neami national Improving Mental Health and Wellbeing

The ALIVE National Centre for Mental Health Research Translation

Implementation Co-Evaluation Learnings: UMHCC Site Report.

215 Grenfell Street, Adelaide, SA

Opening:

24 hours per day, 7 days per week

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

Greater Adelaide Demographics

2021 ABS Census Data shows:

Total population	1, 387, 290
Female	51.0%
Median age (years)	31
Aboriginal and/or Torres Strait Islander people	1.7%
Australian Born	68.7%
Long-term mental health condition (including anxiety and depression)	9.8%

What did the co-evaluation do?

We sought to map journeys and strengthen implementation by understanding:

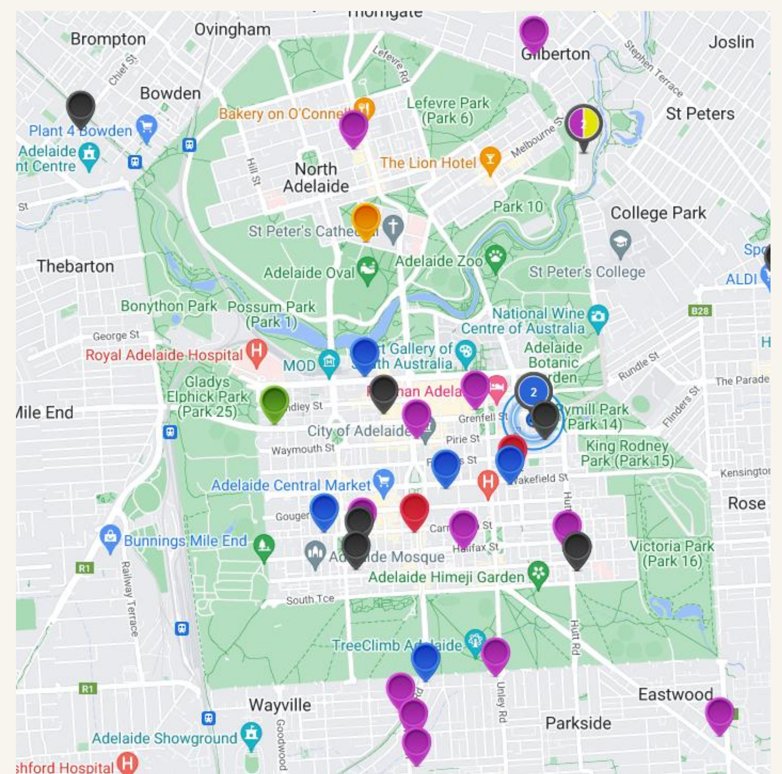
- Who attended the services and the experiences of care?
- Who delivered care and how has the practice approach evolved?
- Which implementation strategies and factors to strengthen?

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

Local mental health eco-system

An ecomap of the Adelaide 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/no38

Who was involved

Anonymised, monthly group level service activity summaries provided between 27/11/2023 – 27/03/2024.

53 guests returned a survey about their care experiences

45 staff returned a survey about their work experiences

30 staff in month 1 and 20 staff in month 3 working at/or with the service completed a survey about the implementation of the model of care.

14 guests had a conversation about their care experiences.

8 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
595	**567**	**554**

Average Age	Australian Born	Self Referred
33 years	**97%**	**83%**

Average length of stay

3.9 hours

Otherwise attend emergency Department (Monthly)

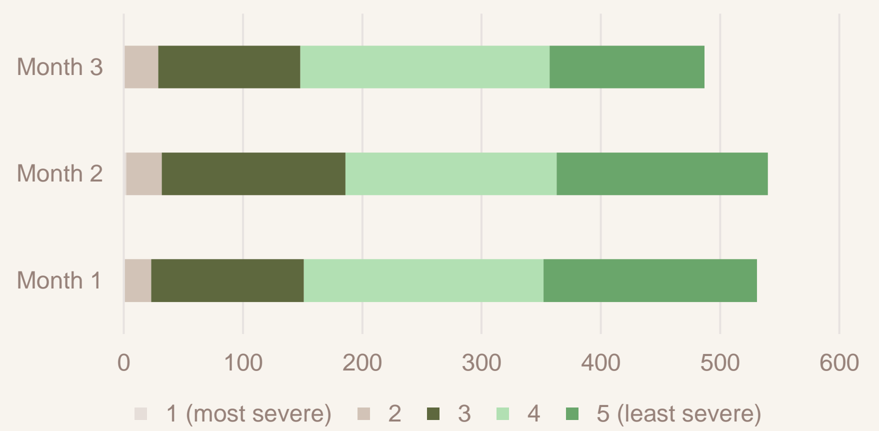
41.7%

Monthly: guests presenting with suicide distress

18%

What was the level of need

- 38% of guests were triage level 4 indicating they were semi urgent, and to be seen within 60mins
- 58.6% of guests had accessed the service before
- 44% of guests each month would not have sought support elsewhere
- 10.9% of guests each month were onward referred to a voluntary mental health hospital admission



