neami national Improving Mental Health and Wellbeing

The ALIVE National Centre for Mental Health Research Translation

Implementation Co-Evaluation Learnings: Geelong Site Report.

8 Station Street, Norlane, VIC

Opening:

Mon – Fri: 12 pm – 9 pm

Weekends/ public hols: 1 pm – 6 pm

To contact the research team please email: alive-hub@unimelb.edu.au

Greater Geelong Demographics

2021 ABS Census Data shows:

Total population	271, 057
Female	41.4%
Median age (years)	39
Aboriginal and/or Torres Strait Islander people	1.3%
Australian Born	77.6%
Percentage with a long-term mental health condition (including anxiety and depression)	11.1%

What did the co-evaluation do?

We sought to map journeys and strengthen implementation by understanding:

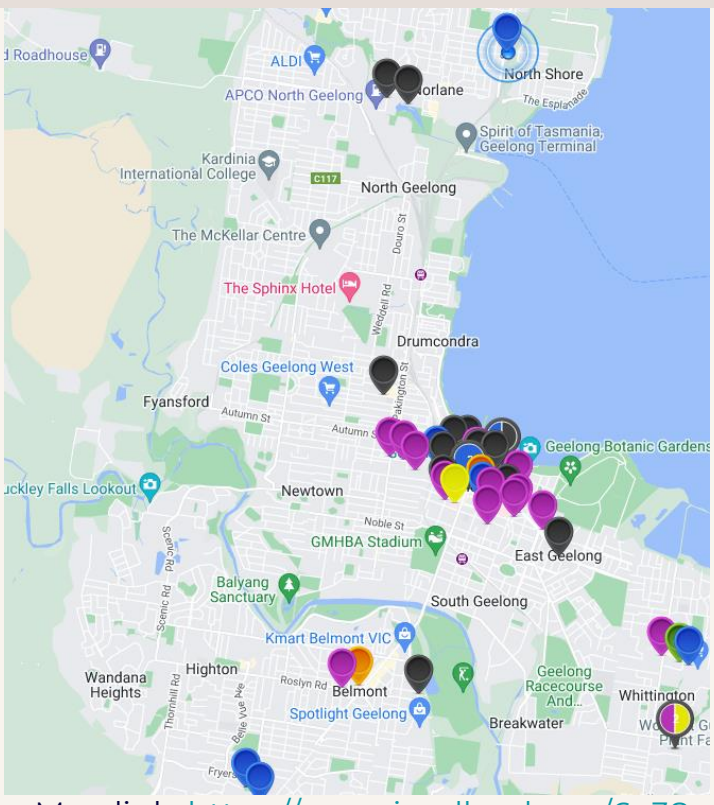
- Who attended the services and the experiences of care?
- Who delivered care and how has the practice approach evolved?
- Which implementation strategies and factors to strengthen?

Data was collected between 26/10/2023 and 28/03/2024.

Local mental health eco-system

An ecomap of the Geelong mental health local community and its service, support and social systems is developing.

Ecomaps are used to form a picture about the availability of direct mental health and wider services within the local context. The map can be accessed at the link below.



Map link: https://go.unimelb.edu.au/6o38

Who was involved

Anonymised, monthly group level service activity summaries provided between 30/10/2023 – 31/01/2024.

23 guests returned a survey about their care experiences

13 staff returned a survey about their work experiences

38 staff in month 1 and 17 staff in month 3 working at/or with the service completed a survey about the implementation of the model of care.

10 guests had a conversation about their care experiences.

12 staff had a conversation about their working experiences and perspectives

Read more about this project at the ALIVE National Centre Website: https://go.unimelb.edu.au/69w8

This co-partnership commenced after the first year of services operating in 2022 with data collection in 2023-2024 when sites were named Head to Health. In May 2024 the Federal Government renamed them Medicare Mental Health Centres.

