neami national Improving Mental Health and Wellbeing

The ALIVE National Centre for Mental Health Research Translation

Implementation Co-Evaluation Learnings: Townsville Site Report.

32 Walker Street, Townsville, QLD.

Opening:

Mon – Fri: 10 am – 8:30 pm

Weekends/ public hols: 12 pm – 8:30 pm

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

Townsville Demographics

2021 ABS Census Data shows:

Total population	179,011
Female	49.7%
Median age (years)	36
Aboriginal and/or Torres Strait Islander people	8.8%
Australian Born	78.8%
Percentage with a long-term mental health condition (including anxiety and depression)	10.4%

What did the co-evaluation do?

We sought to map journeys and strengthen implementation by understanding:

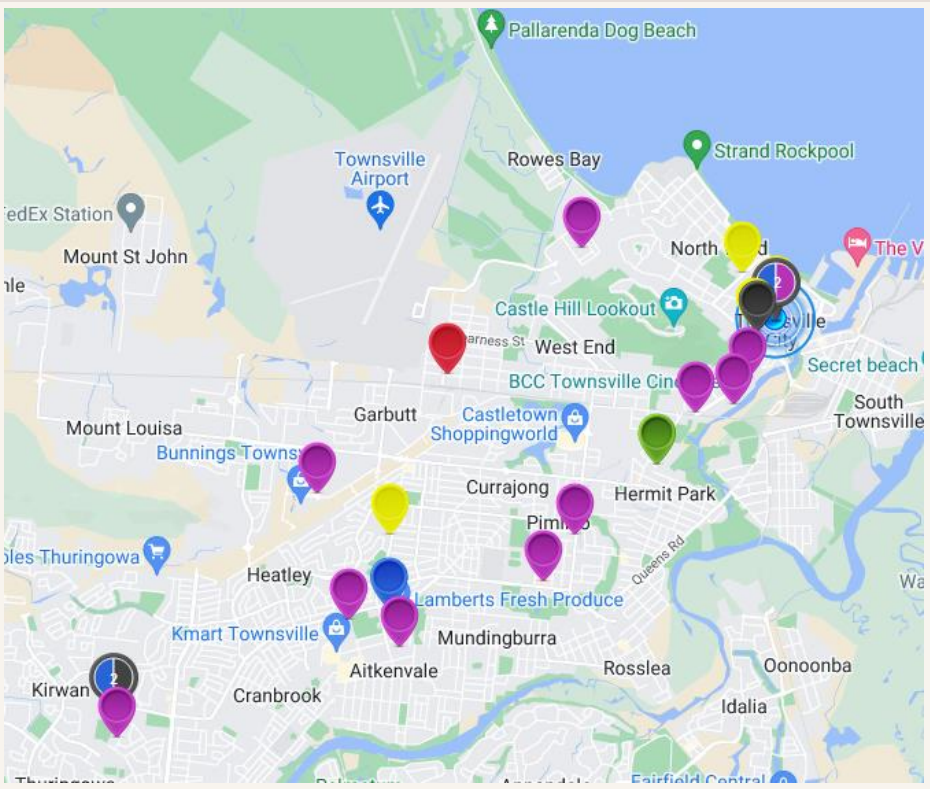
- Who attended the services and the experiences of care?
- Who delivered care and how has the practice approach evolved?
- Which implementation strategies and factors to strengthen?

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

Local mental health eco-system

An ecomap of the Townsville 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/du38

Who was involved

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

35 guests returned a survey about their care experiences

13 staff returned a survey about their work experiences

20 staff in month 1 and 18 staff in month 3 working at/or with the service completed a survey about the implementation of the model of care.

8 guests had a conversation about their care experiences.

4 staff and **1 staff group** 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
355	**323**	**300**

Average Age	Australian Born	Self Referred
39 years	**86%**	**85%**

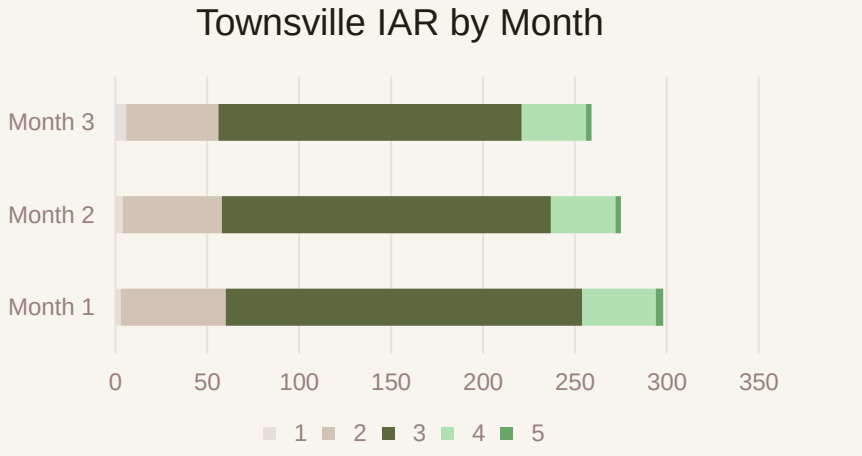
Average length of closed episodes

110 Days

First Nations Guests	Monthly: guests presenting with suicide distress
14%	**20%**

