

# Commissioning and Youth Mental Health

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## Addressing an Undertreated Health Issue

### Young people

Young people are disproportionately affected by mental ill-health. Mental ill-health is the leading cause of disability for 10-24 year olds, accounting for almost half (45 %) of the disease burden in this age group.<sup>1</sup> The onset of mental ill-health peaks between the ages of 12 and 24 years<sup>2</sup> and effects one in four young people every year. Yet young people are less likely to access health services.

Young people are almost half as likely to visit a doctor for a mental health related matter compared with the general population. The rate of consultations is lower outside major cities and in areas of lower socioeconomic status. Only 22 percent of Australians aged between 16 and 24 years of age with a diagnosable mental disorder access professional help.<sup>3</sup>

### Government policy

The Australian Government has released a new mental health policy in response to the National Mental Health Commission's review of mental health programmes and services. The policy gives the 31 Primary Health Networks (PHNs), established by the Australian Government responsibility for planning mental health services. For young people, headspace services will be integrated with broader youth services at a regional level.

Funding of mental health services is also being reformed with the government introducing commissioning as a model of competitive service provision within the primary health sector. PHNs will commission youth mental health services across a broad continuum of care, from mild illness to more severe disorders requiring more acute and longer term intensive care. The provision of flexible funding permits PHNs to expand the range of mental disorders treated with funding allocated for Early Psychosis Youth Services. Services commissioned by PHNs are required to fit within the existing service environment and not duplicate services.

### Service environment

In order to navigate the service environment in which a PHN will operate the role of other mental health service providers needs to be mapped. These providers might be local area services or specialist state-wide services. A wide range of services will need to be considered, such as:

- Child and Adolescent Mental Health Services (CAMHS) funded by State and Territory governments
- Mental health teams and services provided by local hospitals networks (LHNs)
- Existing headspace centres
- Community managed sector for mental health (CSOs/NGOs)
- Privately practicing psychiatrists and other allied health practitioners
- Aboriginal Medical Services
- Counselling services
- Forensic mental health
- Community health
- Alcohol and other drug services
- Online programs.

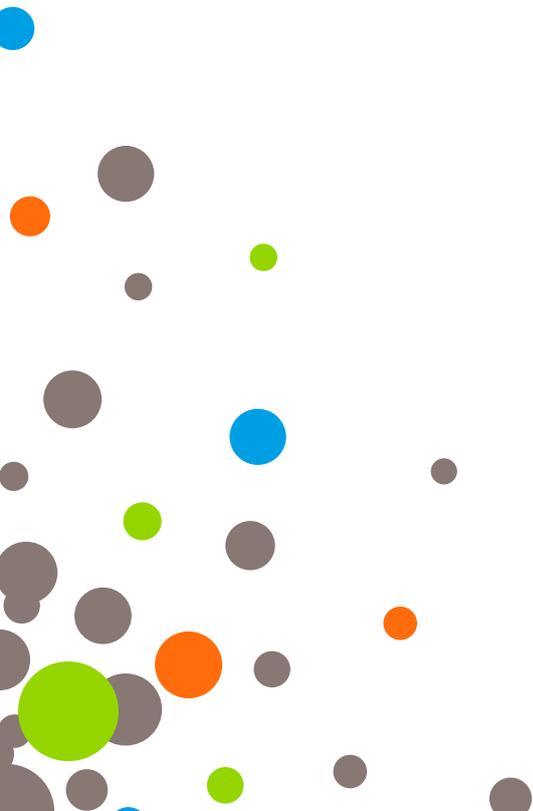
### Stepped care model

The government has also defined a stepped model of care for primary mental health care and clinical service delivery. The model includes what needs to be achieved and the relevant services to achieve these objectives. The model provides a further overlay for defining the role for PHNs in service provision for young people with varying degrees of mental ill-health.



Importantly, the government has identified 'expanded primary care system capacity' as one of six system changes needed to implement the stepped care model. In identifying a defined role in service provision for people with severe mental ill-health the government may inadvertently be signalling that the Commonwealth intends to provide services, through PHNs that have traditionally been funded by State and Territory governments. It is possible that the Australian Government's new mental health policy may have the perverse outcome of reducing services from other providers.

There is evidence of such a "reduction in effort" by State and Territory governments, resulting in extra demand on federally funded services and programs. The establishment of Commonwealth mental health initiatives (i.e. headspace) had led to states withdrawing or reducing their services.<sup>4</sup> As a result, headspace which was designed to provide treatment for mild-moderate illnesses has been increasingly seeing people with more severe illnesses who would have previously been eligible/seen by a state service. This situation and the potential for a further withdrawal by state services would likely reduce the capacity of PHNs to achieve improved mental health outcomes for young people within the existing funding envelope.



