Primary Health Network Mental Health Reform Lead Site Project (Lead Site Project)

PART A FINAL EVALUATION REPORT: PROCESSES AND IMPACTS, JULY 2016 – DECEMBER 2018

July 2019

Bridget Bassilios[1], Sanne Oostermeijer[1], Michelle Williamson[1], Angela Nicholas[1], Anna Machlin[1],
Meredith Harris[2], Philip Burgess[2], Claudia Sparti[2], Susie Fletcher[1], Jane Gunn[1], Jane Pirkis[1]

---

[1] The University of Melbourne

[2] The University of Queensland

Acknowledgments

This report would not have been possible without the support of many who generously gave their time and made valuable contributions. In particular, the evaluators would like to thank the Evaluation Advisory Group for their advice; the 10 Lead Site Primary Health Networks (PHNs) who have shown a high level of commitment to data collection, provided input on our stakeholder consultation questions and facilitated our access to data and to various stakeholder groups; all the stakeholder groups – consumers, carers and carer representatives, referrers, mental health practitioners, training providers, other providers/services – who provided their views on, and experiences of, the PHN-led mental health reforms; headspace National Office for providing routinely collected data; Strategic Data Pty Ltd for building online surveys and providing us with data from the minimum dataset; and Robert Lukins for general project support.

The evaluation of the Lead Site Project is funded by the Australian Government Department of Health.

Table of contents

List of tables

1. Executive summary

1.1 Background

Australia's 31 Primary Health Networks (PHNs) were established in July 2015 in response to the National Mental Health Commission's review of mental health programs and services[1] and the Australian Government's response to that review.[2] PHNs have been tasked with understanding the needs of their communities, supporting GPs and other primary care providers in a variety of ways so that they can offer optimal care, and purchasing or commissioning services.[3] PHNs have an explicit focus on those in their communities who are most in need, including patients with mental illness.[3] Commencing from 2016-2017,[4] PHNs received approximately $1.030 billion (GST exclusive) in funding over three years so they can commission services in six mental health priority areas:

1. Low intensity services;
2. Psychological therapies for underserviced populations;
3. Child and youth services (including services delivered by headspace);
4. Services for adults with severe and complex mental illness;
5. Indigenous mental health services; and
6. Suicide prevention.[4]

Achieving positive outcomes in the six priority areas is expected to be underpinned by two approaches to service delivery. The first is improved integration of services through evidence-based regional mental health and suicide prevention plans in collaboration with Local Hospital Networks and Districts (LHNs and LHDs), and service mapping to identify needs and gaps, reduce duplication, remove inefficiencies and encourage integration.[4] The second approach involves a mandate to introduce and operationalise stepped care. The general principle behind the stepped care approach is that an individual with mental health problems receives the least intensive level of care that is likely to be effective given their treatment need, making the best use of available workforce and technology.[4] The six priority areas and the principles that underpin them are closely aligned with eight targeted priority areas of the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan).[5]

The Department of Health has provided PHNs with a range of tools and resources to support them with achieving their remit in relation to planning, commissioning, implementing, and integrating stepped care primary mental health services within their local regions. For example, the Department of Health website (http://www.health.gov.au/PHN)[6] provides resources for PHNs such as needs assessment guides, grant and program guidelines, commissioning resources, guidance materials, data and circulars. The Department of Health has commissioned the University of Queensland to assist PHNs to use the decision support tools available through the National Mental Health Service Planning Framework (NMHSPF).[7, 8] In addition, in October 2017, the Department of Health launched the Digital Mental Health Gateway (Head to Health), which aims to provide a central entry point for national low intensity telephone- and web-based mental health services (www.headtohealth.gov.au).[9, 10] Finally, the Department of Health is providing opportunities for knowledge transfer across the PHN network through forums such as bi-annual stepped care workshops.

1.1.1 THE PRIMARY HEALTH NETWORK MENTAL HEALTH REFORM LEAD SITE PROJECT (LEAD SITE PROJECT)

All 31 PHNs have been funded to commission primary mental health services in the above-mentioned six priority areas. However, 10 PHNs have been selected to act as mental health reform leaders in the PHN Mental Health Reform Lead Site Project (the Lead Site Project). These are:

1. Eastern Melbourne;
2. South Eastern Melbourne;
3. North Western Melbourne;
4. Central and Eastern Sydney;
5. Murrumbidgee;
6. North Coast;
7. Perth South;
8. Brisbane North;
9. Tasmania; and
10. Australian Capital Territory.

These Lead Sites have been tasked with providing enhanced services in nominated key focus areas (e.g., by fast-tracking their activity in these service areas, establishing different partnerships and funding arrangements for services, and/or trialling approaches that are innovative in terms of types and modes of commissioned services). The key focus areas are listed below (the first two are overarching areas, and the next three are service delivery areas):

1. Regional planning and service integration;
2. Stepped care;
3. Low intensity services;
4. Services for youth with, or at risk of, severe mental illness (youth enhanced services); and
5. Clinical care coordination for adults with severe and complex mental illness.

All 10 Lead Sites are focussing on regional planning and service integration, stepped care and low intensity services. Three Lead Sites (Australian Capital Territory, South Eastern Melbourne, and Tasmania) are also focussing on services for youth with, or at risk of, severe mental illness. Three other Lead Sites (Brisbane North, North Coast, and North Western Melbourne) are also focussing on clinical care coordination for adults with severe and complex mental illness. Lead Sites are offered more frequent opportunities than other PHNs to share their knowledge and collaborate (e.g., through face-to-face meetings and telephone conferences).

1.1.2 EVALUATION OF THE LEAD SITE PROJECT

The evaluation of the Lead Site Project aims to gather information on the approaches taken by Lead Sites to the planning, integration and delivery of mental health services, and to identify the implications for future government policy and the activities of PHNs more generally. The evaluation has been guided by the Lead Site Project Evaluation Framework.[11]

The evaluation has two major parts (Part A and Part B) each with separate requirements. The focus of this report is Part A, which is led by the University of Melbourne's Centre for Mental Health and relates to the first four of the five focus areas (regional planning and service integration; stepped care; low intensity services; and youth enhanced services). The approach to evaluation of these areas shares the same set of evaluation questions and similar data sources and methodology. Part B[c] is led by the University of Melbourne's Department of General Practice and relates to the fifth focus area (clinical care coordination for adults with severe and complex mental illness).

Part A evaluation questions

The overarching primary evaluation questions for the Part A evaluation are:

1. What approaches were undertaken by Lead Sites to the planning, commissioning, management and delivery of services in each of the focus areas?
2. What activities and approaches were found by the Lead Sites to be effective in achieving objectives in each of the focus areas?
3. What were the barriers and facilitators to achieving objectives in each of the focus areas?
4. What are the implications for future activity by PHNs and primary health care reform more generally?

1.2 Approach

We used mixed quantitative and qualitative data collection and analysis methods to assess implementation processes and impacts (early outcomes) of Lead Sites' activities in relation to each of the focus areas. We collected/collated and analysed data in two rounds to give Lead Sites an opportunity to implement their commissioning activities by the second round. Round 1 data collection focused on early implementation processes and was conducted from September 2017 to May 2018; the findings from Round 1 have been published in an interim report.[12] The current report focuses primarily on Round 2 data collection, which was conducted from September 2018 to April 2019 and elicited implementation processes and early impacts. Data sources included:

a. **Routinely collected data (Round 2: July 2016 to December 2018; Round 1: July 2016 to December 2017)**
Service use data (including service contacts, episodes of care, consumer socio-demographic and clinical characteristics, and outcomes) were obtained and analysed from the following sources:

- Primary Mental Health Care Minimum Data Set (PMHC MDS) (all 31 PHNs);
- Access to Allied Psychological Services (ATAPS) MDS (all 31 PHNs); and
- headspace MDS – only for services funded by PHNs (all 31 PHNs).

Note that routinely collected data for all 31 PHNs were analysed to provide context, and all other data sources relate specifically to the 10 Lead Sites.

b. **Stakeholder consultations**
We conducted consultations with key stakeholder groups from each of the Lead Site regions. Table 1 shows the stakeholder groups, methods of consultation and number of stakeholders consulted in both data collection rounds. Our consultations with these stakeholders garnered their views on commissioning, referring to, delivering, or receiving, services. Lead Site staff acted as intermediaries for our recruitment of all other stakeholder groups.

---

[c] Part B of the evaluation involves a trial that has become known as Link-me. General practices that are participating in Link-me identify patients with severe and complex mental illness who are eligible for clinical care coordination, as well as patients with lower level needs who are eligible for low intensity services. The Link-me trial will provide information on the effectiveness and cost-effectiveness of both low and high intensity services. The final results of the trial will be submitted to the Department of Health in September 2020.

Table 1. Stakeholder groups, methods of consultation and number of participants

Stakeholder group	Consultation method	Round 2	Round 1
Consumers	Online survey	304	150
Regional carers (or representatives)	Focus groups, interviews, written responses, surveys	24	9
Referrers	Online survey	96	121
Mental health practitioners	Online survey	223	349
Regional and other key stakeholders[d]	Focus groups, interviews, written responses	70	62
Lead Site staff	Focus groups, interviews	68	58
Other key stakeholders[e]	Focus groups, interviews, written responses	2	11
Total		787	760

c. **Observational and participatory data**
Observations were made during our attendance at national PHN workshops and Lead Site meetings in both data collection rounds.

d. **General input**
In both rounds, input was sought from other key stakeholders either directly or indirectly involved in the PHN-led mental health reforms, but not specifically involved in the Lead Site Project. In Round 2, general input was from Orygen and headspace and specifically related to child and youth mental health services. In Round 1, Orygen, headspace and nine national and state or territory carer representatives provided general input.

1.3 Findings

1.3.1 CONTEXT

Between July 2016 and December 2018, the 10 Lead Sites provided 534,127 commissioned service contacts to 113,974 consumers in 122,423 episodes of care. Lead Site service volume accounted for just over one third of the total provided by all 31 PHNs, which is consistent with Lead Sites representing just under one third of all PHNs. Lead Sites provided services to a substantial proportion of males (36%) and Indigenous people (6%). Most Lead Site consumers were diagnosed with affective or anxiety disorders (16% and 15%, respectively); diagnosis was missing for 28% and recorded as ‘other’ for 20% of consumers. Seventy-two percent of Lead Site consumers resided in major cities, which is appropriate, given that Lead Sites mainly service geographic areas in major cities. Over one third of consumers receiving episodes of care through Lead Sites were from areas in the lowest two Index of Relative Socio-economic Disadvantage (IRSD) quintiles; that is, areas of greatest disadvantage.

1.3.2 PROGRESS IN EACH OF LEAD SITE FOCUS AREAS

Part A evaluation findings regarding the Lead Site Project’s progress in each of the four focus areas is summarised below.

---

[d] Mostly included management staff from commissioned provider organisations and LHNs and a few professional/peak body representatives.

[e] This group of stakeholders was not from Lead Site regions and provided ‘general input’ as described below under data source (d).

1.3.2.1 Regional planning and service integration

Round 2 data suggest that most Lead Sites are in the preparatory stages of developing their regional plans. Almost half of the Lead Sites stated that joint regional planning with their LHN provided an opportunity for greater collaboration and for creating regional change. Good relationships with LHNs and other regional stakeholders are seen as paramount to conducting the regional planning process. The preparatory stages of regional planning generally consist of the creation, and meeting, of committees and groups comprising regional stakeholders. It also involves needs analyses and consultation activities, which Lead Sites consistently reported involves consumers and carers.

The most common strategy undertaken by Lead Sites to promote service integration was to have a centralised intake process. Otherwise, Lead Sites' approaches to achieving service integration in their regions were diverse. The introduction of the NDIS, and its effects on the primary care mental health workforce, and continued 'siloed' funding streams for mental health services were seen as the primary barriers to service integration.

1.3.2.2 Stepped care

Most Lead Sites have fully implemented their stepped care model, and positive effects of this model were beginning to be seen in Round 2. These effects included better targeting of services to meet consumer need. Lead Sites were using intake and assessment procedures to ensure appropriate assignment of consumers to services at various levels of care and were engaging in education with referrers and providers regarding the stepped care model. The primary difficulty identified with implementation of the stepped care model related to lack of transition of consumers to higher or lower levels of care as needed. Some Lead Sites also saw a need to offer greater support for providers to transition their consumers.

Our analysis of routinely collected data provided several insights about the implementation of stepped care in Lead Sites. For example, the delivery of services across the steps has improved in Round 2 compared with Round 1. Specifically, there was an increase in the proportion of service contacts attended for the lower and higher intensity principal focuses of treatment (from 3% to 8% for low intensity psychological interventions and from 2% to 11% for clinical care coordination). Related to this trend, in Round 2, there was appropriate variation in the types of referrers (e.g., 53% GPs, 31% self-referral) and mental health practitioners (e.g., 20% general psychologists, 11% clinical psychologists, 9% low intensity mental health workers, 10% other types of practitioners). The average number of attended service contacts varied appropriately by principal focus of treatment (i.e., from five for low intensity psychological interventions and six for psychological therapy to 13 for clinical care coordination).

1.3.2.3 Low intensity services

Round 2 data indicated that Lead Sites are implementing a range of low intensity service types to meet the needs of a range of specific target groups. However, many are experiencing low uptake of this new type of service and are expending significant efforts in change management processes to implement and promote low intensity services to relevant referrers and other stakeholders. Lead Sites are facing difficulties in explaining and promoting low intensity services, attracting and retaining workforce, and overcoming consumers' more traditional preferences for face-to-face mental health services when other low intensity service modalities are indicated, such as telephone or online services.

From January 2016 to December 2018, Lead Sites reported 43,507 attended service contacts in which low intensity psychological intervention was the principal focus of treatment. This comprises 8% of all service contacts delivered in that time. This percentage has increased from 3% in Round 1. These low intensity service contacts were delivered within 8,367 episodes of care (6.8% of the total Lead Sites episodes of care). On average, those receiving low intensity services had five service contacts within their episode of care, which is slightly lower than the overall average of six contacts per episode of care. Lead Sites are delivering proportionally more low intensity service contacts and episodes of care than are non-Lead Sites (8.1% vs 4.4% and 6.8% vs 4%, respectively). Of the low intensity psychological intervention episodes (n = 1,282) in which pre- and post-treatment K10 data were available for consumers, 64% significantly improved.

1.3.2.4 Services for youth with, or at risk of, severe mental illness

Few commonalities were identified in the approaches of Lead Sites to their planning, commissioning and implementation of services for youth with, or at risk of, severe mental illness in Round 2. This might reflect the vast array of services (e.g., case management, assertive outreach, service navigation, enhanced headspace service) for this target group being implemented across Lead Sites. However, one commonly cited difficulty with implementing youth enhanced services was the ability to recruit appropriately trained clinicians. This was suggested as an area in which the Department of Health might assist Lead Sites. It was also suggested that the PMHC MDS should be modified in order to more systematically capture the delivery of youth enhanced services.

1.3.3 PRIMARY EVALUATION QUESTIONS

Responses to each of the four primary evaluation questions are provided below.

1. What approaches were undertaken by Lead Sites to the planning, commissioning, management and delivery of services in each of the focus areas?

Table 2 summarises the key approaches taken by Lead Sites to the planning, commissioning, management and delivery of services in each of the four focus areas. Lead Sites used multiple approaches to achieve the objectives across the four focus areas, and these were confirmed by other stakeholders. Some approaches, such as building relationships with a broad range of stakeholders, offering a range of opportunities for stakeholders to provide input, conducting service mapping and needs analysis, and including contractual obligations of commissioned providers to help achieve focus area objectives. (e.g., care coordination, clinical governance) were common across multiple focus areas. Indeed, although some of these strategies were not specifically mentioned by Lead Sites in relation to some focus areas, it makes sense that they were relevant to all four focus areas. Conversely, some approaches were more relevant to particular focus areas – operating a central intake system for stepped care, commissioning services that offer a variety of means and delivery modalities for low intensity services and commissioning services that provide clinical and non-clinical care for youth with, or at risk of, severe mental illness.

Table 2. Key approaches taken by Lead Sites to planning, commissioning, management and delivery of services

Approach	Focus area: Regional planning and service integration	Stepped care	Low intensity services	Youth-severe services
Building relationships with a broad range of regional stakeholders, including LHNs/LHDs, consumers and carers (via relevant peak bodies)	✓		✓	
Leveraging existing relationships with stakeholders (e.g., established groups or committees)	✓			
Offering a range of opportunities for stakeholder consultations to maximise planning and implementation input from a broad range of stakeholders. Example mechanisms for involving stakeholders include meetings, workshops, forums, co-design, partnerships, involvement in procurement panels, pre-commissioning briefings, round table discussions, and youth advisory consultations	✓		✓	✓
Conducting service mapping to identify regional needs, and reviewing service data and changing types of services or modalities of commissioned in response to consumer preference (e.g., more face-to-face low intensity services)	✓		✓	✓
Operating a central intake system via a clinical team or digital tool		✓	✓	
Commissioning individual providers to deliver services in a single step		✓		
Commissioning individual providers to deliver services across all steps		✓		
Providing ongoing communication, education, and promotion of services for referrers and providers		✓		
Change management work (e.g., through building relationships and providing supports and resources)		✓		
Commissioning a range of services using a variety of means and modalities (e.g., digital, phone, face-to-face including outreach)			✓	✓
Targeting specific hard-to-reach groups (e.g., CALD people, ATSI people, LGBTQI people, people in residential aged care, disengaged youth, justice involved youth)			✓	✓
Taking a holistic approach to commissioning services (i.e., combining clinical and non-clinical treatments)				✓
Seeking input from Orygen / headspace National	✓			✓
Including obligations in contracts with commissioned providers (e.g., to ensure care coordination or request clinical governance frameworks)	✓		✓	✓
Implementing a range of service delivery models with headspace (e.g., co-location of low intensity or youth enhanced services, provision of intake and referral to youth enhanced services)			✓	✓

2. What activities and approaches were found by the Lead Sites to be effective in achieving objectives in each of the focus areas?

The Lead Site Project appears to be achieving its goals, as evidenced by positive outcomes for a significant numbers of consumers. The percentage of completed episodes in which the consumer showed significant improvement was 38% (95% CI [confidence interval] 37.7-38.8) for episodes rated using the Kessler-10[13, 14] (K10, N = 30,938) and 48% (95% CI 35.7-59.8) for episodes rated using the Strengths and Difficulties Questionnaire-Parent Child version (SDQ-PC, N = 63).[15] This is equivalent to a reduction of five points or more on the K10 and three points or more on the SDQ-PC from episode start to end. K10 outcome data should be interpreted in the context that only 25% of all Lead Site episodes had episode start and end K10 scores recorded in the PMHC MDS and, of these, 93% were for headspace consumers. The proportion of Lead Site episodes we found to be classified as significantly improved (38%) on the K10 is consistent with those previously published by headspace (36%).[16] However, we also found that the percentage of episodes classified as improved was higher for those who were relatively older (≥ 21 years) (44%); had worse K10 scores at episode start (49%); had a principal focus of psychological therapy (62%), low intensity psychological intervention (64%) or clinical care coordination (58%); and had a greater number of attended service contacts (43% for 6-9, and 45% for >10, service contacts).

Table 3 summarises the main approaches that Lead Sites and other stakeholders found to be effective for the planning, commissioning, management and delivery of services in each of the four focus areas. Lead Sites considered multiple approaches to be effective for achieving the objectives across the four focus areas. Building relationships with a broad range of stakeholders and facilitating good relationships between various stakeholder groups were the most commonly mentioned and applicable effective approaches to achieving the objectives of all four focus areas. Otherwise, there was little overlap in effective approaches across the four focus areas, particularly youth enhanced services. For example, using mental health nurses to facilitate stepping up or down was relevant to stepped care and building workforce capacity was deemed to be an effective approach for providing services to youth with, or at risk of, severe mental illness. Other approaches not specifically mentioned in relation to a certain focus area are likely to still be applicable. For example, removing the requirement for a GP Mental Health Treatment Plan was not specifically mentioned in relation to low intensity services but would clearly facilitate access to this type of service. Analysis of outcome data showed that many consumers had experienced significant improvements in their mental health status.

Table 3. Main effective approaches for achieving objectives in each of the focus areas

	Focus area			
Approach	Regional planning and service integration	Stepped care	Low intensity services	Youth severe services
Lead Sites building good relationships with a broad range of range of stakeholders, especially LHNs/LHDs and providers (including promoting provider ownership of services)	✓	✓	✓	✓
Lead Sites facilitating good relationships among all stakeholders (e.g., hosting events to bring together service providers)	✓	✓	✓	✓
Co-developing the regional plan with stakeholders to foster more buy-in for implementation	✓			
Undertaking partnership brokerage training	✓			
Basing regional plan on existing (rather than new) services	✓			
Basing regional plan on strong needs analysis and service mapping	✓			✓
Communication, education, and promotion of services targeting referrers, providers and regional and other key stakeholders	✓	✓		
Reviewing existing commissioned services for evidence of integration	✓			
Operating a central intake system to promote service integration and stepped care	✓	✓		
Incorporating obligations into provider contracts		✓	✓	
Commissioning a broad range of services (before deciding which ones to retain)		✓		
Providing psychiatric consultation services		✓		✓
Using mental health nurses to facilitate stepping up or down		✓		
Removing the requirement for a GP Mental Health Care Plan		✓		
Using the infrastructure of existing services as a platform for new services			✓	✓
Implementing services with a good evidence base (e.g., NewAccess)			✓	
Complementing clinical care with wrap-around services (e.g., vocational, educational and parental support such as that offered via the headspace model), preferably through a one-stop-shop (e.g., headspace)				✓
Formalising relationships with stakeholder via official agreements				✓
Developing processes or protocols to facilitate smooth transition between services				✓
Providing services for carers of young people				✓
Implementing assertive outreach				✓
Replicating existing services in new locations				✓
Building workforce capacity (e.g., training via Orygen)				✓
Allowing provider sufficient time for service development				✓
Co-designing service (with youth advisory group)				✓
Building effective service linkages by using a variety of service models (e.g., co-location, consortium-led) and working with other services to build referral pathways				✓

3. What were the barriers and facilitators to achieving objectives in each of the focus areas?

Table 4 summarises the key barriers to achieving objectives in each of the focus areas as identified by Lead Sites and other stakeholders. Most barriers mentioned were related to the focus area of regional planning and service integration. Examples included engaging or collaborating with stakeholders, particularly LHNs/LHDs and the public mental health sector; changing requirements for the regional plan; delayed release and limited utility of the National Mental Health Service Planning Framework (NMHSPF) and the competitive funding environment discouraging collaboration. There was less overlap in the barriers experienced across the four focus areas compared with that observed for approaches used and approaches deemed to be effective. For example, consumers not being appropriately stepped up or down and being incorrectly assigned to steps by GPs was a unique barrier to stepped care. There were, however, some barriers that affected more than one focus area, such as workforce issues affecting all focus areas, although not specifically mentioned for stepped care; and problems associated with data collection requirements.

Table 4. Key barriers to achieving objectives in each of the focus areas

	Focus area			
Barrier/challenge	Regional planning and service integration	Stepped care	Low intensity services	Youth severe services
Engaging or collaborating with stakeholders, especially LHNs/LHDs (e.g., attendance at regional planning groups)	✓			✓
Building relationships with the public mental health sector	✓			
The changing requirements for the regional plan	✓			
Delayed release and limited utility of NMHSPF	✓			
Workforce issues (e.g., recruitment, retention, impact of introduction of NDIS, shortage of suitably qualified/experienced providers including psychiatrists)	✓		✓	✓
Siloed funding streams for mental health services	✓			
Disparate national and state/territory funded mental health programs	✓			✓
Communication issues (e.g., conveying clarity of PHN vision for, and role in, regional planning to stakeholders; what true integration looks like; ambiguous eligibility criteria)	✓			✓
Tight timelines (e.g., for consultation, building relationships, planning to implementation, tender processes, upskilling staff)	✓		✓	
Uncertainty about sustainability (of PHNs, short-term funding and contracts with providers)	✓			
Competitive funding environment discourages collaboration	✓			
Data sharing issues (e.g., privacy relating to use of central intake systems)	✓			✓
Problems with data collection requirements (e.g., additional reporting requirements associated with pooling funding, misalignment of PMHC MDS with stepped care approach and its inability to capture youth enhanced services, duplicate state and PHN reporting, accurate measurement of effect)	✓	✓		✓
Lack of interface between the Fifth Plan and the National Drug Strategy	✓			
Consumers not being appropriately stepped up or down (due to clinician lack of knowledge, clinician desire to provide continuity of care, financial disadvantage for clinician, consumer refusal, difficulty tracking consumers)		✓		
Referrer and provider resistance to change		✓	✓	
GPs sometimes incorrectly assessing the step (or intensity of service) that a consumer needs		✓		
Administrative burden of referring to, or providing, services		✓		
The concept of, or language used for, low intensity services implying they are a lesser service			✓	
More complex youth cohort than expected				✓
Work intensity impact on commissioned providers				✓
Appropriateness of services for specific consumer groups (e.g., CALD)	✓			✓
Mental health system too complex to navigate for consumers, carers, referrers and providers				✓
Lack of funding (e.g., psychiatry specific)				✓

NMHSPF. National Mental Health Service Planning Framework

Table 5 summarises the key facilitators of achieving objectives in each of the focus areas as identified by Lead Sites and other stakeholders. Some of these facilitators were specifically mentioned by stakeholders and we deduced others based on all data sources, including our observations. There were many facilitators for Lead Sites to achieve objectives in each of the focus areas, and most facilitators were relevant to all four focus areas. Good relationships and collaborations with stakeholders were key among the facilitators across the four focus areas. Other important facilitators included stakeholder awareness of the reforms and services, a seamless referral process, innovative commissioned providers (e.g., offering a range of services in a variety of ways, having a multidisciplinary team), strong clinical governance, Lead Sites' collegiality; and the responsiveness of, and supports and resources provided by, the Department of Health. Capacity for providing outreach services and upskilling the workforce were considered to uniquely facilitate services for youth with, or at risk of, severe mental illness.

Table 5. Key facilitators of achieving objectives in each of the focus areas

	Focus area			
Facilitator	Regional planning and service integration	Stepped care	Low intensity services	Youth severe services
Good relationships between stakeholders	✓	✓	✓	✓
Collaboration with other stakeholders, including schools	✓	✓	✓	✓
Shared PHN and state government responsibility for implementing regional plan	✓	✓		
Stakeholder knowledge and awareness of reforms (including PMHC MDS data reporting requirements) e.g., through communication from Lead Sites and public awareness campaigns	✓	✓	✓	✓
Fully developed stepped care model	✓			
Seamless referral process aided by Lead Sites providing various supports and resources to referrers and providers (e.g., training, options for stepping up or down, written resources)	✓	✓	✓	✓
Commissioned provider delivering a range of services		✓		✓
Commissioned provider capacity for outreach				✓
Commissioned provider with multidisciplinary team		✓		✓
Upskilling and supporting the workforce				✓
Defined, specific eligibility criteria	✓	✓	✓	✓
Service model flexibility (e.g., uncapped number of sessions, different modalities)		✓	✓	✓
Collegial, solution-focused approach of Lead Sites and other PHNs (e.g., the formation of the Strategic Regional Planning Network)	✓	✓	✓	✓
The Department of Health and Lead Sites working together collaboratively	✓	✓	✓	✓
Additional funding and other resources (e.g., guidance documents, stepped care workshops, Lead Site meeting) from the Department of Health to support Lead Site activities, innovation and sharing lessons learned	✓	✓	✓	✓
Responsiveness of the Department of Health to Lead Site needs (e.g., National Initial Assessment and Referral in Mental Healthcare Project)	✓	✓	✓	✓
Strong clinical governance framework	✓	✓	✓	✓

4. What are the implications for future activity by PHNs and primary health care reform more generally?

Table 6 outlines the extensive suggestions made by stakeholders for improving future activity by PHNs and primary health care reform more generally. Numerous suggestions were made in respect of each of the four focus areas. Four suggestions relevant to all or most of the focus areas were involving people with lived experience in all stages of service implementation, improving engagement and representation of a diverse range of stakeholders in consultations, strengthening relationships with and between providers, and developing systems and tools to facilitate integration (e.g., though central intake and common electronic records). Suggestions specific to regional planning and service integration are related to engaging with stakeholders to include their input while clearly articulating the PHN role in planning and integration, and the need for planning and integration processes to be iterative. Suggestions for improving the implementation of stepped care were focused on supporting providers to step consumers up or down and tracking consumers across the steps, and strategies for improving service integration. Suggestions for improving uptake of low intensity services related to flexibility in type and dose of treatment and changing the language used to name and describe services. Finally, suggestions for improving youth enhanced services related to service characteristics and availability, clarifying eligibility criteria and addressing workforce shortages to improve seamless consumer access; and access to good localised data and resourcing for evaluation to improve planning and contribute to the evidence-base, respectively.