Who Attended

Unique guests

Month 1	Month 2	Month 3
145	**162**	**158**

Average Age	Australian Born	Self Referred
41 years	**77%**	**78%**

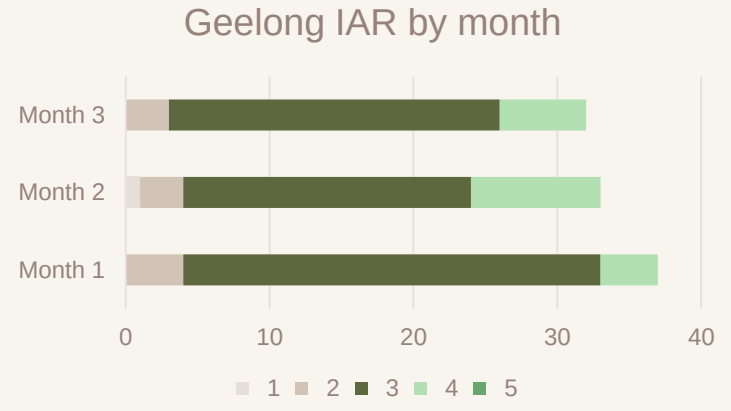
Average length of closed episodes

129 Days

Discharge to GP	Monthly: guests with suicidal risk
36%	**16%**

What was the level of need

- Most guests were classified IAR 3 indicating moderate intensity services were recommended
- Mean monthly K-10 scores were 33 indicating higher levels of distress
- 11% of guests were experiencing homelessness
- 20% of guests were accessing mental health support for the first time
- 30% of guests discharged to another PHN funded service



"Having a free and accessible service is huge. It's a massive help."
(Geelong Guest)

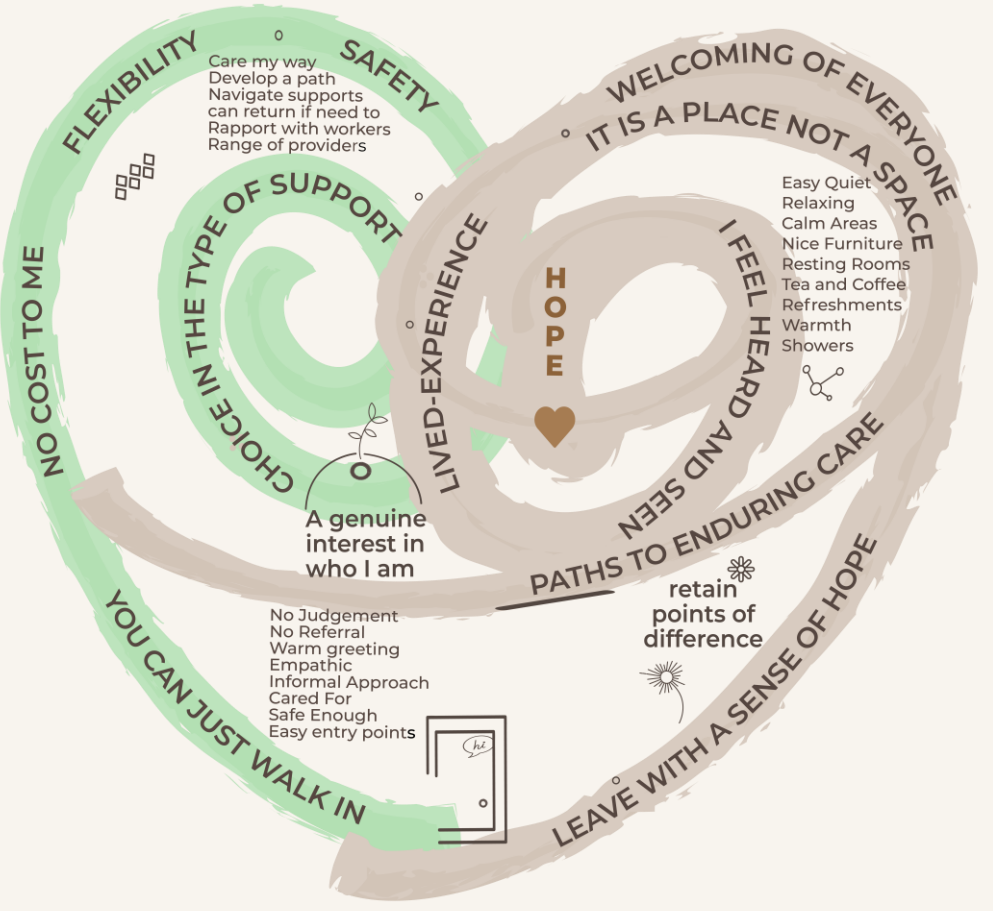
Experiential model of care based on guest surveys and conversations

The Heart of the Model of Care this image reflects an experiential model of care for Medicare Mental Health Centres and the Urgent Mental Health Care Centre (SA).

