neami national Improving Mental Health and Wellbeing

The ALIVE National Centre for Mental Health Research Translation

Implementation Co-Evaluation Learnings: Darwin Site Report.

16 Scaturchio Street, Casuarina, NT

Opening:

Mon – Fri: 10 am – 10 pm

Weekends/ public hols: 12 pm – 8 pm

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

Greater Darwin Demographics

2021 ABS Census Data shows:

Total population	139, 902
Female	59.4%
Median age (years)	34
Aboriginal and/or Torres Strait Islander people	10.4%
Australian Born	63.8%
Percentage with a long-term mental health condition (including anxiety and depression)	5.9%

What did the co-evaluation do?

We sought to map journeys and strengthen implementation by understanding:

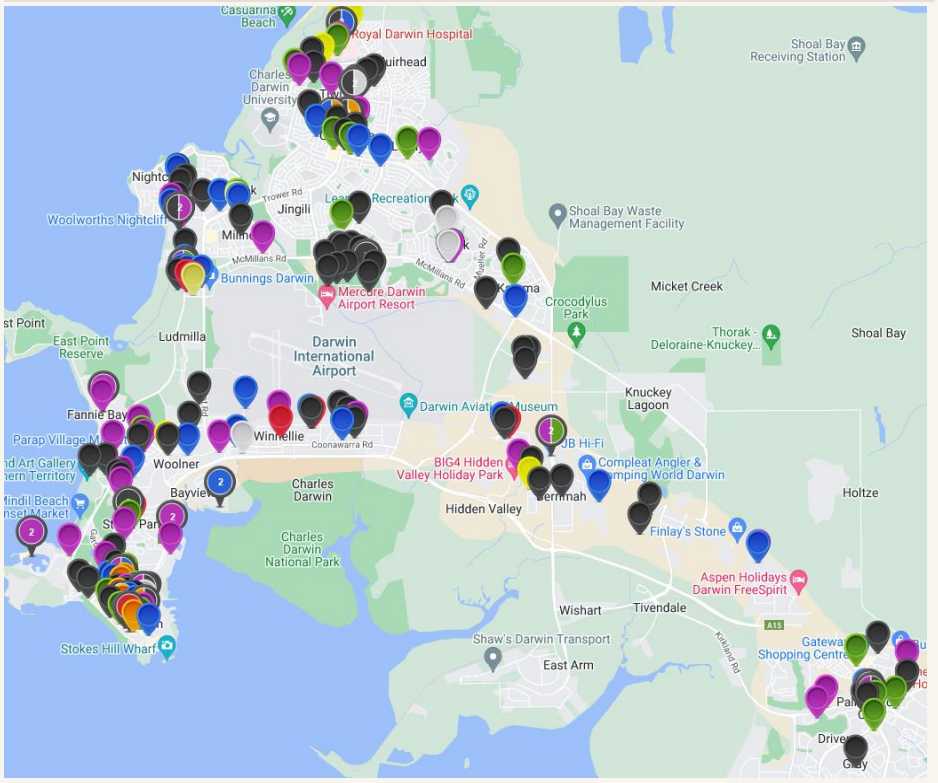
- Who attended the services and the experiences of care?
- Who delivered care and how has the practice approach evolved?
- Which implementation strategies and factors to strengthen?

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

Local mental health eco-system

An ecomap of the Darwin 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/2o38

Who was involved

Anonymised, monthly group level service activity summaries provided between 20/11/2023 – 20/02/2024.

25 guests returned a survey about their care experiences

18 staff returned a survey about their work experiences

21 staff in month 1 and 13 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.

6 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
282	**276**	**250**

Average Age	Australian Born	Self Referred
42 years	**83%**	**65%**

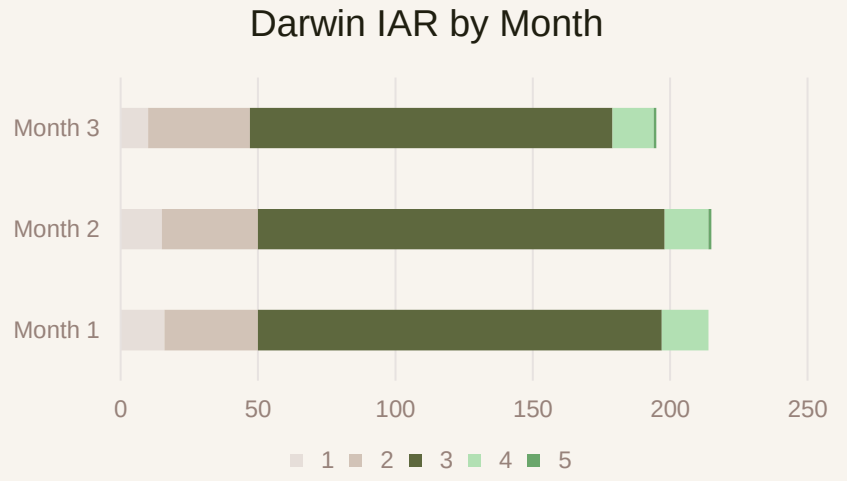
Average length of closed episodes

104 Days

First Nations Guests	Monthly: guests presenting with suicide distress
23%	**17%**