What was the level of need

- Initial Assessment and Referral decision support tool outcomes indicated most guests scored 3 indicating moderate intensity services recomended.
- Mean monthly K-10 scores were 33 indicating higher levels of distress
- 24% of guests had accessed the service before
- 23% of guests were accessing mental health support for the first time



"..even when there are times I have not felt like going there I have talked to them on the phone and they have been readily available." (Townsville Guest)

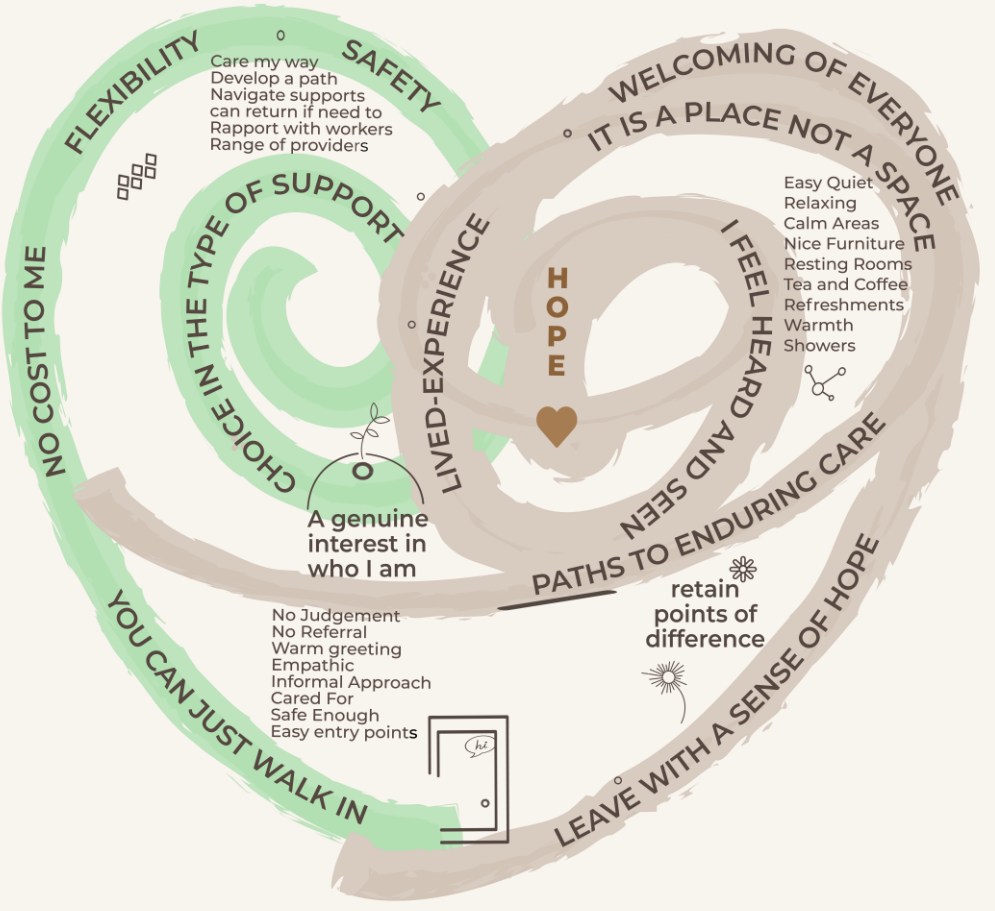
Experiential model of care based on guest surveys and conversations

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 Townsville

Themes from guest conversations

Guests reported that the centre was **accessible** and presented a **positive addition** particularly with the lack of bulk-billed options in Townsville

"it was just a place where even if it didn't have an appointment, but I was stressed out I could just stop and reset" (Townsville Guest)

The environment and amenities like refreshments created a **welcoming vibe** and made **guests feel comfortable and cared** for.

"the entire vibe of the waiting area feels more like a like a cafe type situation. Like it's really relaxing and like you can you know, they have colouring in books, you can make yourself tea and coffee, like it's just very inviting.." (Townsville Guest)

Most guests **self-referred** through walk-ins or word of mouth, or recommendations from a **GP, community-based service, charity or post hospital presentation**

"by the time I said, we need to get me some help. And I got up to the hospital. And I remember them telling me all about the services" (Townsville Guest)

Some guests appreciated the **presence of the service as a safety net**

"Because I think I like knowing I have that safety net. Because you know, if when you're falling, you fall. If the safety net can catch you before you fall, then I'd rather keep that" (Townsville Guest)

Care felt **more welcome, personal and genuinely human** that experiences in other services. Care **lacked judgement** and was **focused on relationships**

"They don't care whether you've got a mental health condition or not" (Townsville Guest)

Key guest survey outcomes

All guests were satisfied with the care environment.

