of primary mental health care services funded by the Australian Government."

Glossary and abbreviations

Item	Description
Aboriginal and Torres Strait Islander person	Refers to a person who identifies as an Aboriginal and/or Torres Strait Islander and is accepted as such by the community with which he or she lives.
Carer	The language used to refer to people who have lived experience of mental health challenges and the people who provide informal support for them is contested. Further, because this report refers to various groups of stakeholders with lived experience, we need language to distinguish them. Due to the lesser complexity of needs in NPS-M and CoS consumers, 'carers' for the individuals in these programs are more likely to be friends, family, kinship groups or other support people rather than formal carers. As a result, 'carers' are referred to in this report as 'friends, families and other support people'. See glossary entry on 'friends, families and support people' for further detail on this.
Consumer	As noted above in 'carers', the language used to refer to people who have lived experience of mental health challenges and the people who provide informal support for them is contested. 'Consumers' is a broadly accepted term in Australia to refer to people who have lived experience of mental illness and psychosocial disability and/or use public mental health services. As a result, this report will use this language for people with lived experience of mental health challenges. Consumers may also be referred to as 'clients', 'customers', 'patients' or 'persons with lived experience' when referencing external sources that use that terminology.
Continuity of Support (CoS)	The CoS is a Commonwealth funded program designed to provide psychosocial supports to former clients of ceased Commonwealth community mental health programs (Partners in Recovery, Support for Day to Day Living and Personal Helpers and Mentors Service) who were receiving services at 30 June 2019 and are ineligible for supports under the NDIS.
Culturally and linguistically diverse (CALD)	Culturally and linguistically diverse individuals are those born overseas in countries where English is not the primary language spoken and/or individuals born in Australia whose preferred language spoken is not English.
D2DL	Day to Day Living is a previous Commonwealth-funded psychosocial support program.
Friends, families and other support people	Friends, families, kinship groups and all other support people who play a vital role in supporting people living with severe mental illness by providing practical and emotional support to the person and assisting them with building capacity and the tasks of daily living. For simplicity of language, on occasion we refer to all as 'families' or 'family members', in line with the idea of 'chosen families' as people with who strong supportive ties are formed.
Individualised support	Individualised support refers to support provided to consumers where the composition of that support is tailored to the individual needs and goals of the consumer.
Key lines of enquiry (KLEs)	High-level research questions that guide the evaluation. The KLEs for this evaluation were determined from the scope of enquiry, theory of change and program logic as outlined in Section 2.1.
Local Health Network (LHN) or Local Health District (LHD)	These entities manage the delivery of public hospital services and other community-based health services as determined by their state or territory government.

Item	Description
National Disability Insurance Agency (NDIA)	The NDIA is an independent statutory agency established to implement and administer the National Disability Insurance Scheme (NDIS).
National Disability Insurance Scheme (NDIS)	The NDIS is an Australian government program that provides support to people with disability, their families and carers. The main component of the NDIS is individualised packages of support to eligible people with disability, including people with psychosocial disability.
NMHSPF	National Mental Health Service Planning Framework
National Psychosocial Support Measure (NPS-M)	The NPS-M is a Commonwealth-funded program designed to provide support to people with severe mental illness and associated psychosocial functional impairment who are not more appropriately supported through the NDIS.
National Psychosocial Support Transition Program (NPS-T)	The NPS-T is a Commonwealth funded program that provides targeted support to people who were previously accessing psychosocial services through ceased Commonwealth community mental health programs (Partners in Recovery, Support for Day to Day Living and Personal Helpers and Mentors Service) on 30 June 2019 to test their eligibility for the NDIS, and also provides psychosocial supports while they undertake this process.
PHaMs	Personal Helpers and Mentors (previous Commonwealth-funded psychosocial support program)
PIR	Partners in Recovery (previous Commonwealth-funded psychosocial support program)
PHN	Primary Health Networks
PMHC-MDS	Primary Mental Health Care Minimum Data Set
Psychosocial disability	Psychosocial disability is an impairment or restriction, arising due to mental illness, that can limit, for example, an individual's ability to function, think clearly, enjoy full physical health or manage their social and emotional welfare.
Psychosocial support	Psychosocial support refers to non-clinical services that assist people with severe mental illness to build skills to manage their mental illnesses, improve their relationships with family and others and increase social and economic participation.
Severe mental illness	Severe mental illness refers to mental illness characterised by a severe level of clinical symptoms and degree of disablement to social, personal, family and occupational functioning.
Support providers	Support providers refers to those organisations involved in the planning and delivery of psychosocial supports. This may include government and non-government organisations.

Appendix A PHN profiles

Nous developed PHN profiles for all 31 PHNs to describe how they implemented the NPS-M and CoS programs. These profiles were tested and validated with each PHN.

This Appendix (attached separately) includes the PHN Profiles:

- **ACT:** Australian Capital Territory PHN
- **NSW:** Central and Eastern Sydney; Hunter New England and Central Coast; Murrumbidgee; Nepean Blue Mountains; North Coast; Northern Sydney; South Eastern NSW; South Western Sydney; Western NSW and Western Sydney PHNs
- **NT:** Northern Territory PHN
- **QLD:** Brisbane North; Brisbane South; Central Queensland, Wide Bay, Sunshine Coast; Darling Downs and West Moreton; Gold Coast; Northern Queensland and Western Queensland PHNs
- **SA:** Adelaide and Country SA PHNs
- **TAS:** Tasmania PHN
- **VIC:** Eastern Melbourne; Gippsland; Murray; North Western Melbourne; South Eastern Melbourne and Western Victoria PHNs
- **WA:** Country WA; Perth North and Perth South PHNs.

Appendix B Stakeholders consulted

This appendix outlines the volume of stakeholders invited to consultations for the evaluation, and the volume of stakeholders who agreed to consultation and were subsequently engaged.

PHNs

31 PHNs were invited to both a group information session and individual consultations:

- 22 PHNs attended the group information session
- 58 representatives from 30 PHNs attended 32 individual consultations
- 31 PHNs corresponded via email to refine implementation profiles
- 55 representatives from 18 PHNs attended four group consultations.

Service providers

143 service provider staff from 35 organisations across all eight states and territories were invited to group information sessions. The evaluation team conducted interviews with 21 stakeholders from 15 organisations.

Voices of lived experience

Recruitment of those with lived experience was implemented via all current service providers (in addition to the sample of service providers consulted above).

- 136 service providers contacted via PHNs (where different contact people were identified for different PHNs within the one service provider organisation, these were contacted separately and are counted here as different service providers).
- 95 meetings conducted with 105 service providers.

Consumers

- 105 service providers agreed to distribute questionnaires to consumers
- 3,136 reply paid envelopes sent out for questionnaires
- 501 questionnaire responses received (196 online; 255 paper; 50 telephone)
- 349 questionnaire responses agreed to potential contact about an interview
- 138 consumers contacted to request an interview
- 63 consumers interviewed.

Friends, families and other support people

- 68 consumers agreed to pass on interview invitation to an informal support person
- 87 service providers and three carer peaks agreed to pass on interview invitations to informal support people
- 23 informal support people expressed an interest in being interviewed
- 23 informal support people contacted to request an interview
- 17 informal support people interviewed.

Consumer peaks

- 10 consumer peaks contacted (email + telephone follow-up)
- four consumer peaks interviewed.

Carer peaks

- 17 carer peaks contacted (email plus telephone follow-up)
- three carer peaks interviewed (plus two interviews pending).

Sector peak bodies[165]

The evaluation team spoke to 18 representatives from the following three organisations:

- Community Mental Health Australia
- Mental Health Australia
- Mental Illness Fellowship of Australia.

State and territory governments and their regional health services

The evaluation team consulted with 33 representatives from eight state and territory governments from the following departments:

- ACT Community Services Directorate (ACT)
- NSW Health (NSW)
- Department of Health (NT)
- Queensland Health (QLD)
- SA Health (SA)
- Department of Health and Human Services (TAS)
- Department of Health and Human Services (VIC)
- Mental Health Commission (WA).

The evaluation team spoke to 27 individuals from 18 regional health services across all states and territories.

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[165] The evaluation has sought to consult with the National Mental Health Commission; however, they have not been available to date.

Appendix C Summary analysis of PMHC-MDS data for psychosocial support services

C.1 Background and purpose

The purpose of this report is to provide summary information regarding the consumers and service use of the NPS-M and the CoS programs from the PMHC-MDS. The analysis was conducted by Strategic Data Pty Ltd at the request of the Australian Government Department of Health (the Department) based on a template provided by Nous Group Pty Ltd.

Stakeholders involved in the evaluation consistently reported concerns regarding the quality of data in the PMHC-MDS including both its accuracy and completeness. Central to these concerns is that it is not possible to positively identify consumers of the NPS-M and CoS programs within the PMHC-MDS and that the consumer numbers based on current methods to identify NPS-M and CoS produce widely different consumer numbers compared with 12-month performance reports provided to the Australian Government Department of Health by PHNs as part of separate reporting processes (see Sections 2.1 and 2.2). Because of these concerns, the analysis below needs to be treated with caution and should not be used as the sole source of information for planning decisions.

C.2 Overall number of NPS-M and CoS consumers

This section provides a description of the method used to identify NPS-M and CoS consumers within the PMHC-MDS and a comparison of the total number of NPS-M and CoS consumers in the PMHC-MDS with 12-month performance reports provided separately to the Australian Government Department of Health.

Process for extracting NPS-M and CoS consumers from the PMHC-MDS

The PMHC-MDS holds data from a number of programs funded by the Australian Government Department of Health including the NPS-M and CoS programs and also the Primary Mental Health Care Flexible Funding Pool[166]. Current fields in the PMHC-MDs do not allow for the positive identification of consumers within each funding stream and assumptions need to be made in order to identify which consumers have been funded under which funding stream.

The analysis below includes all episodes from the PMHC-MDS which have the ‘Principal Focus of Treatment Plan’ field marked as ‘Psychosocial Support’. If the episode was also marked as ‘Continuity of Support’ these records have been listed under the CoS program. Episodes that had the ‘Principal Focus of Treatment’ but not ‘Continuity of Support’ are assumed to be provided under the NPS-M program. The analysis includes data covering the period from the start of the programs (1 January 2019 for NPS-M and 1 July 2019 for CoS) until the end of September 2020.[167]

PHNs and service providers consulted as part of the evaluation noted that there were errors in reporting due to a misunderstanding of the new ‘Continuity of Support’ field. Some staff who were entering data had interpreted ‘Continuity of Support’ to reflect ongoing or continuous service provision to a client rather than a recipient of support through the ‘Continuity of Support’ program.

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[166] Australian Government Department of Health, Primary Mental Health Care Minimum Data Set: Overview of purpose, design, scope and key decision issues, 2016.

[167] Figure 29 and Figure 30 have both been limited to the 12 month period from 1 July 2019 to 30 June 2020 to allow for comparison between the PMHC-MDS and the 12-month performance reports.

C.3 Comparison between 12-month performance reports to the Department and PMHC-MDS

Comparing consumer numbers in the PMHC-MDS and 12-month performance reports suggests that the PMHC-MDS potentially captures consumers who are not receiving support under the NPS-M and CoS programs. For this reason, the analysis that follows needs to be treated with a high amount of caution and should not be used as the sole data source to make planning decisions.

PHNs provide 12-month performance reports directly to the Department alongside ongoing reporting into the PMHC-MDS. These reports include consumer numbers for the NPS-M and CoS programs that are manually collated by PHNs for the report to the Department. Figure 29 presents consumer numbers from the PMHC-MDS and 12-month performance reports to the Department over the 1 July 2019 to 30 June 2020 period. There is wide discrepancy between consumer numbers from the two data sources with the PMHC-MDS recording approximately two times the number CoS consumers and approximately 1.5 times the number of NPS-M consumers over the same period.