## Improving youth mental health through commissioning

The government is aiming to improve the efficiency of primary health services and health outcomes through the implementation of service commissioning. PHNs are responsible for hitting the health reform target. The aim of improving services is a task that cannot be underestimated, with healthcare commissioning having been described as 'complicated and demanding'<sup>6</sup> with 'significant challenges to be overcome'<sup>7</sup>. International experiences provide lessons for PHNs in the transition to commissioning. The commissioning of health services has previously been implemented in New Zealand (1993), the United Kingdom (2001) and parts of Canada (2003 and 2006).

General resources which provide an overall guide included the Paul Hamlyn Foundation guide for commissioning mental health services for young people and NHS commissioning groups' strategies for the integration of mental health services. Specific resources from the United Kingdom related to commissioning of youth mental health services are also available. It will take time for Australian resources to reach a comparable level. The Primary Health Care Research and Information

Service has made a start by hosting a clearinghouse website [phcris.org.au/guides/intro\\_phns.php](http://phcris.org.au/guides/intro_phns.php). The Australian Healthcare and Hospitals Association has convened a Mental Health Network to facilitate knowledge sharing between PHNs.

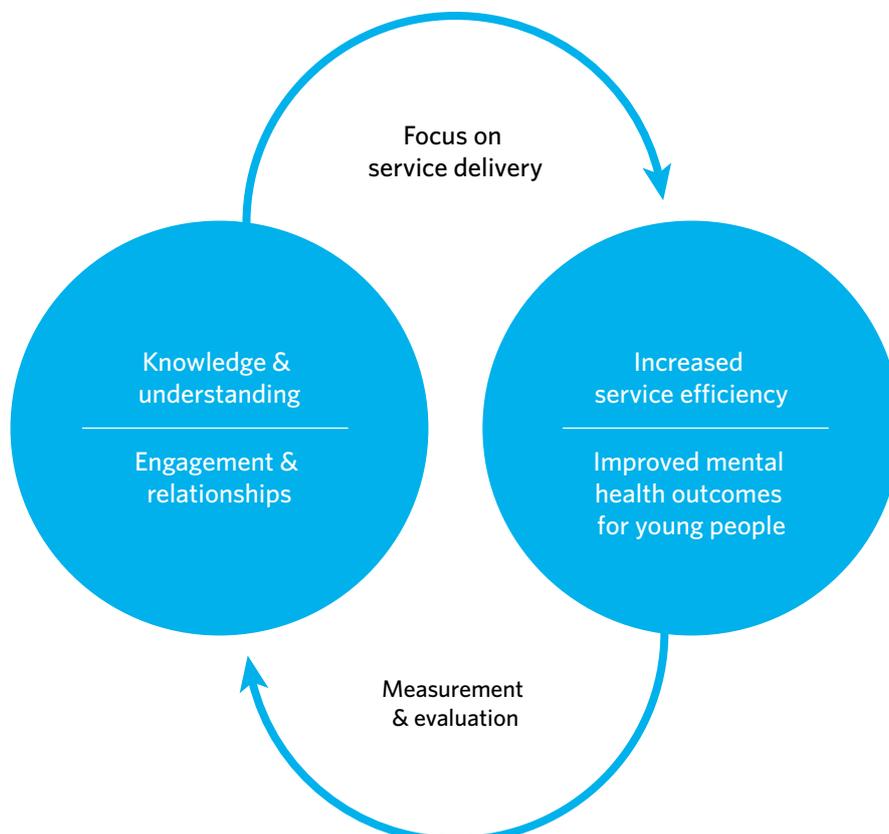
### The commissioning cycle

International experience has shown that successful commissioning consists of four elements. The elements are:

- Knowledge and understanding
- Engagement and relationships
- A focus on improved service delivery
- Measurement and evaluation

The four elements form an iterative cycle of improvement in knowledge and relationships to deliver improved services in order to achieve improved service efficiencies and health outcomes. The measurement and evaluation of these outcomes should increase knowledge and facilitate continued engagement with the community and service providers.

Figure 1 – Iterative cycle of service improvement



## Knowledge and understanding

PHNs will need to undertake a comprehensive assessment of service needs and map existing services to identify gaps and opportunities for improved service delivery. PHNs are responsible for identifying the primary health needs of the population within their bounded area, in particular those people at risk of poor health outcomes, not only those people already accessing services.