The Heart of the Model of Care draws together the perspectives of guests across all first wave Centres from 192 survey responses and 54 longer conversations.

Surveys and conversations established that services were providing a sense of hope that built on readily accessible, walk-in and fee free care that was delivered in a person-centred, flexible, respectful and non-judgemental way.

The care environments were providing relational care that guests valued and felt was dependent on integrated peer perspectives and clinical care.



How guests experienced care at Geelong

Themes from guest conversations

There was **flexibility in hours and ability to engage**, with the team, and future availability if needed.

"They also were there to support me to help me through it but it was really easy, which I really liked it simple and not as stressful....."

The service **compared favorably to prior experiences** of support and access.

"....there's nowhere else I've got to go. Yeah. And I think I've explained that to higher up when I had to actually exit. And then I've reconnected a few months later. Because I am serious. When I say that, that has helped save my life...."

The **human interactions** and experiences at the service helped create a **supportive, accepting and understanding environment**.

"... That was probably the biggest thing. They actually just listened. But it wasn't so clinical style, it was very much talking to me like I was a person..."

The **inclusive nature** of the service helped guests to **feel safe** and to **express their identities** without fear of judgment

"... Being LGBTQIA+ doesn't feel *like a big deal at the service ..."*

The **integration of peer and clinical supports** enhanced their **acceptance, understanding and connection**

"...having that Peer worker, and having someone who understood and related to me, really helped me see some ways through it all"

Key guest survey outcomes

All guests who responded were satisfied with:

- The welcome received and care provided
- Waiting times
- Staff and being supported by a team of clinicians and peer workers
- Inclusion in decision making about their health
- Future help or onward connections

All guests felt:

- Heard
- Cared for
- Safe
- Understood
- Care focused on things that mattered to them
- They had a chance to make sense of what was going on for them

Over 90% of guests felt:

- More hopeful of a way moving forward
- Supported to access wider supports and resources

Guests felt improvements could include:

- More parking and clearer signage out the front
- Greater information and linkages with other services
- Open from 9am – longer hours
- Another Head to Health service in Geelong CBD

"Usually when I try to get help mentally it takes up to 6 months to even get to the stages I got to in less than 2 days with Head to Health. I'm blown away by the support and extremely thankful" (Geelong Guest)

Developing understanding of the implementation

An implementation theory called Normalisation Process Theory (NPT) helped understand how the model of care was being implemented and integrated into standard practice across four key areas (see https://normalization-process-theory.northumbria.ac.uk/ for more information):

- **Coherence** - How people make sense of the model of care;
- **Cognitive Participation** - How people and teams build and normalise the model of care;
- **Collective Action** - How people work and interact within the model of care and use skills and resources to integrate the model of care; and
- **Reflexive Monitoring** - How people assess and understand how the model of care affects the people interacting with the model of care

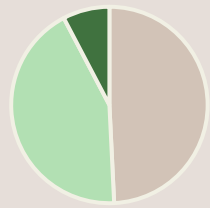
How staff were heard

There were three key pathways for staff to contribute to the project.

- 17 Geelong staff **returned a survey** about working at the Medicare Mental Health Centre, their roles, training and support, work with guests and broader service factors.
- 7 Geelong staff **had a conversation** with the project team about their experiences, service implementation and how the service was progressing.
- 42 staff working at/with the Geelong Service **completed a survey** at two stages to help understand the implementation of the model of care based on NPT called **NoMAD**.

"The service model is great. Sometime people feel like they are not sure what they should be doing. They feel things changes a lot but not getting the support they need. Everyone is doing their best to support each other." (Geelong Staff)

Overview of Staff Mix



Key Staff Outcomes

Staff identified that clinical and peer worker integration was challenged by ambiguity and a lack of clarity of scopes of practice. This led to clinicians and peers feeling devalued within the service and unclear what their contributions should be.

"So you don't even have agreement between peers what their role looks like. And I feel that clinicians are just picking up whatever they decide not to do at times."

The service development and implementation focused on creating an operational service and the support structures organisationally were not mature to support staff which increased staff burden and load.

"from the outset, lack of policy, lack of framework, lack of role definition. And so much changing backward and forward, and just not having direction from management from the top down..."