Figure 29 | National consumer numbers in 12-month performance reports and PMHC-MDS[168]

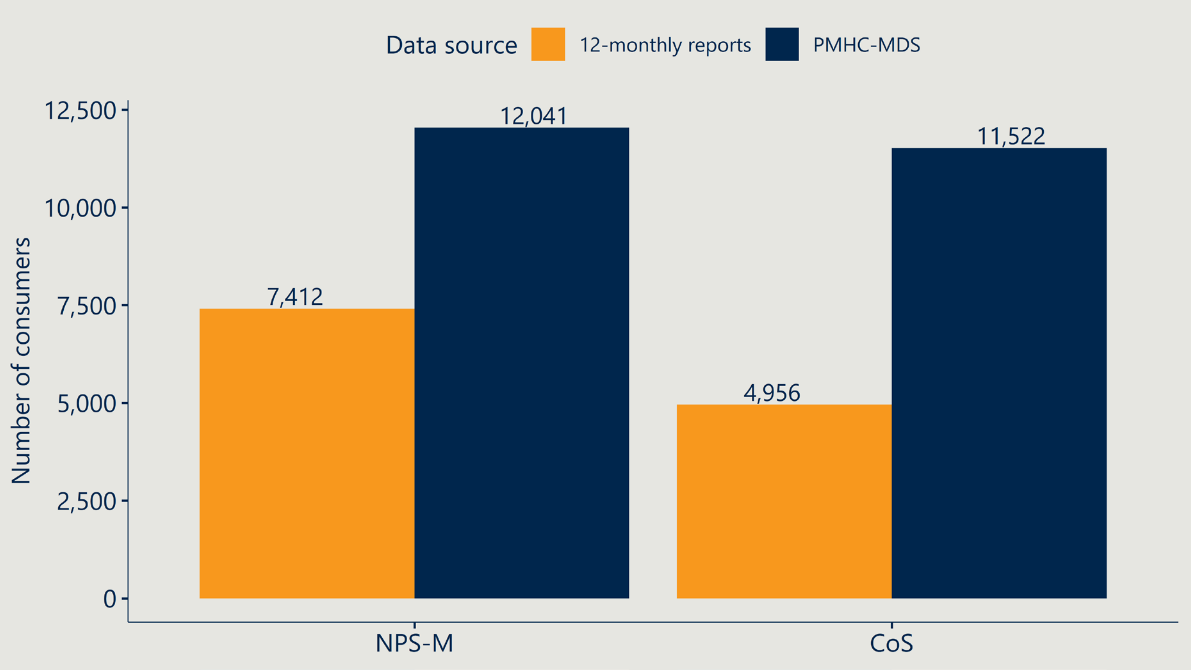

Figure 30 presents distribution across PHNs of the ratio of consumer numbers in the PMHC-MDS to 12-month performance reports. Some PHNs have a ratio close to 1 which reflects equal numbers of consumers in both data sources. A substantial proportion of PHNs have ratios greater than one reflecting more consumers in the PMHC-MDS compared with 12-month performance reports. Some PHNs have a ratio of more than 10 which reflect 10 times as many consumers in the PMHC-MDS as are reported in 12-month performance reports.

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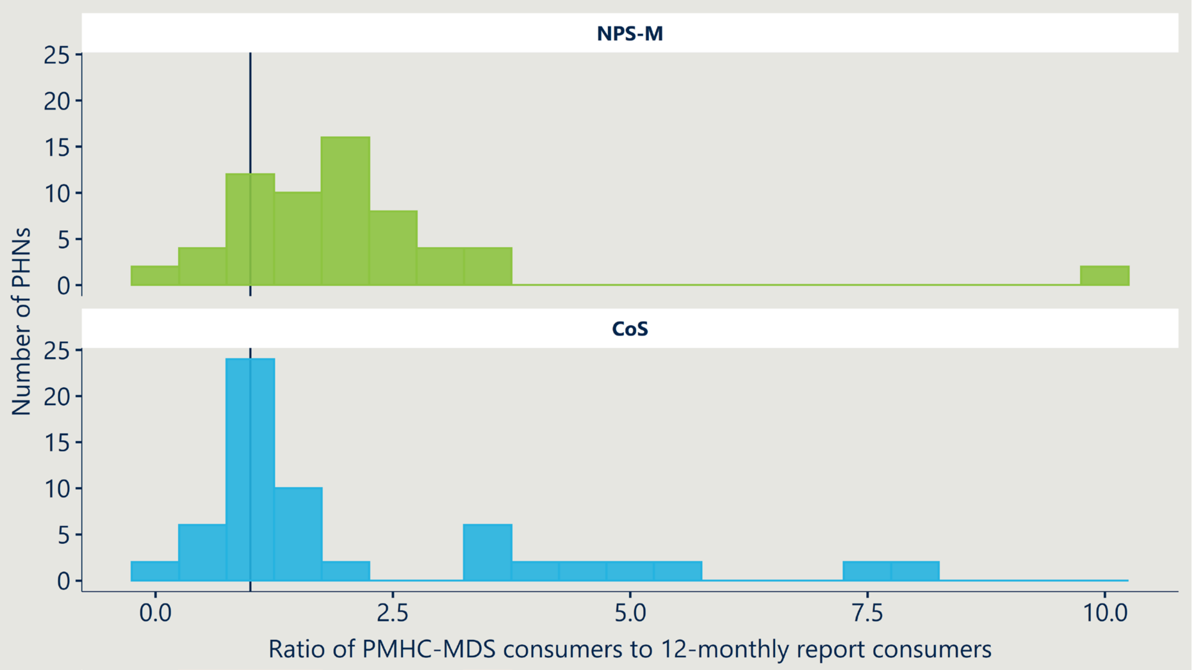
[168] Data from both sources covers the period 1 July 2019 to 30 June 2020. PHMC-MDS consumer numbers have been adjusted to account for individual consent rates within PHNs.

Figure 30 | PHN consumer numbers in 12-month performance reports and PMHC-MDS[169]



C.4 Consumer demographics

This section summarises key demographic information about consumers include age, gender, self-reported Aboriginal and Torres Strait Islander status.

C.4.1 Consumer age

Figure 31 presents the distribution of ages for consumers in the NPS-M and CoS programs.

- The average age was similar for both programs, with the CoS cohort slightly younger (40.6 years) than the NPS-M cohort (43.5 years).
- The CoS program had a wider age distribution than the NPS-M program including more participants under 18 years of age.

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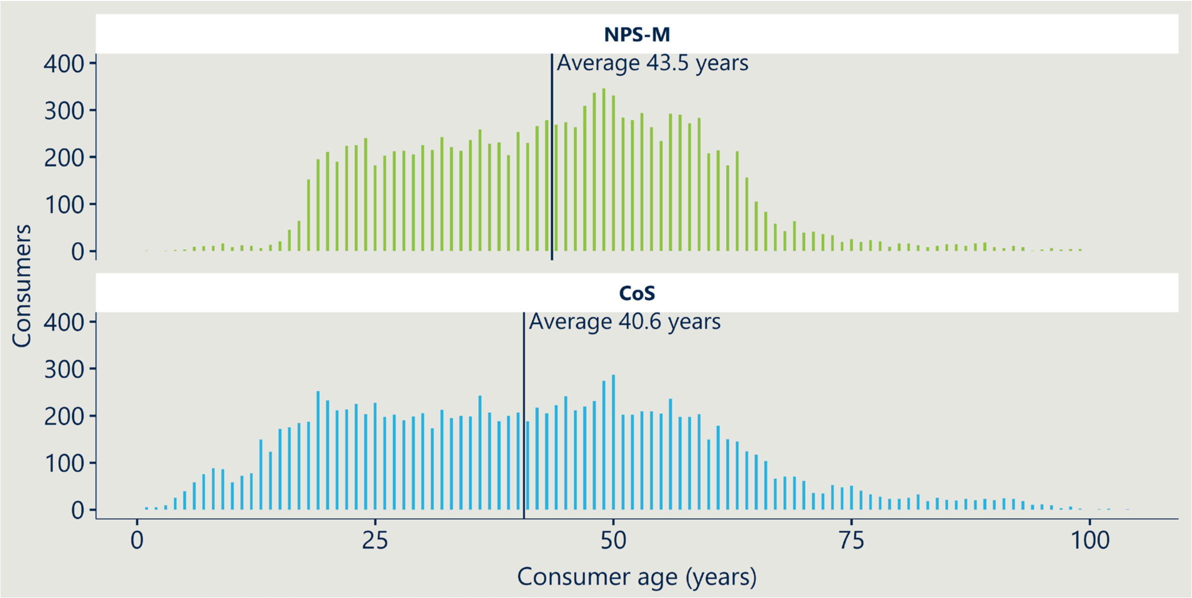
[169] Data from both sources covers the period 1 July 2019 to 30 June 2020. PHMC-MDS consumer numbers have been adjusted to account for individual consent rates within PHNs.

Figure 31 | Consumer age[170]

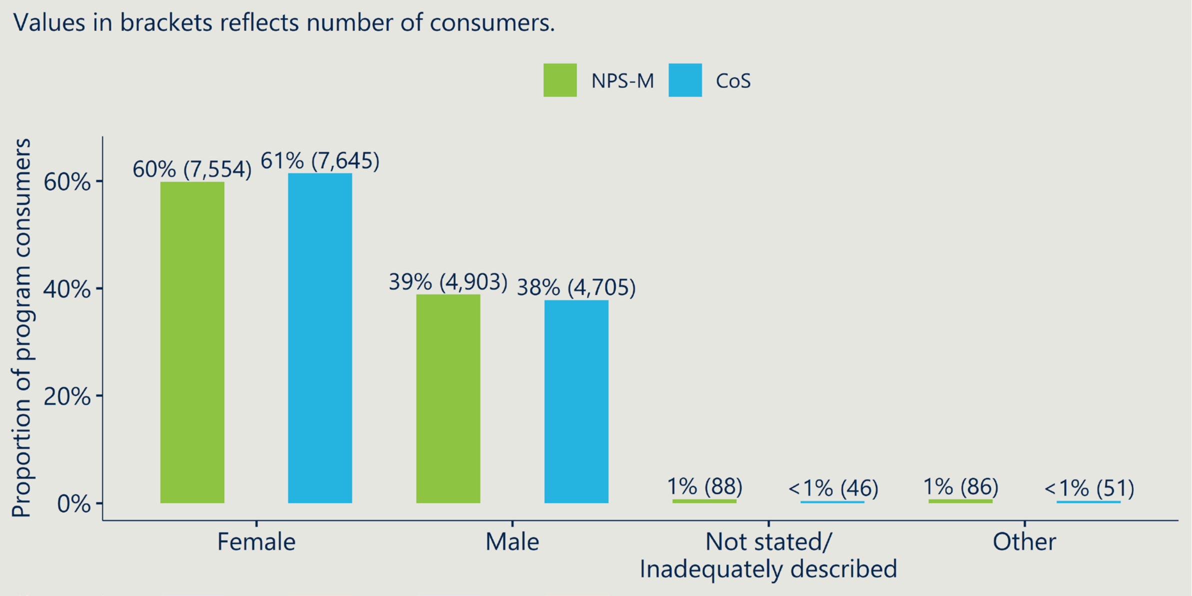


C.4.2 Gender

Figure 32 presents the gender balance for the NPS-M and CoS programs.

- Both NPS-M and CoS had a much higher proportion of females (60% and 61%, respectively) than males (39% and 38%, respectively).
- There was not a substantial difference in gender composition between the two programs.

Figure 32 | Consumer gender[171]



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[170] Data is from the PMHC-MDS from the start of NPS-M and CoS programs until 30 September 2020. Consumers with reported age 0 have been excluded from the chart.

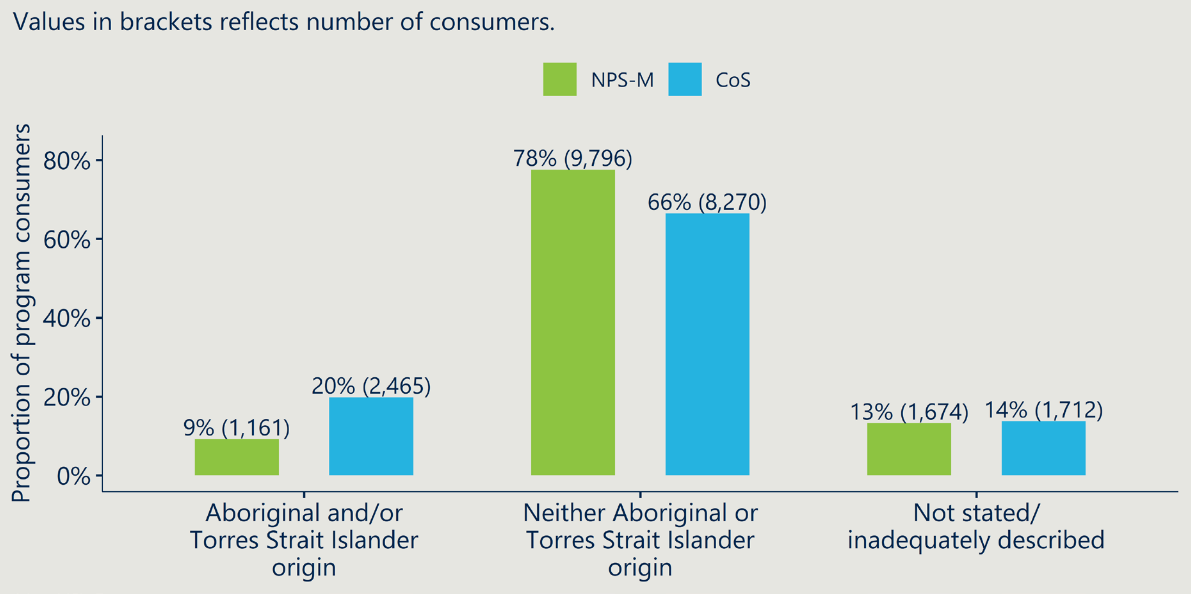
[171] Data is from the PMHC-MDS from the start of NPS-M and CoS programs until 30 September 2020.