The basis for decisions on service commissioning is intended to move the focus from practice as usual to a 'strategic' population-based approach (providing services for everyone not just those who access care). Internationally, the best outcomes have been achieved where commissioners begin with clearly stated objectives.<sup>8</sup>

## Data

Available data shows the prevalence of mental ill-health among young people is high. Identifying those people missing out on services and their level of need is, however, more difficult requiring comparison of prevalence and service use data.

The 2015 Australian Child and Adolescent Survey of Mental Health and Wellbeing analysed the prevalence of mental disorders and service use.<sup>9</sup> The survey reported that almost two-in-three (65.1 %) 12-17 year olds with a diagnosable mental disorder had used services for emotional and behavioural problems. Older data from the 2007 National Survey of Mental Health and Wellbeing had previously found that less than a quarter (23 %) of 16-24 year olds who were identified as having a mental health issue were accessing services.<sup>3</sup>

In the United Kingdom a number of tools have been developed to assist commissioners in understanding their population and associated health needs. High rates of utilisation of analytical tools (i.e. predictive tools and demand forecasting models) to aid commissioning have been reported.<sup>10</sup> Examples include; the *Any town* tool which uses system modelling to map how an intervention could improve health services and the current development of a dynamic modelling tool that links health, social and education areas together. These tools provide an example of the types of resources that would increase the knowledge and understanding available to inform service planning and commissioning.

Orygen, The National Centre of Excellence in Youth Mental Health is currently developing an interactive service system planning tool that simulates alternative youth mental health service systems configurations at PHN, State and National level. This planning tool incorporates demographic, epidemiological, service availability, help-seeking and workforce data with

clinical guidelines, evidence reviews and expert opinion in order to explore the potential impacts of alternative uses of youth mental health service system resources.

Detailed regional data, however, has not been widely collected and this shortfall will need to be addressed. The Mental Health Expert Reference Group advised the government that PHNs needs to be supported through:

*the provision of data and information by the Commonwealth relevant to a regional level to facilitate their role in mental health planning and commissioning and help build this capacity.<sup>11</sup>*

The collection of quantitative data on regional prevalence and levels of service need should also include qualitative data about young people's experiences finding and accessing services and receiving treatment. A combination of quantitative and qualitative data will provide PHNs with a picture of the service environment and experience they will be building upon.

## Getting to the details

Consideration of the risk factors for developing mental ill-health will further the understanding of what services young people need. The Joint Commissioning Panel for Mental Health in the United Kingdom advises commissioners to consider all possible risk factors for mental ill-health and not just those which relate to the design and delivery of services.<sup>12</sup> Risk factors include individual attributes and behaviours, social and economic circumstances and environmental factors. The integration of headspace and other youth services provides an opportunity for PHNs to commission services that mitigate these risks.

Going to young people to hear their perceptions of what they need will also be important. An emphasis on youth engagement in the headspace model mean many centres have established Youth Advisory Groups (YAGs). YAGs offer a promising resource for PHNs. These local groups help shape headspace centres through service model development, translation of research into practice, community awareness campaigns and new ideas to build capacity for young people and their families to support their own mental health.

Organisational guidelines for proposing and planning a new headspace centre will also provide a useful resource. Guidelines should help PHNs construct a framework for measuring existing service coverage and the gaps in youth mental health services. Existing data held by local headspace centres and the national office would also be useful for PHNs. Sharing this data could nurture the relationship between commissioner and provider.

### Barriers

Gaps in available data

Quantifying service need beyond existing service take-up

### Enablers

Engagement with young people

Data collation and a single tool for access

Understanding non-health related risk factors for mental ill-health

Service providers sharing data with PHNs

Development of an Australian interactive service system planning tool

### Resources

CAMHS Strategic Modelling Tool  
[www.scwcsu.nhs.uk/camhs](http://www.scwcsu.nhs.uk/camhs)

Making integration a reality  
[www.cypiapt.org/site-files/Youth%20Access%20Making\\_Integration\\_a\\_Reality\\_Part\\_1.pdf](http://www.cypiapt.org/site-files/Youth%20Access%20Making_Integration_a_Reality_Part_1.pdf)

Peter Hamlyn Foundation: Stage 1: Identifying needs  
[www.phf.org.uk/reader/commission-better-mental-health-wellbeing-services-young-people/stage-1-identifying-needs/](http://www.phf.org.uk/reader/commission-better-mental-health-wellbeing-services-young-people/stage-1-identifying-needs/)

## Engagement and relationships

Where good relationships exist commissioners and service providers will have a head start in the move to commissioning. Pre-existing relationships may, however, also be a hindrance where commitment to the intended innovation and collaboration of commissioning is missing or “business as usual” is assumed.