Over 90% of guests were satisfied with: ease of access to the service; the welcome received; wait times; and their inclusion in decision making about their health.

Over 80% of guests were satisfied with: staff they interacted with, being supported by peer/clinical teams; and the care provided.

Over 75% of guests were satisfied with future help or connection to other supports

Over 90% of guests felt heard and safe.

Over 80% of guests felt cared for; understood; that care focused on things that mattered to them; they had a chance to make sense of what was going on for them; and more hopeful moving forward.

Over 75% of guests felt supported to access wider supports and resources.

Guests felt improvements could include:

- Longer visits, more intensive services, disappointed at being closed off after a time;
- More flexibility for phone appointments;
- Too much focus on referrals to other services and not enough direct care within the service options;
- Greater awareness in the community of the services.

"I felt very heard. I felt seen. And the lady gave me lots of attention" (Townsville 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

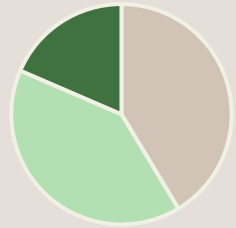
How staff were heard

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

- 13 Townsville staff **returned a survey** about working at the Medicare Mental Health Centre, their roles, training and support, work with guests and broader service factors.
- 5 Townsville staff and 1 group of 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 Townsville Service **completed a survey** at two stages to help understand the implementation of the model of care based on NPT called **NoMAD**.

"We learn a lot from our guests and staff" (Townsville Staff)

Overview of Staff Mix



Key Staff Outcomes

Staff appreciated that care being offered to guests was different to other service in that it was accessible, fee free and allowed guests to share their stories and be heard in a timeframe that worked for the guest, and a caring response can be developed to address the person's needs.

"..if someone comes in, and they need to talk for two hours, because they're in crisis, we can do that. We don't cost any money. So we're accessible. We come at it from a different perspective to most health care agencies"

Staff felt the culture was positive and that they were being well supported.

"encouragement of working collaboratively. We all have different knowledge that we can share, use towards supporting the guests"

There were some tensions in balancing safety for guests and staff and maintaining an accessible service

"...meet the middle ground of not being intimidating and not having glass barriers up in front of people talking to them through that it's not like institution....."

The administrative burden was high with multiple data systems to navigate.

"an intake interview takes an hour and a half, you will easily spend another hour doing the computer work. And that's not writing your notes. That's just navigating the two systems that we have"

"..we get to bring ourselves." (Townsville Staff)

Implementation Opportunities

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

"So everyone works together to make a good outcome for that person who is presenting. And we do we work as a team, and it goes really well. It's like poetry in motion" (Townsville Staff)

UNDERSTANDING (Coherence Construct): The guests experienced care that felt different, and staff also agreed that the model of care differed from usual ways of working. Staff could see value in the model for their work but indicated that staff had a variable understanding of the model of care. Team culture was seen as a strength. Townsville staff were satisfied with how they were supported by the team and felt valued for their work.

"I think that we just naturally have a team more respectful of each other now, but it's been a hard. I think I hard road to get there to be honest."

ENGAGEMENT (Cognitive Participation Construct): Service staff agreed that key people were driving the model of care. Staff saw the model of care as a legitimate part of their role and would support and work in new ways to deliver care. Staff agreed that they and the service effectively adapted to meet and manage demand and need.

"I love flexibility. Yeah, I think it's so great. I love about the lived experience thing is that we get to bring our own frameworks and our own perspectives."

ENACTMENT (Collective Action Construct): The model of care was readily integrated into working roles and did not disrupt working relationships. Most service staff were confident in others' ability to use the model and felt work was assigned to those with appropriate skills. The experiential survey indicated staff were satisfied with training, but the implementation survey showed that staff felt that the model needed further training and resourcing support.

"So everyone works together to make a good outcome for that person who is presenting. And we do we work as a team, and it goes really well. It's like poetry in motion"

REFLECTING (Reflexive Monitoring Construct): Staff were aware of reports of the model of care and felt that the service effectively supported guests and responded to community need. Most staff were happy with how the service connected with existing services. A need to better engage with Aboriginal and Torres Strait Islander communities and organisations was identified. Community awareness raising of what the service was and what it offered needed further work.

"Throughout working in Head to Health I found that services were still unaware of what Head to Health was and how they supported"

Implementation Strategies

STRATEGY 1: Continue to support the model of care with systemised and ongoing training that is regularly re-visited. 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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