C.4.3 Aboriginal and Torres Strait Islander people

Figure 33 presents the proportion of Aboriginal and Torres Strait Islander people in the NPS-M and CoS programs.

- Both programs had a greater proportion of self-identified Aboriginal and Torres Strait Islander people than the Australian population (3.3%).[172]
- The CoS program had more than twice the proportion of self-identified Aboriginal and Torres Strait Islander people than the NPS-M program.

Figure 33 | Consumer-reported Aboriginal and Torres Strait Islander status[173]



C.4.4 Principal diagnosis

Figure 34 shows the principal diagnosis for each episode in the NPS-M and CoS programs.

- The most common diagnoses for the NPS-M program were major depressive disorder, post-traumatic stress disorder and schizophrenia.
- The most common diagnoses for the CoS program were mixed anxiety and depressive symptoms, major depressive disorder and depressive symptoms.
- More than 16% of episodes did not report the principal diagnosis of the consumer or listed it as 'Other' in both programs.

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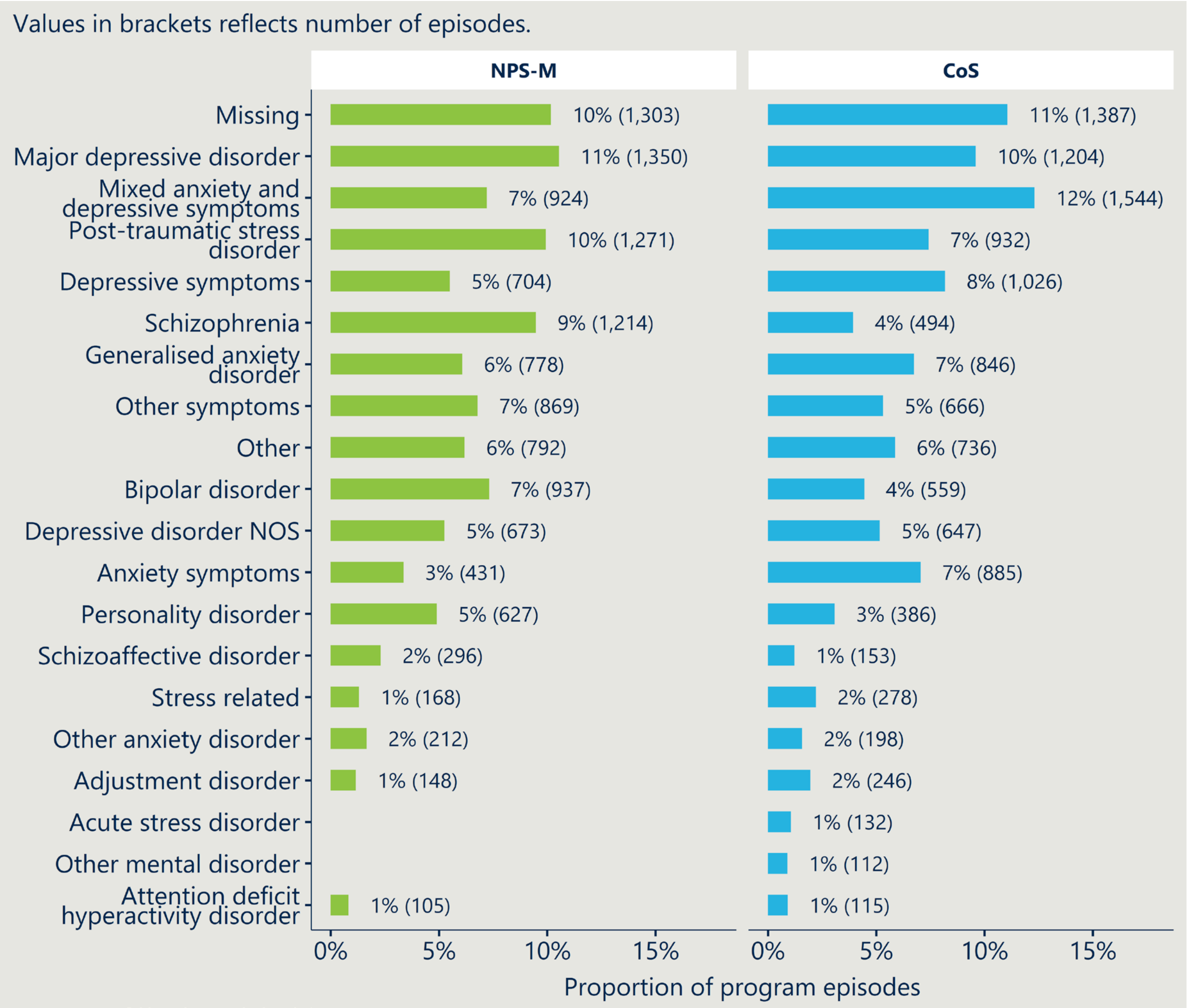
[172] Australian Bureau of Statistics, Estimates of Aboriginal and Torres Strait Islander Australians, 2018. Accessed via https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/jun-2016

[173] Data is from the PMHC-MDS from the start of NPS-M and CoS programs until 30 September 2020

Figure 34 | Episode principal diagnosis[174]



C.4.5 GP Mental Health Treatment Plan

Figure 35 shows the proportion of NPS-M and CoS consumers with a Mental Health Treatment Plan.

- The proportion of consumers with a Mental Health Treatment Plan is uncertain, as the status was unstated, unknown or inadequately described for many consumers.
- A greater proportion of consumers in the CoS program appear to hold a Mental Health Treatment Plan compared with the NPS-M program.

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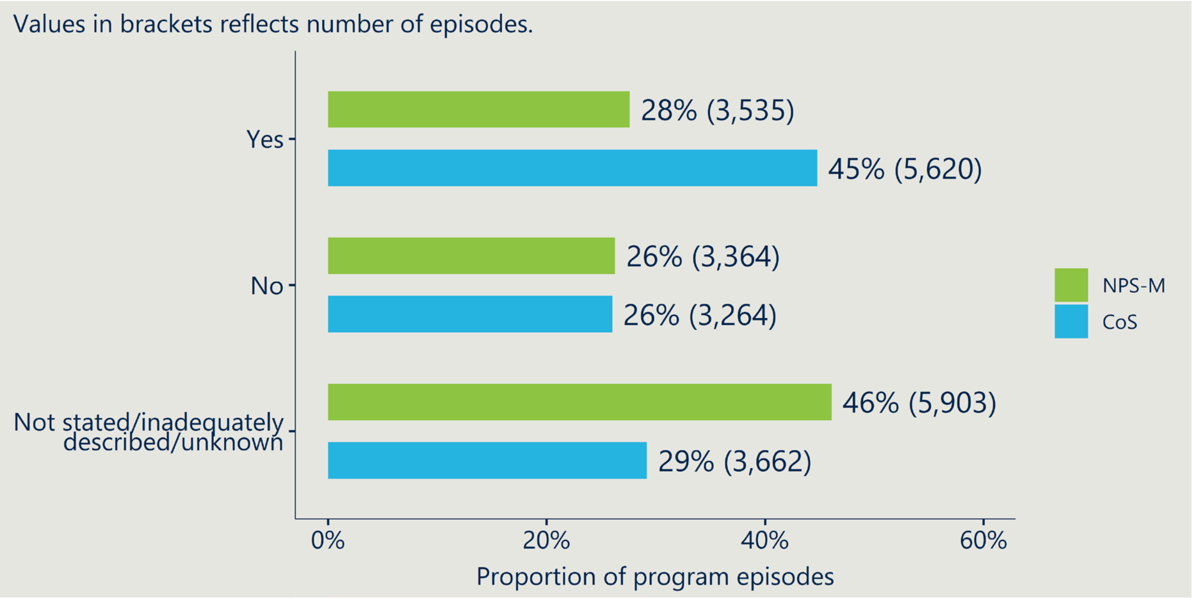
[174] Data is from the PMHC-MDS from the start of NPS-M and CoS programs until 30 September 2020

Figure 35 | Episode Mental Health plan holder[175]



9.1.2 Labour force status

Figure 36 shows the labour force status for the NPS-M and CoS programs.

- The number of consumers who are employed in both programs is very low compared with the Australian population (9% for NPS-M and 16% for CoS vs 61% in the Australian population)[176]
- The consumers in both programs had higher levels of unemployment compared to the Australian population (35% for NPS-M and 25% for CoS vs 7% in the Australian population).[177]

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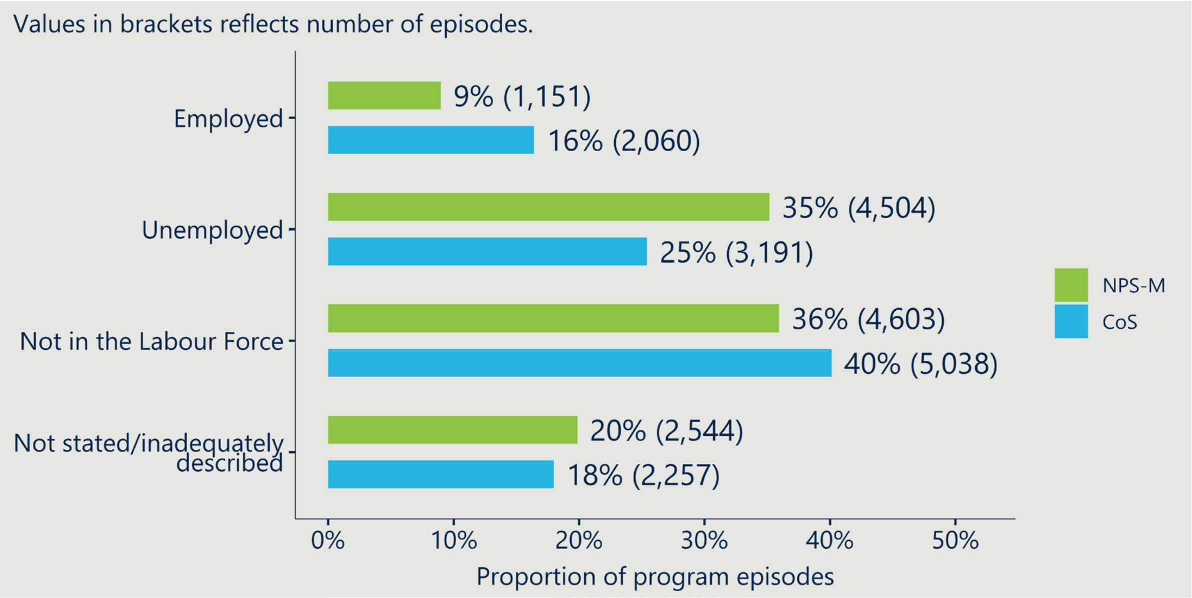
[175] Data is from the PMHC-MDS from the start of NPS-M and CoS programs until 30 September 2020

[176] Australian Bureau of Statistics, Labour force, Australia, 2020. Accessed via https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia/latest-release

[177] Australian Bureau of Statistics, Labour force, Australia, 2020. Accessed via https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia/latest-release

Figure 36 | Episode labour force status[178]

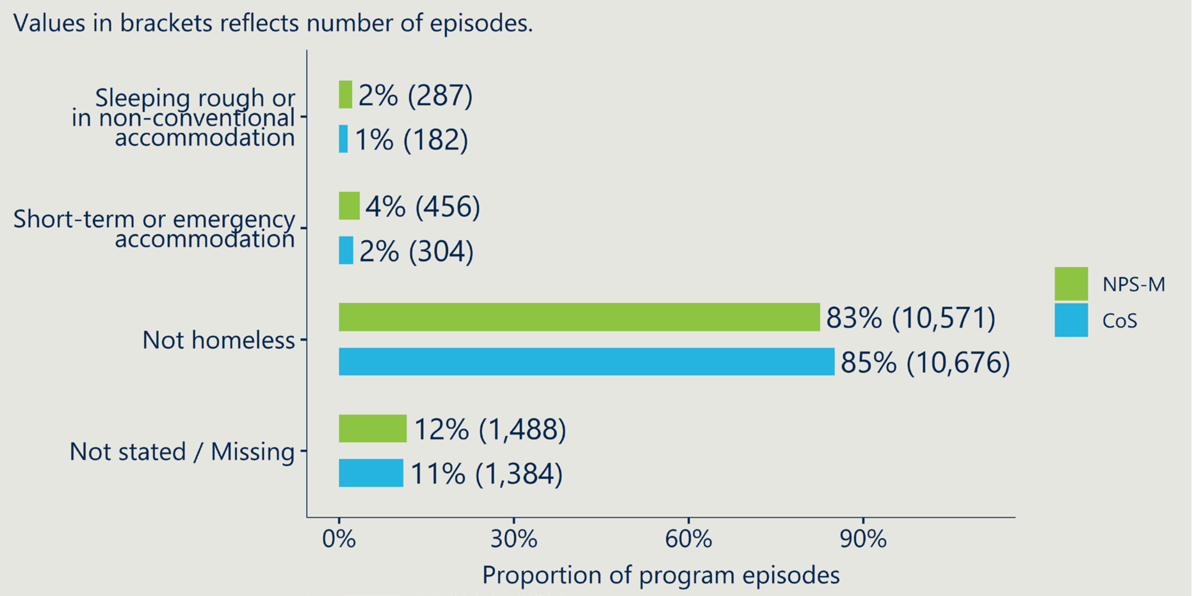


C.4.6 Homelessness status

Figure 37 shows the proportion of NPS-M and CoS consumers who were sleeping rough, in short-term accommodation or not homeless.