The commissioning role of PHNs will be supported by maintaining established relationships and initiating engagement where relationships need to be made. The Australian Government has identified ‘stakeholder relationship management and engagement’ as a core function of PHNs; going so far as to prohibit the subcontracting of the role. PHNs will need to relate directly with both service providers and the community.

## Developing trust

Successful relationships between PHNs and service providers will be dependent on a shared level of trust. Without trust, service delivery will likely be reduced to contractual obligations. The political risk of government contracts mean ‘highly detailed and prescriptive contracts have increasingly become the norm’.<sup>13</sup> International experiences have shown that ‘adversarial and legalistic approaches’ undermine the relational basis of successful commissioning.<sup>14</sup>

Commissioners will need to have the capacity to negotiate both the transaction of services and foster the relationships necessary to develop a trusting relationship with service partners. New Zealand initiated *High trust contracting* in 2009 and has more recently streamlined the process for working with trusted agencies. Of this approach the New Zealand Productivity Commission has written:

*Trust models capitalise on the intrinsic motivation of provider employees and organisations. They require careful design to ensure quality is adequately monitored through peer monitoring or regulatory oversight, as sometimes the freedom that trust gives providers can be misused to the detriment of funders and clients.*<sup>15</sup>

The New Zealand experience provides a helpful guide for how PHNs judge, facilitate and encourage trust relationships.

## Engaging young people

Successful commissioning will also require a relationship with the community and in particular young people. Engagement will be enhanced by utilising accessible forms of engagement, engaging with a variety of contact people (youth workers, school welfare officers) and supporting the involvement of young people. Guidelines for commissioning from the United Kingdom advise that the experience of young people and their feedback on services should also form part of the measurement and evaluation process.<sup>16</sup>

Engagement with young people may be best achieved through working with young people (e.g. YAGs at headspace centres) and their families. Parents of 12-14 year olds for example will likely have valuable feedback on the quality and experience of accessing services. The employment of a dedicated staff member responsible for establishing and managing engagement is another option. Positions for a youth engagement officer have already been advertised by some PHNs. How engagement with young people is structured is important, for example; formal consultation exercises can be a “turn-off” for young people.<sup>16</sup>

### Other services

PHNs are expected to develop collaborative relationships with hospitals and community based organisations to reduce service duplication. The interface between the National Disability Insurance Scheme and the PHNs has been identified as one relationship needing clarification.<sup>17</sup> Good relationships with other PHNs will also be necessary, for example where treatment requires a patient to move across PHN regions. In some cases cross border (state and territory) relationships will also need to be developed or maintained.

An investment of time is necessary to support and maintain relationships. Staff changes present another challenge in maintaining relationships between PHNs and service providers, user groups and other organisations.

#### Barriers

A history of contractual relationships

Business as usual approach

Using formal engagement structures to engage young people

Staff turnover in the health sector

#### Enablers

Developing and modelling trust relationships

Exploring new ways of engaging with young people (including employing dedicated staff; identifying existing youth bodies)

Expectation that service providers and other parts of the health sector are open to forming a new basis for working together

#### Resources

NHS Salford Clinical Commissioning Group and Salford City Council: Integrated mental health commissioning strategy 2013-2018 (Section 2.8) [www.salford.gov.uk/d/7-4251\\_IMH\\_Strategy\\_v7.pdf](http://www.salford.gov.uk/d/7-4251_IMH_Strategy_v7.pdf)

New Zealand Productivity Commission, More effective social services. [www.productivity.govt.nz/sites/default/files/social-services-final-report-main.pdf](http://www.productivity.govt.nz/sites/default/files/social-services-final-report-main.pdf)

### Focus on improved service delivery

Improved health outcomes through improved service delivery is the objective of reforms to primary mental health services. A number of factors can enable increased access to mental health services by young people. These enablers include: being accessible by public transport, having extended opening hours, a safe,

confidential and comfortable environment that nurtures confidence and reducing waiting times. The co-location of services can reduce the need to raise awareness of service availability among young people. Feedback from young people indicate that accessibility needs to be balanced with discretion to reduce the risk of stigmatisation. For example, not locating youth mental health services too close to venues frequently visited by young people.<sup>18</sup> While the design of reception and waiting rooms is important, some older young people have identified that headspace centres are too 'youthy'.<sup>5</sup>