Table 6. Suggestions for improving PHN activity in Lead Site Project focus areas

	Focus area			
Suggestion	Regional planning and service integration	Stepped care	Low intensity services	Youth severe services
Funding mechanisms that support the reforms (e.g., alignment of state and national funding or models that support providers to engage with other services)	✓	✓		
Making integration part of the national health reform agenda by seeking more input from, and collaboration and alignment with, other Departments and sectors	✓			
Better engagement and representation of certain stakeholder groups in consultations (e.g., consumers, carers, private providers, local mental health services) and diversity within each stakeholder groups via • PHNs developing an organised and systematic consultation framework • PHNs using multiple consultation methods to maximise opportunities for stakeholder participation • PHNs better promoting opportunities for carers to contribute	✓		✓	✓
Involving people with lived experience at all stages – from planning to implementation (e.g., PHNs making carer involvement a contractual requirement)	✓	✓	✓	✓
Ongoing regional planning and regular review of planning with input from new stakeholders	✓			
Increased focus on evaluation and quality processes (e.g., build evidence about low intensity programs and use of peer-led, unaccredited workforce)	✓		✓	
More time for effective consultation and planning	✓	✓		
PHNs strengthening relationships with and between referrers and via efforts to improve communication with and information sharing among providers and between providers and referrers providers (e.g., formalising relationships and processes in tender and contract documents; opportunities and resources for providers to share best practice by hosting regional network events)	✓	✓	✓	✓
PHNs clearly articulating their role in the regional mental health system	✓			
Developing systems and tools to facilitate Integration – e.g., intake (one-door entry) system to improve triaging, common electronic records	✓	✓		✓
Review stepped care model		✓		
Supporting providers to step consumers up or down (e.g., agreed protocols, system for tracking consumers across steps)		✓		
Ongoing/better communication from PHNs to stakeholders about the rationale and process of stepped care (e.g., better targeted marketing strategies for each stakeholder group including campaigns for the public)		✓		
More specific guidance for PHNs on assessment and referral		✓		
More co-located, integrated, complementary and/or holistic (wrap-around) services		✓		✓
More integration (e.g., national services into stepped care model, youth enhanced services with other youth services)		✓		✓
More consideration of the impact of the NDIS		✓		
More equitable services across regions		✓		
Availability of more sessions			✓	
Broader therapeutic scope			✓	
Using better language used to name and describe services			✓	
Access to good localised data				✓
Service specifications informed by learnings from successful service models				✓
Innovative strategies to address workforce shortages (e.g., focus on core competencies and alternative workforce options, sustainable strategies to improve access to psychiatry, especially in rural and remote areas)				✓
Longer service contracts with commissioned providers				✓
Address service gaps and high demand				✓
Responsive, flexible services (e.g., outreach)				✓
Improved access to psychiatry				✓
Clearer eligibility criteria				✓
Resourcing for local evaluation				✓
Better use of technology and ehealth				✓
Reducing competition between providers				✓
Co-designing services				✓
Extending type (e.g., young carers) and availability of services (e.g., after hours)				✓
Better promoting available services				✓

1.4 Recommendations

This report has highlighted noteworthy achievements of the Lead Sites in leading the primary mental health care reforms. Lead Sites' achievements are evidenced by the significant progress they have made in engaging a diverse range of stakeholders to contribute to regional planning and service integration. They have commissioned a wide range of stepped care services and a variety of services that are low intensity or target youth with, or at risk of, severe mental illness. However, the implementation process has not been without challenges and barriers. Therefore, we have made some recommendations, based on our evaluation findings, that are intended to strengthen activity and progress with primary mental health care reforms across all 31 PHNs.

Ultimately, the goal of PHN-led mental health reforms is to ensure that consumers and carers receive the right, efficient, integrated and effective mental health care at the right time. This is reliant on commissioned mental health providers delivering such services. The following five high level recommendations – and associated actions by PHNs and the Department of Health – are likely to contribute to this goal.

RECOMMENDATION 1: STRENGTHEN ENGAGEMENT AND RELATIONSHIPS WITH REGIONAL AND OTHER KEY STAKEHOLDERS

Key finding 1: Collaboration and strong relationships with regional and other key stakeholders is essential to achieving the goals of regional planning, service integration and stepped care.

PHNs should build/strengthen/maintain effective linkages with and between a broad range of regional and other key stakeholders; and include them in their planning, commissioning and implementation activities. To this end, PHNs could use creative means to encourage collaboration among stakeholders. Approaches that were successful include:

- Joint planning and commissioning arrangements between PHNs and LHNs;
- Co-design of services;
- Commissioning via consortium-led or partnership arrangements; and
- Use of formalised partnership agreements.

The **Department of Health** could contribute to national service integration efforts by strengthening relationships and collaboration with other relevant government departments (e.g., employment, welfare payments, justice) and health services (e.g., state/territory mental health, physical health, non-government organisations providing psychosocial support). Some options for achieving this might include convening a whole of government mental health conference that involves heads from other sectors, establishing an inter-departmental committee that meets at least annually, or developing collaboration arrangements with integrated partnerships between states/territories, LHNs and PHNs.

Key finding 2: PHNs vary in the extent to which they involve consumer and carer stakeholders in commissioning related activities.

PHNs should involve consumers and carers or representatives in all stages of commissioning (from planning to implementation and evaluation). Each PHN should employ and remunerate at least one consumer and carer representative. PHNs could:

- Play a role in resourcing and upskilling consumers and carers in a way that fosters true co-design of services with support from the Australasian international association for public participation (iap2; https://www.iap2.org.au) and the PHN National Mental Health Lived Experience Engagement Network (MHLEEN);
- Seek advice from PHNs, such as Brisbane North, that are already successfully engaging consumers and carers; and

- Use contractual agreements to ensure that providers also involve consumers and carers in their design and delivery of services.

The **Department of Health** could ensure that consumers and carers are involved in all stages of commissioning by including this as a contractual obligation of PHNs and providing funding devoted to this purpose. An existing (e.g., through iap2) or new tool could be used to measure the extent of genuine involvement by people with lived experience, which could be included in the Department of Health mandated KPIs.

RECOMMENDATION 2: IMPROVE STEPPED CARE SERVICE COMMISSIONING, IMPLEMENTATION AND PROMOTION

Key finding 3: A range of innovative, flexible (e.g., type, modality, length) and responsive stepped care services should be commissioned, promoted and governed to meet consumer and carer needs and preferences, and increase access.

PHNs should:

- Commission a broader range of stepped care services, including non-clinical/wrap-around/complementary services (e.g., educational, vocational, social) – particularly for people with higher intensity mental health needs – either through individual or multiple service provider agencies. Commissioned services should use multiple delivery modalities (e.g., face-to-face, phone and ehealth) and help to increase access (e.g., by offering after hours or outreach appointments); and

1. Take a flexible, iterative approach to planning, commissioning and implementing services that facilitates changes in response to evolving regional needs.

Key finding 4: Provider and community stakeholder understanding, and implementation of stepped care and low intensity services needs to be improved.

PHNs should:

2. Further promote the stepped care model and low intensity services to improve stakeholder awareness and access to services by using clear and ongoing communication and lay language that emphasises the strengths and benefits of stepped care and low intensity services. This communication could be targeted at referrers and other regional stakeholders, particularly GPs. It could also be targeted at the broader community (e.g., through information sessions, communications pieces);
3. Offer more support to referrers to help them effectively refer consumers to the intensity of services they need (e.g., through use of central intake);
4. Offer more support to providers to step consumers up or down, ensuring that processes are as simple as possible; and
5. Incorporate step-up/step-down protocols in contracts with providers.

The **Department of Health** should:

- Play a role in using the lay and strengths-based language (mentioned above) to describe stepped care and low intensity services more broadly across other health services, so that it is understood that this is the health system approach; and
- Explore means of using funding mechanisms to better support stepped care and service integration (e.g., incentivising providers to step consumers up or down as appropriate).

RECOMMENDATION 3: ADDRESS WORKFORCE ISSUES

Key finding 5: There is a notable shortage in access to psychiatry and the capacity of the existing mental health workforce needs to be built and maintained.

PHNs should:

- Explore innovative ways of improving access to psychiatry and GP services for people with higher intensity needs, especially in rural and regional locations (e.g., telehealth) and for young people;
- Build the capacity of the commissioned provider workforce, particularly in the context of youth enhanced and low intensity services (e.g., training mental health practitioners in core competencies for delivering youth enhanced services and peer workers to deliver low intensity services, offering other professional development opportunities), and in rural and regional areas; and
- Offer commissioned providers professional development opportunities and/or use contracts with commissioned providers to mandate clinical supervision so that providers can maintain or build on competencies, receive support and ensure service quality.

The **Department of Health:**

- Should progress the Mental Health Workforce Strategy; and
- Could facilitate PHN efforts to address workforce issues by providing them with funding that may be required to implement these activities or incentivising psychiatrists and GPs to contribute to this type of service delivery.

RECOMMENDATION 4: IMPROVE PHN ACCESS AND CONTRIBUTION TO QUALITY DATA

Key finding 6: PHNs need access to comprehensive, meaningful regional data to inform their needs assessments and commissioning priorities.

PHNs could work with key regional stakeholders, such as LHNs and GPs, to gain access to these data.

The **Department of Health** could facilitate PHN access to regional data on federally funded services (e.g., MBS, PBS) on an ongoing basis (e.g., at contract renewal).

Key finding 7: PHNs need to contribute to the mental health system evidence base by collecting and reporting good quality data on the uptake and outcomes of commissioned services in their regions.

PHNs should:

- Foster commissioned provider awareness of the value of data collection and reporting requirements;
- Build the capacity of providers (e.g., offering PMHC MDS training);
- Incorporate data compliance requirements in contracts with providers; and
- Conduct local evaluations, particularly of new and innovative services.

The **Department of Health** could explore mechanisms for building the capacity of PHNs to conduct local evaluations of new services.

Key finding 8: The PMHC MDS does not adequately capture key elements of the new PHN-commissioned service delivery system.

The **Department of Health** should commission appropriate modifications to the PMHC MDS to capture service delivery system changes (e.g., transition of consumers between steps, consumers simultaneously receiving services across steps, uniform recording of youth enhanced services).

RECOMMENDATION 5: THE CAPACITY OF PHNs TO LEAD THE PRIMARY MENTAL HEALTH REFORMS SHOULD CONTINUE TO BE SUPPORTED

Key finding 9: Department of Health support of PHNs and responsiveness to their needs has facilitated the achievements of PHNs.

The **Department of Health** should continue to:

- Provide resources (funding and guidance) for mental health services commissioned by PHNs;
- Take a collaborative and responsive approach to PHN needs;
- Build the capacity of PHNs at a national level while supporting the flexibility and diversity of PHNs at the regional level. This includes providing guidance materials and commissioning special projects when needed, such as the existing National Initial Assessment and Referral in Mental Healthcare Project; and
- Support PHNs with refining centralised intake (e.g., through the National Initial Assessment and Referral in Mental Healthcare Project) and exploring options for common electronic records to facilitate service integration and tracking consumers across the stepped care approach.

Key finding 10: Key barriers – such as tight timeframes and engaging carers – need to be addressed.

The **Department of Health** could:

1. Grant PHNs flexibility with timeframes and contract lengths where possible to facilitate better regional planning and service development; and
2. Commission a project to explore carer needs and find out how to better engage carers in the PHN-led primary mental health care reforms.

1.5 Conclusions

PHNs have been charged with a significant undertaking to modify Australia's primary mental health care system by engaging a diverse range of stakeholders in their regions, and planning and commissioning stepped care services to improve the mental health of people in their regions. The services commissioned by PHNs are intended to specifically target hard-to-reach groups and not the entire help-seeking population, which is better served through other components of Australia's mental health system (e.g., the larger-scale Better Access program, state-funded public mental health services and the not-for-profit sector). Lead Sites' efforts appear to be improving access to care and leading to positive outcomes for significant numbers of consumers. The four focus areas of the Lead Site Project – joint regional planning and service integration, stepped care, low intensity psychological interventions and youth enhanced services – are still relatively new elements of the Australian primary mental health care landscape and will continue to mature with time. Together, key stakeholders are investing impressive efforts to improve the mental health of hard-to-reach groups of the Australian population through better regional planning, service integration and ensuring that consumers get the right care at the right time, and importantly, in accordance with their preferences.

2. Background

2.1 Primary mental health care reform

Since 2001, the Australian Government has been funding primary mental health care through various complementary targeted and population-based national programs to improve treatment rates and outcomes for people with mental disorders.

Most recently, primary mental health care delivery in Australia has undergone a period of significant change as a result of inter-related sets of policy reforms in primary care and mental health care. In primary care, the new policy context was set by the establishment of 31 Primary Health Networks (PHNs). These were established in July 2015 following a review of their predecessors, Medicare Locals.[17] The objective of PHNs is to increase 'the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time.'[3] (p.7) PHNs are to achieve this objective by understanding the needs of their communities, supporting GPs and other primary care providers in a variety of ways so that they can offer optimal care, and purchasing or commissioning services.[3] PHNs have an explicit focus on those in their communities who are most in need, including patients with mental illness.[3]

The mental health policy context has been guided by the National Mental Health Commission's review of mental health programs and services[1] and the Australian Government's response to that review.[2] This has led to an expanded role for PHNs in the planning and commissioning of primary mental health care services, via what is known as the Primary Mental Health Care Activity (the Activity).[4] The Activity forms part of the larger PHN Grant Program and contributes to its objectives by 'increasing the efficiency and effectiveness of primary mental health and suicide prevention services for people with or at risk of mental illness and/or suicide, and improving access to and integration of primary mental health care and suicide prevention services to ensure people with mental illness receive the right care at the right time.'[4] (p.1)

Under the Activity, pooled funding of approximately $1.030 billion (GST exclusive) has been made available to PHNs over three years commencing in 2016-2017[4] so they can commission services in six mental health priority areas:

1. Low intensity services;
2. Psychological therapies for underserviced populations;
3. Child and youth services;
4. Services for adults with severe and complex mental illness;
5. Indigenous mental health services; and
6. Suicide prevention.[4]

Achieving positive outcomes in the six priority areas is expected to be underpinned by two approaches to service delivery. The first is improved integration of services through evidence-based regional mental health and suicide prevention plans, and service mapping to identify needs and gaps, reduce duplication, remove inefficiencies and encourage integration.[4] The second approach involves a mandate to introduce and operationalise stepped care. The general principle behind the stepped care approach is that an individual with mental health problems receives the least intensive level of care that is likely to be effective given their treatment need, making the best use of available workforce and technology.[4] The six priority areas and the principles that underpin them are closely aligned with eight targeted priority areas of the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan).[5]

Prior to these reforms, the Australian Government funded Medicare Locals to implement targeted primary mental health care programs. The most significant of these was the Access to Allied Psychological Services (ATAPS) program, which operated from July 2001 to June 2016 and increasingly targeted hard-to-reach groups from 2008. From July 2003 (when routinely collected data became available) to June 2016, ATAPS offered over 2.8 million sessions and 530,000 episodes of low-cost or free mental health care to 470,000 people.[18] Of these, 387,000 sessions were offered, and 68,000 episodes of care were delivered, in the final year of operation of ATAPS (July 2015 to June 2016).[18] The evaluation of ATAPS showed that, where outcome data on standardised measures were available, the mental health of its consumers improved.[18] In an effort to improve efficiency and effectiveness, the services previously delivered via ATAPS and other federally funded programs[f] have now been subsumed under the Activity. This means that PHNs are expected to commission these and other types of services according to the needs of their local communities.

Additionally, as part of the Activity, it is expected that PHNs will maintain (and expand) the delivery of primary mental health services targeting young people aged 12 to 25 years with, or at risk of, mild to moderate mental illness. This includes commissioning headspace centres (of which there are currently 100 nationwide) that have been delivering primary mental health services to young people since 2006.[19] Services delivered by headspace are also funded through sources additional to those offered via the PHN program grant (e.g., the Medicare Benefits Schedule [MBS][g]).[20]

Finally, to further contextualise the current PHN-led mental health reforms, it should be noted that they are taking place alongside the continuation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative, which was introduced in November 2006. Funding for Better Access is unlimited in the sense that as many eligible people[21] who want services can receive them. Over 2.4 million people (over 10% of the population) accessed at least one service through the initiative in 2016-2017.[22] However, there is currently a limit of 10 individual and 10 group sessions per person per calendar year.[21]

2.1.1 SUPPORT AND RESOURCES FOR PHNS

The Department of Health has provided PHNs with a range of tools and resources to support them with achieving their remit in relation to planning, commissioning, implementing, and integrating stepped care primary mental health services within their local regions. For example, the Department of Health website (http://www.health.gov.au/PHN)[6] provides resources for PHNs such as needs assessment guides, grant and program guidelines, commissioning resources, guidance materials, data and circulars. The Department of Health has commissioned the University of Queensland to assist PHNs to use the decision support tools available through the National Mental Health Service Planning Framework (NMHSPF)[h].[7, 8] In addition, in October 2017, the Department of Health launched the Digital Mental Health Gateway, Head to Health, which aims to provide a central entry point for national low intensity telephone- and web-based mental health services (www.headtohealth.gov.au).[9, 10] Finally, the Department of Health is providing opportunities for knowledge transfer across the PHN network through forums such as bi-annual stepped care workshops.

---

[f] Examples of former federally funded programs are the Mental Health Services in Rural and Remote Areas (MHSRRA), and the Mental Health Nurse Incentive Program (MHNIP) that provided clinical care coordination for people with more severe mental illness.

[g] The MBS is Australia's publicly funded universal health care system.

[h] The NMHSPF is a tool designed to help plan, coordinate and resource mental health services to meet population needs.[8] It is an evidence-based framework providing national average benchmarks for optimal service delivery across the full spectrum of Australian mental health services.[8] In order to facilitate optimal service delivery, the NMHSPF brings together data about the epidemiology of mental disorders, resources, costs, workforce availability, bed-based services, state ambulatory programs, federal clinical programs, community support sector programs, high intensity adult community support services and youth resources.[7] PHNs were provided with reports containing these data for their geographic regions in 2017.[7]

2.2 The Primary Health Network Mental Health Reform Lead Site Project (Lead Site Project)

All 31 PHNs have been funded to commission primary mental health services in the above-mentioned six priority areas, but 10 have been selected to act as mental health reform leaders in the PHN Mental Health Reform Lead Site Project (the Lead Site Project). The Lead Site PHNs are the following:

- Eastern Melbourne;
- South Eastern Melbourne;
- North Western Melbourne;
- Central and Eastern Sydney;
- Murrumbidgee;
- North Coast;
- Perth South;
- Brisbane North;
- Tasmania; and
- Australian Capital Territory.

These Lead Sites have been tasked with providing enhanced services in nominated key focus areas (e.g., by fast-tracking their activity in these service areas, establishing different partnerships and funding arrangements for services, and/or trialling approaches that are innovative in terms of types and modes of commissioned services). The key focus areas are listed below (the first two are overarching areas, and the next three are service delivery areas):

1. Regional planning and service integration;
2. Stepped care;
3. Low intensity services;
4. Services for youth with, or at risk of, severe mental illness (youth enhanced services); and
5. Clinical care coordination for adults with severe and complex mental illness.

All 10 Lead Sites are focussing on regional planning and service integration, stepped care and low intensity services. Three of the 10 Lead Sites (Australian Capital Territory, South Eastern Melbourne, and Tasmania) are also focussing on services for youth with, or at risk of, severe mental illness. Another three of the 10 Lead Sites (Brisbane North, North Coast, and North Western Melbourne) are also focussing on clinical care coordination for adults with severe and complex mental illness. In addition to the supports available to all PHNs (mentioned in Section 1.1.1), Lead Sites are offered more frequent opportunities to share their knowledge and collaborate (e.g., through face-to-face meetings and telephone conferences).

Suicide prevention activities sit outside the Lead Site Project but are the focus of a parallel project known as the National Suicide Prevention Trial. The National Suicide Prevention Trial involves selected PHNs providing enhanced suicide prevention activities. The National Suicide Prevention Trial involves 11 PHNs, five of which are also participating in the Lead Site Project (Brisbane North, North Coast, North Western Melbourne, Perth South and Tasmania).

2.2.1 OVERARCHING FOCUS AREAS OF THE LEAD SITE PROJECT

2.2.1.1 Regional planning and service integration

As part of their contractual obligations under the Activity, PHNs were required to develop a Regional Mental Health and Suicide Prevention Plan (Regional Plan), originally due to be completed by September 2017 and then extended to March 2018.[7] However, this undertaking was removed as a contractual obligation in 2017 by the Department of Health to alleviate the burden associated with multiple reporting requirements. This decision was made in the context that under the Fifth Plan, PHNs also need to complete joint regional mental health and suicide prevention plans with Local Hospital Networks (LHNs)[i] and other stakeholders, including consumers[f] and carers[j].[5] [24, 25] The Council of Australian Governments (COAG) endorsed the Fifth Plan in August 2017.[5] As a result, all PHNs are continuing to undertake planning activities and work towards joint regional plans in accordance with the Fifth Plan.

The term 'regional planning' is used throughout this report to refer to service planning in local PHN areas either in association with Regional Plans specifically or planning processes and activities more broadly.

2.2.1.2 Stepped care

As previously mentioned, PHN-led primary mental health care reforms require PHNs to plan and commission services for their local geographic regions within a stepped care approach. Stepped care is defined as:

> '… an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as one directional steps, but rather offer a spectrum of service interventions.'[26]

A stepped care approach promotes person-centred care in which individuals are more likely to receive a service that optimally matches their needs, does not under- or over-service them, and makes the best use of workforce and technology.[26] It also promotes early intervention and the availability of lower intensity steps to support individuals before mental illness manifests.[26] Within a stepped care approach and where clinically appropriate, it is possible for an individual to simultaneously receive services of varying intensity (across the steps).[26]

Additionally, a stepped care approach to planning and commissioning primary mental health services necessitates the broadening of the mental health workforce. For example, a low intensity workforce, including people appropriately trained (e.g., Certificate III or IV, recognised cognitive behavioural therapy [CBT] training) or a supported peer workforce[k] could deliver services to people with, or at risk of, mild mental illness. Peer workers can provide services that complement clinical services of higher intensity provided by GPs, mental health professionals (psychologists, mental health nurses and other allied health professionals) and psychiatrists.[26, 28]

2.2.2 SERVICE DELIVERY FOCUS AREAS OF THE LEAD SITE PROJECT

---

[i] LHNs are entities established by state and territory governments to manage single or small groups of public hospitals, including managing budgets and being directly responsible for performance. LHNs can also manage other health services (e.g., community health services). LHNs are termed variably across jurisdictions (e.g., Local Hospital Districts in New South Wales, Health and Hospital Services in Queensland, Local Health Services in South Australia and the Tasmanian Health Service in Tasmania).[7]

[j] Throughout the report, the term consumer is used to refer 'to a person who has had a personal experience of mental illness and who has used mental health services' and the term carer is used to refer to 'a person who provides unpaid care and support to a relative or friend who is experiencing a mental illness'.[23]

[k] Peer workers are 'employed on the basis of their personal lived experience of mental illness and recovery (consumer peer worker) or their experience of supporting family or friends with mental illness (carer peer worker)' in addition to other required skills and experience for their role.[27]

2.2.2.1 Low intensity services

PHNs have been tasked with improving 'targeting of psychological interventions to most appropriately support people with, or at risk of, mild mental illness' in their local regions by developing and/or commissioning low intensity mental health services.[10] Low intensity services are intended to provide an efficient and less expensive option to psychological services available through Better Access and other primary mental health care services funded from the PHN flexible pool, as a form of early intervention.[10] Low intensity services support self-management, emphasise skill development, are short term, are highly focused and offer an important initial service 'step' within a stepped care approach.[10] Low intensity services are also intended to complement Head to Health.

2.2.2.2 Services for youth with, or at risk of, severe mental illness

PHNs are required to commission primary mental health care services for children and young people with, or at risk of, mental illness being managed in primary care, including headspace centres nationally.[19] They are also specifically mandated to develop and commission new early intervention services to meet the needs of young people with, or at risk of, severe mental illness who can be appropriately managed in the primary care setting. This includes supporting transition arrangements associated with services formerly funded under the Early Psychosis Youth Services program and commissioning services to meet the unique and diverse needs of young people (e.g., additional services, complex packages of care, broader range of professional support).[19]

All 31 PHNs are expected to commission services in this focus area, but as mentioned at the start of Section 1.2, three Lead Sites (Australian Capital Territory, South Eastern Melbourne and Tasmania) have been tasked with providing enhanced or innovative services. The Department of Health has commissioned Orygen: The National Centre of Excellence in Youth Mental Health (Orygen) to support all 31 PHNs in the development and commissioning of services for young people with, or at risk of, severe mental illness. Examples of the support offered by Orygen include guidance for PHNs to help them identify effective and evidence-based programs and models of service in their regions and effectively implement and evaluate programs and services.[29] Orygen is providing this support using multiple mechanisms (e.g., hosting national forums or regional meetings, online and face-to-face opportunities that promote collaboration between PHNs and other key stakeholders).[29]

2.2.2.3 Clinical care coordination for people with severe and complex mental illness

PHNs are required to commission primary mental health care services through the primary mental health care funding pool for people with severe mental illness being managed in primary care.[30] This includes clinical care coordination through the phased implementation of primary mental health care packages and the use of mental health nurses.[30] PHNs have an important role in promoting links and easy-to-navigate referral pathways between clinical services they commission using the flexible funding pool and broader support services for people with severe mental illness.[30] Broader support services may include other federally funded programs in which PHNs may be directly or indirectly involved, like Partners in Recovery (PIR)[l] and Support for Day to Day Living

---

[l] PIR aims to support people with severe and persistent mental illness with complex needs and their carers and families, by getting multiple sectors, services and supports they may come into contact with (and could benefit from) to work in a more collaborative, coordinated and integrated way. PIR is transitioning to the NDIS.[31]

(D2DL)[m]; relevant services provided by LHNs; and services delivered through the National Disability Insurance Scheme (NDIS)[n].[30]

As mentioned at the start of Section 1.2, three Lead Sites (Brisbane North, North Coast, and North Western Melbourne) have been funded to trial innovative models of care to support clinical care packages for individuals with severe and complex mental illness.[30]

2.3 Evaluation of the Lead Site Project

The evaluation of the Lead Site Project aims to gather information on the approaches taken by Lead Sites to the planning, integration and delivery of mental health services, and to identify the implications for future government policy and the activities of PHNs more generally. The evaluation has been guided by the Lead Site Project Evaluation Framework.[11]

The Department of Health commissioned our team from the University of Melbourne to evaluate the Lead Site Project. The evaluation has two major parts (Part A and Part B), each with separate requirements. Part A is led by the University's Centre for Mental Health and relates to the first four of the five focus areas (regional planning and service integration; stepped care; low intensity services; and services for youth with, or at risk of, severe mental illness). The approach to evaluation of these areas shares the same set of evaluation questions and similar data sources and methodology.

Part B is led by the University of Melbourne's Department of General Practice and relates to the fifth focus area (clinical care coordination for adults with severe and complex mental illness). This part of the evaluation involved a trial that became known as Link-me. General practices that participated in Link-me identified patients with severe and complex mental illness who were eligible for clinical care coordination, as well as patients with lower level needs who were eligible for low intensity services. Findings from the Link-me trial will provide information on the effectiveness and cost-effectiveness of both low and high intensity services. The final results of the trial will be submitted to the Department of Health in September 2020.

2.3.1 PART A EVALUATION

Data for the Part A evaluation, which involves all 10 Lead Sites, were collected in two Rounds. Round 1 findings are described in an interim report.[12] In the current report, we present findings from Round 2 and highlight any changes since Round 1. The Lead Sites are de-identified throughout the report except where we provide contextual information on the overarching and service delivery focus areas of the Lead Site Project.