- Both programs had higher levels of homelessness than the Australian population (6% for NPS-M and 3% for CoS compared with 0.5% in the Australian population).[179]
- NPS-M had a larger proportion of people who are homeless (6%) compared to the CoS program (3%).

Figure 37 | Episode homelessness status[180]



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[178] Data is from the PMHC-MDS from the start of NPS-M and CoS programs until 30 September 2020

[179] Australian Institute of Health and Wellness, Homelessness and homelessness services, 2018. Accessed via https://www.aihw.gov.au/reports/australias-welfare/homelessness-and-homelessness-services

[180] Data is from the PMHC-MDS from the start of NPS-M and CoS programs until 30 September 2020

C.5 Referral pathways into NPS-M and CoS

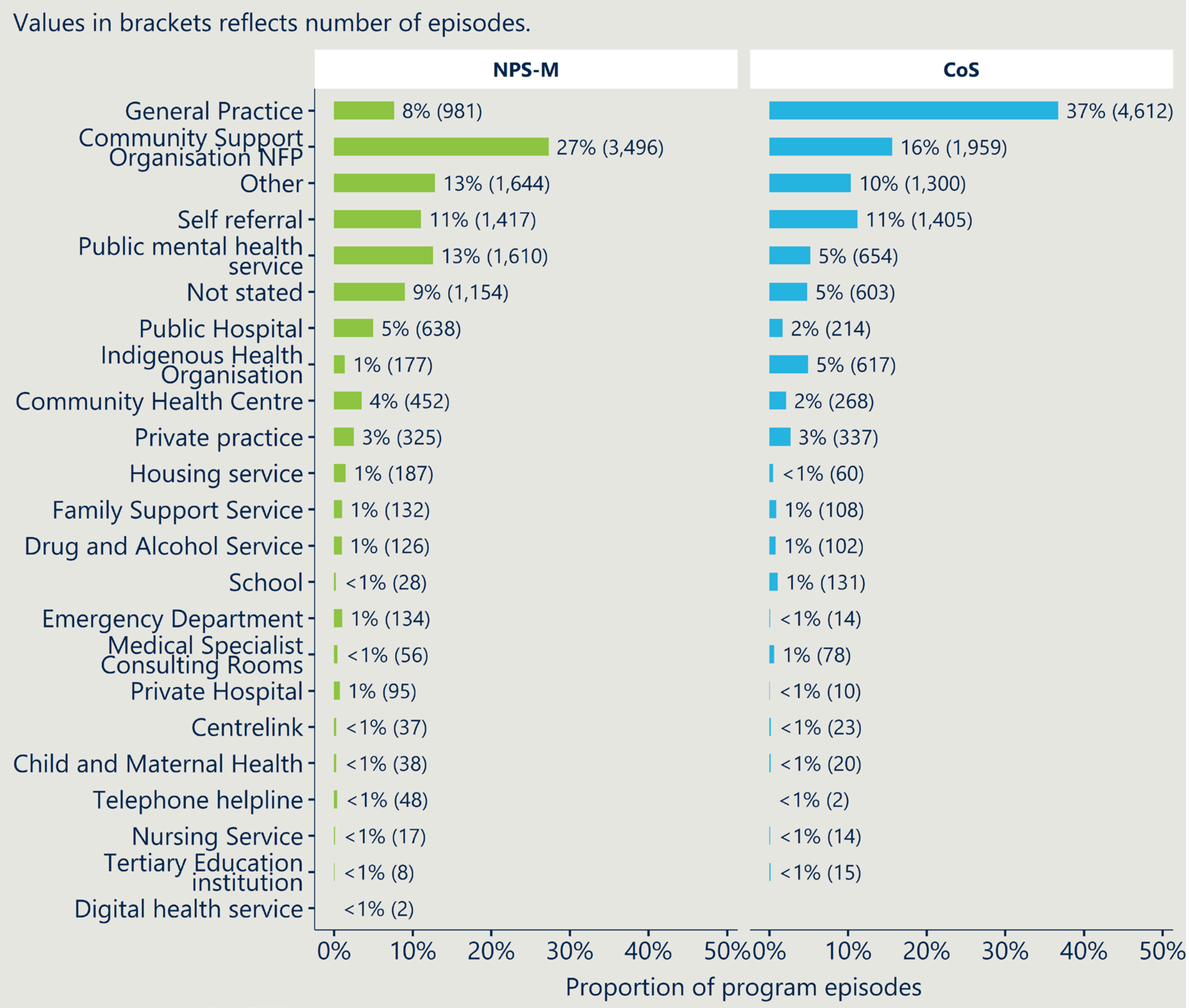
This section summarises the organisation and profession of referrers for both programs.

C.5.1 Referral organisation

Figure 38 shows the type of organisation which referred the consumer to the NPS-M or CoS program.

- The main sources of referral for the NPS-M program were not-for-profit community support organisations, public mental health service and self-referral. The main sources for the CoS program were general practices, not-for-profit community support organisations and self-referral.
- CoS consumers were more likely to have been referred by general practices than NPS-M participants,.[181]
- Self-referral was responsible for a sizeable number of referrals (11%) across both programs.

Figure 38 | Episode referrer organisation[182]



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[181] The nature of the CoS program is the consumers transition from previous psychosocial support programs (PHaMs, D2DL and PIR) and the NPS-T. It is not clear why some many consumers have General practice listed as the episode referrer organisation.

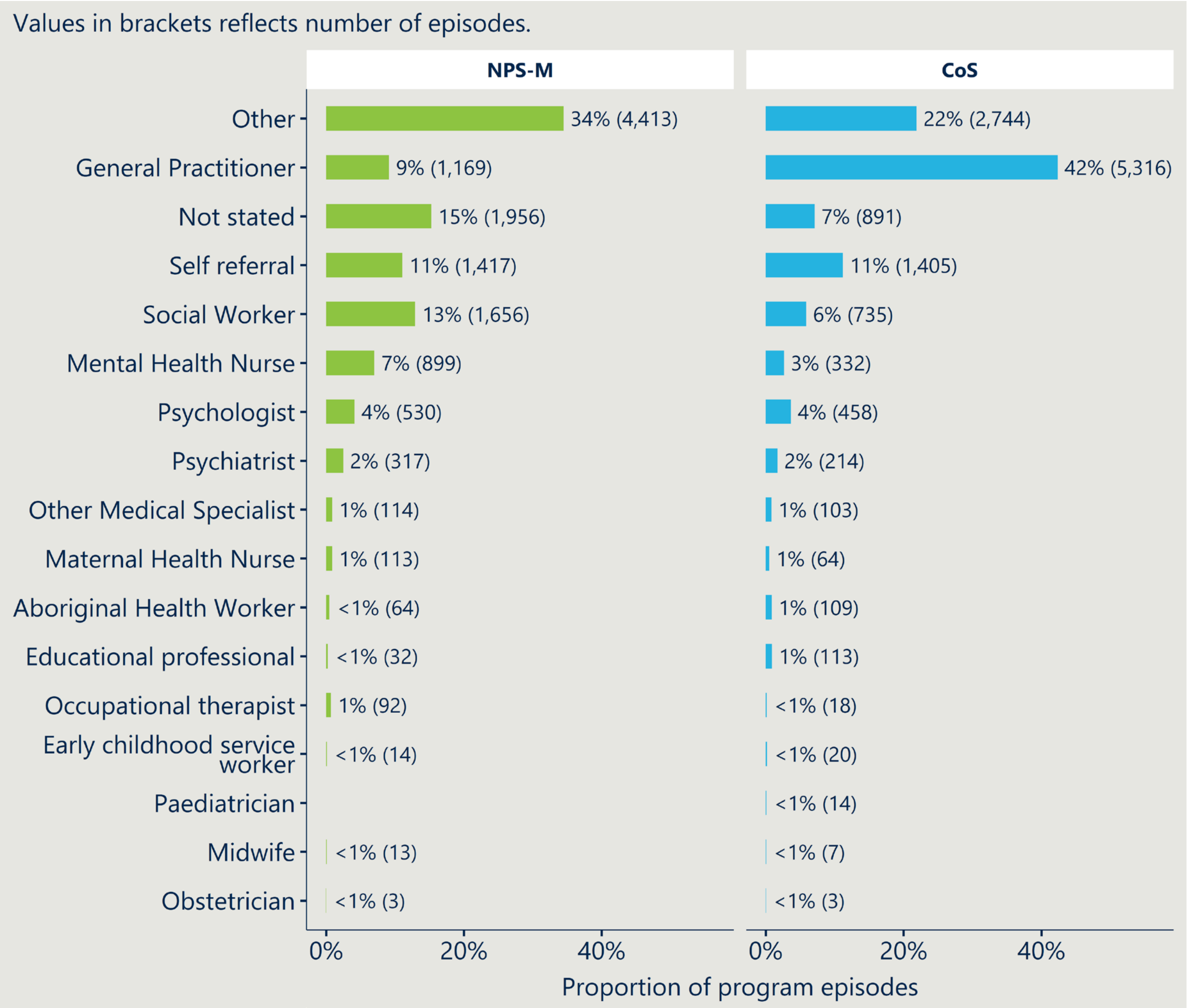
[182] Data is from the PMHC-MDS from the start of NPS-M and CoS programs until 30 September 2020

C.5.2 Referral profession

Figure 39 shows the reported profession of the individual who provided the referral into the NPS-M or CoS program.

- General practitioners were the main referrers into the CoS program.
- The majority of NPS-M referees were classified as ‘Other’, potentially holding roles at a not-for-profit community support organisation the most common referring organisation (Figure 38 above).

Figure 39 | Episode referrer profession[183]



Values in brackets reflects number of episodes.

C.6 NPS-M and CoS service use

This section examines the utilisation of the NPS-M and CoS services, as reported in the PMHC-MDS.

C.6.1 Episode length

Figure 40 shows the average and overall length of closed episodes in the NPS-M and CoS programs.

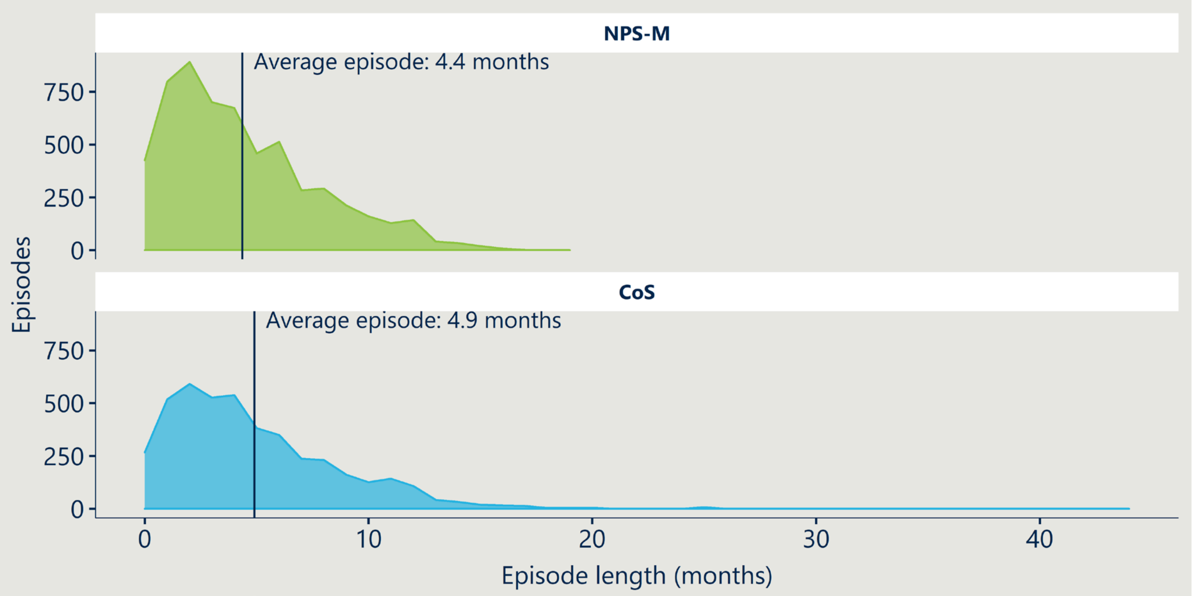
- The average episode length for CoS (4.9 months) was slightly longer than the NPS-M program (4.4 months).

