neami national Improving Mental Health and Wellbeing

The ALIVE National Centre for Mental Health Research Translation

Implementation Co-Evaluation Learnings: Penrith Site Report.

11 Henry Street, Penrith, NSW

Opening:

Mon, Wed– Fri: 1 pm – 9:30 pm

Tues: 1pm-5pm

Weekends/ public hols: 1pm – 9:30pm

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

Penrith City Demographics

2021 ABS Census Data shows:

Total population	217,664
Female	50.6%
Median age (years)	35
Aboriginal and/or Torres Strait Islander people	5.0%
Australian Born	71.3%
Percentage with a long-term mental health condition (including anxiety and depression)	8.9%

What did the co-evaluation do?

We sought to map journeys and strengthen implementation by understanding:

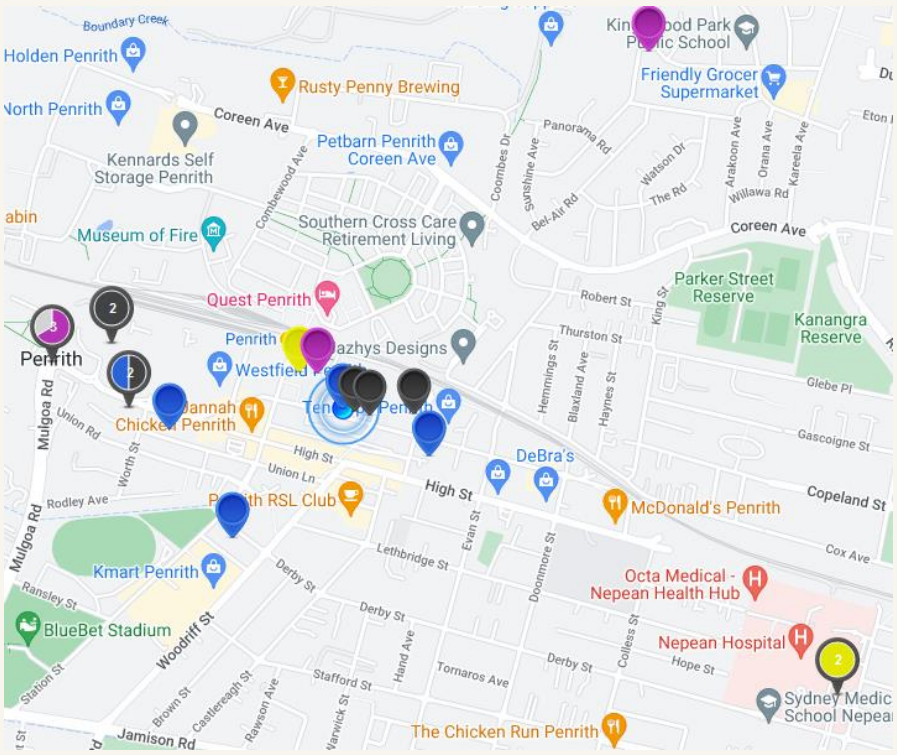
- Who attended the services and the experiences of care?
- Who delivered care and how has the practice approach evolved?
- Which implementation strategies and factors to strengthen?

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

Local mental health eco-system

An ecomap of the Penrith 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/3qk8

Who was involved

Anonymised, monthly group level service activity summaries provided between 04/12/2023 – 04/03/2024.

56 guests returned a survey about their care experiences

17 staff returned a survey about their work experiences

27 staff in month 1 and 15 staff in month 3 working at/or with the service completed a survey about the implementation of the model of care.

12 guests had a conversation about their care experiences.

7 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
190	**204**	**239**

Average Age	Australian Born	Self Referred
38 years	**97%**	**81%**

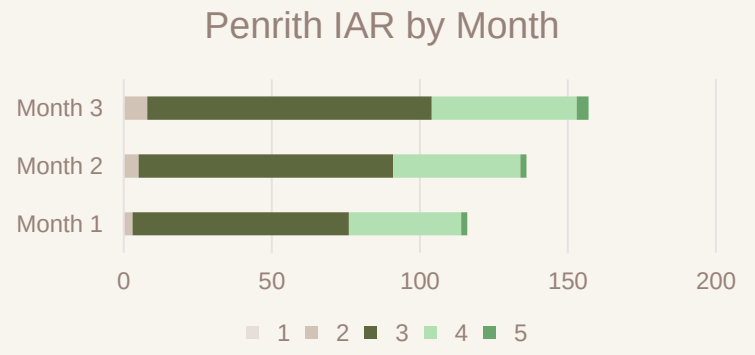
Average length of closed episodes

147 Days

First Nations Guests	Monthly: guests presenting with suicide distress
15%	**16%**

What was the level of need

- Initial Assessment and Referral decision support tool outcomes indicated most guests had score 3-4 (moderate to high intensity services).
- Mean monthly K-10 scores were 35 (higher levels of distress).
- Routine data indicated 16% reported suicidal distress.
- 15% of guests had accessed the service before (considered returning guests).
- 36% of guests were accessing mental health support for the first time.