2.3.1.1 Evaluation objectives

As described in the Evaluation Framework that was developed by the Department of Health,[11] the objectives of Part A are to:

1. Describe the process taken by Lead Site PHNs to regional planning and integration, implementation of a stepped care model of service delivery and establishment of services in the identified service delivery focus areas (low intensity and services for youth with, or at risk of, severe mental illness);

---

[m] D2DL is a structured activity program that aims to improve quality of life for individuals with severe and persistent mental illness by offering structured and socially based activities in recognition that meaningful activity and social connectedness are important factors that can contribute to people's recovery.[32]

[n] The NDIS, introduced in July 2016, provides support for Australians with disability (under the age of 65), their families and carers to live an ordinary life by helping them access mainstream services and supports, access community services and supports, maintain informal support arrangements, and receive reasonable and necessary funded supports.[33]

2. Gather and analyse information from a broad range of informants at the regional level in response to key questions identified as essential for informing future primary mental health care service delivery;
3. Understand the factors impacting on the effectiveness of services commissioned by PHNs; and
4. Identify the implications of activity across the project for future PHN activity and government policy in relation to primary mental health care.[11]

2.3.1.2 Evaluation questions

The Evaluation Framework also outlines four primary evaluation questions for Part A, operationalising them in slightly different ways depending on the specific focus area to which they are applied, and following them with more specific secondary evaluation questions.[11] The overarching primary evaluation questions are:

1. What approaches were undertaken by Lead Sites to the planning, commissioning, management and delivery of services in each of the focus areas?
2. What activities and approaches were found by the Lead Sites to be effective in achieving objectives in each of the focus areas?
3. What were the barriers and facilitators to achieving objectives in each of the focus areas?
4. What are the implications for future activity by PHNs and primary health care reform more generally?

3. Method

3.1 Design

The Evaluation Framework indicates that Part A should focus on implementation processes and early outcomes.[11] In program evaluation language, this is described as a process and impact evaluation.[34, 35] A process evaluation typically assesses the systems and infrastructure underpinning a program, looks at the processes through which the program is being delivered, and seeks information on indicators like reach and quality. An impact evaluation measures the immediate effect of the program in terms of the extent to which it is meeting its lower- and mid-level objectives. These types of evaluation can be distinguished from an outcome evaluation, which measures the longer-term effects of the program, assessing whether it is meeting its higher-level objectives.[34, 35]

The Evaluation Framework is explicit about the evaluation questions to be addressed in Part A (see Section 1.3.1.2) and about the primary data sources to be used to answer these. Often, multiple data sources are used to answer a single question. ‘Triangulating’[36] data in this way allows us to determine whether different information drawn from different perspectives presents a similar picture. If it does, this will strengthen the conclusions we can draw. If it does not, it will point to areas and issues that require further exploration.

3.2 Primary data sources

We collected and analysed routinely collected data and data from stakeholder consultations in two rounds to track implementation progress and give Lead Sites an opportunity to commission services by Round 2. We conducted Round 1 data collection and analysis from September 2017 to May 2018. We collected Round 2 data from September 2018 to April 2019. We gathered and analysed data from observational or participatory data as they became available. Routinely collected data for all 31 PHNs were analysed – for services delivered from 1 July 2016 to 31 December 2017 in Round 1, and from 1 July 2016 to 31 December 2018 in Round 2 – to provide context. All other data sources relate specifically to the 10 Lead Site PHNs. Lessons learned from Round 1 data collection were used to improve data collection in Round 2.[12] Specifically, in Round 2, we: did not analyse annual activity work plans and 12-month performance reports, modified some of the questions we asked of stakeholders, removed processes related to linking consumer survey data with routinely collected data, added a safety protocol as part of the consumer survey procedures, and used multiple strategies to increase representation of carer stakeholder views.

The Evaluation Framework lists a series of primary data sources against each primary evaluation question for each focus area.[11] We have grouped those used in Round 2 into the following categories:

a. **Routinely collected data (on services delivered from July 2016 to December 2018)**

Service use data (including service contacts; episodes of care; consumer socio-demographic and clinical characteristics; and outcomes) from the:

- Primary Mental Health Care Minimum Data Set (PMHC MDS) (all 31 PHNs);
- Access to Allied Psychological Services (ATAPS) MDS (all 31 PHNs);
- headspace MDS (HAPI system) (all 31 PHNs).

b. **Stakeholder consultations**

- Consultations with staff from Lead Sites via focus groups (see Appendix 1);
- Consultations with referrers and mental health practitioners via surveys (see Appendices 2 and 3, respectively);
- Consultations with Lead Site regional and other key stakeholders (e.g., LHNs, other individual providers or services) via focus groups and/or written responses (see Appendix 4);
- Consultations with consumers via surveys (see Appendix 5); and
- Consultations with carers:
    i. carer representatives from Lead Site regions via focus groups or written responses (see Appendix 4);
    ii. carers via surveys (see Appendix 6).

c. **Observational and participatory data**

- From national PHN workshops and Lead Site events.

d. **General input**

- Input from key stakeholders either directly or indirectly involved in the PHN-led mental health reforms, but not specifically involved in the Lead Site Project (e.g., Orygen, headspace).

Before commencing data collection or making any changes to our procedures, we obtained approval from the Melbourne School of Population and Global Health's Human Research Ethics Advisory Group and the Human Ethics Sub-Committee at the University of Melbourne.

3.2.1 SUMMARY OF THE RELATIONSHIP BETWEEN EVALUATION QUESTIONS AND DATA SOURCES

Table 7 provides a schematic representation of the relationship between each primary evaluation question and each of the categories of Round 2 data sources. It indicates the data sources that were used to inform each primary evaluation question in each of the focus areas. It reinforces the cohesiveness of the evaluation questions and illustrates the fact that each data source was used to answer multiple evaluation questions.

We primarily used routinely collected administrative data to provide broad insights about reach of services commissioned by Lead Sites. In addition to setting the scene, this data source informed some of the evaluation questions. Our consultations with various groups of stakeholders garnered their views on commissioning, referring to, or delivering, services. Our consultation with consumers and carers elicited their experiences of receiving services. Finally, we supplemented these key data sources with observational and participatory data from our attendance at workshops and meetings, and general input about PHN-led mental health reforms. The Round 2 evaluation findings are therefore presented in this order in the current report.

Table 7. Data sources used to inform primary evaluation questions in each focus area

Primary evaluation question[o]	Focus area	Data source								
		Routinely collected data[p]	Consultation with Lead Sites	Consultation with referrers	Consultation with mental health practitioners	Consultation with other Lead Site regional stakeholders[q]	Consultation with consumers	Consultation with carers	Observational and participatory data[r]	General input[es]
What approaches were undertaken by Lead Sites to the planning, commissioning, management and delivery of services in each of the focus areas?	Regional planning and service integration		✓			✓		✓	✓	✓
	Stepped care		✓			✓	✓	✓	✓	✓
	Low intensity services		✓			✓	✓	✓	✓	✓
	Services for youth with, or at risk of, severe mental illness		✓			✓	✓	✓	✓	✓
What activities and approaches were found by the Lead Sites to be effective in achieving objectives in each of the focus areas?	Regional planning and service integration		✓			✓		✓	✓	
	Stepped care	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Low intensity services	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Services for youth with, or at risk of, severe mental illness		✓	✓	✓	✓	✓	✓	✓	✓
What were the barriers and facilitators to achieving objectives in each of the focus areas?	Regional planning and service integration		✓			✓		✓	✓	✓
	Stepped care		✓	✓	✓	✓	✓	✓	✓	✓
	Low intensity services		✓	✓	✓	✓	✓	✓	✓	✓
	Services for youth with, or at risk of, severe mental illness		✓	✓	✓	✓	✓	✓	✓	✓
What are the implications for future activity by PHNs and primary health care reform more generally?	Regional planning and service integration		✓			✓		✓	✓	✓
	Stepped care		✓	✓	✓	✓		✓	✓	✓
	Low intensity services		✓	✓	✓	✓		✓	✓	✓
	Services for youth with, or at risk of, severe mental illness		✓	✓	✓	✓		✓	✓	✓

---

[o] The Evaluation Framework operationalises these primary evaluation questions in slightly different ways depending on the specific focus area they are applied to and follows them with more specific secondary evaluation questions

[p] Consultations with regional and other key stakeholders – e.g., LHNs, other service providers

[q] Service use data from the PMHC, ATAPS and headspace MDSs, administrative funding data

[r] Observational or participatory data from national PHN workshops and Lead Site meetings

[s] Input from Orygen and headspace – not exclusively or necessarily involved with Lead Site region

4. Routinely collected data

4.1 Summary of approach

We analysed routinely collected administrative data covering the period from July 2016 to December 2018. Specifically, the data were from the Primary Mental Health Care (PMHC) MDS,[37] the former Access to Allied Psychological Services (ATAPS) MDS and the headspace MDS . PMHC and ATAPS data were extracted on 19 February 2019 and headspace data were extracted on 1 February 2019. We added Australian Standard Geographical Classification – Remoteness Area (ASGC-RA)[38] and Index for Relative Socio-Economic Disadvantage (IRSD)[39] to the data by using consumer postcodes and 2016 Australian Bureau of Statistics Census data.

4.2 Minimum data set

As mentioned in Section 2, routinely collected administrative data are primarily presented to provide context before discussion of other data sources that more directly address the evaluation questions. Routinely collected data provide information about the volume and type of services provided, and consumer outcomes, in relation to two of the Lead Site Project focus areas – stepped care (using principal focus of treatment plan [principal focus] as a proxy; see Box 3.1 below) and low intensity services. The data do not provide information about services for youth with, or at risk of, severe mental illness because these services are not identified in routine reporting.

Box 3.1. PMHC MDS key concepts

Service contact – provision of a service by a PHN commissioned mental health service provider for a client where the nature of the service would normally warrant a dated entry in the clinical record of the client. Service contacts can be either with the client or with a third party (e.g., carer or family member) and/or other service provider and do not include services of an administrative nature (e.g. telephone contact to schedule an appointment).

Episode of care – a more or less continuous period of contact between a client and a PHN-commissioned provider organisation/clinician that starts at the point of first contact, and concludes at discharge. Episodes comprise a series of one or more Service contacts.

Discharge – discharge may occur clinically (at the end of treatment) or administratively in instances where contact has been lost with the client (e.g., client could not be contacted, declined further contact, moved out of area or was referred elsewhere). A new episode is deemed to commence if the person re-presents to the organisation.

Principal focus of treatment plan (principal focus) – the range of activities that best describes the overall services intended to be delivered to the client throughout the course of the episode (e.g., psychological therapy, low intensity psychological intervention, clinical care coordination, complex care package, child and youth specific mental health service, Indigenous specific mental health service). For most clients, this will equate to the activities that account for most time spent by the service provider.

This section should be read with four important caveats in mind:

- First, although ATAPS and headspace data were mapped to PMHC MDS data fields, the three data sources capture different information. This is important because the analysis period was July 2016 to December 2018, but PMHC MDS reporting requirements commenced in July 2017. This means that data for the first 12 months of the reporting period were collected via the former ATAPS MDS (see Section 3.2.1.1) which did not include many of the details collected in the PMHC MDS (e.g., low intensity services and other principal focuses of treatment were not differentiated in the ATAPS data). Therefore, the picture presented of PHN-commissioned activity only covers the full range of services for the most recent 18-month period of the 30 months reported. This means there is a higher proportion of missing data than will be expected over time as the PMHC MDS becomes the dominant administrative data source for the collection of PHN-commissioned primary mental health services.

- Second, the PMHC MDS data reported here for all 31 PHNs represents around 85% of known episodes of care and 86% of known service contacts. Unreported data for episodes and contacts are for consumers who have not consented to their de-identified data being provided to the Department of Health. Furthermore, anecdotal evidence suggests that some PHNs are not entering or uploading data for non-consenting consumers in the PMHC MDS at all, which means the proportion of data on which we are reporting is likely to be even lower, compared with all episodes of care and service contacts.
- Third, there are at least some data for our analysis period that were not entered or uploaded in the PMHC MDS before the data extraction date for this report.
- Fourth, it is possible that there is some duplication across (and within) the three administrative data sources that we were unable to identify because different client identifiers can be used for the same person.

One further note on the PMHC MDS data is that headspace services are funded through a variety of sources, such as PHNs and the MBS. Our report includes only headspace service contacts funded by PHNs, which accounts for 51% of headspace contacts. Child and youth mental health services principal focus data therefore capture mostly PHN-funded headspace services and other PHN-funded child and youth mental health services provided by other non-headspace services.

4.2.1 SERVICE VOLUME

Service volume data are provided for all 31 PHNs and broken down by Lead Site status and principal focus.

4.2.1.1 Service contacts through all 31 PHNs

Our starting point for data extraction was that at least one attended service contact for a given episode of care took place in the period from 1 July 2016 to 31 December 2018. This means that contacts for an episode of care where all contacts were unattended ('no show', n = 6,502) were excluded from our analysis of service contacts. In total, 1,543,845 service contacts that were attended took place from 1 July 2016 to 31 December 2018. A further 88,545 service contacts recorded in this period were unattended but were part of the episodes in which other service contacts were attended.

Table 8 presents the relative contribution of ATAPS, PMHC and headspace data. As mentioned above, the majority of service delivery data were captured via the ATAPS MDS in the first two six-month blocks of the reporting period (61% and 52%, respectively). This trend has been reversing over time, with around three-quarters of data captured via the PMHC MDS and one-quarter via the headspace MDS in the most recent six-month block of the reporting period. Table 8 also shows that attended service contacts have continued to increase in each adjacent six-month period – by 14% in January to June 2017, 31% in July to December 2017, 14 % in January to June 2018 and 5% in July to December 2018.

Table 9 presents the number and proportion of attended service contacts by Lead Site status and which is consistent with Lead Sites representing around one third of all PHNs. Overall, most service contacts had a principal focus of psychological therapy (43%) or child- and youth-specific mental health services (35%). However, service contacts via Lead Sites involved proportionally more low intensity services than non-Lead Sites (8% vs 4%), which is consistent with the Lead Site focus on this service area.

Table 8. Attended service contacts through all 31 PHNs by data source and six-month period (July 2016 – December 2018)

Data source	Six-month period											
	Jul-Dec 16		Jan-Jun 17		Jul-Dec 17		Jan-Jun 18		Jul-Dec 18		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
ATAPS[t]	131,345	60.6	129,076	52.1	40,767	12.6	5,435	1.5%	3	0.0	306,626	19.9
headspace	71,560	33.0	82,644	33.4	91,094	28.2	98,296	26.7%	106,630	27.5	450,224	29.2
PMHC	13,917	6.4	35,815	14.5	191,508	59.2	264,709	71.8%	281,046	72.5	786,995	51.0
Total [u]	216,822	100	247,535	100	323,369	100	368,440	100	387,679	100	1,543,845	100

---

[t] It is unclear why service contact data is captured in the former ATAPS MDS in the most recent 18 months of the reporting period; it is possible some of these data are associated with date entry errors.

[u] There are an additional 33 attended service contacts not included in the service contacts total for a new principal focus ‘psychosocial support’, which was added to the PMHC MDS on 21 December 2018.

Table 9. Attended service contacts by Lead Site status and principal focus (July 2016 – December 2018)

	Lead Site				Non-Lead Site				Total	
Principal focus	**Freq.**	**% within Lead Sites**	**% within principal focus**	**% of total**	**Freq.**	**% within Non-Lead Sites**	**% within principal focus**	**% of Total**	**Freq.**	**%**
Psychological therapy	205,026	38.4	31.2	13.3	451,321	44.7	68.8	29.2	656,347	42.5
Low intensity psychological intervention	43,507	8.1	49.7	2.8	44,070	4.4	50.3	2.9	87,577	5.7
Clinical care coordination	57,626	10.8	43.5	3.7	74,922	7.4	56.5	4.9	132,548	8.6
Complex care package[v]	1,469	0.3	17.7	0.1	6,808	0.7	82.3	0.4	8,277	0.5
Child and youth specific mental health service	186,617	34.9	34.6	12.1	352,567	34.9	65.4	22.8	539,184	34.9
Indigenous-specific mental health service	5,772	1.1	15.5	0.4	31,366	3.1	84.5	2.0	37,138	2.4
Other	34,110	6.4	41.2	2.2	48,664	4.8	58.8	3.2	82,774	5.4
Total	534,127	100.0	34.6	34.6	1,009,718	100.0	65.4	65.4	1,543,845	100.0

Note: Percentage within Lead Sites (and non-Lead Sites) provides the column percentage; for example, % within Lead Sites uses 534,127 contacts (total number of contacts in Lead Sites) as denominator. Percentage within principal focus provides the row percentage; for example, the first row uses 656,347 contacts (total number of psychological therapy contacts) as the denominator. Finally, the percentage of total column for both Lead Sites and non-Lead Sites uses 1,543,845 (total number of all contacts) as the denominator.

---

[v] The complex care package data field was intended for exclusive use by the three Lead Sites involved in the Link-me trial, with a possible wider roll-out in the future, pending results of the trial. However, it appears that non-Lead Sites are also using this data field, and the reasons for this are unknown.

4.2.1.2 Mental health practitioners providing service contacts through all 31 PHNs

A total of 12,889 mental health practitioners provided service contacts, 40% of whom did so for Lead Sites, from July 2016 to December 2018 (Appendix 7). Among the Lead Sites, most practitioners were general psychologists (20%) or clinical psychologists (11%), low intensity mental health workers (9%), and ‘other’ types of practitioners (10%). Practitioner type was missing for 34% of practitioners from Lead Sites.

Across both all PHNs and Lead Sites specifically, the average age of practitioners was 46 years (SD = 13). Gender and Indigenous status were not stated or were inadequately described for most Lead Site practitioners (58% and 67%, respectively). Of Lead Site practitioners with these data fields recorded, the majority were female (33%) and did not identify as being of Aboriginal or Torres Strait Islander origin (33%). Eighty-five percent of Lead Site practitioners were recorded to be actively delivering services. Trends were generally similar for non-Lead Site practitioners, with the exception that non-Lead Site practitioners were proportionally four times as likely to identify as being of Aboriginal origin (Appendix 7).

Eighteen percent of Lead Site practitioners had completed recognised training in the delivery of culturally safe services to Aboriginal and Torres Strait Islander peoples. These data were missing for most Lead Site practitioners (65%). Again, this picture was similar for non-Lead Site practitioners (Appendix 7).

Appendix 7 also provides a breakdown of types of practitioners delivering services by principal focus, noting that practitioners can deliver services across multiple principal focuses (Tables 55 – 61). Notwithstanding that practitioner type was not stated for significant proportions of practitioners, across all 31 PHNs:

- 7,652 practitioners provided psychological therapy, most of whom were general psychologists (28%), clinical psychologists (8%), social workers (7%) or mental health nurses (6%);
- 1,304 practitioners provided low intensity psychological interventions, most of whom were general psychologists (24%), mental health nurses (14%), social workers (11%), low intensity mental health workers (10%), clinical psychologists (7%), GPs (5%) and other practitioner types (19%);
- 810 practitioners provided clinical care coordination, around 50% of whom were mental health nurses and 21% were other practitioner types;
- 109 practitioners provided complex care packages, most of whom were mental health nurses (55%), general psychologists (17%) and clinical psychologists (13%);
- 5,814 practitioners provided child and youth specific mental health services, most of whom were classified as ‘other’ (17%), low intensity mental health workers (16%), clinical psychologists (14%), general psychologists (8%), social workers (6%); and
- 1,348 practitioners provided Indigenous-specific mental health services, most of whom were general psychologists (12%), clinical psychologists (4%), social workers (4%) and Aboriginal and Torres Strait Islander health/mental health workers (4%) and this information was missing for more than two thirds (69%) of these practitioners.

4.2.1.3 Episodes of care through all 31 PHNs

As mentioned above, our starting point for data extraction was that at least one attended service contact for a given episode of care took place in the period from 1 July 2016 to 31 December 2018. This means that the episode start date could have commenced before 1 July 2016; we set 1 January 2016 as the cut-off episode start date to include ATAPS episodes of care inherited by PHNs for service continuity. Of the episodes recorded as having at least one attended service contact in our analysis period, 2,121 episodes were excluded from our episode analysis because they commenced prior to 1 January 2016 (specifically, with recorded dates ranging from May 2006 to December 2015).

In total, 360,131 episodes of care provided by all 31 PHNs met our inclusion criteria. Of these, 44.5% were from headspace, 17.5% from ATAPS and 38% from PMHC administrative data sets. Overall, around

16% of these episodes were still open at the time of data extraction, 46% were closed because treatment had concluded, 11% were administratively closed, and this information was missing for 26% of episodes (Appendix 8, Table 63). Lead Sites had proportionally fewer missing data than non-Lead Sites for episode completion status (21% vs 29%).

Overall, the average number of service contacts per episode of care was 5.7 (SD = 7.4, range: 1 – 371) for all contacts, and 5.4 (SD = 7.1, range: 1 - 348) for attended contacts only. For all service contacts, the average number of contacts per episode was slightly higher for Lead Sites (M = 6.1, SD = 8.2, range: 1 – 371) than non-Lead Sites (M = 5.5, SD = 7.0, range: 1 – 286). When only attended contacts were considered, the average number of contacts per episode was also slightly higher for Lead Sites (M = 5.9, SD = 7.9, range: 1 – 348) than non-Lead Sites (M = 5.2, SD = 6.7, range: 1 – 286). Appendix 8 provides a breakdown of average service contacts per episode of care by Lead Site status and principal focus for all contacts (Table 6.3) and attended contacts only (Table 64). It shows that for Lead Sites:

- The lowest average number of attended contacts is for episodes with an Indigenous-specific mental health service focus (M = 4.9, SD = 6);
- The highest average number of attended contacts is for episodes with a clinical care coordination focus (M = 12.9, SD = 17.8); and
- Episodes involving low intensity psychological interventions and psychological therapy focuses provide a similar average number of sessions (M = 5.2, SD = 6.0 and M = 5.8, SD = 5.1, respectively).

Figure 1 shows the uptake of episodes by principal focus over time from January 2016 to December 2018. It shows an overall trend of an increasing number of episodes of care provided per quarter, with a temporary drop in the fourth quarter of each year. The number of episodes delivered for psychological therapy and child- and youth-specific services appear to have plateaued. It can also be seen that episodes of care involving low intensity psychological interventions and clinical care coordination commenced in the third quarter of 2016 and those involving complex care packages in the third quarter of 2017.

Figure 1. Uptake of episodes of care through all 31 PHNs by principal focus and quarter (January 2016 – December 2018)

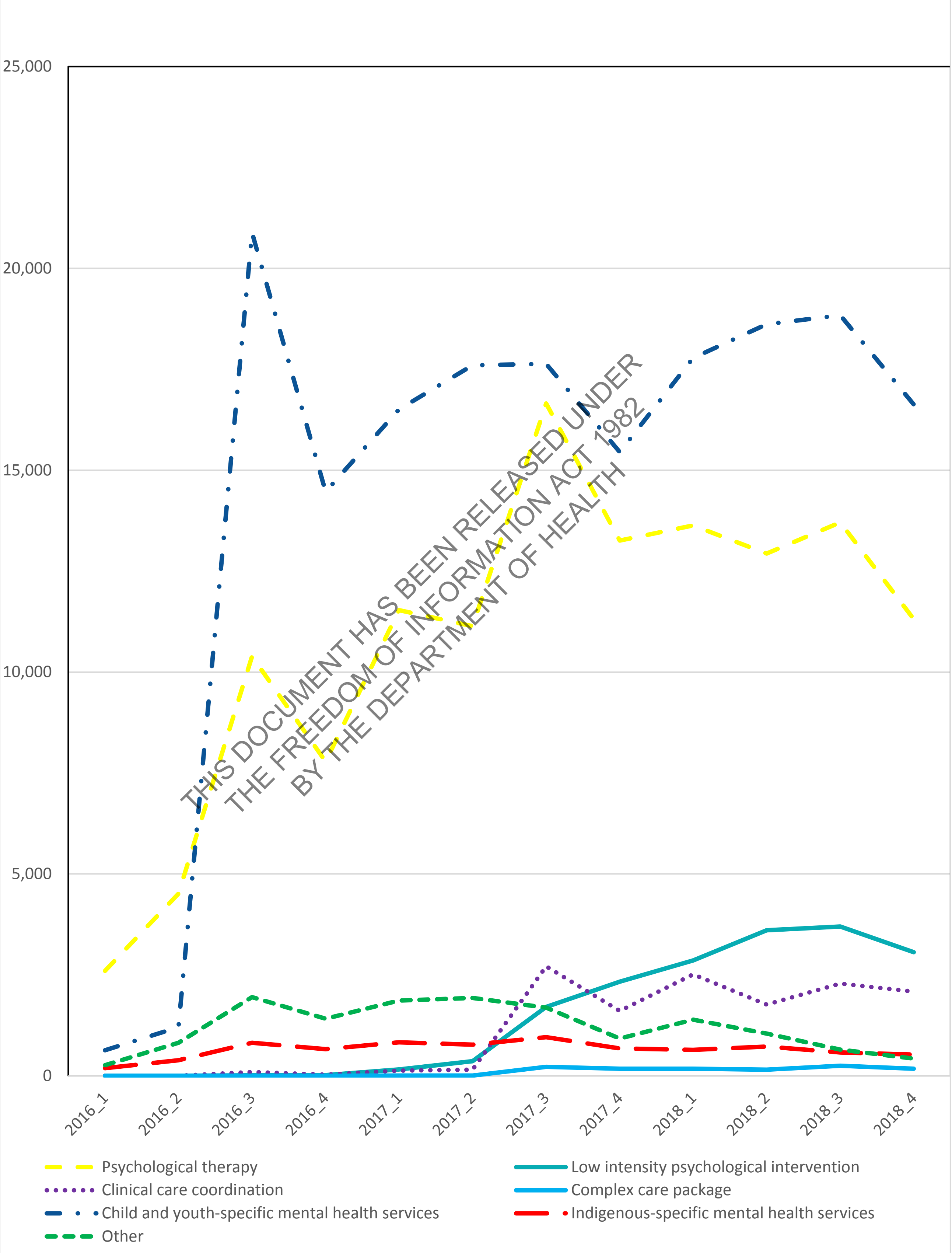

Table 10 presents the number and proportion of episodes by Lead Site status and principal focus of treatment plan. It shows that overall, 34% of all episodes of care were provided by Lead Sites. Of the Lead Site episodes, the majority were for child- and youth-specific mental health services (54%); followed by psychological therapy (30%); low intensity psychological intervention (7%); ‘other’ services, which includes former ATAPS Tier 2 services (5%); clinical care coordination (4%); Indigenous-specific mental health services (1%); and complex care packages (less than 1%). Proportionally, compared with episodes of care provided by Lead Sites, episodes provided by non-Lead Sites were more likely to involve psychological therapy (39%), Indigenous-specific mental health services (3%) and complex care packages (less than 1%); and less likely to involve low intensity psychological interventions (4%) and child- and youth-specific mental health services (46%).

Table 10. Episodes of care by Lead Site status and principal focus of treatment plan (January 2016 – December 2018)

	Lead Sites				Non-Lead Sites				Total	
Principal focus of treatment plan	**Freq.**	**% within Lead Sites**	**% within principal focus**	**% of total**	**Freq.**	**% within Non-Lead Sites**	**% within principal focus**	**% of total**	**Freq.**	**% of total**
Psychological therapy	36,075	29.5	27.9	10.0	93,389	39.3	72.1	25.9	129,464	35.9
Low intensity psychological intervention	8,367	6.8	47.0	2.3	9,437	4.0	53.0	2.6	17,804	4.9
Clinical care coordination	4,464	3.6	33.4	1.2	8,903	3.7	66.6	2.5	13,367	3.7
Complex care package[w]	181	0.1	15.6	0.1	981	0.4%	84.4	0.3	1,162	0.3
Child- and youth-specific mental health service	66,127	54.0	37.5	18.4	110,115	46.3	62.5	30.6	176,242	48.9
Indigenous-specific mental health service	1,256	1.0	16.2	0.3	6,486	2.7	83.8	1.8	7,742	2.1
Other	5,953	4.9	41.5	1.7	8,397	3.5	58.5	2.3	14,350	4.0
Total	122,423	100.0	34.0	34.0	237,708	100.0	66.0	66.0	360,131	100.0

Note: Percentage within Lead Sites (and non-Lead Sites) provides the column percentage; for example, % within Lead Sites uses 122,423 episodes (total number of episodes in Lead Sites) as denominator. Percentage within principal focus provides the row percentage; for example, the first row uses 129,464 episodes (total number of psychological therapy episodes) as the denominator. Finally, the percentage of total column for both Lead Sites and non-Lead Sites uses 360,131 episodes (total number of all episodes) as the denominator.

---

[w] The complex care package data field was intended for exclusive use by the three Lead Sites involved in the Link-me trial, with a possible wider roll-out in the future pending results of the trial. However, it appears that non-Lead Sites are using this data field more than Lead Sites and the reasons for this are unknown.