---

[183] Data is from the PMHC-MDS from the start of NPS-M and CoS programs until 30 September 2020

- The number of episodes drops sharply at the 6 and 12-month mark, suggesting some PHNs have imposed time restrictions to services.

Figure 40 | Length of closed episodes[184]

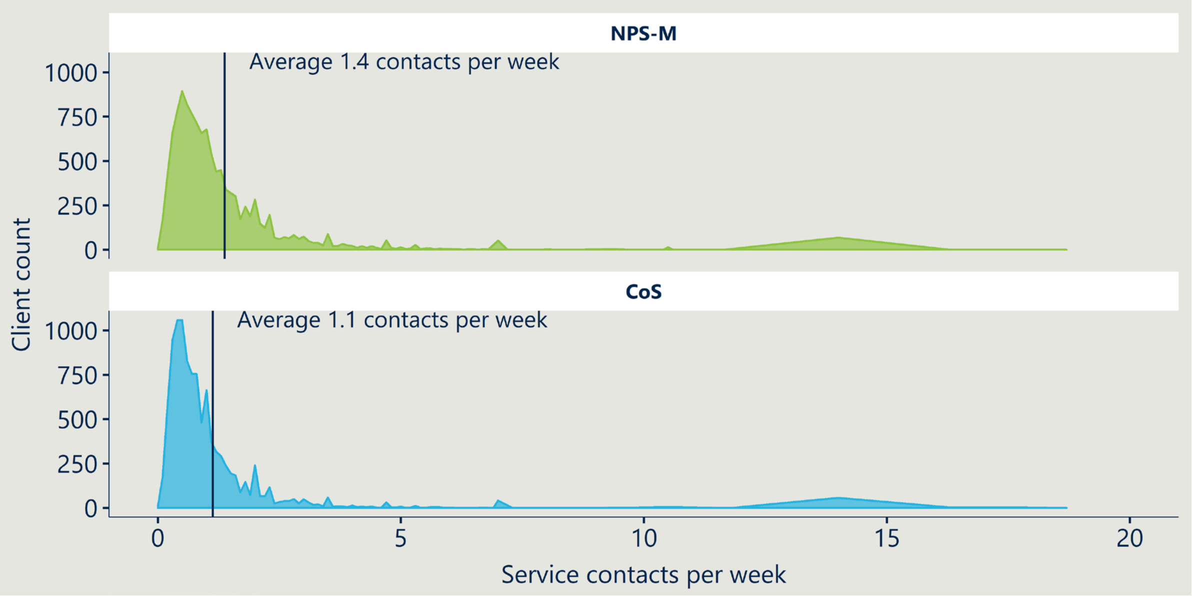


C.6.2 Service contacts per week[185]

Figure 41 shows the number of contacts per week for each consumer in the NPS-M and CoS programs.

- NPS-M consumers had slightly more contacts per week than CoS consumers (1.4 and 1.1, respectively).
- Both programs have a small number of consumers with a high number of service contacts per week representing service provision of two times per day.

Figure 41 | Service contacts per week



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[184] Data is from the PMHC-MDS from the start of NPS-M and CoS programs until 30 September 2020

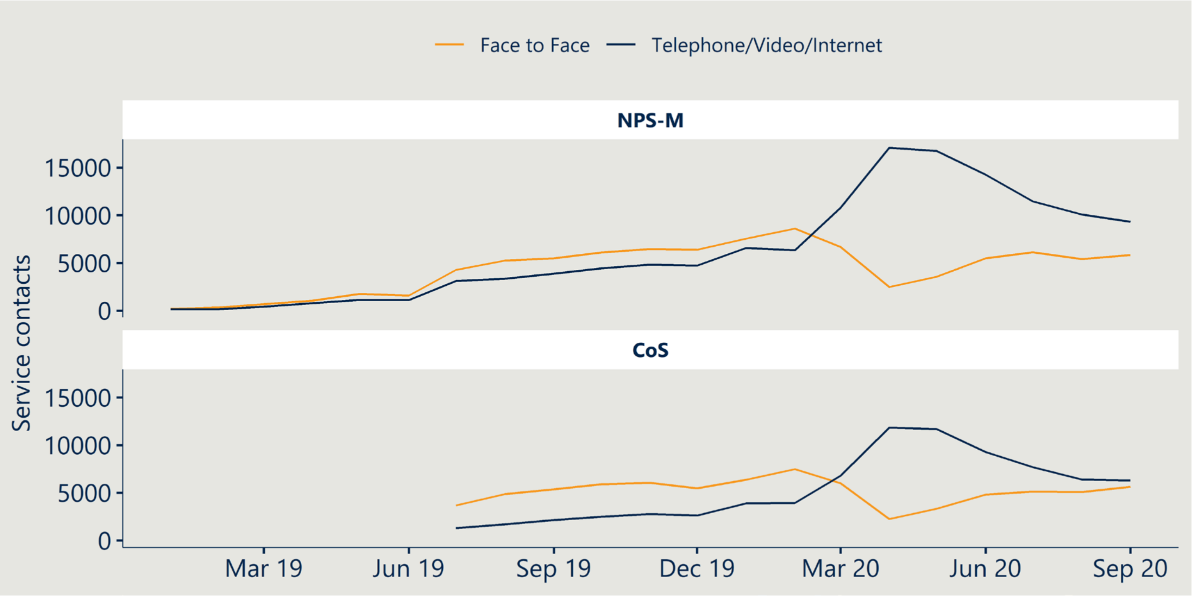
[185] Data is from the PMHC-MDS from the start of NPS-M and CoS programs until 30 September 2020

C.6.3 Service delivery method through COVID-19

Figure 42 shows the number of services delivered through different modes (Face-to-face and Telephone/Video/Internet).

- Both programs increased the number of service contacts throughout the life of the programs.
- Initial both programs had a higher number of Face to Face service contacts compared with other modes.
- After March 2020, there was a large increase in the number of Telephone/Video/Internet service contacts and a sharp decline in the number of Face to Face service contacts, likely due to COVID-19 restrictions.

Figure 42 | Service delivery method over time[186]



C.6.4 Individual and group support

Figure 43 shows the delivery mode utilised in the NPS-M and CoS programs.

- The majority of contacts for both programs were delivered through individual services rather than groups of clients.
- There is a peak in individual service delivery between March and June 2020 that may be related to increased demand during the COVID-19 pandemic.

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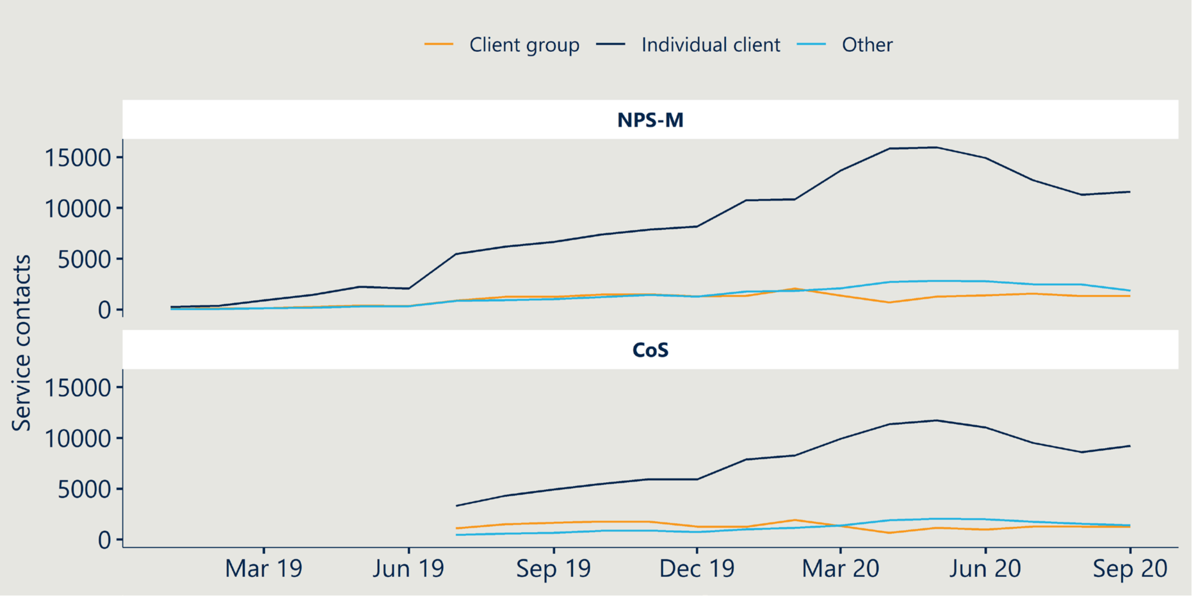
[186] Data is from the PMHC-MDS from the start of NPS-M and CoS programs until 30 September 2020

Figure 43 | Individual and group service delivery over time[187]



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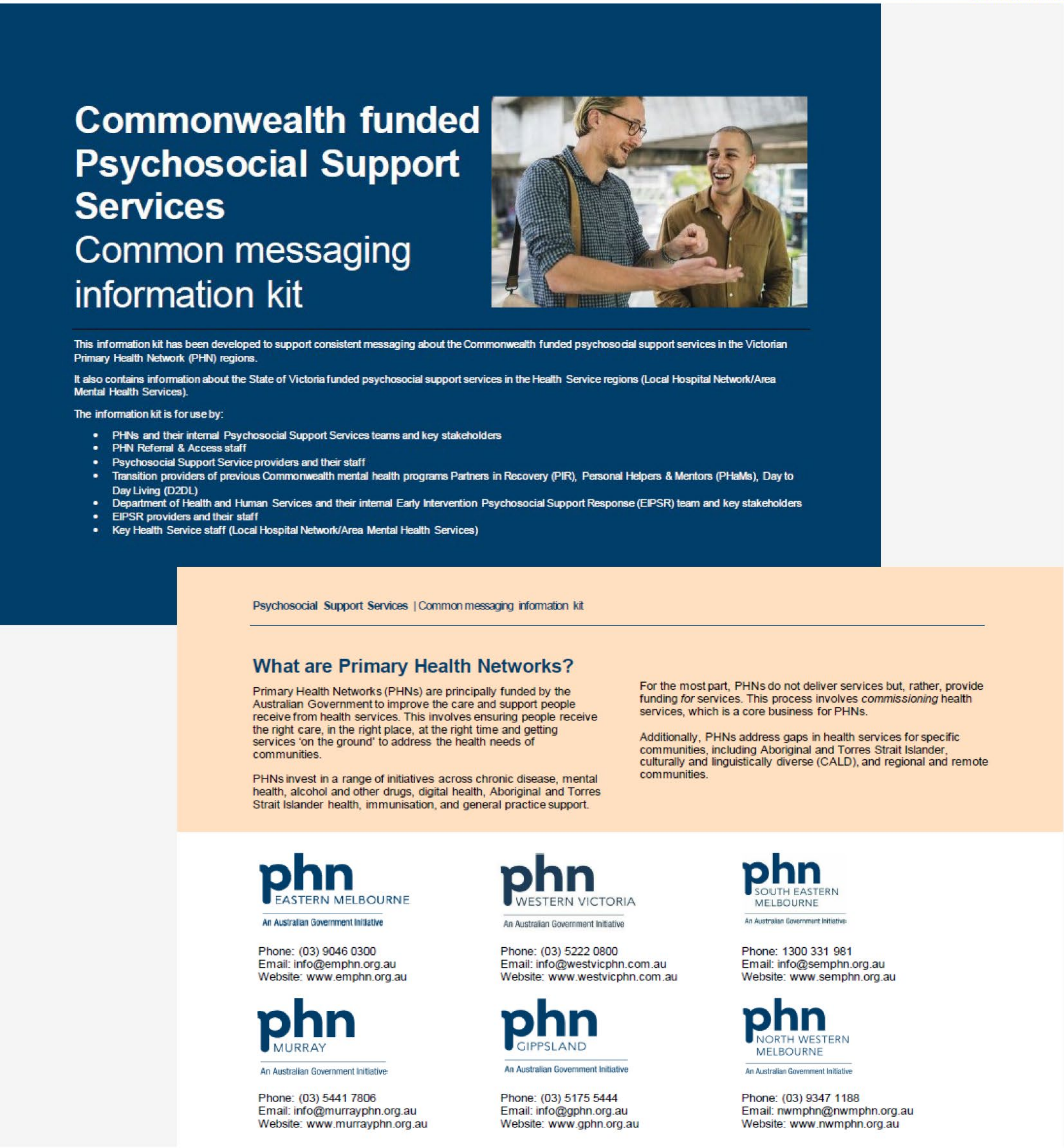
[187] Data is from the PMHC-MDS from the start of NPS-M and CoS programs until 30 September 2020

Appendix D Eastern Melbourne PHN additional detail for case study

This appendix includes additional detail for the Eastern Melbourne PHN case study. This includes Eastern Melbourne PHN's:

- common messaging information kit
- depiction of its psychosocial support service, highlighting the key points of collaboration that support an integrated and stepped care approach.