"...And they made you feel like safe, comfortable. Like you could really talk to them. And I've never really had that first impression with a lot of places.."
(Penrith Guest)

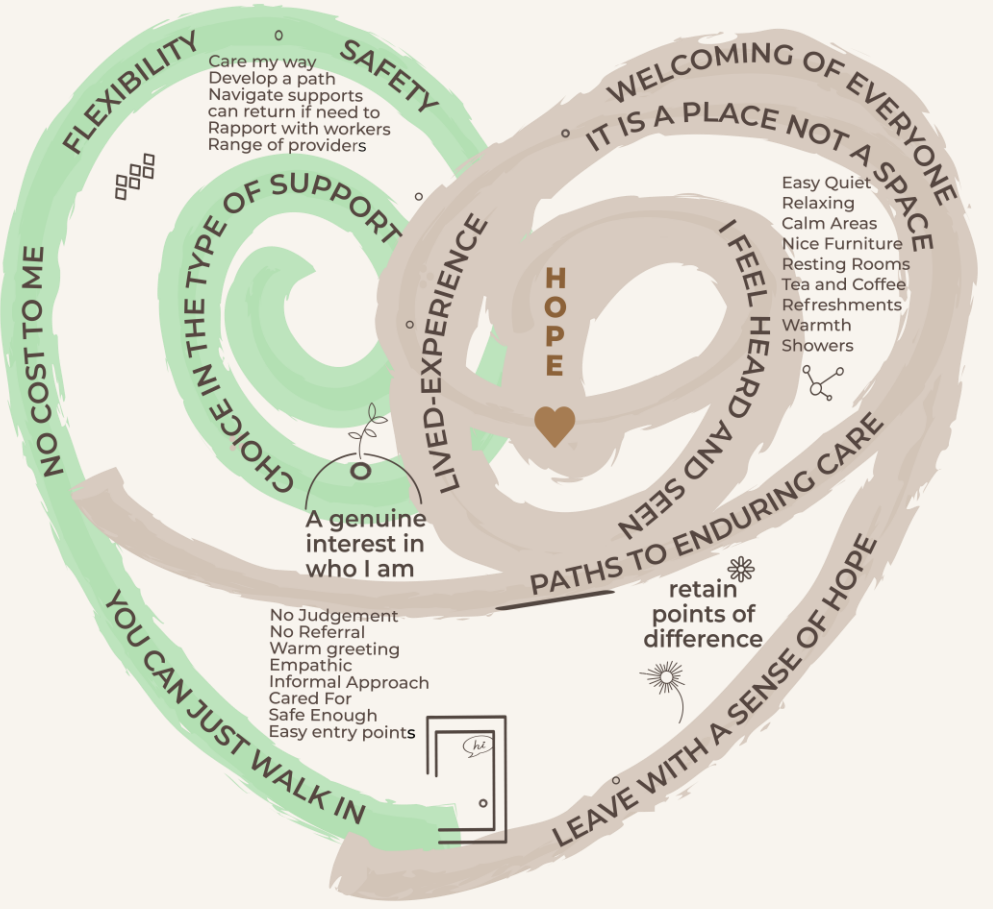
Experiential model of care based on guest surveys and conversations

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 Penrith

Themes from guest conversations

Guests appreciated that the service was **cost-free** and offered **safe, calming and welcoming** spaces over **flexible** hours.

"It's more casual. It's not as formal and cold. Right. It feels like genuinely feels like everyone really cares"

Guests felt **connected and cared for as people** and that care was **inclusive and non-judgmental**.

"... they don't have any stigma. They don't care if you have a mental health condition or not.."

Guests recognised the services were offering **a new approach** that was **holistic** and **integrated lived experience** perspectives.

“it was good to have someone that actually been through mental health themselves not someone that doesn't really have that understanding.."

Guests wanted more clarity on the **pathways in, out and through the service.**

“You know, like, say, Hey, this is our first step. We're going to do this. We're going to see a clinical nurse, we're going to book in with a psychologist you want to go .... what is your what is your pathway and how are we going to get there"

Guests appreciated the **responsiveness** and **flexibility** to respond to need and crisis.