4.2.1.4 Referral sources for episodes of care through all 31 PHNs

Overall, GPs were the main source of referrals for episodes of care (59%), followed by self-referral (27%) and 'other' referrers (6%) (Appendix 8, Table 66). The remaining referrer types (e.g., psychiatrist, psychologist, mental health nurse, social worker, paediatrician) provided approximately 4% of referrals (n = 13,127). Compared with non-Lead Sites, Lead Site referral sources were less likely to be GPs (53% vs 62%) and more likely to be self-referrals (31% vs 25%).

Overall, the referrer organisation was not stated for 24% of episodes of care (Appendix 8, Table 67). For self-referrals, the referrer organisation was not applicable (27%). Consistent with GPs being the primary source of referrals, general practice was also the most common referrer organisation type (38%). 'Other' referrer organisations provided 6% of referrals, and the remaining referrer organisations (e.g., private practice, Indigenous health organisations, community health centres) provided 6% of referrals.

4.2.1.5 Consumers

Overall, 329,069 individuals received episodes of care. Almost 35% of individuals (n = 113,974) received episodes of care from Lead Sites. Of the total number of individuals, the majority (92%) received one episode of care, 7% received two and less than 1% received three episodes of care (Appendix 9).

4.2.2 LEAD SITE CONSUMER CHARACTERISTICS

There was little variation in the characteristics of consumers of Lead Sites and non-Lead Sites (Appendices 9 and 10). Therefore, the characteristics of consumers who received episodes of care from the 10 Lead Sites only are the focus of this section and are reported using two different denominators. One denominator (N = 113,974) represents person-level characteristics that tend to remain stable over time, and the other (N = 122,423) represents episode-level characteristics that can change from episode to episode. Stable person-level characteristic data are presented in Appendix 9 and volatile episode-level consumer characteristics are presented in Appendix 10. Note that because we combined three minimum data sets, we mainly describe data fields that were common across all three data sets.

4.2.2.1 Lead Site person-level socio-demographic characteristics (N = 113,974)

The majority of consumers who received services via Lead Sites were female (58%); 36% were male (Appendix 9). Almost 6% of consumers were Indigenous. The majority of consumers who received services via Lead Sites (61%) were born in Australia, and English was the main language spoken at home (79%).

4.2.2.2 Lead Site episode-level socio-demographic characteristics (N = 122,423)

The majority (63%) of individuals receiving episodes of care through Lead Sites were aged 12-25 years, and 6% were aged 11 years or under (Appendix 10, Table 69). For the remaining age groups, the number of individuals receiving care decreased with increasing age: 26-35 (8.5%); 36-45 (7.9%); 46-55 (7.3%); 56-65 (n = 4.8%); 66+ years (3%).

The majority of individuals receiving an episode of care through Lead Sites were from a major city (72%), 20% were from an inner regional area, 6% from an outer regional area, and less than 1% were from a remote or very remote area (Appendix 10, Table 70). These figures are appropriate given that Lead Sites mainly service geographic areas in major cities and inner regional areas and non-Lead Sites mainly service outer regional, remote or very remote areas.

There were slightly fewer individuals receiving episodes through Lead Sites who were from the two lowest Index of Relative Socio-economic Disadvantage (IRSD) quintiles (areas of greatest disadvantage - ISRDs 1 and 2: 36%) than from the two highest quintiles (areas of least disadvantage - IRSDs 4 and 5 = 43%). Refer to Appendix 10, Table 70.

4.2.2.3 Lead Site episode level clinical characteristics (N = 122,423)

Thirty-six percent of consumers from Lead Sites had a GP mental health treatment plan, and this information was missing or unknown for 58% of consumers (Appendix 10, Table 71). There was a suicide referral flag for 6% of episodes of care provided through Lead Sites, and this information was unknown for 55% (Appendix 10, Table 72).

Principal diagnosis was missing for 28% of individuals receiving episodes through Lead Sites and for 20% the ‘other’ category was used (Appendix 10, Table 73). The most common diagnosis was affective disorders (16%), closely followed by anxiety disorders (15%). Subsyndromal problems were attributed to 13% of episodes of care, 3% to ‘other mental disorders’, and 2% to childhood and adolescence disorders.

Use of medication by consumers from Lead Sites was recorded as unknown for around two thirds or more of consumer per medication type (Appendix 10, Table 75). Twelve percent of consumers from Lead Sites were taking antidepressants; 3%, anxiolytics; 2.7%, antipsychotics; 1.9%, hypnotics and sedatives; and 0.4%, psychostimulants.

4.2.3 LEAD SITE SERVICE CONTACT CHARACTERISTICS

Like the consumer characteristics, there was little variation in characteristics of service contacts provided through Lead Sites and non-Lead Sites (Appendix 11). Therefore, the service contact characteristics for the 10 Lead Sites only are the focus of this section. Note that because we combined three minimum data sets, we mainly describe data fields that were common across all three data sets.

Within Lead Sites:

- 55% of service contacts involved structured psychological interventions and 19% involved assessments;
- 87% of service contacts were face-to-face;
- 88% of service contacts involved an individual client, 4% a group of clients and 4% family or support networks;
- 61% of service contacts were 46-60 minutes, 11% were 61-75 minutes and 10% were 1-15 minutes in duration; and
- 98% of service contacts involved the consumer’s presence (i.e., the consumer was involved).

The overwhelming majority of Lead Site service contacts did not involve a consumer co-payment (99.9%). For the 463 Lead Site contacts that involved a consumer co-payment, the amount charged was $30 or less for 27% of contacts, and between $40 and $150 for 73% of contacts (M = $95.53, SD = $52.53, range: $1 - $150). For the majority of non-Lead Site service contacts (95%) which incurred a co-payment, the amount was $30 or less (M = $16.09, SD = $23.18, range: $1 - $150).

The majority of service contacts through Lead Sites (67%) indicated that further services were planned as part of the episode of care; this information was unknown for 31% of service contacts and was not captured in the former ATAPS MDS.

4.2.4 CONSUMER MENTAL HEALTH OUTCOMES IN THE LEAD SITES

The routinely collected data included consumer outcome measure scores collected at various points in a consumer's episode of care (episode start, review or episode end). The five measures were: the K10+[x] for all populations; the K5[y] as an alternative to the K10 for use with Aboriginal and Torres Strait Islander clients; and three SDQ measures[z] (the SDQ-PC for children and the SDQ-PY and SDQ-YR for youth).

Appendix 12 provides complete details of the outcome data integrity checks, and cohort analyses of episode types and completed episodes that were conducted in order to identify records for episodes of care that could be included in our analyses of mental health outcomes.

4.2.4.1 Identifying the cohort for analysis

The sampling frame for analysis of outcomes was the two and a half year period from 1 July 2016 to 31 December 2018. There were 360,131 in-scope episodes supplied by all 31 PHNs. Of these, 122,423 (34%) were episodes supplied by the 10 PHN Lead Sites and were the focus of the analysis of consumer mental health outcomes.

Of the 122,423 in-scope episodes supplied by Lead Sites, 49,041 (40%) were episodes with no outcome collection occasions. This left 73,382 (60%) in-scope episodes with at least one outcome collection occasion for any of the five measures.

Table 11 shows that there were 117,840 outcome collection occasions reported for the 73,382 episodes with at least one outcome collection occasion, noting that an episode of care can have multiple outcome collection occasions (e.g., at episode start and at episode end). As described in Appendix 12, we undertook a series of data integrity checks of these 117,840 outcome records. A total of 104,999 (86% of 117,840) outcome records met the data integrity criteria and so were retained for inclusion in our analyses. Table 11 shows that the percentage of outcome records retained was somewhat higher for the K10 (90%) than for the K5, SDQ-PC and SDQ-YR (70%) and SDQ-PY (60%).

---

[x] The Kessler Psychological Distress Scale (K10) is a 10-item measure of global psychological distress. It measures symptoms such as nervousness and agitation, psychological fatigue and depression that the respondent has experienced over the last four weeks.[13, 14] The K10+ is an extension of the K10 that includes an additional four questions that ask respondents to nominate the number of days totally and partially unable to study or work due to symptoms reported in the previous 10 questions, number of health professional consultations sought as a result of these symptoms, and the extent to which physical health problems were the main cause of distress.

[y] The Kessler 5 (K5) measure of psychological distress consists of a subset of five questions from the K10.

[z] The Strengths and Difficulties Questionnaire (SDQ) is a measure of positive and negative psychological attributes of young people aged 2-17 years. There are different SDQ measures according to consumer age and respondent. There are also baseline and follow-up versions; these use different reporting periods and the follow-up version includes two additional items that enquire about the intervention effects.[15] The versions specified for PMHC MDS reporting are the baseline and follow-up versions of the: SDQ-PC (parent report measure for children aged 4-10); SDQ-PY (parent report measure for youth aged 11-17); and SDQ-YR (self-report measure for youth aged 11-17).

Table 11. In-scope episodes and outcome collection occasions by measure

Measure	Supplied		Retained		% retained	
	Episodes	Outcome collection occasions	Episodes	Outcome collection occasions	Episodes	Outcome collection occasions
K10	71,241	115,099	66,213	103,125	92.9	89.6
K5	527	675	394	492	74.8	72.9
SDQ-PC	949	1,192	707	832	74.5	69.8
SDQ-PY	413	542	278	322	67.3	59.4
SDQ-YR	252	332	185	228	73.4	68.7
Total	73,382	117,840	67,777	104,999	92.4	89.1

The outcome measure records that met minimum levels of data integrity (N = 104,999) were further examined to determine if they could be included in the analyses of consumers' mental health status and, where possible, mental health outcomes. Note that outcome analyses are only possible where there are at least two measures per consumer within an episode of care. Further, to assess outcomes at the end of treatment, it is necessary to identify matched pairs of measures corresponding to the Start and End of treatment.

From the 104,999 ratings, 33,738 (32%) were single ratings and thus can have no outcome 'status'; the remaining 71,261 ratings included 68,078 (96%) ratings that were the first or last rating in a sequence. The 68,078 ratings formed 34,039 pairs of ratings of which 33,590 (99%) formed a valid sequence (e.g., a rating made at episode start followed by a rating made at review). Of the 33,590 valid pairs, the vast majority (31,051 or 92%) were completed episodes (i.e., comprised an episode start rating and an episode end rating). These 31,051 completed episodes were used for analyses of consumer outcomes.

4.2.4.2 Outcome classification for completed episodes – overview

In this report, outcome analyses are conducted using the total score on the K10, the total score on the K5, and the total difficulties score for each of the SDQ measures. Mental health outcomes - i.e., the difference or 'change' between episode start and episode end scores - were classified using Cohen's Effect Size metric.[40] A 'moderate' effect size threshold was set at half a standard deviation of the total score at episode start for each measure (using all available ratings).

For the K10, the change threshold was 5, therefore mental health outcomes were classified as 'significant improvement' if the change score was 5 or more, 'significant deterioration' if the change score was -5 or less, and 'no significant change' if the change score was between -4 and 4. For the K5 and SDQ-PY, the change threshold was 3, therefore mental health outcomes were classified as 'significant improvement' if the change score was 3 or more, 'no significant change' if the change score was between -2 and 2, and 'significant deterioration' if the change score was -3 or less. For the SDQ-PC and SDQ-YR, the change threshold was 4, therefore mental health outcomes were classified as 'significant improvement' if the change score was 4 or more, 'no significant change' if the change score was between -3 and 3, and 'significant deterioration' if the change score was -4 or less.

Table 12 shows the distributions of K10 and K5 total scores and SDQ total difficulties scores at episode start and episode end for the 31,051 completed episodes. Note that of the 30,938 episodes with K10 scores at episode start and end, 93% were for headspace consumers. The distributions shifted from relatively higher scores at episode start to relatively lower scores at episode end.

Table 12. Distribution of K10, K5 and SDQ measure scores at episode start and episode end for completed episodes

Measure	Episode occasion	Freq.	Mean	SD	p10	p25	p50	p75	p90
K10	Start	30,938	29.3	8.7	17	23	30	36	40
K10	End	30,938	26.1	9.1	14	19	26	33	38
K5	Start	17	16.6	3.5	12	13	17	19	21
K5	End	17	14.4	5.0	7	11	15	18	20
SDQ-PC	Start	63	18.4	6.2	10	14	19	23	26
SDQ-PC	End	63	15.3	6.4	7	10	15	20	25
SDQ-PY	Start	18	17.9	7.4	9	13	19.5	22	28
SDQ-PY	End	18	15.7	6.7	7	11	13.5	21	26
SDQ-YR	Start	15	20.8	5.8	14	16	22	24	28
SDQ-YR	End	15	17.0	6.5	5	13	19	22	23

Note. SD = standard deviation, p = percentile.

Table 13 presents an overview of the classification of outcomes for consumers with completed episodes. Note that outcomes were classified only for the K10 and SDQ-PC. For the other measures the number of completed episodes was less than 30; estimates based on small numbers will have high relative standard errors and may be unreliable. For the K10 and SDQ-PC, the table provides an estimate of the percentage of episodes in which the consumer was classified as significantly improved, no significant change, or significantly deteriorated, along with the 95% confidence interval (CI) and relative standard error percentage[aa] for each estimate.[41] Differences between percentage estimates were interpreted as being statistically significant if their 95% confidence intervals did not overlap, noting that this is a conservative approach.[42] Estimates with a relative standard error percentage ≥ 10% may be subject to sampling error; higher relative standard errors should be interpreted with greater caution.

It can be seen that:

- For episodes in which consumer outcomes were rated using the K10 (N = 30,938), 38% were classified as significantly improved, 51% as no significant change and 11% as significantly deteriorated. All of the outcome class estimates differed significantly from each other; and
- For episodes in which consumer outcomes were rated using the SDQ-PC (N = 63), 48% were classified as significantly improved, 40% as no significant change and 13% as significantly deteriorated. The estimated percentage of episodes in which the consumer was classified as significantly deteriorated differed significantly from the percentages classified as no significant change and significantly improved.

It should be noted, however, that the relative standard error percentages indicate that the estimates for the K10 are robust, but that the estimates for the SDQ-PC should be interpreted with caution.

[aa] The standard error is a measure of the spread of estimates around the 'true value'. The relative standard error percentage is the standard error expressed as a percentage of the estimate.[41]

Table 13. Classification of outcomes for completed episodes by measure (%)

Measure	Outcome	Freq.	Estimate within outcome class	95%CI lower-bound estimate	95%CI higher-bound estimate	Relative standard error %
K10	All	30,938				
K10	Significantly improved	11,823	38.2	37.7	38.8	0.7
K10	No significant change	15,660	50.6	50.1	51.2	0.6
K10	Significantly deteriorated	3,455	11.2	10.8	11.5	1.6
SDQ-PC	All	63				
SDQ-PC	Significantly improved	30	47.6	35.7	59.8	13.2*
SDQ-PC	No significant change	25	39.7	28.4	52.1	15.5*
SDQ-PC	Significantly deteriorated	8	12.7	6.5	23.4	33.0**

CI = confidence interval

*Relative standard error %: * 10-24%; ** 25-49%; *** ≥ 50%.

4.2.4.3 Outcome classification by episode-level domains: K10

Table 14a and Table 14b show outcomes for all completed episodes in which consumer outcomes were rated using the K10, by selected episode-level domains[bb]. Outcomes were similar across gender groups. They were also reasonably similar across age groups, although a somewhat greater percentage (44%) of consumers aged ≥ 21 years had episodes classified as significantly improved, compared to the younger age groups (35-38%). Outcomes were similar across groups defined by remoteness area and IRSD quintile.

Outcomes were also similar across principal diagnosis groups. There appeared to be a positive gradient between outcome score category at episode start and outcome classification; that is, the greater the level of psychological distress at episode start, the greater the probability of being classified as significantly improved.

Outcomes varied according to the principal focus of the treatment plan. The vast majority (93%) of completed episodes were for 'child- and youth-specific mental health services'; therefore, the corresponding percentage of consumers classified as significantly improved (36%) was similar to the overall figure. The corresponding percentages were higher for episodes where the principal focus was 'psychological therapy' (62%), 'low intensity psychological intervention' (64%), and 'clinical care coordination' (58%). Note that outcomes could not be reported for episodes where the principal focus was 'complex care package' or 'indigenous-specific mental health services' or 'other' because there were fewer than 30 completed episodes.

There appeared to be a dose-response relationship between number of attended service contacts and outcome classification; that is, the greater the number of attended service contacts, the greater the percentage classified as significantly improved. Outcomes were similar across referrer profession groups and year of referral.

[bb] See Appendix 12 for information about how these domains were selected.

Table 14a. Classification of outcomes for completed episodes rated using the K10 (%), by socio-demographic and clinical domains

	Freq.	%	Outcome		
			Significantly improved	No significant change	Significantly deteriorated
All	30,938	100.0	38.2	50.6	11.2
Gender					
Male	11,303	36.5	38.1	51.5	10.4
Female	19,034	61.5	38.4	50.0	11.6
Other	601	1.9	35.6	53.1	11.3
Age band – median split					
≤ 17 years	13,961	45.1	34.9	52.1	13.1
≥ 18 years	16,977	54.9	40.9	49.4	9.6
Age band - quartiles					
≤ 14 years	7,898	25.5	34.6	52.0	13.4
15-17 years	6,063	19.6	35.3	52.1	12.6
18-20 years	9,512	30.7	38.2	51.2	10.6
≥ 21 years	7,465	24.1	44.4	47.2	8.4
Remoteness area					
Major cities of Australia	23,368	75.5	37.9	51.1	11.0
Inner regional Australia	6,232	20.1	38.6	49.7	11.7
Outer regional/ remote/ very remote Australia	1,338	4.3	42.0	46.4	11.6
IRSD quintile					
1 (greatest disadvantage)	3,926	12.7	38.3	50.6	11.2
2	6,120	19.8	37.5	50.8	11.7
3	6,994	22.6	38.9	50.2	11.0
4	6,030	19.5	37.2	51.5	11.3
5 (least disadvantage)	7,868	25.4	38.9	50.3	10.8
Principal diagnosis					
Anxiety disorders	8,127	26.3	38.2	49.6	12.2
Affective disorders	6,769	21.9	40.0	48.6	11.4
Other mental disorders	2,762	8.9	36.6	50.7	12.7
Other	8,120	26.2	40.7	49.8	9.5
Missing	5,160	16.7	32.9	56.1	11.0
K10 score category at episode Start					
Low	2,158	7.0	1.3	82.8	15.8
Moderate	4,172	13.5	20.8	60.4	18.8
High	8,687	28.1	35.9	49.3	14.8
Very high	15,921	51.5	49.0	44.4	6.5

IRSD = Index of Relative Socio-economic Disadvantage.

Table 14b. Classification of outcomes for completed episodes rated using the K10 (%), by treatment and system-related domains

			Outcome		
	Freq.	**%**	**Significantly improved**	**No significant change**	**Significantly deteriorated**
All	30,938	100.0	38.2	50.6	11.2
Principal focus of treatment plan					
Psychological therapy	678	2.2	62.2	33.8	4.0
Low intensity psychological intervention	1,282	4.1	63.6	33.2	3.2
Clinical care coordination	103	0.3	58.3	35.9	5.8
Complex care package	6	0.0	.	.	.
Child- and youth-specific mental health services	28,845	93.2	36.5	51.8	11.7
Indigenous-specific mental health services	2	0.0	.	.	.
Other	22	0.1	.	.	.
Number of attended service contacts					
≤ 3	9,006	29.1	30.2	59.4	10.5
4-5	6,158	19.9	35.7	53.4	10.9
6-9	8,234	26.6	42.9	46.5	10.5
≥ 10	7,540	24.4	44.7	42.4	12.9
Referrer profession					
GP	13,882	44.9	40.7	48.2	11.1
Other	3,249	10.5	40.6	47.9	11.5
N/A – Self referral	13,474	43.6	34.9	53.8	11.2
Not stated	333	1.1	44.1	48.3	7.5
Year of referral					
≤ 2016	5,551	17.9	37.5	50.6	11.9
2017	13,024	42.1	38.4	50.3	11.3
≥ 2018	12,363	40.0	38.3	51.0	10.7

‘ . ’ = not reported because there were <30 completed episodes.

4.2.4.4 Outcome classification by episode-level domains: SDQ-PC

Table 15a and Table 15b show outcomes for all completed episodes in which consumer outcomes were rated using the SDQ-PC, by the selected episode-level domains. A greater percentage of males (56%) had episodes classified as ‘significantly improved’ than females (40%). Limited data were available for other strata of socio-demographic variables. Where available, these showed that outcomes for consumers aged ≥ 8 years and consumers residing in inner regional Australia were similar to the overall pattern.

Limited data were available for clinical domains. Where available, these showed that outcomes for consumers with missing data on principal diagnosis episodes were similar to the overall pattern, while the percentage of those with a high SDQ-PC total difficulties score at episode Start score was high (62%) relative to the overall pattern.

Data for episodes according to principal focus of treatment plan were limited. Where available, they showed that outcomes for episodes where the principal focus was ‘psychological therapy’ or ‘child- and youth-specific mental health services’ were similar to the overall pattern.

Limited data were available for treatment and system-related domains. Where available, these indicated that outcomes for episodes involving ≥ 10 attended service contacts, and where the referrer was a GP, were similar to the overall pattern.

Table 15a. Classification of outcomes for completed episodes rated using the SDQ-PC (%), by socio-demographic and clinical domains

			Outcome		
	Freq.	%	Significantly improved	No significant change	Significantly deteriorated
All	63	100.0	47.6	39.7	12.7
Gender					
Male	32	50.8	56.3	31.3	12.5
Female	30	47.6	40.0	46.7	13.3
Other	1	1.6	.	.	.
Age band – median split					
≤ 7 years	23	36.5	.	.	.
≥ 8 years	40	63.5	45.0	47.5	7.5
Age band - quartiles					
≤ 5 years	12	19.0	.	.	.
6-7 years	11	17.5	.	.	.
8 years	13	20.6	.	.	.
≥ 9 years	27	42.9	.	.	.
Remoteness area					
Major cities of Australia	20	31.7	.	.	.
Inner regional Australia	30	47.6	50.0	43.3	6.7
Outer regional/ remote/ very remote Australia	13	20.6	.	.	.
IRSD quintile					
1 (greatest disadvantage)	7	11.1	.	.	.
2	22	34.9	.	.	.
3	20	31.7	.	.	.
4	8	12.7	.	.	.
5 (least disadvantage)	6	9.5	.	.	.
Principal diagnosis					
Anxiety disorders	4	6.3	.	.	.
Affective disorders	1	1.6	.	.	.
Other mental disorders	6	9.5	.	.	.
Other	12	19.0	.	.	.
Missing	40	63.5	50.0	40.0	10.0
SDQ-PC score category at episode Start					
Close to average	14	22.2	.	.	.
Slightly raised	10	15.9	.	.	.
High	39	61.9	61.5	28.2	10.3

IRSD = Index of Relative Socio-economic Disadvantage

‘ . ’ = not reported because there were <30 completed episodes

Table 15b. Classification of outcomes for completed episodes rated using the SDQ-PC (%), by treatment and system-related domains

	Freq.	%	Outcome		
			Significantly improved	No significant change	Significantly deteriorated
All	63	100.0	47.6	39.7	12.7
Principal focus of treatment plan	.	.	.	.	.
Psychological therapy	33	52.4	51.5	39.4	9.1
Low intensity psychological intervention	3	4.8	.	.	.
Clinical care coordination	0	0.0	.	.	.
Complex care package	0	0.0	.	.	.
Child- and youth-specific mental health services	27	42.9	.	.	.
Indigenous-specific mental health services	0	0.0	.	.	.
Other	0	0.0	.	.	.
Number of attended service contacts	.	.	.	.	.
≤ 3	0	0.0	.	.	.
4-5	7	11.1	.	.	.
6-9	23	36.5	.	.	.
≥ 10	33	52.4	42.4	48.5	9.1
Referrer profession	.	.	.	.	.
GP	31	49.2	48.4	29.0	22.6
Other	10	15.9	.	.	.
N/A – Self referral	1	1.6	.	.	.
Not stated	21	33.3	.	.	.
Year of referral	.	.	.	.	.
≤ 2016	13	20.6	.	.	.
2017	27	42.9	.	.	.
≥ 2018	23	36.5	.	.	.

‘ . ’ = not reported because there were <30 completed episodes.

4.3 Summary and comparison to interim report

In Round 2, routinely collected data for the two and a half year period from 1 July 2016 to 31 December 2018 were analysed. In Round 1, the analysis covered the one and a half year period from 1 July 2016 to 31 December 2017. Findings from the analyses of routinely collected data inform two of the four evaluation focus areas – stepped care (by using principal focus of treatment [principal focus] as a proxy) and low intensity services.

In Round 2, 1,543,845 mental health service contacts were attended in 360,131 episodes of care provided to 329,029 individuals through all 31 PHNs. Just over one third of these services and episodes were commissioned by the 10 Lead Sites.

Most service contacts through Lead Sites had a principal focus of psychological therapy (38%) or child- and youth-specific mental health services (35%); less common were clinical care coordination (11%) and low intensity psychological interventions (8%). Similar trends were observed for non-Lead Sites but Lead Sites provided proportionally more service contacts involving low intensity psychological interventions and clinical care coordination, and less involving Indigenous-specific mental health services.

Episodes of care provided through Lead Sites most commonly involved a principal focus of child- and youth-specific mental health services (54%), psychological therapy (30%), or low intensity psychological interventions (7%). Consistent with their Lead Site focus areas, Lead Sites provided proportionally more episodes of care involving child- and youth-specific services and low intensity psychological interventions than non-Lead Sites. Compared with non-Lead Sites, Lead Site referral sources were less likely to be GPs (53% vs 62%) and more likely to be self-referrals (31% vs 25%).

In Lead Sites, the average number of all attended service contacts per episode of care was six; and was highest at 13 for episodes with a clinical care coordination focus. There was a small difference in the average number of Lead Site attended service contacts involving low intensity psychological interventions and psychological therapy principal focuses (five and six, respectively).

The addition of an extra year of Lead Site data resulted in more than a two-fold increase in the number of attended service contacts, from 220,104 in Round 1 to 534,127 in Round 2; and almost a two-fold increase in episodes of care from 64,045 to 122,423. In relation to stepped care, Lead Sites appeared to be delivering services across the steps to a greater extent in Round 2 than they were in Round 1, with an increase in the proportion of service contacts attended for the lower and higher intensity service type principal focuses (from 3% to 8% for low intensity psychological interventions and from 2% to 11% for clinical care coordination).

Outcome analyses were conducted using completed episodes supplied by the 10 Lead Site PHNs. In Round 2, the addition of an extra year of Lead Site data meant that 31,051 completed episodes could be used for analyses of consumer outcomes; this was an almost two-fold increase over Round 1 (17,323 completed episodes). Despite this increase, there were sufficient completed episodes to enable the analysis of outcomes only for episodes in which consumers outcomes were rated using the K10 and SDQ-PC. In Round 2, outcomes for these episodes were further stratified by selected socio-demographic, clinical, treatment and system-related domains, where numbers permitted.

The following patterns of outcomes in Lead Sites were identified:

- For episodes in which consumer outcomes were rated using the K10 (N = 30,938), 38% were classified as significantly improved (similar to the 37% reported in Round 1). The percentage classified as improved was higher for consumers who: were relatively older (≥ 21 years); had worse K10 scores at episode start; had a principal focus of 'psychological therapy', 'low intensity psychological intervention' or 'clinical care coordination'; and had a greater number of attended service contacts; and
- For episodes in which consumer outcomes were rated using the SDQ-PC (N = 63), 48% were classified as significantly improved (similar to the 52% reported in Round 1). The percentage classified as improved was higher for consumers who were male or had a high score on the SDQ-PC at episode start.

5. Context for Lead Site Project focus areas

This report presents evaluation results by data source. The exception is this section which is based on multiple data sources and provides contextual information for other results sections that more directly address the evaluation questions.

5.1 Overarching focus areas

5.1.1 REGIONAL PLANNING AND INTEGRATION

In recognition of the role PHNs and LHNs play in supporting service integration at the regional level, under the first action of the Fifth Plan, Commonwealth and state and territory governments have directed PHNs and LHNs to jointly develop and publicly release regional mental health and suicide prevention plans by mid-2020. Expectations are that PHNs and LHNs will:

- Engage stakeholders, including consumers and carers, in implementing integrated regional planning and service delivery;
- Undertake joint needs assessments to identify gaps, duplications and inefficiencies;
- Examine innovative funding models, such as joint commissioning and fund pooling packages of care; and
- Commission services according to joint regional plans covering the lifespan from children through to young adults and older people.[24]

The Regional Planning Guide outlines a 13-step process of developing a joint regional plan. The steps include a range of considerations from information gathering type activities to decision making and finally gaining agreement.[1] The guide includes the caveat that LHNs and PHNs are not required to follow this process and different regions may vary in the sequence taken.[24]

Information elicited from focus groups with PHN staff, conducted from September to December 2018, indicated that one Lead Site had completed their regional plan and released this as a public document as required under the Fifth Plan. The remaining nine Lead Sites were at various earlier stages of preparing the plan, mainly focused on information gathering. Four Lead Sites were already working with their LHNs and five Lead Sites were already engaging a range of stakeholders by establishing groups and committees.