These are captured overleaf.



Commonwealth funded Psychosocial Support Services

Common messaging information kit

This information kit has been developed to support consistent messaging about the Commonwealth funded psychosocial support services in the Victorian Primary Health Network (PHN) regions.

It also contains information about the State of Victoria funded psychosocial support services in the Health Service regions (Local Hospital Network/Area Mental Health Services).

The information kit is for use by:

- PHNs and their internal Psychosocial Support Services teams and key stakeholders
- PHN Referral & Access staff
- Psychosocial Support Service providers and their staff
- Transition providers of previous Commonwealth mental health programs Partners in Recovery (PIR), Personal Helpers & Mentors (PHaMs), Day to Day Living (D2DL)
- Department of Health and Human Services and their internal Early Intervention Psychosocial Support Response (EIPSR) team and key stakeholders
- EIPSR providers and their staff
- Key Health Service staff (Local Hospital Network/Area Mental Health Services)

Psychosocial Support Services | Common messaging information kit

What are Primary Health Networks?

Primary Health Networks (PHNs) are principally funded by the Australian Government to improve the care and support people receive from health services. This involves ensuring people receive the right care, in the right place, at the right time and getting services 'on the ground' to address the health needs of communities.

PHNs invest in a range of initiatives across chronic disease, mental health, alcohol and other drugs, digital health, Aboriginal and Torres Strait Islander health, immunisation, and general practice support.

For the most part, PHNs do not deliver services but, rather, provide funding *for* services. This process involves *commissioning* health services, which is a core business for PHNs.

Additionally, PHNs address gaps in health services for specific communities, including Aboriginal and Torres Strait Islander, culturally and linguistically diverse (CALD), and regional and remote communities.

phn EASTERN MELBOURNE
An Australian Government Initiative
Phone: (03) 9046 0300
Email: info@emphn.org.au
Website: www.emphn.org.au

phn WESTERN VICTORIA
An Australian Government Initiative
Phone: (03) 5222 0800
Email: info@westvicphn.com.au
Website: www.westvicphn.com.au

phn SOUTH EASTERN MELBOURNE
An Australian Government Initiative
Phone: 1300 331 981
Email: info@semphn.org.au
Website: www.semphn.org.au

phn MURRAY
An Australian Government Initiative
Phone: (03) 5441 7806
Email: info@murrayphn.org.au
Website: www.murrayphn.org.au

phn GIPPSLAND
An Australian Government Initiative
Phone: (03) 5175 5444
Email: info@gphn.org.au
Website: www.gphn.org.au

phn NORTH WESTERN MELBOURNE
An Australian Government Initiative
Phone: (03) 9347 1188
Email: nwmphn@nwmphn.org.au
Website: www.nwmphn.org.au

Pictured: Cover page of the 'Common messaging information kit', used to support consistent communication of information about Commonwealth-funded psychosocial support services in Victoria.

Primary audience for this communication: PHNs, service providers, and LHN staff.

Psychosocial Support in the Community

National Disability Insurance Scheme (NDIS)

Local Area Coordinator (LAC)

Local Area Coordinator (LAC)

Local Area Coordinator (LAC)

EMPHN Stepped Care

A new Psychosocial Support Service

Time-limited and tiered support for consumers with severe mental illness who are not receiving NDIS support.

Psychosocial supports focus on:

- receiving practical help such as daily living tasks,
- being supported in mental and physical health, education, work, housing and recreational needs,
- getting connected with others, family, friends, peers, community, mainstream supports, and other services.

This service is delivered by Neami National and funded by the Australian Government under the PHN program.

Local Hospital Network (LHN)

Early Intervention Psychosocial Support Response (EIPSR)

Other services via EMPHN's Referral and Access team

Email: referral.access@emphn.org.au

Phone: (03) 9800 1071

Fax: (03) 8677 9510

Pictured: EMPHN's depiction of its psychosocial support service, highlighting the key points of collaboration that support an integrated and stepped care approach.

Primary audience for this communication: service providers and other support services.

Appendix E Estimated PHN MMM rurality

The MMM is used by the Australian Government Department of Health to define whether a location is a city, rural, remote or very remote. The model measures remoteness and population size on a scale from one (major city) to seven (very remote). Nous has used postcode level MMM data to estimate an aggregate value for each PHN, presented in Table 9. Values represent the weighted mean of the MMM values for all postcodes in each PHN, weighted by the population of the postcode.

Table 9 | Estimated PHN MMM values

State/territory	PHN	Estimated MMM value
ACT	Australian Capital Territory	1.2
NSW	Western Sydney	1
	Northern Sydney	1
	Central and Eastern Sydney	1.1
	South Western Sydney	1.3
	Nepean Blue Mountains	1.6
	Hunter New England and Central Coast	2.4
	South Eastern NSW	2.6
	North Coast	3.5
	Murrumbidgee	4.5
	Western NSW	4.6
NT	Northern Territory	3.8
QLD	Brisbane North	1.1
	Brisbane South	1.3
	Gold Coast	1.4
	Central Queensland, Wide Bay, Sunshine Coast	2.9
	Darling Downs and West Moreton	3
	Northern Queensland	3.7
	Western Queensland	6.5
SA	Adelaide	1
	Country SA	4.1
TAS	Tasmania	3
VIC	Eastern Melbourne	1.1

State/territory	PHN	Estimated MMM value
	South Eastern Melbourne	1.1
	North Western Melbourne	1.2
	Western Victoria	2.8
	Murray	3.7
	Gippsland	4.5
WA	Perth South	1.1
	Perth North	1.1
	Country WA	4.7

Appendix F International country profiles

This appendix comprises the following international country profiles:

- New Zealand
- The United Kingdom
- Canada.

These are outlined in turn.

COUNTRY PROFILE: **New Zealand**

1. Types and models of psychosocial services

New Zealanders with severe mental illness access psychosocial supports through the Primary Health Care system. New Zealand's model for delivering psychosocial supports through the disability system has been included as it provides useful lessons in delivering integrated psychosocial supports.

PRIMARY HEALTH CARE

Population access and eligibility

Primary mental health care services (PMH services) are available to people at any age with mental health and/or addiction issues.

New Zealand also provides additional funding to expand access, deliver earlier intervention and strengthen primary-specialist integration, and build on gains in resilience and recovery for people who have the highest needs (including people with severe mental illness).

Aims, purpose and objectives

Psychosocial supports are classified as PMH services. Broadly primary mental health care services aim to:

- increase access to talking therapies and other psychosocial interventions
- prevent, detect and treat mental health problems early (youth program).

Scope of psychosocial supports

Individually tailored packages of care can include psychosocial interventions such as:

- self management education
- peer support services
- employment services.

Note: These are examples and are not comprehensive. District Health Boards (DHBs) have discretion to choose the types of psychosocial supports they provide.

DISABILITY SUPPORT

Population access and eligibility

Eligible:

- has a physical, intellectual or sensory disability or some developmental disabilities in children and young people, such as autism
- limits ability to function independently
- is likely to continue for at least 6 months.

People with other mental health issues more generally are not eligible:

- mental health and addiction conditions such as schizophrenia, severe depression or long-term addiction to alcohol and drugs.

Aims, purpose and objectives

- Disabled people and their families have greater choice and control in their lives.
- Key principles include self-determination, with the system investing early, being person-centred, being easy to use, supporting disabled people to live an everyday life like others at similar stages, able to access mainstream services, being mana enhancing, and building and strengthening relationships between disabled people, their whānau and community.

Scope of psychosocial supports

- Individualised funding – provides a flexible annual budget to purchase household management and personal care assistance.
- Behaviour Support Services work with a disabled person and their support network to reduce the impact of the person's challenging behaviour.
- Community day services help disabled adults who can't find work to take part in their community and improve their personal skills by providing access to regular meaningful social contact and stimulating activities.
- Supported Living is a service that helps disabled people to live independently.

Model of care spotlight: New Model for Disability Support (incl. Enhanced Individualised funding)

A new model for disability support is being trailed in Bay of Plenty, Lakes, Waikato, Auckland, Hutt Valley and Otago/Southland regions. It gives people more choice and control over support and funding in their everyday lives.

Local Area Coordinators

Work with disabled people to plan for a good life and be connected with services and their communities.

- Providing accurate and timely information about local communities, supports and services.
- Working with local communities to ensure disabled people are included and can contribute to their communities.
- Assisting disabled people and their families/whānau to: i) clarify their goals, strengths and needs and to plan for a good, everyday life, ii) use local community networks to develop practical solutions to meet their goals and needs, and iii) access supports and services.

Choice in Community Living

An alternative to residential services, and aims to open up opportunities for disabled people and their family to have more choice and control about their living circumstances – where they live, who they live with and how they are supported.

- People receive financial support for living costs which can be used flexibly to choose the type of housing they want to live in.
- People can choose from a range of home care/support options procured by the Ministry of Health.
- People have access to a facilitation based support service to help them build a new life in the community.

Enhanced Individualised Funding (EIF)

Gives people with disability a flexible pool of money that can be used for a wide range of supports.

- Funding can be spent on: i) a disability support (or the additional cost of living with a disability), ii) part of your plan and helps you progress towards your goals, iii) support that is the responsibility of the Ministry of Health.
- The funding does not cover anything that you would be expected to pay for if you were not disabled. So, personal expenses such as a ticket to the movies for yourself, food, insurance, whiteware, bills, or any goods or services that you would pay for yourself if you weren't disabled, do not count.

COUNTRY PROFILE: **New Zealand**

2. Key players, funding and governance

PRIMARY HEALTH CARE - Funding and Commissioning

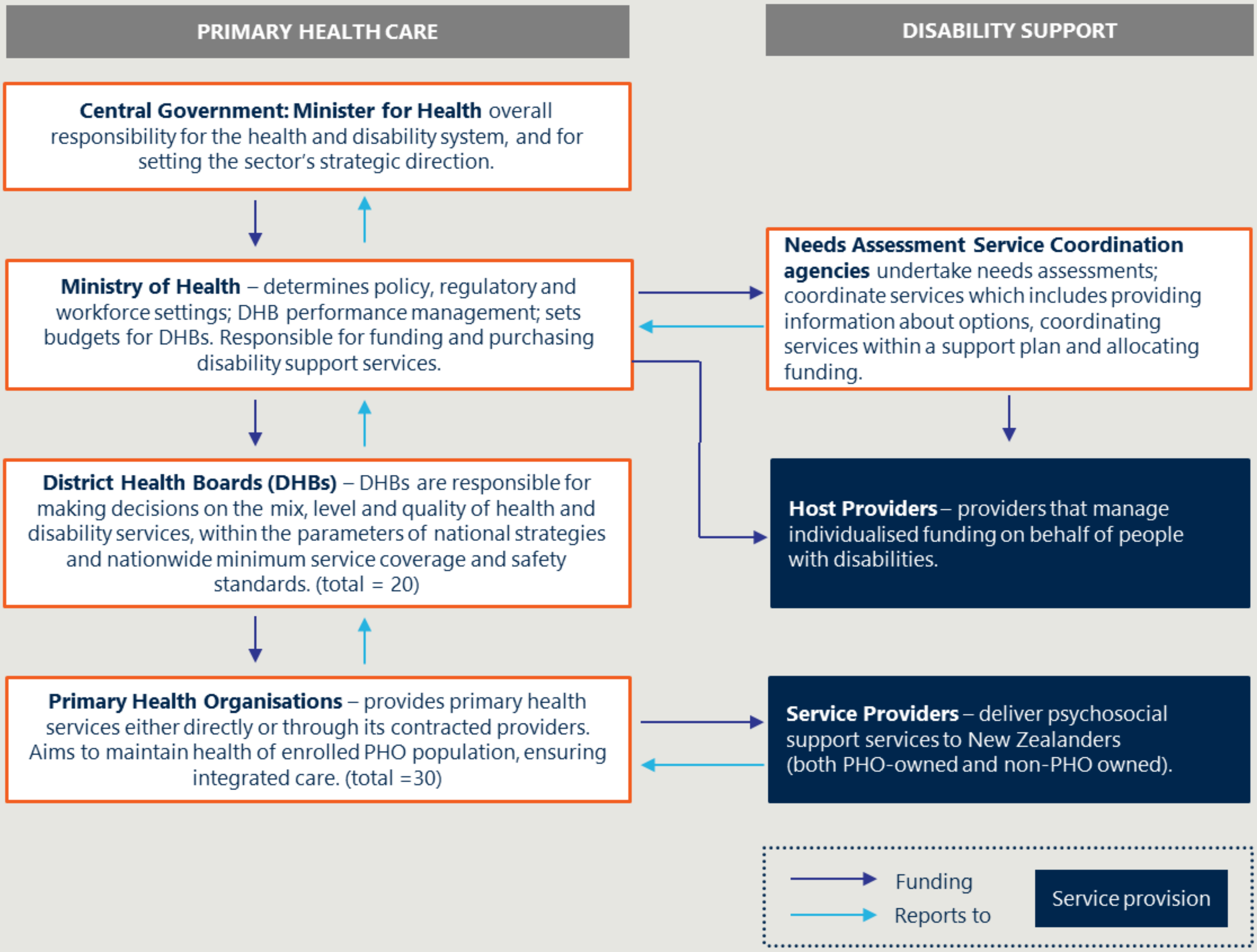
Population-based commissioning model: For health services (including mental health services), a DHB's annual budget is determined by population needs through a population-based funding formula (PBFF).