Staff valued the approach and intent of the service, but felt that unclear service aims, scopes of practice and articulation of the model of care, support and training, and workflow were challenging workplace culture and were exerting a toll on staff, with high absenteeism and turnover.

".. I think we've been coping with too little for too long. I think we set a precedent. And I think now it's like, oh, well, you're fine. But at what cost?"

"Peers require greater clarity around scope of practice. While our team gets along great, the lack of clarity around roles can create disharmony." (Geelong Staff)

Implementation Opportunities

Outcomes from the implementation survey (NoMAD), staff feedback and guest experiential model of care have identified implementation learnings for the Geelong Centre. Some learnings are common across Centres, and others are more specific to Geelong. These are outlined here along with suggested implementation strategies to address the learnings.

"..the inconsistency among staff really determines someone's experience of our service. They're allocated to someone, and then what happens after that is very dependent on the staff member that they are working with..." (Geelong Staff)

UNDERSTANDING (Coherence Construct): The model of care felt different to staff at Geelong who could see its value and potential. There was variable understanding amongst staff of what the purpose of the model of care was and how peers and clinicians work together within the model.

"... at the highest levels of NEAMI, there is not enough attention paid to the peer lived experience scope of practice..."

ENGAGEMENT (Cognitive Participation Construct): Staff had variable views on whether key people were driving the implementation of the model of care. Staff were open to working in new ways and supporting the model. Staff valued their roles and how they worked together, but this lacked clarity.

"the learning from colleagues, different ways of looking at things, whether you know, that the clinical assessments that I haven't had as much experience at the you know, the service navigation, getting an understanding of the networks, you know, because it is collaborative."

ENACTMENT (Collective Action Construct): Most staff felt they could easily integrate the model of care into existing work. Some staff felt the model disrupted working relationships. Staff were largely unclear or lacked confidence in others' ability to use the model of care, and felt work was not allocated to those with appropriate skills. Most staff felt that training and resourcing was not sufficient. We heard casual workers were not meaningfully included in planning or support.

"we do often use a lot of casual workers. And it's a real shame that they don't get the same level of support as the non-casual or permanent staff, I think that's a big gap"

REFLECTING (Reflexive Monitoring Construct): There was varying awareness of the effects of the model of care, but most staff agreed it was worthwhile and that feedback could improve the model. Staff felt they could adjust how they worked within the model.

"...the person can be seen straight away, or they walk in or if they're referred, they usually picked up within 24 hours or several days. So it's very quick from that point of view. So that side of it is good"

Implementation Strategies

STRATEGY 1: Develop clear scopes of practices to define role responsibilities and boundaries. Systematise training in the model of care and re-visit this regularly. Promote the value of the model of care from guest and supporter perspectives.

STRATEGY 2: Create a culture of staff retention through facilitated training and supervision, whole of team co-learning, and safety in having challenging conversations within teams. Focus on staff ways of working to develop team safety and cohesion.

STRATEGY 3: Build community awareness of the service models and points of difference, and place in the service system for the general public and other health and mental health services.

STRATEGY 4: Build on the experiential model of care to inform service development and to ensure staff are aware of the impacts of the model of care on guests and the mental health system. Foster integration within communities and paths into enduring care for people.

For more information about the implementation co-evaluation

A series of Implementation Co-Evaluation Snapshots have been developed that draw on key findings across the project. These can be accessed clicking the images or via the QR codes below.

Project overview and outputs and updates

https://alivenetwork.com.au/our-projects/head-to-health-implementation-co-evaluation/

About the project

Who accessed support

Who delivers care

The Guest Experience

Implementation challenges

Next Steps: The Co-Partnership Continues

The ALIVE National Centre has commenced ***Whose Care? … Our Care!*** Funded by the Medical Research Future Fund until 2029 as part of a Million Minds Initiative Targeted Research Call to co-create collective strategies with priority populations to address structural inequalities.

Neami National Medicare Mental Health Centres and Locals are invited to continue in this project to:

- identify structural inequalities locally that are impacting on mental health and wellbeing;
- review service models for cultural responsiveness, communication accessibility and peer integration;
- Form action groups around services to develop collective strategies to address structural inequalities.

For more information about the ALIVE National Centre

www.alivenetwork.com.au

The ALIVE National Centre

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