"It is just a very pleasant and welcoming place to go and it's very non-judgmental, very calm and supportive environment" (UMHCC Guest)

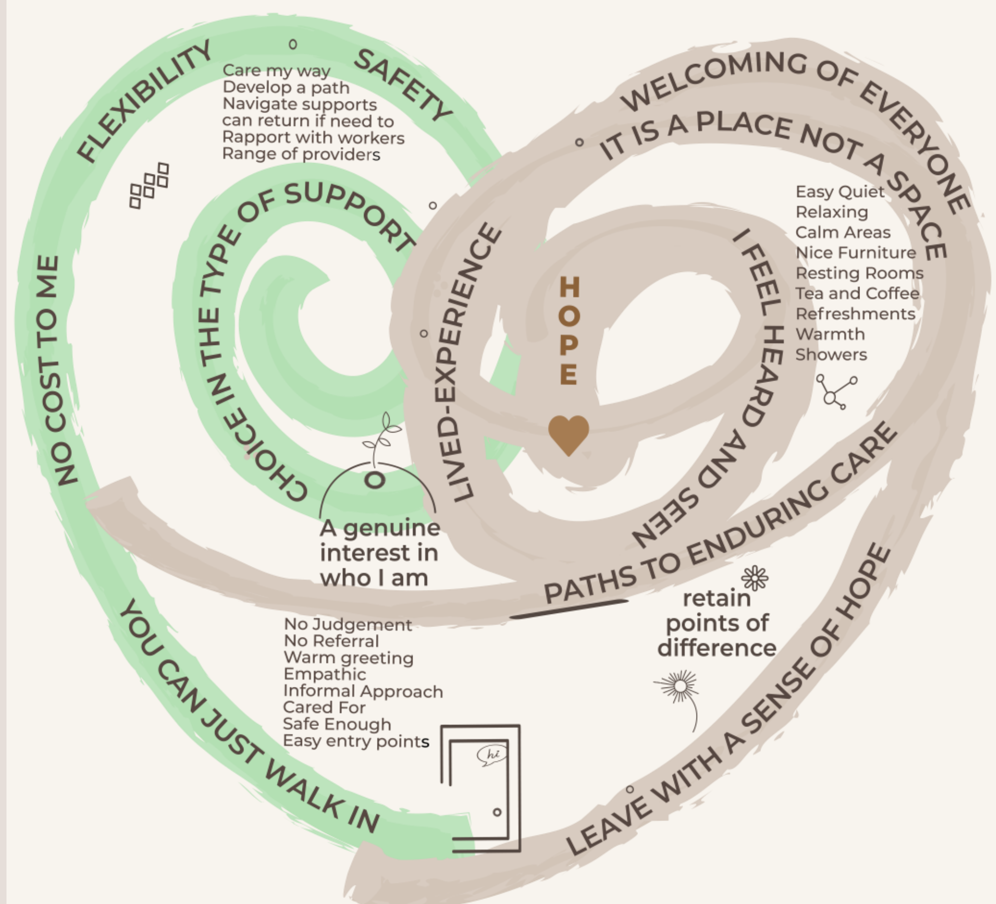
Experiential model of care based on guest surveys and conversations

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 UMHCC

Themes from guest conversations

Guests appreciated that the service offered **readily accessible care** without an appointment in a **safe and calm space**.

"it's definitely a lot more cosy than if you were to go into a mental health at like a hospital or whatever"

The care felt more **focused on the person** and connection and guests felt **accepted and heard without judgement**.

"One of the things that's really come across is that sort of it's the listening and the empathy.... asking not just about what's wrong, but also about like my life in general, and showing an interest in me as a person rather than as you know, a collection of mental health symptoms"

Many of the guests have accessed the service across multiple presentations and have **built relationships with the service and its staff.**

"I've been able to build connections there. And it's like, having people that understand and that I can trust. And it's a safe place"

The care **did not feel formulaic**. The approach to care felt **genuine** and was **not time pressured** like other services.

"they were happy for you to stay as long as you might need to..."

One guest noted the inclusion of "Urgent" in the name may make it feel the service was not applicable to some seeking support

"Because some people might be deterred by the fact that is 'urgent', maybe they might think, you know, only if it's a life or death situation I shouldn't go there"

Peer staff supported the **relational approach** and provided more ready **building of rapport**.

"And a bit of one-on-one advice. And many of them have had their own experiences with mental health. So, it's always good to see someone who has overcome that or is working on that"

Guests felt Improvements could include

- Free parking close to the service
- Less paperwork on arrival
- Changing the locked entrance door.
- More clinicians available to ease waiting times
- Pronoun badges needed
- Providing multi-lingual specialists.
- Choice of staff to speak with.

Key guest survey outcomes

All guests were satisfied with ease of access.

