The Evaluation of National Psychosocial Support Programs - QAMH Summary

The Australian Department of Health recently released its Evaluation of National Psychosocial Programs. This independent evaluation, which was finalised in April 2021 but only made publicly available last week, was conducted by the Nous Group in partnership with University of Sydney. It is a comprehensive report, drawing upon feedback from over 500 consumers and carers, all 31 Primary Health Networks, and state/territory regional health networks. Its stated aim was to evaluate the appropriateness, effectiveness, efficiency and impact of the National Psychosocial Support Measure (NPS-M) and Continuity of Support (CoS) programs which were introduced by the Australian Government in 2019.

A lot has changed in the community mental health and wellbeing landscape since this report was conducted. We've had the Productivity Commission's Report into Mental Health, two federal budgets which promised almost $3 billion of additional mental health funding, a National Mental Health and Suicide Prevention Agreement, bilateral agreements from six of the eight states/territories, the Omicron variant wreaking havoc across the nation, and catastrophic flooding. We are now on the eve of a federal election and in Queensland we are in the middle of the Inquiry into Opportunities to Improve Mental Health Outcomes for Queenslanders.

Despite this, there is a lot to be gained from reflecting on the findings and key recommendations in this report. Unlike previous reports, reviews and inquiries, the Nous Group's report is entirely focussed on programs delivered by the community mental health and wellbeing sector. It is a largely positive evaluation and at a time when our sector has been ignored in the National Agreement and federal budget, this is indeed welcome news.

The Nous report has made 18 recommendations in total. There is a lot of detail in the report, and we encourage you to read it and its recommendations in full to identify which are most relevant to your organisation. Below is a summary of what the report investigated, some key findings and recommendations impacting QAMH members.

- Together, the NPS-M and CoS programs supported 12,368 consumers in the period 1 July 2019 to 30 June 2020 (total of 2,795 in Queensland).

- 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.

- The overwhelming majority of consumers who provided feedback indicated they had positive experiences and were very satisfied with the support provided by NPS-M and CoS.

- Almost all (n=460, 92%) of consumers surveyed said their life had improved from using the service, with most (n=340, 68%) saying 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%)

- 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%)

- Acknowledging that the K10+ and K5 outcome measures are potentially misaligned with recovery-oriented models of support, data from select PHNs provided evidence that these outcome measures improved. Across both the NPS-M and CoS programs K10+ scores decreased throughout the program, reflecting a decrease in psychological distress. In 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.

- Short funding cycles and tight timeframes between formal confirmation and delivery of services negatively impacted the ability to provide co-designed planning and effective commissioning, as well as limiting the provision of a stable and qualified 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.

- 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 on an on-going basis, with most noting they required more time to do this.

- While the programs were intentionally designed to be locally tailored and implemented, this has led to fragmented service delivery and additional administrative costs. It has also created a level of confusion for stakeholders including consumers and service providers about what support was available and to who. The report recommends a single nationally branded program which would streamline the programs in the future.

- In the transition to the NDIS, separate arrangements (NPS-M and CoS) may have been necessary. But in reality the type of supports provided and the needs of participants were not found to vary significantly between the two programs. In the post-transition context, a single funding stream and single program would reduce administrative costs and confusion.

- Consumers reported that some people need long-term support with soft re-entry points to cater for fluctuating needs. Distress about having to exit the program after a certain time period was common. PHNs reported that 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.

- 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.

- It was not possible to assess the cost-effectiveness of the programs in terms of achieving outcomes for consumers and efficiencies across the broader health system due to limitations with data currently available.

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.

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).

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.

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.

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

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.