"Look on the night. That I just rocked up. And they let me in even though there were supposed to be closed. They let me in anyway because it was quarter to ten. They shut it at 930 but there was still people here"

Key guest survey outcomes

All guests were satisfied with:

- The ease of access;
- The physical environment.

Over 95% of guests were satisfied with:

- Wait times;
- Staff they interacted with;
- Being supported by a team of clinicians and peers;
- Care provided;
- Future help or connection with other supports;
- How they were included in decision making about their care.

Over 95% of guests felt:

- Heard;
- Cared for;
- Safe Enough;
- Understood;
- Able to make sense of what was going on;
- Supported to access wider supports and resources.

Over 90% of guests felt:

- Hopeful of a way moving forward.

Guests felt improvements could include:

- More support to access other services in an ongoing way;
- More awareness of external Aboriginal supports and community connection;
- Enhance sensory elements in the waiting rooms (e.g. calming music/ aromatherapy);
- More ‘Chill Out’ spaces when not in an appointment.

"... and you could lay there for an hour or whatever. They used to just make me a cup of coffee and put a blanket on. Just so I could clear my head" (Penrith 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

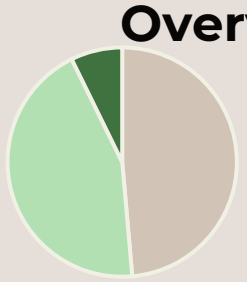
How staff were heard

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

- 17 Penrith 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 Penrith 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 Penrith Service **completed a survey** at two stages to help understand the implementation of the model of care based on NPT called **NoMAD**.

"I think it is filling a gap in the system, people who wouldn't otherwise know where to go, now they can come to us" (Penrith Staff)

Overview of Staff Mix



Key Staff Outcomes

Most staff believed the service was bridging gaps in the system and made a valuable contribution meeting the needs of guests in relational ways. The team worked effectively to meet these needs but there was need to improve team culture.

"connecting with, like, guests has felt really profound and meaningful.... I see clinicians engaging with people and having really important and beautiful connections as well"

Staff were unclear about their roles, or those of other staff, and scopes of practice. Model of care implementation could be improved. Greater integration of peer and clinical perspectives is needed with more work building on existing cross-disciplinary learning.

"when people understand each other and what they can deliver, that makes it a lot easier"

A clear need was identified for improved orientation, training, support and developmental pathways for staff, and improved service leadership within the service and through Neami.

"we can do really great work in mental health, but all of our mental health has suffered because we haven't been well supported."

Administrative burdens were high, and staff turnover was a challenge.

"I've got an hour and a half of inputting all the data from an intake, which can be quite exhausting"

"I've never really been told what my lane is. And my lane kind of twists and turns and follows all these roundabouts." (Penrith Staff)

Implementation Opportunities

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

"We still had good relationships, and we still were able to learn from each other and have really productive conversations" (Penrith Staff)

UNDERSTANDING (Coherence Construct) Peer and clinical staff had unclear scopes of practice and variable levels of understanding, and training in mental health care and the model of care. Staff identified the service provided greater connection with guests, but there were variable views in whether the model differed from usual ways of working.

"....often I've had difficulties and tensions with people that have different approaches"

ENGAGEMENT (Cognitive Participation Construct) Staff were open to working in new ways, but there was disagreement about who was driving the model forward. Some staff felt the new ways of working disrupted work relationships. Staff turnover was high which challenged providing consistent care delivery and the development of the service culture. Some evolutions were challenging for scope of practices.

"The PHN recently want us to see children, people under 18, and when I signed on to my role, I wasn't expecting to work with people under 18."

ENACTMENT (Collective Action Construct) Staff integrated the model of care into their roles, but there was not confidence that the model was understood well, or resourced and supported appropriately. Staff felt a need for better orientation, training and support. There was a lack of clarity within the community and sector around what the services are seeking to do, and how they are delivering care.

"..I work with people who are in quite acute distress and sharing quite high risk situations, which can be a bit difficult in terms of navigating my lived experience and responses to that that also"

REFLECTING (Reflexive Monitoring Construct) Services were seen to be bridging gaps in the system and creating new understandings between staff and guests. Staff had different levels of awareness of what the impacts of the model were and the value and all were willing to use feedback to support the model of care.

"It's really eye opening. And them sharing that with the guest, even as a clinician was, what the actual on the ground experience was look like. Yeah, it's really beneficial. Breaking the stigma"

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

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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