5.1.2 STEPPED CARE

At the third stepped care workshop held in Brisbane in June 2018, written information about stepped care arrangements at eight Lead Sites were collated and circulated by Brisbane North PHN. We contacted the remaining two Lead Sites (North Coast and Perth South) and asked them if they could provide us with equivalent information for their PHNs, which they did in April 2019. The template used to provide this information focused on intake functions, assessment/triage processes, clinical intervention types/streams available, step up/down protocols and procurement processes. Table 16 summarises these arrangements. Clinical streams available are not described here because there was little variation between the Lead Sites given that their service streams are with the six mental health priority areas. Because of their diversity, step up/down protocols are described in text only. It should be noted that the vast majority of this information was collated in June 2018, and Lead Sites may have progressed with or modified their stepped care approaches since then.

Table 16. Stepped care arrangements in Lead Sites (June 2018)

	ACT	BN	CES	EM	Murr	NC	NWM	PS	SEM	Tas
Direct referral to providers	✓	✓ [cc]	✓	✓ [dd]		✓				✓ [ee]
Centralised intake										
• For all available services				✓	✓		✓	✓	✓	
• For some specific services	✓		✓			✓				
• Includes referral to non-PHN commissioned services	-	*planned*	-	✓	✓		-	✓	✓	
Procurement process										
• Individual providers across steps	✓	✓ [ff]	✓		✓	✓	✓	✓	✓	✓
• Provider offers full range of steps				✓						

ACT, Capital Health Network; BN, Brisbane North PHN; CES, Central and Eastern Sydney PHN; EM, Eastern Melbourne PHN; Murr, Murrumbidgee PHN; NC, North Coast PHN; NWM, North Western Melbourne PHN; PS, Perth South PHN – part of Western Australia Primary Health Alliance (WAPHA); SEM, South Eastern Melbourne PHN; Tas, Primary Health Tasmania.

The referral mechanism for eight Lead Sites involved some sort of centralised intake system. Of these, six Lead Sites operated this system for all their commissioned services, but in one case (Eastern Melbourne) providers can also directly perform an intake function. The centralised intake service was only for some services types in three Lead Sites using this system and was therefore combined with direct referral to commissioned providers for other service types. The referral mechanism involved direct referral to providers only for two Lead Sites (Tasmania and Brisbane North). The extent of assessment or screening undertaken as part of intake and referral in Lead Sites varies from those equipping referrers with digital systems to assess consumer needs and generate appropriate commissioned service options (e.g., Brisbane North, Perth South) to those with clinical intake teams who contact all referred consumers for telephone-based screen involving risk assessment, eligibility testing, mental health history and enquiry into consumer preferences (e.g., Murrumbidgee). The centralised intake process included referral to non-PHN commissioned services in four Lead Sites, with a fifth Lead Site planning on incorporating this feature in the future. All but one Lead Site (Eastern Melbourne) procured individual providers across single steps of their stepped care model. One Lead Site (Brisbane North) procured services across all steps for one of their target groups – Aboriginal and Torres Strait Islander people.

The types and stages of step up/down protocols were diverse. Briefly, these protocols included:

- Clinical intake team decision (Murrumbidgee PHN);
- Use of web-based assessment and referral systems:
    - The electronic referral system (rediCASE) suggests suitable service options based on a range of factors such as psychological distress, risk assessment and functional impact of symptoms (Brisbane North PHN);
    - The Target D clinical prediction tool developed by the University of Melbourne from their 10-year longitudinal study of primary care patients (the *diamond* study),[43] which involves the completion of a 2-minute questionnaire on an iPad in general practice (Perth South PHN). An algorithm built in to the questionnaire predicts the severity of each patient's depressive symptoms in three months' time, triages them into one of three severity groups (mild, moderate, or severe) and provides referral options accordingly.

[cc] Brisbane North PHN uses common, decentralised initial assessment and referral using an electronic system (rediCASE)

[dd] Eastern Melbourne PHN has a dual intake in which referrals for all services are made either via their centralised intake service or their providers' intake service

[ee] Primary Health Tasmania's commissioned providers utilise agreed clinical assessment and triage tools to determine appropriate service delivery.

[ff] With the exception of the Integrated Aboriginal and Torres Strait Islander service which covers all steps.

- Clinical staging (from 0 – at-risk but asymptomatic to 4 – chronic and unremitting disorder) is determined by using a combination of assessment information about help-seeking, and level of symptoms and functioning; and is regularly reviewed with services recalibrated accordingly (Eastern Melbourne PHN);
- Contractual support to commissioned providers who are required to identify referral pathways (through monitoring tools for ongoing assessments and crisis pathways) (Central and Eastern Sydney);
- Exploring or in the process of developing or changing guidelines and/or tools to support decision making (Primary Health Tasmania, North Coast PHN, Capital Health Network and North Western Melbourne PHN). For example, North Coast PHN is currently designing and implementing system changes (e.g., contractual specifications, commissioning a central Information, Assessment and Referral Service and adding fields to their client management system – rediCASE) to ensure all clients are regularly assessed and referred to the appropriate level of care.

5.2 Service delivery focus areas

5.2.1 LOW INTENSITY SERVICES

In April 2019, we contacted all Lead Sites and asked them to provide a list of their low intensity services. Table 17 outlines their commissioned and planned low intensity services in varying detail. It shows that coaching services through NewAccess or other programs are the most common type of low intensity service, having been commissioned by six Lead Sites. However, it can also be seen that, consistent with the essence of low intensity services, Lead Sites have commissioned, or plan to commission, services ranging in:

- The type of services offered (e.g., coaching, physical activity, mindfulness, mental health first aid, low intensity psychological interventions delivered by headspace or other services);
- The groups they target (e.g., young people, adults, people in residential aged care facilities, people with perinatal issues, CALD people, survivors of torture and trauma);
- Modality (e.g., face-to-face, phone, SMS) and format (e.g., individual, group) in which they are delivered; and
- The types of practitioners (e.g., credentialed mental health practitioners, peer workers, mental health interns).

Table 17. Low intensity services commissioned or planned by Lead Sites

Lead Site	Low intensity services
ACT	Next Step Low Intensity – coaching service (previously NewAccess, developed by Beyond Blue)
Brisbane North	• World Wellness Group – Problem Management Plus - for people who identify as culturally and linguistically diverse, helps people manage stress and adverse situations. • NewAccess – Beyond Blue telephone coaching program delivered by Mental Illness Fellowship Queensland (MIFQ) • Optimal Health Program – self-development to build self-efficacy, 8-week face-to-face group program, delivered by NEAMI • Peach Tree Perinatal Wellness – for mothers who have infants (aged 0–12 months) experiencing mild postnatal depression and/or anxiety symptoms, 6-week face-to-face group program. • Change Futures – wellbeing for people living in set aged care facilities *Planned:* • Queensland Program of Assistance to Survivors of Torture and Trauma - (QPASTT) - Nexus program
Central and Eastern Sydney	• MoodActive Gym - new evidenced based low intensity mental health service based on physical activity through GP allied health referrals. • Mindfulness in CALD communities - 5-week mindfulness group program delivered in Arabic and Bangla and a self-help component via translated guided meditation recording for use between session • Youth Mental Health First Aid - co-designed and implemented in partnership with key stakeholders and community members from throughout the CESPHN region. • NewAccess Coaching - supports individuals experiencing mild forms of mental illness. Delivered face-to-face, online and by phone. • Black Dog StepCare Service - supports the screening of patients using digital technology, potentially detecting mental health concerns and illness across the step care continuum where it would otherwise go undetected.
Eastern Melbourne	• Lead Site Low Intensity -Steps to Wellbeing delivered by NEAMI National: individual or group face-to-face or individual telehealth coaching delivered by credentialed mental health workers and peer workers • Innovative Low Intensity Perinatal Psychological Services – structured SMS for families which provides psychoeducation and tracks mood to identify need for other services (delivered by University of Newcastle in partnership with Carrington Health); clinician moderated online support in which consumers are supported to access online CBT programs and monitored via telehealth (delivered by Carrington Health); and time limited clinician support - one on one sessions delivered via telehealth, office based or outreach (delivered by Carrington Health) • Mental Health Stepped Care (MHSC) Low Intensity Services –individual and group services delivered by suitably trained worker peer workers or credentialed clinicians

Murrumbidgee	• NewAccess x 3 services
	  o Intereach for adults
	  o headspace Wagga and Griffith centres for young people
	Planned:
	• Low intensity services in residential aged care facilities

North Coast	• NewAccess • Low intensity mental health referral pathways telephone service • WayBack Suicide Support Service *Planned:* All future procurement will be informed by the recommendations arising from the North Coast Collective, which involves agreements with the Mid North Coast LHD and Northern NSW LHD to undertake co-design and joint service planning to inform commissioning of mental health and AOD services from 2019-20. Intends to bring other major providers such as Housing, Family and Community Services, Education and Employment into the collective approach in coming years.
North Western Melbourne	• On the Line - A 24/7 intake and assessment, low intensity telephone, video and online counselling service for people who live and work in northern, central or western suburbs of Melbourne *Planned:* • Expressions of interest for group based and/or individually delivered low intensity services delivered by existing CAREinMIND mental health providers • Early career clinical placement grants for organisations to host student placements. The student will be supported by the organisation to deliver low intensity interventions
Perth South	• PORTS (Practitioner Online Referral Treatment Service): assessment and phone or online treatments, referrals for face-to-face treatment with ORS Psychology Brief Intervention Service (ORBIS) • Target D low intensity at five general practices
South Eastern Melbourne	• Connect Program (delivered by Family Life, previously delivered by Beyond Blue)
Tasmania	• Wellways – face-to-face, individuals and groups; telephone support 9am-9pm weekdays • Mindfulness Australasia

5.2.2 SERVICES FOR YOUTH WITH, OR AT RISK OF, SEVERE MENTAL ILLNESS

5.2.2.1 Youth enhanced services commissioned by youth enhanced Lead Sites

Orygen convened a meeting for the three Lead Sites with a focus on services for youth with, or at risk of, severe mental illness (youth enhanced services) in September 2018. During this meeting lessons learned and updates on the youth enhanced programs of the three Lead Sites with a youth enhanced focus were shared. In preparation for this meeting, Orygen collated written descriptions of the youth enhanced service models from the three Lead Sites. Service descriptions from this written resource are summarised in Table 18 and include: #synergy and the Youth Engagement Team, both commissioned by Primary Health Tasmania; RISE (Recovery, Improve, Support, Empower) and the Extended Recovery Team, both commissioned by South Eastern Melbourne PHN; and Next Step, commissioned by Capital Health PHN in the ACT. All models have a holistic approach and combine clinical and non-clinical treatment components. Three of these services specifically focus on disengaged young people and have an outreach capacity.

Table 18. Youth enhanced services commissioned by the three youth enhanced Lead Sites

Lead Site	Youth enhanced service (provider)	Description
Primary Health Tasmania	#synergy (Life Without Barriers)	This program provides clinical case management and psychological Intervention. It targets young people with, or at risk of, severe and complex mental illness which is causing functional impairment and is impacting adversely on their emotional and social development. It targets young people who are unwilling or unable to be engaged by headspace or Child and Adolescent Mental Health Services (CAMHS). Services are delivered using a mix of outreach, office-based and e-health interventions.
	Youth Engagement Team – YET (Cornerstone Youth Services)	A program for young people who are disengaged from one or multiple areas of their lives (i.e., school, work, family etc.) and who fall through the gap between office-based primary care mental health services and tertiary level services. It is an assertive outreach model of care incorporating a range of biopsychosocial interventions depending on the needs and preferences of the young person.
South Eastern Melbourne[gg]	RISE program (headspace Dandenong and Narre Warren, EACH)	A program designed to address anxiety and depression in young people which has significantly impacted on school engagement. It provides a coordinated and complementary range of strategies including care coordination, family therapy, family peer support, evidence-based psychological interventions and psychiatric support. Services can be either office-based or provided in an outreach capacity.
	Extended Recovery Team – XRT (*headspace* Frankston, YSAS)	A program for young people experiencing chronic depression and/or complex post-traumatic stress disorder for whom conventional clinical services have not led to improved wellbeing. It utilises a variety of approaches and interventions, including referral to appropriate services at headspace or in the community, brokerage, advocacy and counselling.
Capital Health Network (ACT)	Next Step High Intensity Youth Mental Health program (Next Step)	This program provides intensive psychological interventions to young people with moderate to severe mental health presentations. Mental health professionals are provided with specific training to work with young people. Service navigation is a new service component providing additional support for young people with additional complexities associated with their presentation. This is provided in an outreach capacity.

[gg] Two pilot programs now incorporated into BounceBack - intensive treatment service is a combination of primary health care and GPs, specialist private mental health services, alcohol and other drug services, non-government services, and educational and vocational providers.

5.2.2.2 Youth enhanced services commissioned by Lead Sites not focusing on youth enhanced services

In April 2019, we contacted the other seven Lead Sites that are not youth enhanced Lead Sites and asked them to provide a list of their youth enhanced services. Table 19 outlines their commissioned and planned youth enhanced services in varying detail. It shows that seven Lead Sites not focusing on youth enhanced services have commissioned a range of one or more services targeting young people with high intensity needs. Three Lead Sites have commissioned enhanced headspace services. Collectively, the types of services include high intensity or enhanced mental health and/or alcohol and other drug support, suicide prevention, early intervention, case management, clinical care coordination. Services target young people aged 12-25 years who: have high intensity needs; have or are at risk of psychosis; are not currently engaged with mental health services; are at risk of or experiencing homelessness; or are Indigenous Australians. Services are typically delivered face-to-face and may involve outreach. Consistent with the youth enhanced focus, practitioners delivering these services are typically credentialed mental health professionals, in some cases with access to psychiatrists.

Table 19. Youth enhanced services commissioned by Lead Sites not focusing on youth enhanced services

Brisbane North

- Redcliffe Area Youth Service – (Asha) high intensity mental health and suicide prevention program managed by lead agency Redcliffe Area Youth Space (RAYS). Partnership project that also has service hubs in Deception Bay and Caboolture.

Planned:

Will be exploring provision of youth severe service in the southern end of our region from 1 July 2019 onwards. Two options being explored – enhancement to current headspace centres or funding of clinical team within youth service.

Central and Eastern Sydney

- headspace early intervention team (hEIT)
- Comprehensive Assessment Service Psychosis and At Risk (CASPAR)

hEIT and CASPAR are offered through CESPHN's 5 headspace centres to provide an enhanced service to young people with or at risk of severe mental illness

Eastern Melbourne

- Youth Engagement Treatment Team Initiative (YETTI) – Eastern Health community-based tertiary provider of Tier 2 services – enhanced mental health support to young people with complex and emerging mental health needs, includes case management and clinical care coordination delivered mostly by credentialed mental health practitioners, but also family and peer workers
- YFlex - provides intensive clinical, recovery-focused supports and interventions to young people (12-25 years) who are experiencing or at risk of developing complex mental health issues

Murrumbidgee

- Riverina -Murrumbidgee LHD
- Wagga *headspac*e
- Griffith headspace

North Coast

- 4C's (Counselling, Consultancy and Continuity of Care) pilot
- Outreach 360 alcohol and other drug (AOD) and mental health program
- Mental Health Nursing Program

Planned:

All future procurement will be informed by recommendations from the North Coast Collective.

North Western Melbourne

- Enrych – Orygen leads a consortium of partners in Macedon Ranges, Melton and Moorabool and Sunbury to build capacity of each area/organisations to respond to the mental health needs of young people aged 12-25 years with high intensity needs. Each lead agency employs a local team to deliver a combination of face-to-face, outreach and integrated online moderated programs. Supported by Consultant Psychiatrists and in partnership with local primary care and tertiary mental health services.
- MCM-Check In – provides services for young people (12-25 years) who are not currently engaged with specialist mental health services and who have high intensity needs and who may also be at risk of, or experiencing, homelessness. Services include recovery-oriented mental health triage and assessment, therapeutic intervention, case management, and support to young people with psychological distress and may present with challenging, at risk, and suicidal behaviours.
- headspace centres x5 – provide cross sectoral support and targeted approaches for young people with high intensity needs. Delivered through Enhanced Care Coordinators in each site.
- VAHS- Koori Kids (ATSI Mental Health) – delivers comprehensive mental health assessment, care coordination, follow up and treatment for young ASTI people aged 12-25 years

Planned:

- Youth Severe in headspace – intends to enhance the capacity of existing headspace centres within NWMPHN region to respond to the needs of young people with high intensity needs, including linking them with more appropriate services where this may better meet their care needs.

Perth South

- Ruah Community Services: hospital-based, provides functional recovery, links with state early psychosis program

5.3 Summary

One Lead Site had completed their regional plan, five had engaged a range of stakeholders by establishing groups and committees and four were already working with their LHNs. Lead Sites have implemented diverse stepped care arrangements that typically involve centralised intake for some or all of their commissioned services, and commissioning providers to deliver services within one 'step'. Lead Sites have commissioned a range of appropriate (consistent with guidance)[10, 19] low intensity and youth enhanced services. These differences between Lead Sites in stage of regional planning, stepped care arrangements and commissioned services should be kept in mind when interpreting findings directly related to the evaluation questions in other sections of the report.

6. Consultation with Lead Site representatives

6.1 Summary of approach

We conducted 10 focus groups based on a set of pre-determined questions with each of the Lead Sites individually. Two members of our team attended each group, with one team member acting as the facilitator and the other as scribe. One focus group was conducted via Zoom, an online platform for video conferencing, as participants were from four different locations. Two members from one Lead Site participated in individual telephone interviews, since they were unable to attend the focus group in person. All other focus groups were conducted face-to-face. Focus groups were conducted between 25 September and 5 December 2018, approximately 12 months after Round 1. The groups were two hours and 15 minutes to three hours in duration. The telephone interviews were approximately 30 minutes each in duration. The questions we asked (Appendix 1) were drawn from the primary and secondary evaluation questions listed in the Evaluation Framework.[11] These questions focused on the four focus areas of the Lead Site Project evaluation and specifically on any changes or progress made since the previous focus group in Round 1. In general, we asked all listed questions. However, not all questions were relevant to all Lead Sites, as they were at different stages of mental health service commissioning and delivery. We audio-recorded each focus group and the individual telephone interviews. The focus group audio files were professionally transcribed verbatim. The individual telephone interview recordings were summarised by one of the researchers who took notes during the interviews. These transcripts and summary notes taken by the researcher during the phone interviews were then used as data for qualitative analysis.

6.2 Sample and demographic information

Between 2 and 12 Lead Site staff attended each of the 10 focus groups, and 2 individual telephone interviews. There were 68 participants in total: 51 females (75%) and 17 males (25%). Participants were aged between 28 and 64 years, with 37% aged between 40 and 49 years, and 28% between 30 and 39 years. No participants identified themselves as Aboriginal or Torres Strait Islander. Groups commonly comprised the senior PHN mental health manager and a person representing each portfolio within the mental health stream; for example, managers or program officers for youth mental health, suicide prevention, intake, or alcohol and other drugs. However, sometimes participants had a broader responsibility for mental health services in general. Other participants included those responsible for evaluation and research, data and planning, policy and system re-development.

6.3 Regional planning

6.3.1 STAGE OF JOINT REGIONAL MENTAL HEALTH AND SUICIDE PREVENTION PLAN

One Lead Site had completed their joint regional mental health and suicide prevention plan (herein referred to as 'the plan') and released it as a public document. The nine remaining Lead Sites described being in various early stages of preparation for writing their plan.

To prepare for drafting the plan, three Lead Sites were conducting initial consultations with various stakeholders, including the Mental Health Commission, youth services, consumers and carers, the Department of Health, the LHN, and their mental health council. One Lead Site was still deciding on the best approach to take to develop the plan but noted that approach would be focused on 'building engagement and empowering consumers and carers.' One Lead Site stated they had engaged a consultant to lead the planning process. One Lead Site had done a desktop review of existing plans in partnership with a consultant and changed the direction of the plan with a change in leadership of the PHN. Another Lead Site had drafted a plan in partnership with a consultant and was intending to re-visit the plan when they had completed work regarding psychosocial services funding. Another Lead Site had established a report structure and was seeking feedback on the priorities they had set. They reported that they intend to treat the plan as a 'living document' that is consistently updated by reviewing priorities and activities on a quarterly basis.

6.3.2 REGIONAL PLANNING APPROACHES OR ACTIVITIES

Nine Lead Sites provided information on planning approaches or activities they had undertaken since the Round 1 focus groups. We asked a series of questions regarding these activities that related to understanding local mental health needs and service gaps; and engagement of regional stakeholders, including LHNs, regional and other key stakeholders, and consumers and carers.

6.3.2.1 Understanding local mental health needs and service gaps

To understand local mental health needs and service gaps, three Lead Sites reported having undertaken service mapping, including one Lead Site that had co-commissioned their service mapping with the Department of Health. Three Lead Sites had undertaken consultation processes to assist in identifying service needs and gaps, and priority areas for their regional plans, and all had included consumers and carers in that process. One Lead Site had completed a needs assessment using data from a range of sources, including the Australian Bureau of Statistics. Another Lead Site sought information from their key governance groups (e.g., clinical council) to understand local mental health needs and service gaps.

6.3.2.2 Working with Local Hospital Networks

Four Lead Sites commented on how they were working with their LHNs to develop their regional plans. Of these, three Lead Sites talked about strong existing relationships with LHNs, with two having developed this relationship through an existing committee that included their LHNs. One of these Lead Sites had new leadership and reported strengthening the existing relationship with the LHN had resulted in more collaboration. Another referred specifically to working with their LHDs' planners on developing the plan. Preparation to work in partnership with these planners had taken about six months, and the planners had undertaken training in the National Mental Health Planning Framework. The fourth Lead Site reported working with their LHD to draft the regional plan.

A fifth Lead Site commented that they did not yet have any official partnership with the LHN to develop their regional plan.

6.3.2.3 Engaging regional and other key stakeholders in regional planning

Seven Lead Sites outlined approaches they had used to engage regional and other key stakeholders in the regional planning process. Five Lead Sites talked about using established groups and committees for work on their regional plan. One of these Lead Sites had partnership groups to review each chapter and develop chapter-specific implementation plans. Four Lead Sites spoke of establishing new regional planning working groups or committees that included regional stakeholders. These groups and committees ranged from working groups who met once to discuss a particular area or chapter of the plan to strategic partnership groups overseeing implementation of the whole plan. The stakeholders mentioned varied between Lead Sites but included other PHNs within their states; state government health bodies (e.g., hospital and health services); consumers and carers (including peak bodies); Aboriginal and Torres Strait Islander peak bodies; a GP representative; representatives from the alcohol and other drug sector and homelessness services; representatives from the NDIS; and others.

Two Lead Sites spoke about improving their communication with regional stakeholders to develop their regional plan. One Lead Site had improved their relationship with the local Aboriginal Medical Services by ensuring that only one director has contact with them to provide a consistent point of contact. One Lead Site had developed a communications plan for their regional stakeholders and had also employed a project officer to assist in coordination of the plan. Another Lead Site was engaging in several additional community consultations regarding their regional plan. These consultations were to include broad community consultations, as well as targeted consultations with specific groups such as Aboriginal and CALD community members.

6.3.2.4 Engaging consumers and carers in regional planning

Approaches taken by nine Lead Sites to engage consumers and carers in their regional planning are outlined in Table 20. Four Lead Sites referred to engaging consumer and carer peak bodies in groups and committees involved in regional planning. Three Lead Sites talked about involving consumers and carers in various consultation processes, including co-design of models of care and surveys conducted to elicit their views. Two Lead Sites had involved representatives with lived experience in groups and committees relevant to regional planning. Additional strategies described by individual Lead Sites are listed in Table .

Table 20. Approaches to engaging consumers and carers in regional planning

Approach	No. Lead Sites
Consumer and carer peak body involvement in groups and committees	4
Consultation processes with consumers and carers	3
Consumer and carer representatives in groups and committees	2
Looking for a new way to involve consumers and carers to ‘drive the dialogue’	1
Using established consumer and carer community	1
Consumers and carers writing their own chapter in regional plan	1
Consumers and carers writing introduction to each section	1
Consulting specifically with Aboriginal Medical service	1
Developing alternative pathways to accessing different consumers and carers	1

Note. Some Lead Sites mentioned more than one approach; therefore, the total number of Lead Sites is greater than the nine who answered this question.

6.3.3 DIFFICULTIES EXPERIENCED IN REGIONAL PLANNING AND HOW THEY WERE OVERCOME

Nine Lead Sites outlined some difficulty they had experienced in developing their regional plans. These difficulties varied greatly across the Lead Sites and are shown in Table 21.

Table 21. Difficulties experienced in regional planning

Difficulty	No. Lead Sites
Recruiting necessary people to key groups and having them attend meetings	2
LHN boundaries do not always align with those of the PHN, causing reluctance to engage in shared planning	2
PHN covers a large region with large number of stakeholders, and in one case, several LHNs, who need to be involved in regional planning	2
Changing national requirements for the plan and late release of National Mental Health Planning Framework	2
The National Mental Health Planning Framework tool is not useful – data is too old or does not align with own service mapping	2
Political changes in the state make current planning difficult	1
Commonwealth has dual role with state health and consults the state before the PHN, delaying the planning processes	1
Finding a consistent tone for the whole plan when there are different groups writing the different sections	1
Gaining sector buy-in to implement the draft plan	1
Single PHN-state limits resourcing	1
Potential for longer term planning work to negatively affect recently implemented programs	1
Service gaps change, so identifying them needs to be a continuous process	1
Attempted to contract out a regional training provider, but lead did not fulfill their role	1
Developing new strategies to engage with the Aboriginal Controlled Health Organisation	1
Navigating different systems at local, state and national level but also across sectors to collaborate on the regional plan	1

Note. Some Lead Sites mentioned more than one difficulty; therefore, the total number of Lead Sites is greater than the nine who answered this question.

6.3.3.1 Overcoming difficulties in regional planning

Three Lead Sites also discussed strategies they had used to overcome some of these difficulties. To manage the difficulty of recruiting representatives for key groups and having them attend meetings, one Lead Site clearly articulated the purpose of each group, created smaller working groups focused on specific parts of the plan, and recruited representatives from a stakeholder forum to create buy-in to enact the plan. The same Lead Site also highlighted to stakeholders the alignment between the objectives of their respective organisations and those of the regional plan. Another Lead Site was able to develop partnerships with regional stakeholders because of its positive reputation, which they had built by effectively identifying the needs of the community and commissioning services to meet these needs. One Lead Site noted that having the opportunity to engage with other Lead Sites compensated for some of the difficulties of being a single-PHN state.

6.3.4 FACILITORS AND EFFECTIVE STRATEGIES FOR REGIONAL PLANNING

We initially asked Lead Sites separate questions regarding facilitators and most effective strategies for regional planning, but the responses to these two questions were so similar that we have combined the responses here.

Eight Lead Sites described effective strategies they had used for regional planning. Five of these said the most effective strategy was building good relationships with LHDs and other regional stakeholders. These relationships had been built over time and largely pre-dated the requirement for regional planning. Individual Lead Sites also mentioned the following effective strategies for regional planning: co-developing the regional plan with stakeholders to create greater buy-in for implementation; undertaking partnership brokerage training; making the state government also responsible for the regional plan going ahead; developing a plan based around using services that already exist, rather than developing new services; using a planning working group; hiring a good consultant; basing the plan on strong needs analysis and service mapping; and having developed the stepped care model completely before undertaking regional planning.

6.3.5 EARLY IMPACTS OF REGIONAL PLANNING

Four Lead Sites commented on the positive early impacts of regional planning. Two of these Lead Sites stated that having to create a plan with LHDs had created the opportunity for PHNs and LHDs to partner, and this had led to collaborations outside of regional planning. For example, one Lead Site and their LHD had agreed to make all new plans together and were co-commissioning. Two other Lead Sites commented that having the PHN and LHD working together on the regional plan created a commitment to make real change in their regions.

6.3.6 IMPROVING REGIONAL PLANNING

We asked Lead Sites to suggest ways that regional planning could be improved in the future and what additional support and resources they would need from the Department of Health to improve regional planning.