- The aim of the PBFF is to equitably distribute available funding between DHBs according to the relative needs of their populations and the cost of providing health and disability support services to meet those needs. Costs are determined by age, sex, ethnicity and socio-economic groups as defined by NZ index of deprivation (NZDep) quintile group, plus the rural and overseas and refugee adjustments.
- Funding for mental health services is ring-fenced and DHBs cannot spend this money on non-mental health services.

DISABILITY SUPPORT - Funding and Commissioning

- A person's support needs is determined the Needs Assessment Service Coordination agencies, who then determine the intensity of supports (and overall budget) required.
- Funding is paid to a host provider; there are no direct payments to individuals. People who receive individualised funding have the power to decide: i) who provides the support in their home and how much they are paid, iii) when the support is provided, iii) what type of support is provided (as long as it meets the criteria in the service specification).

KEY PLAYERS, FUNDING AND GOVERNANCE ARRANGEMENTS



PRIMARY HEALTH CARE

DISABILITY SUPPORT

Central Government: Minister for Health overall responsibility for the health and disability system, and for setting the sector's strategic direction.

Ministry of Health – determines policy, regulatory and workforce settings; DHB performance management; sets budgets for DHBs. Responsible for funding and purchasing disability support services.

District Health Boards (DHBs) – DHBs are responsible for making decisions on the mix, level and quality of health and disability services, within the parameters of national strategies and nationwide minimum service coverage and safety standards. (total = 20)

Primary Health Organisations – provides primary health services either directly or through its contracted providers. Aims to maintain health of enrolled PHO population, ensuring integrated care. (total =30)

Needs Assessment Service Coordination agencies undertake needs assessments; coordinate services which includes providing information about options, coordinating services within a support plan and allocating funding.

Host Providers – providers that manage individualised funding on behalf of people with disabilities.

Service Providers – deliver psychosocial support services to New Zealanders (both PHO-owned and non-PHO owned).

COUNTRY PROFILE: **United Kingdom**

1. Types and models of psychosocial services

In the United Kingdom (UK), psychosocial supports for people with severe mental illness are increasingly integrated into health care and delivered through the NHS under the Community Mental Health Framework for Adults and Older Adults (which has replaced the Care Programme Approach).

Population access and eligibility

- **Universal access:** Psychosocial support services are available to anybody who needs them and are covered by the NHS. The NHS is moving away from strict access and eligibility criteria for accessing psychosocial supports to a system of Universal Personalised Care.
- **Stepped approach**: The range and intensity of supports vary according to their level of complexity and needs. Under the Personalised Care, psychosocial supports are delivered under two pillars of the model: social prescribing and community-based support, and supported self management.

Aims, purpose and objectives

Through the adoption of this Framework, people with mental health problems will be enabled to:

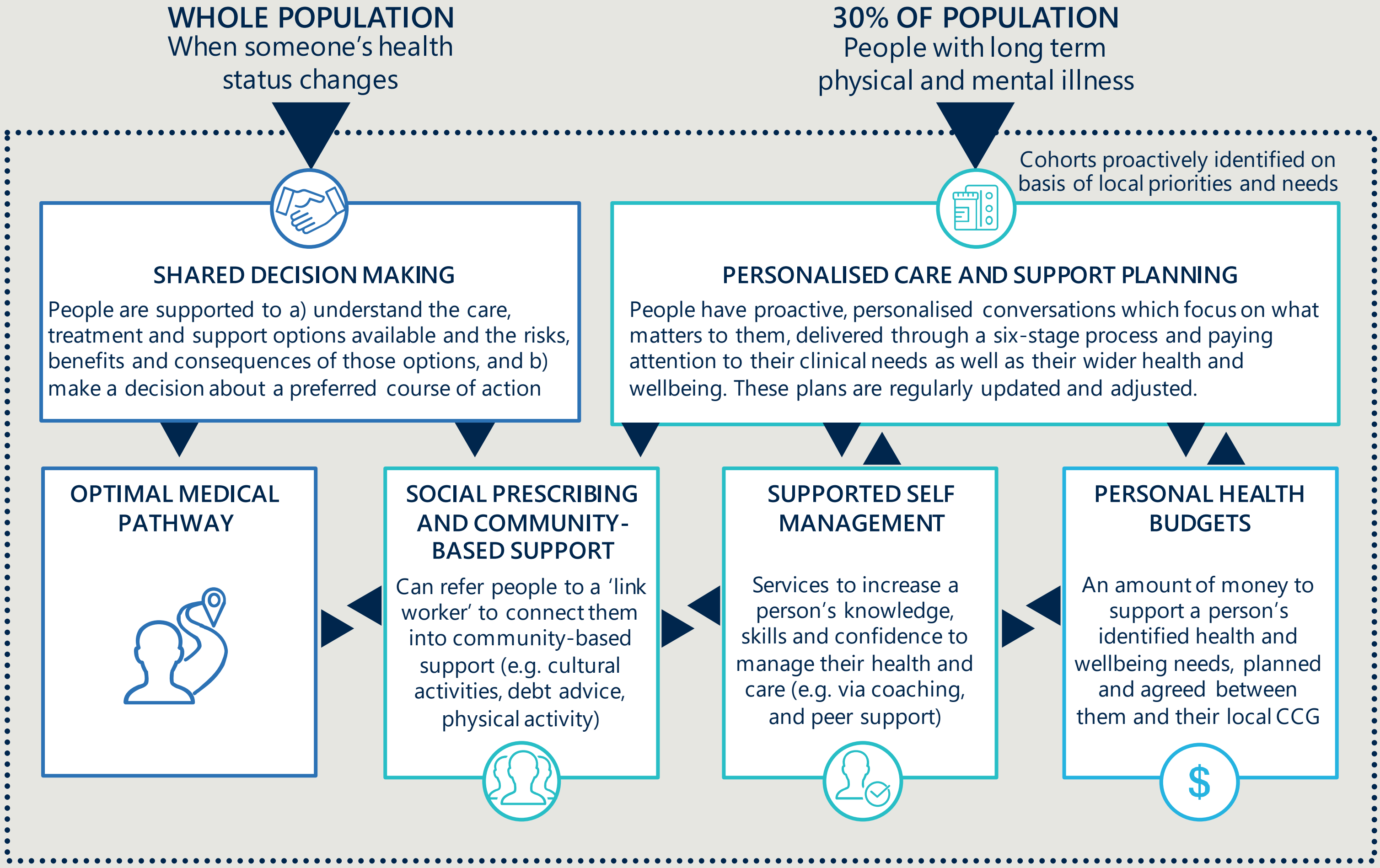
- access mental health care where and when they need it, and be able to move through the system easily, so that people who need intensive input receive it in the appropriate place, rather than face being discharged to no support
- manage their condition or move towards individualised recovery on their own terms, surrounded by their families, carers and social networks, and supported in their local community
- contribute to and be participants in the communities that sustain them, to whatever extent is comfortable to them.

Scope of Services

Community Mental Health Services integrate primary care, secondary care and psychosocial support to meet a range of mental health needs, including:

- advocacy services; community assets (for example, libraries, leisure and social activities, and faith groups)
- assessment, advice and consultation for mental health problems; physical health care; coordination and delivery of care
- co-produced, personalised care and support planning
- effective support, care and treatment for co-occurring drug and alcohol-use disorders
- employment, education, volunteering and training services
- evidence-based interventions for mental health problems, including psychological and pharmacological treatments, and NICE-recommended psychological therapies for people with severe mental illnesses
- help and advice on finances (including benefits)
- housing and social care services
- services enabling access to mental health information and online resources
- specific support groups (such as older adult groups, hearing voices groups, or problem-specific support groups, for example, for diabetes or depression) support that takes into account frailty, mobility issues and sensory impairments, and helps people live independently.

Model of care spotlight: Psychosocial supports as part of a model for Universal Personalised Care



WHOLE POPULATION
When someone's health status changes

30% OF POPULATION
People with long term physical and mental illness

Cohorts proactively identified on basis of local priorities and needs

SHARED DECISION MAKING
People are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action

PERSONALISED CARE AND SUPPORT PLANNING
People have proactive, personalised conversations which focus on what matters to them, delivered through a six-stage process and paying attention to their clinical needs as well as their wider health and wellbeing. These plans are regularly updated and adjusted.

OPTIMAL MEDICAL PATHWAY

SOCIAL PRESCRIBING AND COMMUNITY-BASED SUPPORT
Can refer people to a 'link worker' to connect them into community-based support (e.g. cultural activities, debt advice, physical activity)

SUPPORTED SELF MANAGEMENT
Services to increase a person's knowledge, skills and confidence to manage their health and care (e.g. via coaching, and peer support)

PERSONAL HEALTH BUDGETS
An amount of money to support a person's identified health and wellbeing needs, planned and agreed between them and their local CCG

COUNTRY PROFILE: **United Kingdom**

2. Key players, funding and governance

FUNDING AND COMMISSIONING

Population Budgeting is used to allocate the bulk of healthcare funding to regions. Total healthcare funding is divided among Clinical Commissioning Groups (CCGs) according to their predicted health care needs. The amount each CCG received was determined not only by the number of people in their local area, but also by factors like their age and level of deprivation as these are linked to how much health care they need.

A devolved commissioning model is used to purchase healthcare.

CCGs assess the health needs of their local population to make decisions about the health and care services they need. This needs assessment is taken in conjunction with service providers and local authorities which form sustainability and transformation partnerships They then buy as many of those services as their budget allows from providers like hospitals, GPs, mental health, community and other providers.

NHS England published updated requirements in 2018/19, requiring CCGs to ensure their investment in mental health rises at a faster rate than overall health funding.