### Integration of services

Service integration is central to the government's reforms to primary and mental health. The emphasis on integration reflects existing service fragmentation and inefficiencies in service delivery. A best practice review by headspace supports the need for integration, identifying shortfalls in the provision of alcohol and other drug services and vocational services within headspace centres.<sup>18</sup>

The focus of the government's mental health policy is to ensure patients receive the right care in the right place at the right time. The level and form of integration the government anticipates, however, is not clear. Experiences from commissioning in the United Kingdom has identified the need for integration at a number of levels: staff teams, shared budgets and organisational integration.<sup>19</sup>

The transition to commissioning and integration of youth services within PHNs should provide an impetus for headspace centres to improve service delivery. It is up to PHNs, however, to identify which services need to be commissioned and to specify how they are delivered. International experience teaches that how services are commissioned has the potential to either enable broader care or limit service flexibility. The Joint Commissioning Panel for Mental Health advises commissioners to select services that are:

*integrated, multi-agency services with care pathways that enable the delivery of effective, accessible, holistic evidence-based care.*<sup>12</sup>

### Service innovation

The Australian Government has indicated that dedicated funding will be invested in innovative models of primary health care. New initiatives focused on increased understanding and learning will contribute to the evidence-base for youth mental health services. Investing in evidence-based practice through ongoing research and translation of learning into practice will improve the quality of services being delivered and potential for improved health outcomes. In the United Kingdom, however, there have been few examples of

innovation by primary care trusts<sup>20</sup> suggesting that where PHNs initiate innovation competition for funding might be low.

#### Barriers

Services not designed to facilitate engagement with young people

Need to access multiple services in different locations and separate appointments

Restricted transport options

#### Enablers

Co-location or integration of a broad range of services, not limited to health services

Developing innovative evidence-based treatments and service delivery

#### Resources

Better Mental Health Outcomes for Children and Young People: A resource directory for commissioners [www.chimat.org.uk/resource/view.aspx?RID=104048](http://www.chimat.org.uk/resource/view.aspx?RID=104048)

Guidance for commissioners of child and adolescent mental health services [www.jcpmh.info/wp-content/uploads/jcpmh-camhs-guide.pdf](http://www.jcpmh.info/wp-content/uploads/jcpmh-camhs-guide.pdf)

## Measurement and evaluation

Measurement and evaluation of health outcomes, if the right questions are asked will reveal details of the success and shortcomings of commissioning decisions. The focus on outcomes is intended to put people's health at the centre of the commissioning process. PHNs willing to identify possible errors in commissioning decisions revealed by robust evaluation will be in the best position to improve future services.

### Outcomes focused

Health outcomes need to be the focus of measurement and evaluation of services commissioned by PHNs. Output measurements are no longer enough. Outputs reflect the old model of service contracts in which the number of services supplied was measured rather than the health outcomes of the people receiving treatment. By shifting the focus of service measurement to health outcomes, evidence for an iterative process of continual improvements and innovation will be collected. PHNs have the opportunity to improve upon the "box ticking" of the past to achieve improvements in mental health outcomes for young people.

The findings and data from service measurement and evaluation builds the knowledge and understanding from which services can be improved, innovations developed and future services commissioned. Providing feedback to the public on the findings of service evaluations continues the engagement process. Ongoing engagement will further increase understanding of service needs and expectations.

### Tools for the job

A range of audit tools are available for the measurement and evaluation of health services. Some tools have a general focus (i.e. quality or distribution of services) while others have been designed for a specific purpose. Examples of more generalised audit tools from the United Kingdom include the *Healthy Care Audit Tool* for assessing the quality of services being provided and what can be done to achieve improvements; and the *Health Equity Audit Tool and Guidance* that measures the distribution of services and resources in relation to the health needs of different population groups. Specific audit tools are available to measure service capacity (i.e. *Dual Diagnosis Capability in Mental Health Treatment*) and provide quality improvement measures. In Australia a youth health clinical tool, *One21seventy* has been developed to assess the delivery of services for Aboriginal and Torres Strait Islander young people.