6.3.6.1 General suggestions for improving regional planning processes

Four Lead Sites provided suggestions as to how regional planning could be improved in the future. Two of these Lead Sites stated the importance of having people working on the plan in local-level working groups to foster engagement and to get away from ‘the large bureaucracies’. One Lead Site talked about the importance of having a broad regional plan before commissioning a range of new services. Another Lead Site believed there needed to be more pressure on LHNs to collaborate with the PHN in regional planning; and another Lead Site noted that future planning would be easier now they had completed one regional plan.

6.3.6.2 Additional support and resources needed from the Department of Health to improve regional planning

Five Lead Sites suggested additional supports and resources were needed from the Department of Health in order to improve regional planning. Three suggestions related to additional funding. One Lead Site noted that additional funding would allow the PHN greater flexibility to invest in regional approaches and to attract regional partners. Similarly, another Lead Site referred to currently having minimal ‘leverage’ in the sector. Two Lead Sites both referred to limited funding being allocated to the large task of leading development of the regional plan. Two Lead Sites wanted more explicit and timely guidance from the Department on developing the regional plan. Explicit guidance would include key components of the plan to promote some national consistency. Individual Lead Sites also suggested the following: more time to develop the regional plan (‘Years rather than days, weeks or months’), including time for the PHNs to get established and develop credibility within the region; reducing the burden of duplicate reporting requirements for the Mental Health Commission and the Department of Health, which are similar but separate; and better alignment regional plan development and the timing of the release of the Fifth National Mental Health Plan.

6.4 Regional service integration

6.4.1 APPROACHES TO INTEGRATE PRIMARY MENTAL HEALTH SERVICES WITH OTHER REGIONAL SERVICES

Lead Sites were asked whether they had used any new approaches, strategies or activities to integrate their commissioned services with other regional services since the Round 1 focus groups. Responses to this question largely related to use of a centralised intake process, co-commissioning arrangements with the LHN, and reviewing integration of current services. These approaches are outlined in Table 22.

Table 22. Approaches to integrate primary mental health services with other regional services

Approach	No. Lead Sites
Centralised Intake	5*
Co-commissioning	4
Reviewing activities towards integration of existing services	4
Making integration part of contractual arrangements	4
Current partnership with LHD	2
Alliance arrangements	2
Fostering partnerships on behalf of commissioned services	1
Service Navigation	1
Hosting a forum for providers	1
Improving communication to public about integration	1
Measuring cases in hospital that could be managed in primary care	1
Locally determined service level agreements	1
Using dual funding mechanisms	1
A shared regional plan	1
Creation of service hubs	1
Governance arrangements to support engagement of key players	1
Reviewing data to understand consumer movement through services	1

Note. Some Lead Sites mentioned more than one difficulty; therefore, the total number of Lead Sites is greater than the number who answered this question. *One of these Lead Sites is considering moving to a centralised intake model.

6.4.1.1 Centralised intake

Six Lead Sites mentioned centralised intake as a means of promoting integration of services. One Lead Site reported working with the LHD on intake and service navigation, and two Lead Sites reported they were planning to combine intake models with LHDs to one centralised point of intake in the future. One Lead Site stated they were considering centralised triage and assessment for the future. Another Lead Site reported handling referrals from GPs but noted that referrals between service providers occur at a local level. Another Lead Site noted they have designed a centralised referral form which is processed by an alliance of service providers who decide on the best care for each circumstance.

6.4.1.2 Co-commissioning arrangements

Lead Sites were asked to what extent plans were developed for co-commissioning of services with LHNs, and two Lead Sites reported already successfully co-commissioning services. One Lead Site reported undertaking complementary commissioning, which was defined as commissioning in an environment of full understanding of what others are doing. Another Lead Site reported high-level planning towards co-commissioning.

6.4.1.3 Reviewing integration of existing services

Four Lead Sites described activities being undertaken towards reviewing integration of existing services. This was described by one of these Lead Sites as making sure referring GPs have a good understanding of what services are available. Another Lead Site stated they were looking at frameworks to see where to integrate services and taking the time for strategy planning, utilising the learnings from earlier integration approaches. One Lead Site proposed strengthening pathways to housing and employment by building them into contracts when procuring services and were in the early model-development stage of a whole person response.

6.4.1.4 Other activities to promote integration

Four Lead Sites described making integration part of their contractual arrangements, which one Lead Site was doing through implementing KPIs and another through joint meeting requirements. Two Lead Sites mentioned partnerships with the LHD, and two Lead Sites mentioned alliance-type arrangements of services. A number of other strategies or activities were mentioned by one Lead Site each, and these are listed in Table 22.

6.4.2 MOST EFFECTIVE APPROACHES FOR, AND FACILITATORS OF, ACHIEVING REGIONAL SERVICE INTEGRATION

We asked Lead Sites to state the most effective approaches for, and facilitators of, achieving regional service integration. Their responses are outlined in Table 23 and in the two sections below.

Table 23. Effective approaches for achieving regional service integration

Approach	No. Lead Sites
Implementation and monitoring of the stepped care model	3
Communication with GPs	2
Co-location of youth services with existing services	1
Cross-service meetings	1
Tapping into existing events and communication networks	1
Integration as a contractual obligation	1
Partnership with the LHN	1
Providers stepping client up and down	1
Centralised intake to facilitate appropriate service for clients	1
Target D – online assessment and treatment recommendation	1
Gap identification through review of current practice at time of transition to the new flexible funding model	1

Note. Some Lead Sites mentioned more than one effective approach; therefore, the total number of Lead Sites is greater than the number who answered this question.

6.4.2.1 Most effective approaches for achieving regional service integration

Lead Sites were asked which approaches to integration were most effective. There was consensus among multiple Lead Sites regarding two types of approaches regarded to be effective. First, three Lead Sites identified the stepped care model as driving integration. Two of these Lead Sites noted that integration was occurring at a system level, and one noted that integration is seen at the consumer level. Second, two Lead Sites identified communication with GPs as an effective strategy for integration, where services are contractually required to report back to the referring GP. However, as one Lead Site noted, there is no remuneration for GPs for what potentially could be added administrative burden in receiving these reports. All other strategies were mentioned by one Lead Site each and are summarised in Table 23.

6.4.2.2 Facilitators of regional service integration

Four Lead Sites also identified factors that helped to achieve service integration. One Lead Site identified that being a small region, geographically and population-wise, made integration easier, as did having state-based ministerial support. The same Lead Site also noted that they were able to build upon what was a strong resource base at the beginning. The same Lead Site and one other noted that existing relationships with key stakeholders helped to get everyone 'to the table' to discuss how to work together. Another Lead Site reported having a small workforce had assisted integration because '…they all know each other…', although this Lead Site also noted that the tendering process created a competitive market, which can counter collegiality. This same Lead Site observed that integration occurred at different rates for different organisations, with larger organisations taking longer to change than the smaller, more agile organisations, and that broader political or funding factors may inhibit an organisation's ability to change. Accordingly, two Lead Sites indicated that these contextual factors should be taken into account when considering the degree and speed of service integration. Another Lead Site noted that there is a growing understanding that mental health service delivery needs to change but did not describe how this is to occur in practice.

6.4.3 DIFFICULTIES EXPERIENCED IN DEVELOPING REGIONAL SERVICE INTEGRATION AND HOW THEY WERE OVERCOME

Lead Sites were asked which approaches were least effective for achieving regional service integration. Lead Sites answered this question by listing the barriers to integration. One of the most commonly noted barriers was the introduction of NDIS and the associated workforce movement in the sector that this is causing. Another commonly noted barrier, mentioned by three Lead Sites was the siloed funding streams, either across sectors or across levels of government. Two of these Lead Sites noted that consumers often present with multiple problems. However, a participant from one of these Lead Sites felt that different funding streams was inevitable when working with different levels of government and that it required planning and creativity in the development phase. Another two Lead Sites noted that integration is difficult in its very nature. Two other Lead Sites noted short or misaligned delivery timeframes were a barrier. Two Lead Sites also noted that referrers and providers were often resistant to change or did not have the capacity to change. Other barriers were noted by a single Lead Site each and are summarised in Table 24.

Table 24. Barriers to regional service integration

Barrier	No. Lead Sites
Introduction of the NDIS and associated workforce movement in sector	3
Siloed funding streams inhibiting integration	3
Integration is difficult	2
Short or misaligned timeframes	2
Providers and referrers resistant to change	2
Complications of the process of implementing the reform	1
Other organisations not co-designing	1
MDS does not distinguish between an integrated service offering various service types but counting as a single episode of care and a consumer visiting multiple services counting as multiple episodes of care	1
Dissolution of old services	1
Changes within LHN whilst undertaking regional planning	1
High number of community services creates complexity	1
Dual role with LHN as commissioner and advocate	1
Complexity in the mental health system leading to difficulties attributing causation when evaluating strategies	1
Create competitive market within small workforce	1

Note. Some Lead Sites mentioned more than one barrier to integration; therefore, the total number of Lead Sites is greater than the number who answered this question.

6.4.3.1 Strategies to overcome difficulties with regional service integration

Lead Sites were asked how they had overcome the main difficulties experienced in achieving regional service integration. One Lead Site mentioned that specifying integration at the point of request for tender (RFT) processes and incorporating it into the key performance indicators (KPIs) within service provider contracts helped to set expectations and overcome resistance to change. The same Lead Site noted that even prior to the RFT stage, using co-design as a change management process also helped. This Lead Site also noted that their stepped care model also helped to put things into place. Another Lead Site noted that the Commonwealth's commitment to providing three-year rolling contracts had helped others to see PHNs as a permanent feature of health and as longer-term partners.

6.4.4 EARLY IMPACTS OF REGIONAL SERVICE INTEGRATION ACTIVITIES

Lead Sites were asked to comment on the early impacts of regional service integration activities. Five Lead Sites described positive impacts. These impacts included services meeting client need; improved referral processes; simplified planning processes with LHNs and other partners; co-commissioning because of the multi-partner commitment to the regional plan; and the availability of a psychiatrist helpline for GPs. Two Lead Sites noted two types of evidence that their activities were resulting in service integration. Both mentioned ongoing relationships between services, which was evidenced by networks and working groups continuing past PHN facilitation efforts or referring clients between services. One of these Lead Sites also indicated that they had received a number of emails from clients which described a journey through an integrated system.

6.4.5 IMPROVING REGIONAL SERVICE INTEGRATION

We asked Lead Sites to suggest ways that regional integration could be improved in the future and the additional supports and resources from the Department of Health they would need to achieve regional integration. Their responses are summarised below.

6.4.5.1 General suggestions for improving regional service integration

Lead Sites were asked how regional integration could be improved in the future. Four Lead Sites mentioned a number of factors which they felt were essential for integration in the future. Three Lead Sites mentioned funding models as central to improving service integration. One Lead Site suggested that a completely new way of funding mental health in primary care – that is not reliant on funding GPs based on activity – is needed. This Lead Site explained that if a consumer is not unwell enough to go on a mental health care plan, the GP does not get paid, which acts a barrier for the GP to undertake work associated with referring consumers to low intensity services. Another Lead Site felt the flexible funding offered opportunities for integration which moves away from programmatic silos. One Lead Site described current funding as separated into segments of the client's journey with different providers funded for high, medium and low intensity. This Lead Site suggested well-designed, place-based funding might be better for an integrated experience for the consumer. Other essential ingredients included the importance of relationships and collaboration.

6.4.5.2 Additional support and resources needed from the Department of Health to improve regional service integration

Five Lead Sites specifically desired resources from the Department of Health to aid integration. Two Lead Sites suggested that integration become a fundamental policy requirement and part of the national health reform agenda, which would ensure all other sectors are committed to it. Another Lead Site suggested that the Department provide added funding to resource collaboration efforts for organisations with less capacity for this due to their size. Another suggested PHNs have permission to negotiate paying the gap fee of private providers on MBS-funded sessions. Lastly, one Lead Site wanted PHNs to be given access to MBS and PBS data to better inform planning.

6.5 Stepped Care

6.5.1 STAGE OF DEVELOPMENT AND IMPLEMENTATION OF STEPPED CARE

Nine Lead Sites told us the current stage of their stepped care model planning and implementation. Six of these Lead Sites had their stepped care models fully implemented, and three Lead Sites were at an earlier stage. Despite the full implementation of the model, three Lead Sites talked specifically about the need for ongoing review or a 'continuous improvement' as they learn through implementation of services within the model. One Lead Site was carrying out work to redesign their stepped care model and plan for communication of that model to stakeholders. Another Lead Site was using the principles of stepped care to guide their upcoming commissioning of services while continuing to work on the model. One Lead Site had developed a consultation draft of their stepped care model and had State Department of Health agreement on that document.

6.5.2 APPROACHES TO MATCH SERVICES TO CONSUMER NEEDS

Nine Lead Sites talked about new approaches, strategies and activities undertaken to match services to consumer needs since the Round 1 focus group. The two main strategies used were intake and assessment procedures, and education and promotion of the services to referrers. These, and other strategies used by fewer Lead Sites, are described in more detail below.

6.5.2.1 Intake and assessment procedures

Five Lead Sites talked about strategies relating to intake and assessment procedures to ensure services are matched to consumer need. Three of these Lead Sites reported having current centralised intake functions that differed from each other. For example, one Lead Site stated they have co-located intake staff for each of their services, so these staff discuss referrals between them. One Lead Site stated they have a centralised triage system that triages for risk, but not for service type, such that a consumer at high risk may be triaged into tertiary services, but their commissioned stepped care providers decide which services the consumer will receive within the stepped care model. Another Lead Site was considering using a centralised intake system in the future but does not currently have one. Other procedures to ensure services are matched to consumer need referred to by other Lead Sites were the following: a trial using the StepCare tool developed by the Black Dog Institute, which helps to screen consumers and make suggestions to GPs about level of need and interventions; using outcome tools to make decisions about stepping consumers up or down; use of a clinical staging model whereby consumers are allocated to a stage from 0 to 4 (early risk to severe and complex mental illness) based on a thorough assessment, and this is used to match the consumer to the services they need; and increasing the amount of assessment done at intake to allocate consumers to the right services.

6.5.2.2 Education and promotion

Four Lead Sites used education and promotion strategies regarding their services that were aimed at referrers and consumers to ensure their consumers were appropriately referred and accessing the most appropriate services. Two Lead Sites talked about the comprehensive information on their website available for referrers. In regard to greater education of providers about stepped care, one Lead Site was conducting a forum with allied health professionals to provide additional information about the model and associated services in order to encourage stepping consumers up or down. One Lead Site initially allowed for flexible and open levels of graduated service but found providers struggled with knowing when to step consumers up or down. They therefore developed and communicated to their providers more specific parameters and structure around stepping consumers up and down. Another Lead Site was moving from their focus on education of clinicians to education of consumers regarding stepped care.

6.5.2.3 Other approaches, strategies or activities

Two Lead Sites talked about their referral processes as ways of ensuring consumers are matched to appropriate services within the stepped care model. One of these Lead Sites had developed a referral form for their range of services that indicates the various steps of the model. The other Lead Site had ensured that their mental health-specific Health Pathways aligned with their stepped care model.

Two Lead Sites discussed specifications in contracts with their service providers aimed at ensuring consumers get services that meet their needs. For example, one of these Lead Sites had included KPIs related to stepped care in their service provider contracts, such as referral pathways and the consumer not having to retell their story. The other Leads Site stated that they specify in their tender documents and subsequent contracts the eligibility of consumers they are trying to reach. The tendering service organisation then proposes a service designed to meet the needs of that group.

Individual Lead Sites also noted using other strategies to match services to consumer needs. One Lead Site was planning to make site visits to other PHNs to review their strategies for implementing stepped care and was reviewing products on the market that might be able to support implementation of stepped care. One Lead Site had their providers delivering services across the stepped care model rather than individual services within a single step and had no restrictions on the number of sessions provided. They stated that this model allowed them to step consumers up and down more easily than if they had different providers at the different levels. Another Lead Site had commissioned an independent review of their services that will help them to better implement stepped care. One Lead Site stated they are building upon existing services to better provide stepped care (e.g., in-reach into aged care facilities) and providing training to their existing workforce to enable them to provide services at other steps of the stepped care model to those they are already providing.

6.5.3 STRATEGIES TO ENGAGE REFERRERS, INCLUDING GPS AND OTHERS, TO PROMOTE STEPPED CARE

Six Lead Sites talked about strategies they had used to engage referrers, including GPs and others, to promote stepped care.

6.5.3.1 Engaging GPs

Four of these Lead Sites talked specifically about GP engagement strategies. One Lead Site talked about regular contact with GPs to discuss appropriateness of referrals received by the intake team according to the stepped care model. They also talked about the importance of Health Pathways for facilitating discussion between GP and patient regarding referral to appropriate services. Another Lead Site had their low intensity program coaches write letters to GPs to inform them that their patient was accessing that service and to provide some follow-up information. One Lead Site used their comprehensive primary care team, whose role is to engage with GP practices, to focus on stepped care and associated services. Another Lead Site used a similar approach, but also had their service providers make practice visits to their GPs to talk about their services.

6.5.3.2 Engaging regional service providers and community members

Four Lead Sites talked about strategies for engaging stakeholders other than GPs in discussions around stepped care. One of these Lead Site was providing 'breakfast' events targeting other regional service providers to discuss their stepped care services. Another of these Lead Sites was targeting regional service providers and community members in their education activities around stepped care by giving presentations (e.g., at a community care conference). Two of these Lead Sites stated their service providers have communication plans and engagement strategies for promoting stepped care or their service within the stepped care model aimed at increasing the understanding of potential consumers and referrers. One of these Lead Sites stated this had led to 'a lot of referrals from the general public and from consumers themselves, which is a big change in the sector'. They also discussed using their existing networks, such as their clinical council and community advisory committee, to promote stepped care to other stakeholders, and noted the importance of 'word-of-mouth' information passing between professionals. One of these Lead Sites talked about their engagement strategies varying depending on the needs of the local government area; for example, engaging a target group or practicing demand management. This Lead Site also specifically referred to using social media, such as Facebook, to promote services, while having to be careful not to create a demand for services that could not be met.

6.5.4 EFFECTIVE APPROACHES TO, AND FACILITATORS OF, STEPPED CARE IMPLEMENTATION

Seven Lead Sites told us about their most effective strategies for implementing stepped care. Each Lead Site referred to different approaches or strategies as being most effective, and these are shown in Table 25.

Table 25. Effective approaches to stepped care implementation

Approach	No. of Lead Sites
An iterative approach to stepped care model development, with willingness to adjust based on feedback	1
PHN ongoing support to providers: service data establishment, intake integrated service, contract management, regular meetings etc.	1
Centralised intake within the PHN providing immediate access to information	1
Building stepped care requirements, including stepping up and down, into provider contracts	1
Usefulness and relevance of Health Pathways (as reported by consumers)	1
Developing and disseminating quality information about stepped care (e.g., videos)	1
Smooth transition processes for existing clients following service changes: outgoing provider involved in transition process and individual referral to new services	1
Strength of the stepped care model itself in meeting consumer needs	1
Removing the need for a GP Mental Health Treatment Plan for access to services	1
Developing a psychiatric consultation and advice service to support GPs and their teams, and building this to assist other providers within the stepped care model	1
Mental health nurses facilitating step up and down for individual consumers	1
Retaining a range of services to meet the broad needs of the catchment: e.g., Mental Health Nurses, wrap-around care, in-language services	1
Eliciting consumer self-reported experience and outcome via electronic survey issued at various time points in their journey	1
Using mental health expert advisory group to test some of the concepts of the stepped care model	1
Providing education to GPs and practice managers by directing them to comprehensive information on the website	1

Note. Some Lead Sites mentioned more than one effective approach; therefore, the total number of Lead Sites is greater than the number who answered this question.

6.5.5 FACILITATORS OF STEPPED CARE IMPLEMENTATION

Six Lead Sites talked about factors that had facilitated implementation of their stepped care model. The most commonly named factor was good relationships with other stakeholders, and there were other diverse responses. These responses are summarised below.

6.5.5.1 Good relationships with other stakeholders

Five Lead Sites made reference to the importance of good relationships as a factor that facilitated the implementation of stepped care. One Lead Site talked about their commitment to building good relationships with a range of stakeholders in order to develop their stepped care model 'from the bottom up'. Another Lead Site talked about the stability of their team in maintaining good relationships that in turn has facilitated implementation of stepped care. One Lead Site stated their longstanding relationships with the Department and a range of other services providers, like state-based services, headspace, and community services, facilitated the implementation of stepped care. One Lead Site talked about the importance of working with other PHNs to share resources and establish working groups. Another Lead Site stated that having just one LHD to work with in their state/territory had facilitated the process of developing stepped care and integrating services.

6.5.5.2 Other facilitators

Various other facilitators to the implementation of stepped care were identified by one or two Lead Sites. One Lead Site talked about their system providing GPs with specific feedback around their patient's progress and care as a facilitator to the implementation of stepped care. One Lead Site stated their PHN was now more established than when it had initially commissioned its services, and this longevity and history was important. Another Lead Site had continued a pre-existing low intensity service to meet the requirements for stepped care. Two Lead Sites identified the importance of engaging with GPs. One of these Lead Sites identified the need for this to occur right from the beginning due to the important role GPs play in primary mental health, and the other noted that GPs need support and time management strategies. One Lead Site identified communication with outgoing providers during transition periods as similarly important.

6.5.6 DIFFICULTIES EXPERIENCED IN IMPLEMENTING STEPPED CARE AND HOW THEY WERE OVERCOME

Lead Sites were asked to identify new difficulties in implementing a stepped care approach they had experienced since Round 1. Nine Lead Sites shared their difficulties in stepped care implementation. Key difficulties were service providers not stepping consumers up or down, resistance to change, and other diverse difficulties. All difficulties mentioned by Lead Sites are outlined in Table 26.

Table 26. Difficulties in implementing stepped care

Difficulty	No. Lead Sites
Consumers not stepping up or down	4
Stakeholder resistance to change	3
Incorrect referral/assessment of consumer by GP resulting in incorrect assignment to 'step'	3
Workforce difficulties	2
Negative narrative of peak bodies	1
Perception that face-to-face treatment is best	1
Poor quality of GP treatment plans	1
Providers unsure what PHNs fund	1
Poor internet quality for web-based services in rural areas	1
Not enough time for planning	1
MDS is limited in what it captures	1
Information sharing between providers when client steps up or down	1
Technical language about stepped care is confusing to consumers	1

Note. Some Lead Sites mentioned more than one difficulty; therefore, the total number of Lead Sites is greater than the number who answered this question.

6.5.6.1 Consumers not stepping up or down

Four Lead Sites reported that stepping consumers up or down through the various steps was not occurring in practice and noted several possible explanations as to why this was not occurring. For example, it might be that the clinician does not have the knowledge or awareness around when and how to transition consumers or that sole clinicians or smaller services do not have the financial capacity to operate in this type of business model. Lead Sites also speculated that clinicians might want to provide continuity of care or might need to build trust in other providers they refer to. One Lead Site stated it was inevitable that sometimes a single provider can deliver the spectrum of steps, but sometimes they cannot. Two Lead Sites stated that sometimes the consumer did not want to change service, prohibiting stepping up or down. Three Lead Sites attributed the lack of stepping up or down to 'The perverse incentive of a fee-for-service arrangement'. As one Lead Site indicated, the acuity of the consumer's mental health needs helps with stepping up, but there is no driver to step down.

6.5.6.2 Stakeholder resistance to change

Three Lead Sites identified stakeholder resistance to change as another difficulty in implementing stepped care. Two of these Lead Sites stated that GPs, in particular, are resistant to change. As a result, one Lead Site reported they had undertaken work to support and resource the necessary changes, and to build and maintain relationships during this transition. Another Lead Site noted that some peak bodies, such as the Australian Psychological Society and other clinician groups, received complaints from their constituents and in turn expressed this negative narrative of PHNs to others, which did not match the reality of all providers' perceptions. Additionally, one Lead Site believed that there is still a strong perception held by providers and consumers that face-to-face services are best.

6.5.6.3 Other difficulties implementing stepped care

Three Lead Sites perceived misalignment between consumers' needs as assessed by GPs and consumers' actual needs. As one Lead Site noted, sometimes treatment plans by GPs are of very poor quality. Another Lead Site noted that some providers were unsure where to refer consumers due to confusion over what is or is not PHN-funded. Two Lead Sites expressed difficulties with workforce, either because mental health professionals don't want to work in a primary care setting or because in rural locations it is difficult to access the breadth of workforce required to provide services across a stepped care model. Another Lead Site stated that rural locations also posed difficulties where web-based services were impacted by poor internet access. One Lead Site commented that the technical language of stepped care was confusing when used with the consumer or in the community.

Other difficulties experienced by individual Lead Sites are listed in Table 26.

6.5.6.4 Strategies to overcome difficulties in implementing stepped care

Lead Sites were asked how they had overcome difficulties in implementing stepped care, and they reported a range of approaches. Two Lead Sites described an informal system of providing feedback to GPs when incorrect referrals are made. One Lead Site had clear guidelines for referrers of expectations and procedures. Another Lead Site was in the process of reviewing the mental health treatment plans they had received as part of quality improvement in transitioning consumers between steps without having to re-tell their story.

To address the workforce issues mentioned above, one Lead Site reporting having provided more flexibility in part-time work arrangements, by allowing the provider to recruit multiple small FTE roles. To improve information sharing between providers, one Lead Site reported they had provided training in secure sharing of information. Another Lead Site noted emphasising particular aspects in the RFT to ensure the stepped care model was implemented as intended.

6.5.7 EARLY IMPACTS OF STEPPED CARE

Lead Sites were asked to describe the early impacts of stepped care. Most commonly, they responded that it was too early to see any impacts. Four Lead Sites commented on positive impacts of stepped care. Three of these Lead Sites described individual- and service-level impacts, such as better targeting of those in need or clinical improvement for consumers. Other impacts noted by one Lead Site each included referrers experiencing a better resourced system, a broader mental health workforce, and broad adoption of the stepped care model across the sector. One Lead Site highlighted the value of a broader suite of service options and greater focus on consumer experience when measuring outcomes.

Two Lead Sites described the effectiveness of stepped care through case studies. One of these Lead Sites noted that these case studies are a contractual requirement of commissioned providers.

When explicitly asked, Lead Sites did not identify any negative impacts of stepped care.

6.5.8 IMPROVING STEPPED CARE

We asked Lead Sites to suggest how stepped care could be improved in the future and what additional support and resources they would need from the Department of Health in order to improve stepped care. The 10 Lead sites provided diverse suggestions regarding how planning, commissioning and implementation of stepped care could be improved. These are summarised below.

6.5.8.1 General improvements

Two Lead Sites called for a thorough review of stepped care now that the 'dust has settled', with reference back to the 2014 National Mental Health Commission report (*Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Services*) about why stepped care was recommended. One of these Lead Sites called for a change in culture in which providers value meeting consumers' needs over gaining more referrals for themselves. Another Lead Site suggested re-thinking how providers are funded because alignment with the principle focus of treatment may disincentivise a provider from delivering a less expensive intervention if it means they also get paid less. A related sentiment from another Lead Site was the recommendation that PHNs communicate clearly to consumers and the wider sector why stepped care is being implemented. Similarly, another Lead Site recommended more communication about stepped care from PHNs specifically to referrers. One Lead Site commented that regional plans will improve the system so that consumers do get the right treatment at the right time.

Some Lead Sites made suggestions around support for clinicians and stepping clients up or down. These included a recommendation for agreed protocols for stepping consumers up or down, support for providers to transition consumers between the levels of care and the suggestion of a 'concierge' who operates within a service hub to direct the consumer to the correct level of care. Lastly, one Lead Site stated that a deeper understanding of the broader sector was required. This included a recommendation to look more deeply at who is using Better Access and whether this is the right level of care for them. The same Lead Site also called for a system of tracking consumers across the steps.

6.5.8.2 Additional support and resources needed from the Department of Health

Lead Sites were also asked explicitly what support and resources they require from the Department of Health to improve implementation of stepped care. Two Lead Sites called for alignment of state and national funding. Other supports requested by one Lead Site each were more time for effective consultation and co-design in the planning cycle and more flexibility to focus on certain areas of mental health care. Conversely, another Lead Site called for national clinical guidelines for service delivery, although this Lead Site also praised the current flexibility. One Lead Site called for more specific guidance on assessment and referral. One Lead Site stated that the requirement for a mental health treatment plan should be removed to facilitate access.

6.6 Low intensity services

6.6.1 NEW APPROACHES USED TO TARGET AND DELIVER LOW INTENSITY SERVICES

All Lead Sites answered the question regarding new approaches, strategies or activities they had used to target, commission and deliver their low intensity services since the Round 1 focus groups. One Lead Site stated that there had been no changes to their low intensity services.