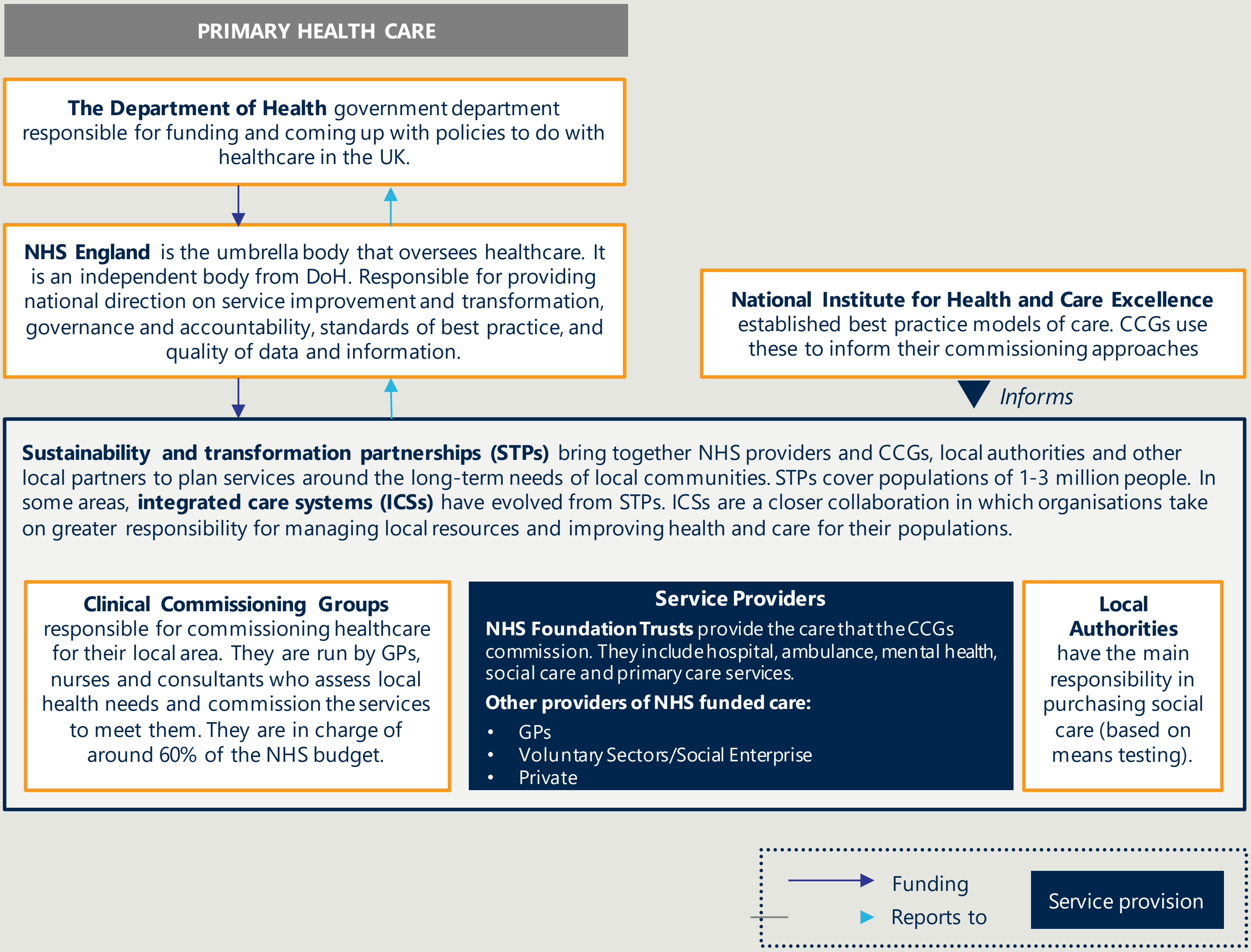
Examples of commissioning models used to integrate psychosocial supports with healthcare

Alliance contracting is a particular area of interest because of its potential to support coalitions of willing organisations – commissioners and providers – to establish long-term legal relationships and share risk. Lambeth CCG, for example, has commissioned an alliance of local providers on an initial seven-year contract to deliver a range of adult mental health services, including improving access to psychological therapies, crisis support, peer support and mental health social work.

Integrated Personal Budgets: an amount of money to support a person's identified health and wellbeing needs, planned and agreed between them and their local CCG. May lead to integrated personal budgets for those with both health and social care needs. This isn't new money, but a different way of spending health funding to meet the needs of an individual.

Area-wide pooled budgets: pooling funds across health and social care enables funds to be optimally allocated according to population needs.

KEY PLAYERS, FUNDING AND GOVERNANCE ARRANGEMENTS



PRIMARY HEALTH CARE

The Department of Health government department responsible for funding and coming up with policies to do with healthcare in the UK.

NHS England is the umbrella body that oversees healthcare. It is an independent body from DoH. Responsible for providing national direction on service improvement and transformation, governance and accountability, standards of best practice, and quality of data and information.

National Institute for Health and Care Excellence established best practice models of care. CCGs use these to inform their commissioning approaches

Informs

Sustainability and transformation partnerships (STPs) bring together NHS providers and CCGs, local authorities and other local partners to plan services around the long-term needs of local communities. STPs cover populations of 1-3 million people. In some areas, **integrated care systems (ICSs)** have evolved from STPs. ICSs are a closer collaboration in which organisations take on greater responsibility for managing local resources and improving health and care for their populations.

Clinical Commissioning Groups responsible for commissioning healthcare for their local area. They are run by GPs, nurses and consultants who assess local health needs and commission the services to meet them. They are in charge of around 60% of the NHS budget.

Service Providers

NHS Foundation Trusts provide the care that the CCGs commission. They include hospital, ambulance, mental health, social care and primary care services.

Other providers of NHS funded care:

- GPs
- Voluntary Sectors/Social Enterprise
- Private

Local Authorities have the main responsibility in purchasing social care (based on means testing).

COUNTRY PROFILE: **Canada**

1. Types and models of psychosocial services

In Canada, psychosocial supports are usually delivered through community mental health centres at the discretion of provincial and territorial governments who have main jurisdiction for health care.

Population access and eligibility

Access to psychosocial supports for people with mental illness varies widely across Canada and depends on provincial/territorial policy and funding decisions.

Scope of Services

Psychosocial supports are often noted as a gap in several Canadian provinces. However some states have dedicated funding for psychosocial support such as Ontario (see column to the right). The Canadian Mental Health Association notes that most provinces provide some level of support in the following areas.

Case study: Ontario

In 2016, Ontario defined a set of core mental health and addictions services that are available to all Ontarians and are backed by dedicated funding. Four of the eight focus areas for core services have psychosocial elements (in bold).

1. Prevention, promotion and early intervention services – promote good mental health and prevent or treat mental health conditions early.

2. **Information assessment and referral services** – provide up-to-date, evidence-based information on mental illness and addictions, and on core services available in Ontario.

3. Counselling and therapy services – counselling and therapy services focus on reducing the severity of and/or remedying the emotional, social, behavioral and self-regulation problems of individuals.

4. **Peer and family capacity building support** – consist of activities that facilitate emotional and practical support and information exchange between people with common lived experiences (either individual experience with mental illness or addiction, or family members who have a loved one with a mental illness and/or addiction). Formalised peer support begins when persons with lived experience, who have received specialised training, assume unique, designated roles within the mental health system to support an individual's expressed wishes.

5. Specialised consultation and assessment – specialised consultation and assessments are designed to provide advice in the assessment, diagnosis, prognosis and/or treatment of an individual with an identified mental health or addiction need.

6. Crisis Support Services – crisis support services are immediate, time-limited services, delivered in response to an imminent mental health crisis or an urgent situation.

7. **Intensive treatment services** – are targeted to clients who have severe and/or complex mental illness and/or addiction that is limiting their functioning in areas such as employment, parenting, household management, schooling, and/or housing.

8. **Housing and social supports** – consists of a range of non-therapeutic and non-medical services aimed at facilitating the recovery, well-being, and functioning of the patient at home, at school, at work and in the broader community.

MODEL OF CARE SPOTLIGHT: ASSERTIVE COMMUNITY TREATMENT MANAGEMENT

Assertive Community Treatment (ACT) is a case management model, with a low client-to-staff ratio of about 10:1. ACT is typically for clients who have serious, persistent mental illnesses and functional impairment, and who are intensive users of the health care system. This model is used around the world, and is heavily used in Ontario and Canada to support people with sever mental illnesses. An ACT team is multidisciplinary, including a psychiatrist and other members such as a social worker, nurse, peer support worker and addiction specialist (see diagram below). An ACT team provides psychiatric treatment, administers and monitors medications, helps clients access community services and assists clients in their activities of daily living. Support is provided 24 hours a day.

COUNTRY PROFILE: **Canada**

2. Key players, funding and governance

Funding and commissioning

Provinces and territories in Canada have primary responsibility for organising and delivering health services and supervising providers. All states have to fund services deemed 'medically necessary' under the Canada Health Act (1985) services.

There is universal coverage for physician-provided mental health care, along with a fragmented system of allied services. However, not all provinces cover other mental health supports including psychosocial supports delivered in private practice by a psychologist, social worker or psychotherapist.

The provinces and territories all provide a range of community mental health and addiction services including case management, help for families and caregivers, community-based crisis services, and supportive housing.

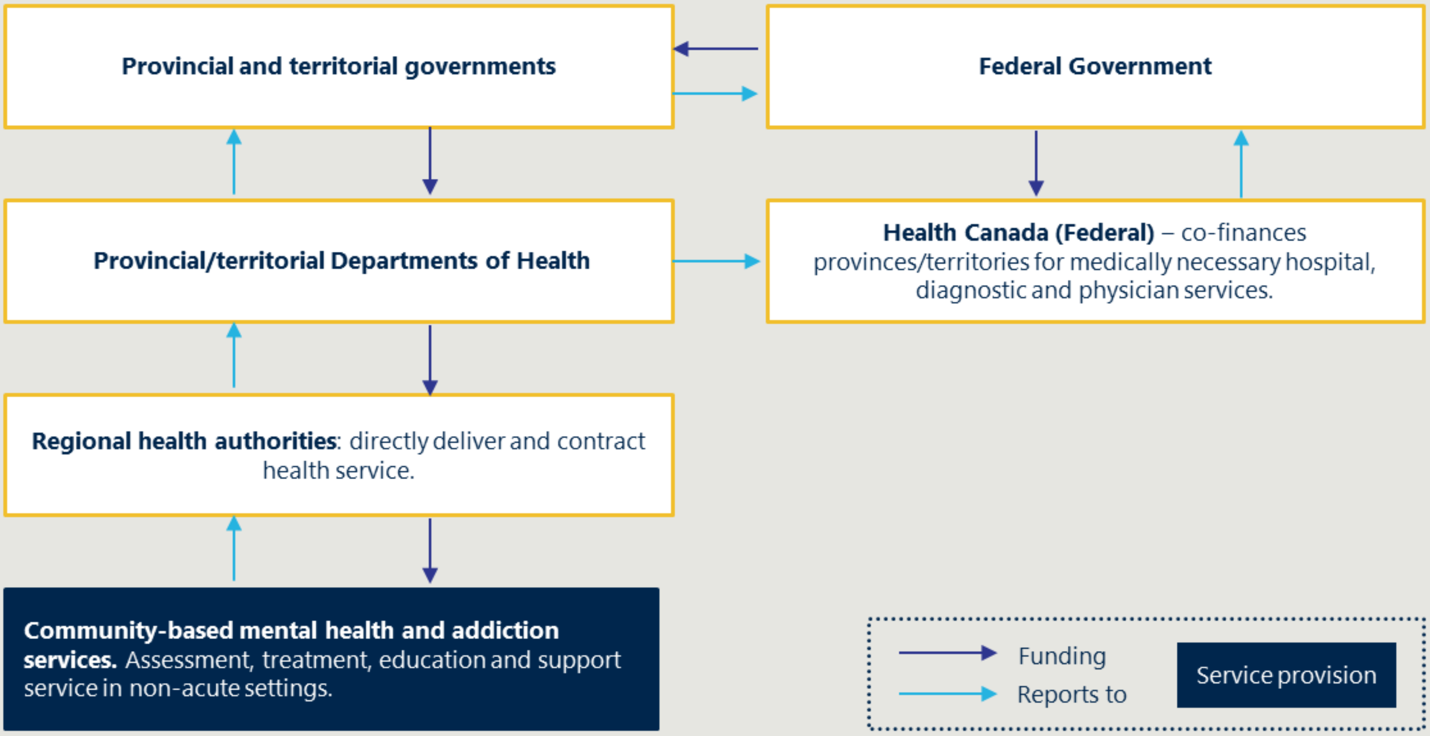
Data and reporting

The Canadian Institute for Health Information (CIHI) notes that there are substantial gaps in community mental health and addiction (MHA) services data and information, which includes psychosocial supports. Gaps in data collection, limited data integration and variation in data standards impede attempts to gain a system-level perspective on community MHA services.

In response to these gaps, CIHI has developed a standardised typology for the mental health and addiction services delivered across Canada's provinces and territories. These categories may give policy makers better oversight of the types of psychosocial support being provided and the model of care. Categories relevant to psychosocial services include:

- Vocational training and rehabilitation – provide education, training and coping skills to support meaningful employment for people living with mental illness and/or addictions.
- Housing services – include supported housing, financial support for housing, and assistance with searching for and obtaining housing.
- Assertive community treatment – intensive community mental health service providing comprehensive services for clients with serious mental illness and complex needs including psychosocial service.
- Shared care – collaboration between general practitioners and psychiatrists and/or other mental health or addiction specialists. Shared care may involve general practitioners having access to psychiatrists by phone, co-location or other collaborative activities
- Consumer groups – self-help, peer or family support groups are run by persons affected by mental illness or addictions. These groups provide support, information and education to clients and/or their families.

KEY PLAYERS, FUNDING AND GOVERNANCE ARRANGEMENTS



ABOUT NOUS

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