What was the level of need

- 69% were classified IAR 3 indicating moderate intensity services were recommended
- Mean monthly K-10 scores were 36 indicating higher levels of distress
- 13% were referred by a GP
- 5% were experiencing homelessness
- 22% were accessing mental health support for the first time



"The referral to other services within and outside of Head to Health have been fantastic I have learnt more and been able to network especially love the IPS program" (Darwin Guest)

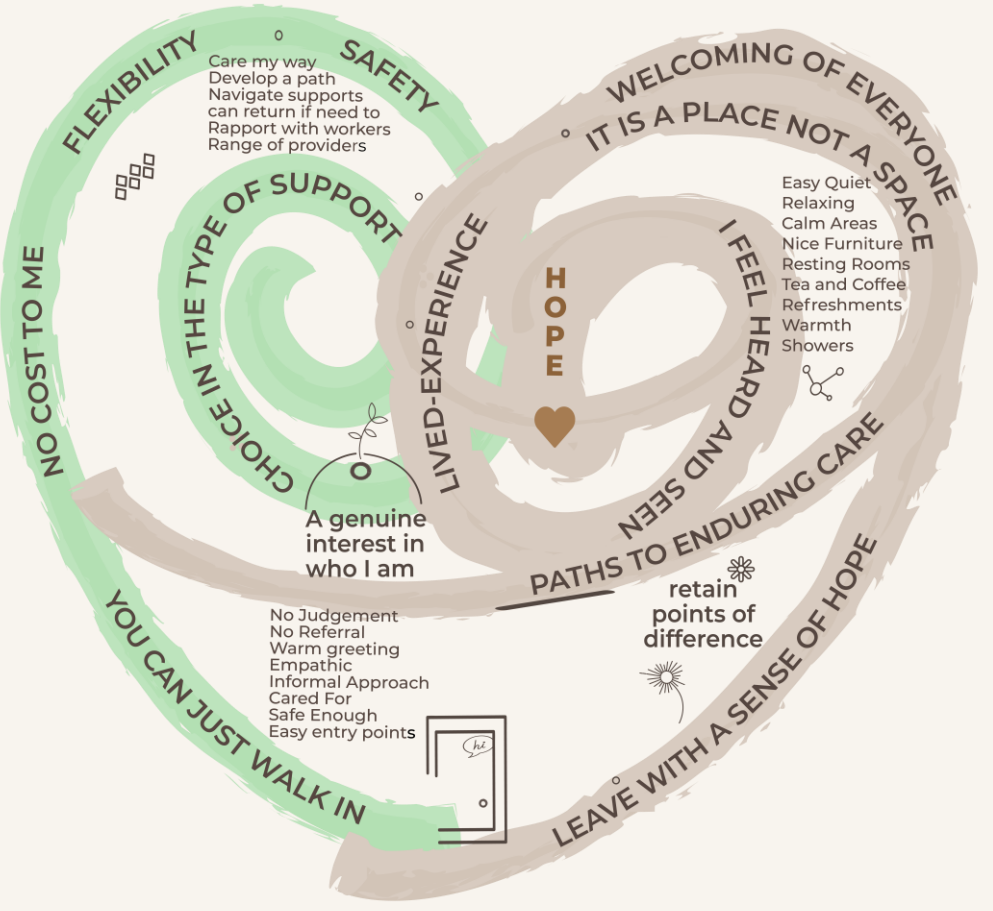
Experiential model of care based on guest surveys and conversations

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 visitors experienced care at Darwin

Themes from visitor conversations

Service was **accessible** and **welcoming alternative to hospital** and differed from previous experiences. Visitors appreciated the **ambience and sensory spaces**.

“I really liked the way they set up their environment. It's very soft, very aware that when people are very stressed, they need a very soft environment not a hard environment”

We heard that visitors appreciated the **relational connections** that were being built.

"And he actually called and checked on me once to twice a week for the first three or four weeks afterwards, just to see how I was doing and if I was okay, and if I needed to come in and just sit for a while. And to me, that was like, wow, somebody actually does care"

The short-term nature of the service posed some **challenges with how separation was managed**. There was a **desire for greater integration across the sector** and **clearer understanding** about what the service and external services could offer visitors.