6.6.1.1 Planning activities

Three Lead Sites mentioned specific planning activities regarding changes to low intensity services. Using learnings from their pilot programs, one Lead Site had decided to fund providers for services across the stepped care spectrum, rather than just for low intensity services. Another Lead Site had undertaken significant planning to introduce NewAccess for Aboriginal communities, including creating an advisory committee, building relationships within the Aboriginal community, engaging an independent evaluator, and ensuring coaching training and materials are culturally appropriate. Another Lead Site spoke about reviewing literature regarding low intensity services, conducting a needs assessment and using co-design to design services. They described co-design as involving a range of people with lived experience, including those from marginalised groups.

6.6.1.2 Processes to appropriately target low intensity services

Five Lead Sites described processes used to ensure appropriate targeting of low intensity services. Two Lead Sites spoke about using a clinical intake tool to direct consumers to the most appropriate services (the intake tool developed by the Black Dog Institute and the K10 as a screening tool). One Lead Site referred to their centralised intake function being used to assess eligibility criteria for the services available. Another Lead Site said they had reviewed their modes of service to ensure they were meeting consumer needs and had implemented more face-to-face services rather than telephone services to meet consumer preference. One Lead Site spoke of an in-depth review of their data following 12 months of service implementation to ensure they are meeting the needs of the hard-to-reach groups identified in their initial needs assessment.

6.6.1.3 Types of low intensity services

During the focus groups we held with Lead Site staff from September to December 2018, we did not systematically ask for a description of all their low intensity services. However, several of them mentioned these services in answering other questions. The following list provides examples of the types of low intensity services currently in place that were mentioned in the focus groups. These categories are not mutually exclusive (e.g., services for CALD communities might also be provided in groups), so the total is greater than the number of Lead Sites:

- New Access with Aboriginal communities (Central and Eastern Sydney PHN);
- New Access with new provider (Bolton Clark) (North Coast PHN);
- New Access (Brisbane North PHN);
- Brief intervention telephone counselling (North West Melbourne PHN);
- Social connection group work (North West Melbourne PHN);
- headspace after hours groups in non-headspace clinic locations; e.g. music, parenting (Perth South PHN);
- In-reach to residential aged care facilities (Brisbane North PHN);
- Supporting CALD population (Brisbane North PHN);
- Optimal Health program as follow-up to suicide prevention services for LGBTI (run by NEAMI) (Brisbane North PHN);

- Perinatal depression (SMS and face-to-face) - pilot is finishing (Eastern Melbourne PHN);
- Group therapy (EACH program) (Eastern Melbourne PHN);
- Steps to wellbeing (NEAMI) is finishing (Eastern Melbourne PHN);
- New Horizons: referrals to low intensity services (including Alcohol and other drug and electronic mental health programs) when people call the state-based NNSWLHD Mental Health line (North Coast PHN);
- Brief telephone counselling (South Eastern Melbourne PHN);
- Mental Health First Aid for under-serviced populations (Central and Eastern Sydney PHN).

6.6.1.4 Using telephone and online modalities

Six Lead Sites discussed the use of online and telephone modalities to deliver low intensity services. One Lead Site stated they had not allocated funds to online interventions because of their limited funding, and instead used free existing online services. Two Lead Sites reported directing consumers to access online services (including smartphone applications and Mindspot) while they are waitlisted for other services. Lead Sites described promoting both free online mental health programs and apps, and those they had commissioned themselves. Two Lead Sites noted promoting the Head to Health digital gateway specifically. One Lead Site referred to development of self-help videos and online courses.

6.6.1.5 Targeting new groups of consumers

We asked Lead Sites if they had targeted new consumer groups with low intensity services since Round 1, and six identified new target groups. Three Lead Sites had targeted services to culturally and linguistically diverse (CALD) groups; two Lead Sites had targeted residential aged care facilities; and two had trained workers to provide services to LGBTQI people. One Lead Site each also mentioned targeting the following consumer groups: justice-involved people; young people, including 12-to-16-year-olds; and Aboriginal and Torres Strait Islander people. One Lead Site had expanded services into a particularly hard-to-reach geographical area; and one further Lead Site noted they were planning to expand services for refugees moving into the area.

6.6.2 DIFFICULTIES EXPERIENCED IN PROCURING AND DELIVERING LOW INTENSITY SERVICES AND HOW THEY WERE OVERCOME

Three Lead Sites stated that their commissioning of low intensity services had proceeded as planned. However, all 10 Lead Sites stated they had experienced some difficulties in procuring and delivering low intensity services. We have classified these difficulties into PHN-level difficulties and service-level difficulties.

6.6.2.1 PHN-level difficulties

Six Lead Sites talked about eight individual types of difficulties. In relation to commissioning, one Lead Site had attempted to contract an alliance for service delivery but had failed because ‘the system was not ready for that type of work’. One Lead Site stated that there was misunderstanding among tenderers regarding the service requirements to be delivered. One stated that many providers were not delivering group work as contractually required, but that they were now working closely with them to implement these group activities. One Lead Site stated that they had planned to create a decision tool for allocation to services, but because national work was being conducted regarding assessment, they had put this on hold. However, this Lead Site stated that the results of this national work were still pending, and their planned decision tool project was on hold.

One Lead Site stated that Beyond Blue’s hold on NewAccess services might be detrimental to its national adoption. They also stated that funding reductions and uncertainties had restricted their ability to commission additional services. One Lead Site had found recruiting low intensity service-consumers and carers as consumer and carer representatives very difficult, as consumer and carer representatives are more likely to be involved with services for low prevalence disorders. Another Lead Site had experienced a great deal of staff turnover and commissioning had largely been left to staff with little mental health services experience, and this had affected the commissioning process.

6.6.2.2 Service-level difficulties

All Lead Sites described at least one service-level difficulty in procuring and delivering low intensity services.

6.6.2.2.1 Uptake of low intensity services

Nine Lead Sites described difficulties with low uptake of some of their low intensity services, while two Lead Sites also stated that demand had been too high for some services. One Lead Site encapsulated many of the difficulties in implementing low intensity services in the following quotation:

> 'I think we're all facing the same issue around that acceptability of low intensity, knowledge of what it is too and then acceptability that it actually is a really worthwhile service. Once someone gets in there, the recovery rate you know speaks for itself... It's just getting people in there.'

Four Lead Sites described receiving few referrals from GPs into low intensity services, citing unfamiliarity with the low intensity services concept, lack of trust in these services compared with established services (like ATAPS), lack of awareness of low intensity services, and wanting in-house services as some of the reasons for the low number of referrals. Two Lead Sites talked about consumers' preference for face-to-face services over telephone services that had resulted in low uptake of telephone-based services: 'most people are aligned with bricks and mortar concept'. Two Lead Sites talked about the time and effort required to gain referral bases for this new type of service. Individual Lead Sites also cited the following difficulties related to low uptake: difficulty identifying number of consumers who should be accessing services (what should the target be?); commissioning a new provider for NewAccess that needed time to build its own referral base; and promotion to the community was not working – even in areas of high need.

Three Lead Sites described how they were attempting to overcome difficulties with low uptake of low intensity services. To promote uptake of low intensity services, one Lead Site described using a clinical triage tool (developed with the Black Dog Institute) to recommend low intensity services to consumers identified as appropriate through the tool. Another Lead Site reported allowing direct referral to NewAccess, rather than requiring consumers to go through centralised intake, in order to remove this barrier to referral. One Lead Site mentioned allowing their low intensity service providers adequate time to develop relationships with local GP practices to build their referral base; and providers had also used language relating to 'wellbeing' rather than 'mental health' to promote services, particularly in rural areas where stigma around mental health concerns might exist.

Three Lead Sites talked about the high demand for their low intensity services. One of these Lead Sites stated they had provided additional funding to a low intensity service to provide a female staff member, in addition to the existing male staff member, to meet high demand for low intensity services. One Lead Site stated there was probably more demand for services than the staffing of their low intensity services could provide. Another Lead Site stated that referrals for some low intensity services for young people go through headspace intake, and uptake of these services were being limited by a waiting list for intake services.

6.6.2.2.2 Change management to introduce low intensity services

Six Lead Sites described a range of change management difficulties that accompany the introduction of a new type of service model into an established sector. Three Lead Sites stated that more time was needed than was allowed to set up a completely new type of service:

> '…it was a huge underestimation of the amount of change that we did in a system, and expected to get referrals and everything.'

Two Lead Sites talked about the difficulties of understanding the requirements of a new type of service (e.g., phone-based or face-to-face) and then making changes as needed based on consumer responses (e.g., changing from phone to face-to-face services and having to recruit new workforce). Two Lead Sites talked about the difficulty of understanding and describing the concept of low intensity services, and the need to develop different language, other than 'low intensity', to promote these services. Two Lead Sites noted they had experienced resistance to the use of an unaccredited workforce to deliver low intensity services, and named GPs, psychologists and the Australian Psychological Society as some who had resisted use of this workforce. One Lead Site also stated that providers of established psychological services had also been resistant to low intensity services, as they see it as 'taking their work away'.

6.6.2.2.3 Workforce challenges

Four Lead Sites described workforce challenges related to low intensity services. Two of these Lead Sites said their providers had difficulties attracting workforce because of the short contracts they could offer based on limited duration of funding. One of these Lead Sites also said they experienced competition for the workforce with the introduction of the NDIS, which was creating additional employment opportunities with more stability. One Lead Site said their providers had offered other advantages to attract potential workforce, such as part-time rather than casual positions. One Lead Site stated that establishment of NewAccess had taken substantial time because the workforce require training, and another talked about the need for continual training due to initial staff turnover (which had since stabilised). The same Lead Site also described challenges of retaining their low intensity workforce, in particular by 'keeping them interested'. This Lead Site had overcome high turnover of low intensity workforce by targeting a workforce committed to this type of work, rather than in a transition phase, such as probationary psychologists; and considering moving towards more opportunities for the low intensity workforce to be trained to provide other types of services.

6.6.2.2.4 Challenges related to the minimum dataset

Three Lead Sites described difficulties with the MDS. One of these Lead Sites talked about the inability to track consumers in their transitions through levels of stepped care since the initial type of service provided defines the types of service reported for the entire episode of care:

> 'So if an episode starts with psychological therapy, that defines the entire content of the episode, even if you switch to low intensity during the episode.'

The second Lead Site talked about the designated assessment tool (K10) not being appropriate for all service settings (e.g., aged care); the result being missing data as clinicians choose not to administer it. The third Lead Site stated that the amount of data collected was burdensome for clinicians and consumers, particularly for short episodes of care.

6.6.2.2.5 Other challenges

One Lead Site stated that one of their providers had experienced technological challenges in delivering online services and had to adapt their services to be delivered in a 'hybrid' model as a result.

6.6.3 FACILITATORS AND MOST EFFECTIVE APPROACHES TO PROCUREMENT AND DELIVERY OF LOW INTENSITY SERVICES

All Lead Sites described at least one facilitator or most effective approach to the procurement and delivery of low intensity services. We initially asked Lead Sites separate questions regarding facilitators and most effective strategies to procurement and delivery, but the responses to these two questions were so similar that we have combined the responses here. Four Lead Sites described the most effective strategy to service implementation as close involvement with their chosen providers in implementation of low intensity services. These Lead Sites talked about regular contact with their low intensity providers, giving them detailed feedback, and engaging in collaborative problem solving to overcome challenges, all of which had assisted in developing appropriate services for the local region in a new service delivery environment:

> ‘I think we manage contracts in quite a different way to what service providers are used to… it's quite different to say a standard contract where you might be given the money and then you don't hear from them for 6 months… We will meet with our providers, sometimes… every month… every 2 months… we are quite interested to understand how things are actually working…’

All other effective approaches were described by individual PHNs and are outlined in Table 27.

Table 27. Facilitators and effective approaches to procurement and delivery of low intensity services

Approach	No. Lead Sites
Close involvement of PHN with their commissioned service providers	4
Good relationships with other providers and understanding the needs of the community	1
Implementing a service (NewAccess) with an evidence base	1
Implementing NewAccess in headspace	1
Linking low intensity providers with GPs	1
Providing information sessions for tendering providers to clarify expectations	1
Sharing learnings between providers on a quarterly basis and implementing improvements as a result	1
Natural maturation of the PHN and programs that enables greater trust from other services	1
Commissioning a range of mental health services, including a range of pilot programs, before deciding which services to continue commissioning	1
Strong partnerships between service providers and community organisations	1
Improving online platforms for delivery of e-services	1
Using low intensity services as an adjunct to face-to-face services, including for people with severe and complex needs who can still benefit from low intensity services in addition to other services.	1

Note. Some Lead Sites mentioned more than one approach; therefore, the total number of Lead Sites is greater than the number who answered this question.

6.6.4 CLINICAL GOVERNANCE ARRANGEMENTS TO MITIGATE RISK

Five Lead Sites commented on changes to their clinical governance frameworks to mitigate risk in low intensity services. Four of these Lead Sites referred to having completed their clinical governance frameworks. Of these Lead Sites, one referred to having updated the framework following implementation of the stepped care model; one described a focus on the centralised intake process and its interaction with clinical services; one noted that their framework was for all services across their PHN and was based on a state-based framework; and one highlighted the changes needed as PHNs transitioned into commissioning organisations from being a service delivery organisation.

Three Lead Sites discussed requiring tendering organisations to provide their clinical governance frameworks as part of the tender process. They also described working with the providers to ensure their frameworks aligned with the expectations of the PHN. All three of these Lead Sites discussed the requirement for providers to report back to the PHN on any critical incidents that occurred, according to the definitions and process of the clinical governance framework:

> ‘Through the tender process what their clinical governance structures are, and then through the contract negotiation… fine-tuned those, to make sure that they're appropriate for what we would expect. And they have expectations that are ongoing within their contract… how they manage incidents of safety and you know what components may constitute things that we need to know about or may want to know about.’

One Lead Site referred specifically to developments in their clinical governance related to the unaccredited workforce providing low intensity services. They referred to their training provider for ‘coaches’ having developed professional practice guidelines. They also referred to supervision requirements for the unaccredited workforce, which includes a focus on professional development, fidelity to the service model, case management, and clinical practice; and of the need for training in mandatory reporting.

One Lead Site also referred to the following components of clinical governance: developing risk management plans if providers are ‘falling over’ in any area of their clinical governance in order to mitigate risk; developing processes and protocols for intake; and inclusion of external personnel on the clinical governance committee.

6.6.5 EARLY IMPACTS OF LOW INTENSITY SERVICES

Eight Lead Sites provided some comment on the early impacts of low intensity services. However, two of these stated that it was too early to tell what the impacts would be. One Lead Site said that the impact had been minimal because they had limited resources to implement low intensity services, though they did say that their low intensity service was attracting a good proportion of men. The remaining five Lead Sites stated that the implementation of low intensity services was creating positive effects. One Lead Site stated that low intensity services were providing access to mental health services for hard-to-reach groups (e.g., aged care and CALD) that have strong stigma attached to mental health issues and that low intensity services then provided a soft entry point for higher intensity services. Advertising low intensity services as ‘wellbeing’ services helped to overcome stigma around accessing mental health services. In addition, this Lead Site was using group programs as a low intensity services to complement complex and severe services provided to consumers with high-level needs. Another Lead Site stated that their provision of after-hours services through the low intensity program was increasing access to services within their community. One Lead Site (stated that use of the K10 to track clinical progress in low intensity services was showing significant positive and sustained effects of the services for consumers. Similar effects were described by another Lead Site, who were using the GAD-7 (Generalized Anxiety Disorder 7-item scale) and the PHQ9 (Patient Health Questionnaire – 9-item scale) to track ‘recovery’ in their low intensity program. They stated their ‘recovery rate’ was 80-100%. One Lead Site also described high rates of recovery for consumers accessing low intensity services. They stated that their low intensity services were also successfully reaching their target cohort of people with financial, and other, barriers to access. They also stated that standard measures showed high levels of consumer satisfaction with the services.

6.6.6 IMPROVING PLANNING, COMMISSIONING AND IMPLEMENTATION OF LOW INTENSITY SERVICES

We asked Lead Sites to make suggestions for how planning, commissioning and implementing low intensity services might be improved in the future, and what additional supports and resources they needed from the Department of Health to this end.

6.6.6.1 General improvements

Seven Lead Sites gave ideas for how the implementation of low intensity services could be improved. There was little overlap between their responses, which are outlined in Table 28.

Table 28. How planning, commissioning and implementing low intensity services could be improved

Strategy	No. Lead Sites
Currently investigating what other low intensity services are needed to improve the overall low intensity program.	1
Need to make better use of social marketing to market low intensity services to consumers, particularly as the language is new.	1
Language of 'low intensity services' needs to be changed in favour of more everyday language.	1
K10 is not a good fit for low intensity services as it uses 'deficits' language when the low intensity service is strengths-focused. Some consumers disengage from the service after completing the K10. The K5 (which is strengths-focused) would be better, particularly for aged care and Aboriginal and Torres Strait Islander groups.	1
Treatments need to be holistic and wrap-around services are needed. In-reach to provide low intensity services in other services such as aged care is very successful.	1
Had run too many pilot programs in the early phases of implementation and would improve their services in future by running a smaller number of pilots.	1
Need for greater community education around low intensity services.	1
Organisations should be accredited to provide New Access rather than individual coaches.	1
Need to have greater and earlier engagement from general practice in order to make low intensity services successful.	1
Supplement NewAccess (which they highly recommended as a model of service) with digital applications to allow access anywhere and anytime.	1
Greater use of a peer support model.	1
Need to have greater early involvement of people with evaluation expertise in order to define success and know how to measure it from the beginning.	1
Need to re-define treatment 'completion': currently based on number of sessions, when the positive effects needed might be reached in a lower number of sessions, but the treatment is seen as 'incomplete' if do not attend specified number of sessions.	1
Provision of more after-hours services.	1

Note. Some Lead Sites mentioned more than one strategy for improvement; therefore, the total number of Lead Sites is greater than the number who answered this question.

6.6.6.2 Additional supports and resources needed from the Department of Health

Five Lead Sites provided suggestions on how the Department of Health could better support implementation of low intensity services. Two of these Lead Sites stated that more time was needed for planning and establishment of initial low intensity services. They referred specifically to additional time for consultation with community members and potential partners to gain better engagement, and for commissioned services to embed themselves in the community, to establish and grow. One Lead Site suggested there needed to be a consistent national strategy for promoting low intensity services and for this to be resourced at the national level. One Lead Site stated that federal and state funding needed to be better aligned to allow for co-commissioning with state-based services. One Lead Site suggested that the NewAccess program should be funded nationally through the Australian government, with allowances made for tailoring to regional needs. Another Lead Site stated that the National Mental Health Planning Framework needs to be improved to allow identification of PHN-specific codes, as it is not very useful in its current state.

6.7 Services for youth with, or at risk of, severe mental illness

Three of the Lead Sites involved in the focus groups (Primary Health Tasmania, South Eastern Melbourne PHN and Capital Health Network [ACT]) are Leads Sites for services for youth with, or at risk of, severe mental illness ('youth enhanced' services). We refer to these here as 'youth enhanced Lead Sites'.

6.7.1 NEW APPROACHES TO DEVELOPING, COMMISSIONING AND TARGETING YOUTH ENHANCED SERVICES

All Lead Sites described some new approaches they took to developing, commissioning and targeting their youth enhanced services since the Round 1 focus groups. We also asked them a series of specific sub-questions regarding strategies they had used to coordinate care with other providers of youth services, how they had promoted their youth enhanced services, and the service eligibility criteria they had used to inform referrers.

6.7.1.1 Approaches to planning and commissioning youth enhanced services

Four Lead Sites, including two youth enhanced Lead Sites, described approaches to planning and commissioning of youth enhanced services that were new since the last focus group. One of these Lead Sites stated that their youth enhanced services had continued as they had been at the last focus group; however, they had commissioned an external evaluator for 2019. Another of these Lead Sites had contracted Orygen to work with four regional areas to develop their clinical workforce and run youth enhanced services in these regions. One youth enhanced Lead Site had also invested in training some of their high intensity workforce to work with young people. The other youth enhanced Lead Site had conducted an additional needs analysis to identify community needs for youth enhanced services, developed service models for these and had recently gone to market.

6.7.1.2 Strategies to coordinate care with other providers

Five Lead Sites, including two youth enhanced Lead Sites, described new strategies they had undertaken to coordinate their youth enhanced services with other service providers. Of these, one Lead site and two youth enhanced Lead Sites stated that it was a contractual requirement of their commissioned providers to integrate with other youth services. Specific requirements included co-location with existing services including headspace, establishing pathways into acute tertiary services, monthly meetings with key stakeholders, and reporting regarding integration activities with wrap-around services. Two Lead Sites talked about establishing strong pathways into other services. One of these Lead Sites commissioned a service to provide functional recovery in partnership with the health service provider. The other Lead Site was ensuring coordination with other services through some co-location of services, outreach services, and ensuring direct referral pathways into services from schools, service providers and young people themselves. This Lead Site had worked closely with the youth enhanced service providers to ensure this coordination occurred. One Lead Site talked about their service provider having links with the local headspace to determine whether their youth enhanced service would take referrals directly from headspace.

6.7.1.3 Promotion strategies for youth enhanced services

Seven Lead Sites, including the three youth enhanced Lead Sites, talked about promotion of their youth enhanced services. Of these, two Lead Sites and one youth enhanced Lead Site talked about promotion of the service occurring through establishing partnerships and linkages with other youth services, rather than direct 'promotion' of the services. Two Lead Sites stated that their youth enhanced services were at full capacity so were not being promoted. One youth enhanced Lead Site required outreach as part of the service provider contract, so that access was improved for hard-to-reach youth. Another youth enhanced Lead Site was developing new youth enhanced services to fit within their stepped care model following a range of pilot projects. Therefore, the new service was not yet being promoted. In the long-term, however, they planned to promote the service themselves (information sessions, videos, leaflets, flyers etc.), as well as receiving referrals from other services via the stepped care model and using outreach to access hard-to-reach groups.

6.7.1.4 Eligibility criteria to inform referrers

Four Lead Sites, including one youth enhanced Lead Site, talked about having changed the eligibility criteria for their youth enhanced services since the last focus group. Of these, one Lead Site reported narrowing their eligibility criteria to limit demand for their service and to ensure that they were targeting young people who were disengaged from services. They were ensuring that a certain number of young people accessing the service did so through outreach, rather than through referral. The second Lead Site had a youth enhanced service that only received referrals from the local early psychosis intervention teams at the local hospitals. The eligibility criteria had been set out in service-level agreements and included age-limits and duration of untreated psychosis (no ultra-high risk). The third Lead Site had targeted their service toward young people with emerging mental health issues and complex needs. The fourth Lead Site (youth enhanced) talked about ongoing refinement of their eligibility criteria from initially broad criteria to narrower criteria that needed to be communicated to referrers in order to meet gaps in current services. Another youth enhanced Lead Site was still developing their eligibility criteria with their youth enhanced services, but these would include particular diagnoses.

6.7.2 NEW OR ADDITIONAL TYPES OF YOUTH ENHANCED SERVICES

6.7.2.1 New services or changes to existing services

Seven Lead Sites, including one youth enhanced Lead Site, described youth enhanced services that were new or had undergone changes since the Round 1 focus group. One of these Lead Sites had commissioned a consortium to run services across four areas in their catchment. These services include support for young people with comorbid alcohol or other drug use issues. The second Lead Site had broadened the age group eligible to access their services from 12 to 18 years to 12 to 25 years. The third Lead Site had funded some co-location work with headspace in two locations. The fourth Lead Site reported funding services focused on assertive outreach across the region and some alcohol and other drug service provision. The fifth Lead Site had also commissioned services specifically targeting young people at risk of being suspended from school due to substance misuse. The sixth Lead Site (youth enhanced) was implementing a new service model with a multidisciplinary team to conduct outreach work and then work with youth with complex mental health needs. The seventh Lead Site was funding a functional recovery service for youth with early psychosis.

6.7.2.2 Services for which headspace had been commissioned

All 10 Lead Sites stated whether they had provided funding to headspace to provide additional services beyond their core mild-to-moderate youth mental health services.

Five Lead Sites, including two youth enhanced Lead Sites, had some youth enhanced services being delivered through headspace centres, though sometimes they were being delivered by another organisation co-located within the headspace centre(s). Of these, two Lead Sites were providing funding to headspace directly to provide youth enhanced services. One of these was providing only additional youth enhanced funding, and the other was funding headspace to provide a spectrum of services from low intensity through to youth enhanced services, including alcohol and other drug misuse services and group work. The other three Lead Sites (including one youth enhanced Lead Site) had funded other providers for youth enhanced services, but these services were co-located with *headspac*e, and some referrals were therefore received through headspace intake.

One Lead Site (youth enhanced) was reviewing their youth enhanced funding, and the youth enhanced providers were uncertain; however, they had previously funded headspace to provide youth enhanced services.

The remaining four Lead Sites stated that their youth enhanced services were not being delivered through headspace centres. Of these, two were not providing funding to existing headspace centres to provide any additional services. However, one of these had funded two additional 'outposts' of their headspace centres to provide core services. Another of these Lead Sites was providing funding for headspace to provide out-of-hours services, but these were core mild-to-moderate services. One Lead Site (youth enhanced) had funded a low intensity coach to be co-located within the headspace service, and their LHD had also agreed to fund the PHN to provide additional coaching staff to be co-located in the headspace centre.

6.7.3 DIFFICULTIES EXPERIENCED IN PROCURING AND DELIVERING YOUTH ENHANCED SERVICES AND HOW THESE HAVE BEEN OVERCOME

Four Lead Sites stated they had commissioned their youth enhanced services as planned, though all Lead Sites identified some difficulties they had experienced in procuring and implementing their youth enhanced services. Most of these difficulties related to workforce, collaboration, and the minimum dataset.

6.7.3.1 Workforce

Six Lead Sites, including the three youth enhanced Lead Sites described some difficulties with accessing a suitably trained workforce to provide youth enhanced services. One of these Lead Sites had commissioned a service that had not previously delivered youth enhanced services, so the service had to build their workforce capacity to do so. The second Lead Site stated that their short funding contracts created difficulties in recruitment. The third Lead Site had difficulties attracting workforce to their rural locations. The fourth Lead Site (youth enhanced) had significant delays in being able to recruit a suitable workforce, compounded by those recruited clinicians also working in private practice and therefore only wanting to work at FTE fractions (e.g., 0.2-0.5 FTE). They also wanted to recruit a workforce to work with a range of presentations but had limited budget to upskill clinicians to fill their knowledge gaps. The fifth Lead Site (youth enhanced) talked about similar difficulties with recruitment, including the limitations of short funding contracts, as well as difficulties retaining clinicians. They related this to the 'risk' associated with working in youth enhanced services, particularly as there are limited services in the catchment to refer young people with severe mental health difficulties. This Lead Site (youth enhanced) also stated that it is difficult to attract clinicians when they can earn much more in private practice and when the public sector offers better conditions. The sixth Lead Site (youth enhanced) described similar difficulties with workforce to those already discussed.

To deal with delays in recruitment, one Lead Site had rolled over unspent funding to increase service delivery once staff were recruited and had ‘moved their workforce around’ in one location to temporarily staff the new service. Another Lead Site talked about the need for greater incentivisation for rural placements among health professionals to reduce their workforce shortages. Another Lead Site (youth enhanced) was allowing their service provider to recruit multiple small FTE roles to fill the full FTE needed. One further Lead Site (youth enhanced) was also tightening their eligibility criteria and strengthening referral pathways in order to ensure appropriate referrals into the youth enhanced services. This strategy is intended to increase workforce retention by ensuring the clinicians are being referred young people with whom they are equipped to work.

6.7.3.2 Collaboration

Four Lead Sites described difficulties in collaborating with key stakeholders related to their youth enhanced services. Two of these Lead Sites had experienced difficulties collaborating with their LHNs, both describing having different views or ideologies. The third Lead Site indicated that the education sector had been most difficult to collaborate with, and the fourth Lead Site stated they had difficulties with headspace National, citing contracting and integration difficulties.

6.7.3.3 Minimum dataset

Three Lead Sites, including one youth enhanced Lead Site, described difficulties with the minimum dataset pertaining specifically to youth enhanced services. One of these Lead Sites had commissioned a service that had never before collected data, so were working with the service to develop data collection processes and improve compliance with data collection and reporting requirements. The second of these Lead Sites has their LHD delivering some youth enhanced services within a headspace centre; therefore, they have three different minimum datasets. To resolve this difficulty of multiple reporting, the LHD is recording headspace (and LHD) data but not the PMHC MDS, but this does not capture all occasions of service, such as phone contacts, and there is not alignment between definitions in the two datasets. Therefore, the PHN also has the LHD provide some additional basic data such as diagnoses and demographics of young people to whom they have provided services. The third Lead Site (youth enhanced) has invested significant resources in assisting their providers to modify their own data collection systems to be compliant with PMHC-MDS requirements, as they are generally incompatible. Despite this work, about half of the youth enhanced providers from this Lead Site have moved to using the PMHC-MDS.