#### Barriers

Measurements are output focused

Data is not focused on patient outcome

#### Enablers

Develop and implement outcome-focused measurements

Use new audit tools for measurement and evaluation

Feed findings into the knowledge and understanding - commissioning cycle

#### Resources

Implementation of routine outcome measurement in child and adolescent mental health services in the United Kingdom: a critical perspective [www.ncbi.nlm.nih.gov/pmc/articles/PMC3973864/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3973864/)

NHS Salford Clinical Commissioning Group and Salford City Council: Integrated mental health commissioning strategy 2013-2018 (Section 5) [www.salford.gov.uk/d/7-4251\\_IMH\\_Strategy\\_v7.pdf](http://www.salford.gov.uk/d/7-4251_IMH_Strategy_v7.pdf)

Peter Hamlyn Foundation: How will you know it is working? [www.phf.org.uk/reader/commission-better-mental-health-wellbeing-services-young-people/will-know-working/](http://www.phf.org.uk/reader/commission-better-mental-health-wellbeing-services-young-people/will-know-working/)

## Delivering improved mental health outcomes for young people through commissioning

PHNs face the challenge of realising the Australian Government's primary and mental health reforms. This challenge demands new knowledge and understanding of population health needs and a reframing of relationships with both service providers and the community. Guidelines developed in the United Kingdom provide PHNs with the advantage of lessons learned from past experiences commissioning youth mental health services. headspace provides a foundation for the integration of mental health services for young people and other youth services with pre-existing or planned headspace centres in each PHN.

The co-location model applied by headspace should facilitate integration with other services. There are also opportunities to improve the integration of services provided through headspace. The four elements of an iterative commissioning cycle of knowledge, service improvement, engagement and evaluation provide a guide for PHNs as they implement government policy and deliver services that improve the mental health of young people.

### References

- Gore, F.M., et al., *Global burden of disease in young people aged 10-24 years: a systematic analysis*. Lancet, 2011. 377(9783): p. 2093-102.
- Kessler, R.C., et al., *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication*. Archives of General Psychiatry, 2005. 62(6): p. 593-602.
- Australian Institute of Health and Welfare, *Young Australians: their health and wellbeing 2011*. 2011, AIHW: Canberra.
- National Mental Health Commission, *The National Review of Mental Health Programmes and Services: Volume 1*. 2014: Sydney.
- Patulny, R., et al., *Are we reaching them yet? Service access patterns among attendees at the headspace youth mental health initiative*. Child and Adolescent Mental Health, 2013. 18(2): p. 95-102.
- Peskett, S., *The challenges of commissioning healthcare: a discussino paper*. International Journal of Health Planning and Management, 2009. 24(2): p. 95-112.
- Australian Healthcare and Hospitals Association, *Mental Health: AHHA Primary Health Network Discussion Paper Series: Paper Two*. 2015, Australian Healthcare and Hospitals Association: Canberra.
- Dickinson, H., *Commissioning public services evidence review: Lessons for Australian public services*. 2015, University of Melbourne: Melbourne.
- Lawrence, D., et al., *The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*. 2015, Department of Health, Canberra.
- Bate, A., et al., *Implementation of the World Class Commissioning Competencies: A survey and case-study evaluation*. 2011, Health Reform Evaluation Programme, Department of Health: United Kingdom.
- Mental Health Expert Reference Group, *Summary of Advice for Government on Mental Health Reform*. 2015, Department of Health: Online.
- Joint Commissioning Panel for Mental Health, *Guidance for commissioners of child and adolescent mental health services*. 2013, Joint Commissioning Panel for Mental Health: United Kingdom.
- Schwartzkoff, J. and G.L. Sturgess, *Commissioning and Contracting for Better Mental Health Outcomes*. 2015: Canberra.
- Ham, C., *Health Care Commissioning in the International Context: Lessons from Experience and Evidence*. 2008, Health Services Management Centre, University of Birmingham.
- New Zealand Productivity Commission, *More effective social services*. 2015: Wellington.
- Woodhouse, A., *How to... commission better mental health and wellbeing services for young people*. 2014, Paul Hamlyn Foundation and Mental Health Foundation: United Kingdom.
- NDIA Mental Health Sector Reference Group, *Mental Health Sector Reference Group Sector Communiqué - December 2015*. 2016: Online.
- Rickwood, D., et al., *Service Innovation Project Component 1: Best Practice Framework*. 2014, headspace National Youth Mental Health Foundation: Melbourne.
- Naylor, C., et al., *Transforming our health care system: Ten priorities for commissioners*. 2015.
- Storey, J., et al., *Clinical leadership through commissioning: Does it work in practice?* Health Services Management Research, 2015. 28(1-2), p. 1-8.

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