"It would be good to have like a little roadmap... so this is Head to Health. These are the services that we offer. These are the services that we could refer you to"

Service had a new and **different approach** that **differed from standard clinical care**. Visitors reported needing to **overcome past service system experiences** to seek care, and the **inclusion of lived experience** was valued.

“They are just people that have lived their life. Most of them had a hard life. Therefore, they've got more empathy and understanding and sympathy. And are more able to encourage you to help yourself"

The service was a **safe space**, but that sense of **safety could vary**. There were indications that increased training in trauma informed care was needed.

“clearly to me, (they were) not trauma informed.”

Key guest survey outcomes

All visitors were satisfied with:
- The physical environment
- Their care

Over 95% of visitors were satisfied with:
- The welcome received
- Future help or connection with other supports
- Inclusion in decision making about their health

Over 95% of visitors felt
- Heard and Understood
- Safe
- Care focused on things that mattered to them
- More hopeful of a way moving forward
- Supported to access wider supports and resources

Over 90% of visitors were satisfied with:
- Ease of access
- Waiting time
- Being supported by clinicians and people with lived experience

Over 90% of visitors felt they:
- Had a chance to make sense of what is going on for them

Over 85% of visitors were satisfied with:
- Staff they interacted with

Guests felt Improvements could include
- Not having to re-tell your story over and over again.
- Long-term service, not just short-term
- Ideas such as workshops, meet and greet lunches that bring people from diverse backgrounds together
- More brochures on understanding personal identities.
- Increased CALD, LGBTIQA+, physical disability, Aboriginal and Torres Strait Islander representation.

“Excellent service. Staff are very good.” (Darwin visitor)

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

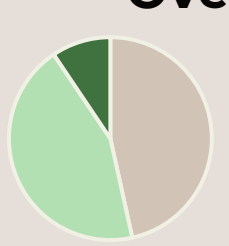
How staff were heard

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

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

"So we really do work towards that collaborative, relational practice model. And within that, people bring different skills and abilities, levels of empathy, understanding, you know" (Darwin Staff)

Overview of Staff Mix



Key Staff Outcomes

The service was seen as providing a valuable alternative to people seeking support and staff felt they were working effectively to support visitors.

"I think we are invaluable, incredible resource for people who are going through mental illness of any kind. I think its because of its accessibility and the support on hand, I think its really great"

There were challenges in bringing together a workforce with different perspectives and experience in mental health and wellbeing support and different understandings of the model of care. A need for greater training in the model of care and cultural safety was indicated.

"There has been tensions, you know, and there has been divisions at time"

Staff retention can be a challenge due to the transitory nature of the workforce, and that this could challenge team culture and articulation of the model of care, requiring ongoing training and support.

"And because of staffing is not really stable. That is also a challenge for peer first, peer last"

There was a need to support challenging conversations and provide structures to provide feedback and debrief outside of direct line management.

"I don't think people feel safe to voice what they really think"

"There is an ever-changing experimentation with roles and responsibilities which leads to confusion, frustration and a lack of communication." (Darwin Staff)

Implementation Opportunities

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

"....it would really help to develop a shared understanding of what the model could look like. We'd probably have to do that quite regularly considering the staff turnover" (Darwin Staff)

UNDERSTANDING (Coherence Construct): Staff indicated that there was an unclear understanding of the model of care and how it impacted on work and differed to usual approaches, and roles within the model. Despite this, staff could see value in the model and valued the relational care. There was a need to balance lived experience and clinical perspectives and incorporate and understand lived experience with differing interpretations of what the wellbeing coach role entailed.

"I think we all still have like different ideas of what it could mean (the model of care). I don't think management understand it very well either"

ENGAGEMENT (Cognitive Participation Construct): There wasn't a clear view that key people were driving the model forward. Staff were mostly supportive of working in new ways and supported the model of care. There was capacity to strengthen leadership and Neami involvement in the service

"I don't have a problem with there being points of tension about how to manage that as in a really productive way that supports the guest, and gets a good outcome for the guest"

ENACTMENT (Collective Action Construct): Most staff felt their roles were valued and that team culture was positive. Most staff had confidence in others understanding of the model but felt that training and resourcing for the model of care was not sufficient. Staff felt onboarding and orientation and training needed to be better supported.

"There should be case consults and huddles. I mean, that works well and people are open and feel safe and can communicate"

REFLECTING (Reflexive Monitoring Construct): Staff felt their work made a valuable contribution to visitors and met their needs, and that the service effectively managed demand. There was a need to improve outreach and promotion and clarifying the role of the service in the ecosystem. Feedback could be used to improve the model of care.

".. it probably complements at a lot of other services .. but it's also lifted and raised expectations of what mental health care is"

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 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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