Over 95% of guests:
- Were satisfied with staff they interacted with
- Felt cared for

Over 90% of guests were satisfied with:
- The welcome received
- Being supported by a team made up of clinicians and people with lived experience
- Physical environment
- Care provided

Over 90% of guests felt:
- Heard
- Care focused on things that mattered to them
- They had a chance to make sense of what was going on

Over 85% of Guests felt:
- Understood

Over 80% of Guests were satisfied with:
- Future help or connection with other supports
- How they were included in decision making about their health

Over 80% of Guests felt :
- more hopeful of a way moving forward
- supported to access wider supports and resources

Over 75% of guests were satisfied with waiting times

".. the main thing that I think works well, for me, particularly, is like just having peer support like and just being able to get that talk therapy and like having that, like that kind of, like, brain to bounce off of ideas" (UMHCC 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.

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

"I think in in starting up the centre, there was a lot of focus on how to best support guests, people in crisis, very little about staff and how to support staff." (UMHCC Staff)

Key Staff Outcomes

The service provided an accessible timely support for crisis that had lower barriers compared with other mental health supports. The fusion model allows multiple voices to contribute:

"they (guests) are getting a lot more support than what they may have got elsewhere, having more voices to assist in in their journey"

The fusion model was recognised as valuable, but there were different interpretations of what this looked like, and experiences varied amongst teams. Consistency was challenged by staff turn-over and staff shortages on shifts, particularly as service demand increased.

"the challenge is still working with those increasing numbers with the same amount of resources and staff"

We heard there were challenges in balancing risk and safety for staff and guests, with different perspectives of safety. Intake and waiting times were seen as a challenge and navigating multiple data systems to report to different entities a challenge.

"So they fill out their forms. A long form. Yes. A lot of, a lot of oversight"

Opportunities for ongoing training, co-learning and formalised support structures needed to be strengthened and managed across the 24-hour roster and inclusive of casual staff.

"....more that time to engage and learn together that's, something we've certainly struggled with as a 24/7 roster"

"...if we don't have capacity for ourselves, we don't have capacity for other people. And I think that's where we fall down a little bit" (UMHCC Staff)

Implementation Opportunities

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

"And essentially, was sort of blown away by the place if you like the, the ethos, the sort of the non diagnostic approach, the non-judgmental approach and the shared responsibility across the workforce" (UMHCC Staff)

UNDERSTANDING (Coherence Construct): All staff recognised that the model of care differed from usual ways of working and valued what the model offered. There were differing perspectives on whether staff understood the model. Most staff felt clear on their roles and the roles of others in the team, but processes were evolving and there were differing views of what the model was and offered.

" I feel like the role description we were provided it does a fairly good job at encapsulating that but at the same time, I think in practice, sometimes the lines can occasionally feel a little bit blurry"

ENGAGEMENT (Cognitive Participation Construct): Key people were seen to be driving the model implementation and staff were willing to work in new ways and support the model of care. There were differing views about how the model was perceived and operationalised and challenges in bringing the clinical and lived experience perspectives together.

"I think everybody has their own philosophy of care about how the centre should operate"

ENACTMENT (Collective Action Construct): A need to better resource the model of care and support staff was a key outcome with improvements needed from onboarding through to ongoing capacity development. Staff integrated the model of care into their roles and most felt that working relationships were not disrupted.

"...something we've certainly struggled with as a 24/7 roster to give people that opportunity to go and learn and not focus on the day-to-day work that we do"

REFLECTING (Reflexive Monitoring Construct): Almost all staff felt their work made a valuable contribution to guests and that their role was valued by the team. All staff indicated that feedback could be used to improve the model and almost all respondents indicated they could modify how they worked within the model of care

"A key focus where we're trying to establish is that each person brings their own area of expertise. And that we have to learn so much from people who have been on the receiving end of a very prescriptive medical model"

Implementation Strategies

STRATEGY 1: Develop clear scopes of practices to define role responsibilities and boundaries and strengthen collaboration. 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 that is addresses casual staff and challenges of the 24/7 roster.

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

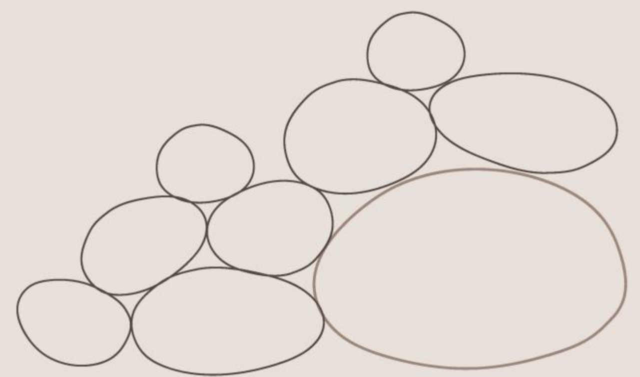
Implementation challenges

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

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