6.7.3.4 Other difficulties

Two youth enhanced Lead Sites described difficulties addressing the social and welfare needs of their primary mental health service consumers. These difficulties were partly attributed to a lack of suitable services (e.g., housing) and partly to the complexities of ensuring that mental health services can work within a broader paradigm so that consumers can receive holistic care. Two Lead Sites, including one youth enhanced Lead Site, described the difficulty of weighing the benefits of meeting complex care needs (e.g., providing psychiatry or working with education, vocational support etc.) to get positive outcomes for fewer young people or providing more basic services to a larger number of young people. Two Lead Sites talked about the difficulties they had experienced in trying to have organisations partner to deliver services. One of these Lead Sites said this was due to differences in approaches to working (community-development vs clinical focus), though these organisations were delivering a service in partnership. The second Lead Site had brought two organisations together and asked them to work together, but this had been unsuccessful. This Lead Site now considers this approach a mistake, since the two organisations are essentially competitors. In future, they would rather ask organisations to find suitable partners and then present the model to the PHN.

Individual Lead Sites also noted the following difficulties with commissioning and implementing youth enhanced services: state-level changes that make implementation difficult; young people not accessing the commissioned service; high ‘did not attend’ rates in youth enhanced services (20 to 30%) (youth enhanced Lead Site); inability to commission a suitable service provider for service navigation (youth enhanced Lead Site); deciding how to evaluate the success of the program including the right assessment tools to use (youth enhanced Lead Site); providing services that meet regional variations in service needs across the state (youth enhanced Lead Site); being unable to meet the need for services within the allocated budget (youth enhanced Lead Site); a lack of trust from referrers in the longevity of the program and consequent reluctance to refer into the program.

One Lead Site was attempting to understand the reasons for young people not accessing their service by conducting a survey with young people in the catchment area (results to come). Another Lead Site (youth enhanced) was attempting to reduce their rate of non-attendance at appointments by implementing greater assessment at intake to better gauge engagement with the service and to stratify the waiting list based on availability to attend appointments. They had also implemented a cancellation policy whereby multiple cancellations or failures to attend resulted in the young person being sent back to the referrer.

6.7.4 FACILITATORS AND EFFECTIVE APPROACHES FOR TARGETING AND DELIVERY OF YOUTH ENHANCED SERVICES

We initially asked Lead Sites separate questions regarding facilitators and most effective approaches for targeting and delivery of youth enhanced services, but the responses to these two questions were so similar that we have combined the responses here.

6.7.4.1 Effective strategies

Eight Lead Sites, including three youth enhanced Lead Sites, described effective strategies or factors that had facilitated targeting and delivery of their youth enhanced services. Responses were varied, and only one common strategy was identified. Four Lead Sites stated that building on existing services was the most effective strategy for implementing youth enhanced services. These Lead Sites, including two youth enhanced Lead Sites, stated this was effective because the services were already embedded in their communities, with existing relationships with important stakeholders that led to ease of referrals and better ability to engage with disengaged young people within that community. One of these Lead Sites (youth enhanced) described the additional advantage of an established workforce who understand the complexities of the target cohort and have had the ability to engage with them. Additional effective strategies described by individual Lead Sites are shown in Table 29.

Two Lead Sites, including one youth enhanced Lead Site, also cited evidence that their strategies for targeting and delivering youth enhanced services had been effective. One of these Lead Sites, who stated assertive outreach was their most effective strategy, said they had received positive feedback from the sector and detailed reports from their providers, which had shown they were reaching their target groups. The second Lead Site (youth enhanced) said the clinical outcomes of their youth enhanced services had been very positive and their external evaluation had shown ‘we’ve identified and we’re reaching the right target cohort.’

Table 29. Facilitators and effective strategies for targeting and delivery of youth enhanced services

Strategy	No. youth enhanced Lead Sites	No. other Lead Sites	Total no. Lead Sites
Building on existing services	2	2	4
Working closely with providers to understand and help overcome challenges in service establishment	1	0	1
Implementing assertive outreach within the youth enhanced service	0	1	1
Replicating existing services in additional locations	0	1	1
Building a strong relationship with the LHN by involving them early in consultation and in procurement to promote ownership over the new service	0	1	1
Strong clinical governance framework and involvement in ongoing monitoring by the PHN	0	1	1
Having a focus on workforce development to ensure clinicians are well trained to work with young people within the youth enhanced services	0	1	1
The allocation of this new funding for youth enhanced services	1	0	1
Allowing the provider sufficient time for refining the service model before service delivery	0	1	1
Having Orygen assist with workforce development	1	0	1
Co-design of the youth enhanced services with a child and youth advisory group	0	1	1
Having information sessions with tenderers to clarify the selection criteria	1	0	1
Identifying a service that really fills a service gap	0	1	1

Note. Some Lead Sites mentioned more than one effective strategy; therefore, the total number of Lead Sites is greater than the number who answered this question.

6.7.4.2 Effective linkages with other youth enhanced services

Four Lead Sites, including one youth enhanced Lead Site, described effective linkages with other youth enhanced services within their community. One of these Lead Sites stated their youth enhanced service provider was consortium-led; the consortium comprises three youth enhanced services with a good relationship with the state child and youth mental health service. The second Lead Site is co-locating their youth enhanced services within council or general youth services and a general practice, and has collaborated with the Doctors in Secondary Schools program. They also had created a service 'hub' in one location that co-locates mental health services with homelessness services. The third Lead Site has a relationship with the headspace lead agencies, dating from when they were a Medicare Local and set up the headspace centres, and also a longstanding good relationship with their LHD; they described the importance of complementary personalities in making these relationships work. The fourth Lead Site (youth enhanced) is working with child and adolescent mental health services (CAMHS) to promote referral of young people who are not eligible for CAMHS services to the PHN. This arrangement has been formalised in a memorandum of understanding. They have also co-located a youth enhanced clinician with a headspace service.

6.7.4.3 Examples of clinical care complemented by vocational, educational and parental support

Four Lead Sites, including one youth enhanced Lead Site, gave examples of clinical care that was being complemented by vocational, educational and parental support. Three of these Lead Sites (including one youth enhanced Lead Site) gave the example of headspace, where these types of wrap-around services are part of the service model. However, the youth enhanced Lead Site did note their headspace was not currently providing vocational services. One of these Lead Sites had commissioned services to deliver parenting education, such as the *Tuning into Teens* program, so parents can better manage with their young people when other services are unavailable. The youth enhanced Lead Site had created a service navigation role in addition to their youth enhanced services. The purpose of this role is to facilitate engagement of young people with services if they are disengaged, and to link young people to vocational support and other services related to ‘social determinants’. Young people are either referred directly to the service navigator following intake or are linked with them by their clinician once the need is identified. The fourth of these Lead Sites had commissioned a service specifically targeting homeless youth, and they noted the importance of homelessness services as a soft entry point to mental health services.

6.7.5 EARLY IMPACTS OF YOUTH ENHANCED SERVICES

Five Lead Sites (including two youth enhanced Lead Sites) commented on positive early impacts of implementing youth enhanced services, and two Lead Sites (including the same youth enhanced Lead Site), on the negative impacts. Positive impacts were as follows:

- Providing wrap-around services, such as vocational and educational services, particularly to homeless young people;
- Built strong relationships across the sector;
- Access for young people to different types of services;
- Filling a service gap (youth enhanced Lead Site); and
- Positive effects on parents following implementation of a family therapy program.

In relation to negative impacts, one Lead Site stated that unsuccessful tenderers build a negative view of the PHN; and one youth enhanced Lead Site stated that while the services had positive effects, they were concerned about the longevity of the services given there was no guarantee of continued funding.

6.7.6 IMPROVING PLANNING, COMMISSIONING AND IMPLEMENTATION OF YOUTH ENHANCED SERVICES

We asked Lead Sites to make suggestions for how planning, commissioning and implementing youth enhanced services might be improved in the future, and what additional supports and resources they needed from the Department of Health to this end.

6.7.6.1 General improvements

Five Lead Sites, including one youth enhanced lead site, provided suggestions for how youth enhanced services could be improved. Of these, three Lead Sites, including one youth enhanced lead site, talked about the need for greater integration with other youth services, including youth justice and corrections, and education. One of three individual Lead Sites also suggested the following: starting with a single cohort to focus on, rather than targeting a range of cohorts; working with existing services rather than creating new ones and disrupting the system; making better use of data, particularly visualisation, with commissioned services to provide direct feedback on their services; mapping needs for headspace centres across different locations, because they differ.

6.7.6.2 Additional supports and resources needed from the Department of Health

Five Lead Sites, including two youth enhanced Lead Sites, provided suggestions for what additional supports and resources were needed from the Department of Health to improve implementation of youth enhanced services. Of these, the two youth enhanced Lead Sites talked about the need for additional funding given the complexities of the target cohort, including a need for more early intervention, inpatient and eating disorders services, to engage disengaged youth, and to better integrate services. Two Lead Sites, including one youth enhanced Lead Site, said they needed more ways to attract clinicians. One of these Lead Sites stated there needed to be more focus on recruiting mental health professionals for regional and rural areas, and both Lead Sites (including one youth enhanced Lead Site) emphasised the need to be able to offer clinicians longer contracts to attract them to work in their services. The youth enhanced Lead Site also stated they need to be able to offer better remuneration in order to compete with other services in recruiting from a limited pool of adequately skilled clinicians to work with this cohort. The final Lead Site would like to see clearer guidelines around youth enhanced programs, including practice examples, as well as more support and information regarding evaluation.

6.8 Summary and comparison to interim report

A total of 68 Lead Site representatives from all 10 Lead Sites participated in the Round 2 focus groups (September to December 2018). The number of representatives involved was slightly higher in Round 2 than in Round 1 (September 2017 to December 2018) in which there were 58 participants from the 10 Lead Sites. Findings from this data source inform all four of the evaluation focus areas. However, the were some differences in the questions asked in the two rounds of data collection in acknowledgement of the earlier and later stages of implementation of the Lead Site focus area– with Round 1 focusing on implementation processes and Round 2 on early effects and future improvements – which means not all responses across the rounds can be compared but comparisons are made where relevant.

Regional planning

At the time of the Round 2 focus groups, most Lead Sites were still in the early stages of developing their regional plans. Almost half of Lead Sites stated that joint regional planning with the LHN provided an opportunity for greater collaboration and for creating regional change. Lead Sites reported that the early stages of regional planning consisted primarily of the creation, and meeting, of committees and groups comprised of regional stakeholders. In Round 2, Lead Sites were focused on regional planning and reviewing their existing commissioned services. As had been the case in Round 1, in Round 2, strong relationships with regional stakeholders remained of paramount importance to Lead Sites in their planning activities. Lead Sites also reported still using a range of strategies to ensure involvement of consumers and carers in their planning processes. In Round 1, Lead Sites had been focused on identifying the service needs of their region and commissioning and implementing the first round of services under the new primary mental health service reforms. Consequently, the strategies, difficulties and facilitators reported focused on these activities.

Service integration

The most common strategy reported by Lead Sites in Round 2 to promote service integration was to have a centralised intake process. However, specifying the requirement for service integration in commissioning documents remained a relatively common means of promoting service integration across both rounds of data collection. In Round 2, the introduction of the NDIS, and its effects on the primary care mental health workforce, as well as continued siloed funding streams for mental health services were seen as the primary barriers to service integration. Service integration activities reported in Round 2 involved reviewing existing services to consider whether integration was being achieved. In Round 1, activities focused on commissioning processes that promoted service integration. With these exceptions, there were limited commonalities in the responses of Lead Sites to questions regarding service integration in Round 2, as in Round 1. This variation in responses may reflect regional variations in services.

Stepped care

In Round 2, most Lead Sites reported having fully implemented their stepped care model and were beginning to see some positive effects of this implementation, such as better targeting of services to meet consumer need. Lead Sites primarily reported using intake and assessment procedures to ensure appropriate allocation of consumers to services at various levels of care. In Round 2, the primary difficulty identified with implementation of the stepped care model related to lack of transition of consumers to higher or lower levels of care as needed, and some Lead Sites saw a need to offer greater support for providers to transition their consumers. In Round 1 of data collection, Lead Sites had still been developing and beginning to implement their stepped care models. At that time, the greatest barrier to the implementation of the stepped care model was seen as the limited time available for model development. Needs assessment and service mapping was the most common means of matching services to consumer needs in Round 1, when Lead Sites were still deciding on which types of services to commission.

Low intensity services

In Round 2, Lead Sites were implementing a range of low intensity service types to meet the needs of a range of specific target groups. Compared with Round 1, in Round 2 Lead Sites spoke more frequently about digital services, but also about having to implement more face-to-face services to meet consumer preference. In Round 2, the most commonly cited difficulty to implementing low intensity services was low uptake. Consequently, many Lead Sites were expending significant efforts in change management processes to implement and promote low intensity services to relevant referrers and other stakeholders. Lead Sites were also facing difficulties in explaining and promoting low intensity services, attracting and retaining workforce, and overcoming consumers' more traditional preferences for face-to-face mental health services when low intensity services are indicated. In Round 1, the most frequently cited difficulties related to use of an unaccredited workforce, though many of the difficulties reported were reported in both rounds.

Youth enhanced services

Recruiting a suitably trained and experienced workforce to work with young people with severe mental illness remained a primary difficulty in both Rounds 1 and 2, and among Lead Sites. This was particularly the case owing to the inability of Lead Sites to offer competitive conditions to suitable clinicians working in other services that might attract them to work in PHN-commissioned youth enhanced services (e.g., salary and stability). This was also suggested as an area where the Department of Health might assist PHNs to improve implementation of youth enhanced services. With the exception of workforce difficulties, few common themes were identified in the responses of Lead Sites regarding their planning, commissioning and implementation of youth enhanced services In Round 2. This diversity might reflect the vast array of youth enhanced services being implemented across Lead Sites. Youth enhanced services were far more established in Round 2 than they had been in Round 1. Consequently, we asked a different series of questions of Lead Sites between these rounds, preventing further comparison of responses.

7. Consultation with referrers

7.1 Summary of approach

We consulted with referrers to Lead Site-commissioned services in February 2019 via online survey (Appendix 2). The survey took approximately 10 minutes to complete. We asked a mix of open-ended and closed questions and elicited demographic information. Survey content related to referrers' views and experiences of referring consumers to received PHN-commissioned mental health services from 1 March 2018 to February 2019. Lead Sites acted as intermediaries by recruiting referrers on our behalf.

7.2 Sample and demographic information

Overall, 96 referrers from all 10 Lead Sites completed the survey, with a range of 1 to 22, and an average of 9, referrers per Lead Site. Table 30 shows the professional and demographic characteristics of these referrers

As shown in Table 30, respondents most commonly worked in a general practice setting (45%) and were GPs (49%). Ten respondents worked in a public mental health service, nine in a private practice and thirteen in 'other settings'. Over one third of participants had been working in their main profession for more than 20 years, with the majority (75%) having over 10 years of experience and one quarter, up to 5 years of experience. The majority (56%) of survey respondents were aged between 40 and 59 years of age, and two thirds were female. Three participants identified as Aboriginal.

Table 30. Referrer professional and demographic characteristics (N = 96)

Characteristic	Freq.	%
Main work setting		
General practice	43	44.8
Medical specialist consulting rooms	1	1
Private practice	9	9.4
Public mental health service	10	10.4
Public hospital	1	1
Community health centre	8	8.3
Community support organisation (not-for-profit)	8	8.3
Child and maternal health	1	1
School	2	2.1
Other	13	13.5
Main current profession		
General practitioner	47	49
Psychiatrist	3	3.1
Paediatrician	2	2.1
Maternal health nurse	1	1
Psychologist	8	8.3
Mental health nurse	7	7.3
Social worker	10	10.4
Occupational therapist	2	2.1
Educational professional	1	1
Other[hh]	15	15.6
Years referrer working in current profession		
Less than 1 year	0	0
1-5 years	24	25
6-10 years	11	11.5
11-15 years	13	13.5
16-20 years	11	11.5
More than 20 years	37	38.5
Age range of referrers b[ii]		
20-29 years	6	6.3
30-39 years	17	17.7
40-49 years	28	29.2
50-59 years	26	27.1
60-69 years	16	16.7
70-79 years	3	3.1
Gender of referrers		
Female	67	69.8
Male	29	30.2
I do not identify with either term		
Indigenous identification of referrers		
Aboriginal	3	3.1
Torres Strait Islander	0	0.0
Neither Aboriginal nor Torres Strait Islander	93	96.9

[hh] Other' profession included managers (n=6).

[ii] One participant did not indicate their age range.

7.3 Engagement in referral process

On average, from March 2018, respondents had referred between zero and 50 consumers per month to Lead Site-commissioned mental health services. The median number of consumers referred was one, and respondents most commonly referred an average of one consumer per month.

The main focus of the majority of referrals was psychological therapy (Table 31). Seventy-eight percent of respondents referred consumers for psychological therapy, over 40% referred for child- and youth-specific mental health services, and over one third for low intensity psychological intervention.

Table 31. Focus of Lead Site-commissioned services for which professionals referred consumers

Service focus	Focus of referred services[jj]		Main focus[kk]	
	Freq.	%	Freq.	%
Psychological therapy	75	78.1	50	52.1
Low intensity psychological intervention	36	37.5	11	11.5
Clinical care coordination	24	25	5	5.2
Complex care package	20	20.8	6	6.3
Child- and youth-specific mental health service	41	42.7	17	17.7
Indigenous -specific mental health service	7	7.3	1	1
Other	13	13.5	6	6.3
Total			96	100

Respondents indicated that they mainly referred adult consumers who were aged over 26 years (70%) (Table 32). However, 84% referred adult consumers, over two thirds referred youth, and close to one third referred children (Table 32). The majority of referrers mainly referred consumers experiencing moderate mental illness (55%). Eighty percent of referrers referred consumers with moderate mental illness and over half referred consumers with either severe or mild mental illness (Table 33).

Table 32. Age of consumers respondents refer

Age group	All age groups[ll]		Main age group[mm]	
	Freq.	%	Freq.	%
Children (0-11 years)	30	31.3	4	4.2
Youth (12-25 years)	65	67.7	25	26
Adults (26+ years)	81	84.4	67	69.8
Total			96	100

[jj] Multiple responses permitted; therefore, total exceeds 100%.

[kk] Primary service focus of referrals.

[ll] Multiple responses permitted; therefore, total exceeds 100%.

[mm] Primary age group of consumers referred.

Table 33. Severity of mental health problems for which respondents refer

Severity of mental health problems	All severities[nn]		Main severity[oo]	
	Freq.	%	Freq.	%
At risk (no current mental illness but previous illness or early symptoms)	22	22.9	11	11.5
Mild mental illness	53	55.2	18	18.8
Moderate mental illness	77	80.2	53	55.2
Severe mental illness	50	52.1	14	14.6
Total			96	100

As shown in Table 34, over 40% referrers found the referral process (for the main focus selected in Table 31) as being 'easy' or 'very easy'. In response to an open questions asking them to explain their endorsed response, most referrers mentioned that referral paperwork was simple to complete and that the process was efficient, and three respondents indicated a mental health nurse helped with the process. However, 40% of individuals found the referral process 'not at all easy' or 'somewhat easy'. These referrers explained that the referral process involved excessive processes or paperwork ('red tape'). These concerns over paperwork and process were also echoed by those who indicated that the referral process was 'neither easy nor difficult'.

Table 34. Ease of referral process for main service focus

Ease of referral process	Freq.	%
Not at all easy	19	19.8
Somewhat easy	19	19.8
Neither easy nor difficult	17	17.7
Easy	25	26
Very easy	16	16.7
Total	96	100

7.4 Stepped care

Over one third of the respondents (37%) indicated that the stepped care approach had not made any difference to how they referred consumers (Table 35). However, a further one third (32%) indicated that the stepped care approach had assisted them in referring consumers to services matched to their needs.

Table 35. Influence of stepped care approach on referrals

Influence of stepped care	Freq.	%
The stepped care approach has made no difference to my referrals	35	36.5
The stepped care approach has assisted me in referring consumers to services matched to their needs	31	32.3
Other	17	17.7
I don't know what the stepped care approach is	13	13.5
Total	96	100

[nn] Multiple responses permitted; therefore, total exceeds 100%.
[oo] Primary severity group of consumers referred.

7.4.1 SUPPORT AND RESOURCES PROVIDED BY LEAD SITE OR EMPLOYER TO FACILITATE STEPPED CARE

A total of 30 referrers (31%) indicated that they had received support from their Lead Site to implement stepped care. Of the 30 referrers who had received support from their Lead Site PHN, over half indicated they had received written resources (Table 36). Over one third of these respondents had been involved in stepped care consultation or been provided options for stepping consumers down or up to less or more intensive services and/or attended professional development/training/workshops or provided individual feedback on their referrals.

Table 36. Lead Site or employer support for stepped care implementation

Type of support	Freq.	%
Involved me in consultations about developing stepped care	10	33.3
Provided options for stepping consumers down or up to less or more intensive services	10	33.3
Professional development/training/workshop	11	36.7
Written resources	16	53.3
Provided individual feedback on my referrals to encourage a stepped care approach	9	30.0
Other, please specify	5	16.7
Total	30	

Note. Multiple responses permitted, therefore total exceeds 100%. One respondent initially answered yes to the question concerning support and then answered this question but went back and changed their initial response to no - we have removed their response from this question.

7.5 Referring to Lead Site-commissioned services: perceived impact on consumers

7.5.1 PERCEIVED POSITIVE IMPACT ON CONSUMERS

We asked referrers to describe any perceived positive impacts for consumers that were associated with their referral to Lead Site-commissioned services. A total of 92 referrers (96%) identified positive impacts for consumers. Of these, 47% identified access to low cost services, and 26% indicated access in general to commissioned services, as positive impacts for consumers. Ten percent identified that the effectiveness of treatment was a positive for consumers.

7.5.2 PERCEIVED NEGATIVE IMPACT ON CONSUMERS

We asked referrers to describe any perceived negative impacts for consumers that were associated with their referral to Lead Site-commissioned services. A total of sixty-five referrers (68%) mentioned a range of negative impacts for consumers. Of these, almost one quarter mentioned concerns with the timeliness of services, describing long wait times or delays in consumers seeing a practitioner. Seventeen percent mentioned concerns with access in general, with 10% stating specific concerns about the limited number of sessions available. Concerns were also raised about the referral and intake process, specifically the administrative or paperwork burden for consumers (9%).

7.6 Referring to Lead Site-commissioned services: impact on referrers

7.6.1 POSITIVE IMPACT ON REFERRERS

A total of 84 referrers (88%) described positive impacts for themselves of being able to refer consumers to Lead Site-commissioned services. Most commonly, these referrers described the positive impact on themselves as being able to provide access to services (14%), and in particular to free services (25%). An appropriate variety of services was also viewed as a positive for referrers (15%).

7.6.2 NEGATIVE IMPACT ON REFERRERS

Fifty-one referrers (53%) described negative impacts for themselves of being able to refer consumers to Lead Site-commissioned services. The process of referral was perceived as having a negative impact on some of these referrers, specifically the burden of paperwork and administration (22%) and/or the burden of care by referrers (10%). Referrers also mentioned concerns about access to PHN-commissioned services in general (10%), particularly the limited number of sessions available (14%) and the length of wait times (10%). The variety of services and appropriateness of qualifications of practitioners were also raised by some referrers as being of concern (10%).

7.7 Additional suggestions

Seventy-one referrers (74%) provided additional comments on Lead Site-commissioned mental health services. Close to one quarter of these individuals mentioned access in general to PHN commissioned mental health services and 10% mentioned changes to the mental health system that have occurred following the introduction of stepped care. These changes were viewed positively by some (e.g., more streamlined approach) and negatively by others who noted the approach was out of touch with current needs.

7.8 Summary and comparison to interim report

In Round 2, 96 respondents from all 10 Lead Sites completed the referrer survey (February 2019), and almost half of the respondents were GPs working in general practice. Referrers were making, on average, one referral per month to Lead Site-commissioned mental health services. Findings from the referrer survey mostly inform the overarching Lead Site focus area of stepped care, and to a lesser extent, low intensity and youth services in general.

Referrals were primarily for adults over 26 years experiencing moderate mental illness to attend psychological therapy. Over 40% of referrers found the referral process easy/very easy, but those less satisfied with the referral process stated there was too much paperwork and too many processes involved. Indeed, for the half of respondents who stated they experienced some negative effects from referring consumers to Lead Site-commissioned mental health services, additional paperwork was the primary concern. Conversely, almost 90% of referrers stated that being able to refer consumers to Lead Site-commissioned services had positive effects on themselves, particularly being able to provide access to free services for consumers. Of the 96% of referrers able to identify positive effects for consumers, low cost and accessibility of the PHN-commissioned mental health services were again seen as the primary benefits. The primary negative effect was having to wait too long to access services. One third of respondents stated that stepped care had assisted them in making referrals that matched consumers' needs, though 37% said it had made no difference. About one third of referrers had received some form of support from their PHN regarding stepped care.

Although there were fewer referrers who completed the referrer survey in Round 2 (February 2019; 96 from 10 Lead Sites) compared with Round 1 (February 2018; 121 from nine Lead Sites), there was slightly more diversity in the types of referring professionals who completed the survey in Round 2. The proportion of referrers receiving support from Lead Sites (or their employers) to implement stepped care increased from one fifth in Round 1 to one third in Round 2, and the types of support received had diversified. There was a slight increase in the number of referrers who mainly referred consumers with both lower and higher severity mental health problems to receive low intensity psychological intervention and clinical care coordination/complex care packages, respectively; although, referrals of adults with moderate mental health problems for psychological care remained the dominant type of referral. Around one fifth of respondents in both rounds of data collection mainly referred consumers to services focused on child and youth mental health. Most respondents across both data collection rounds indicated that the referral process was 'easy' or 'very easy', but proportionally more referrers in Round 2 rated the referral process as 'not at all easy'. Awareness of stepped care among referrers appears to have improved over time, with a threefold increase in the proportion of Round 2 respondents indicating that the stepped care approach had assisted them in referring consumers to services matched to their needs.

The vast majority of referrers in both data collection rounds noted positive impacts for consumers as relating to increased access – including service appropriateness and affordability – and improved mental health outcomes. Just over two thirds of referrers on both rounds noted some negative impacts on consumers. These differed somewhat between rounds. In Round 2 the negative impacts primarily related to waiting periods, limited number of sessions and the administrative burden of referral and intake processes on consumers. In Round 1, the negative impacts had primarily related to concerns about the referral system itself, such as navigating the referral system, consumers not being allowed to choose their own practitioner, and referrer concerns over the knowledge and skills of available clinicians. The proportion of surveyed referrers in both data collections rounds who mentioned some negative impacts for themselves remained constant, at about half, and administrative burden remained a major concern. To a lesser extent, limited access to referral pathways and concerns about the variety, appropriateness and quality of services were noted in both rounds. Some of the concerns raised in Round 1, such as communication issues with PHNs or providers and uncertainty about the longevity of services were not raised in Round 2.

8. Consultation with mental health practitioners

8.1 Summary of approach

We consulted with mental health practitioners of Lead Site-commissioned services in February 2019 via online survey. The survey took approximately 10 minutes to complete. We asked a mix of open-ended and closed questions and elicited demographic information (Appendix 3). Survey content related to practitioners' views and experiences of providing consumers with PHN-commissioned mental health services from 1 March 2018 to February 2019. Lead Sites acted as intermediaries by recruiting practitioners on our behalf.

8.2 Sample and demographic information

Overall, 223 mental health practitioners from eight Lead Sites completed the survey, with a range of seven to 62 (and an average of 28) practitioners per Lead Site. Two practitioners did not indicate the PHN region in which they worked, but their data are included in the totals. Table 37 shows the professional and demographic characteristics of these practitioners.

As shown in Table 37, close to one third of respondents were general psychologists (31%) and 36% worked in private practice. Other commonly identified practitioner professions were mental health nurses (17%) and social workers (15%). Most respondents had worked in their current profession for over 10 years, with one third having more than 20 years of experience in their current profession. Most respondents were aged between 40 and 59 years and were female, and less than 1% were Aboriginal or Torres Strait Islander.

Table 37. Mental health practitioner professional and demographic characteristics (N = 223)

Characteristic	Freq.	%
Main practitioner category		
Clinical psychologist	13	5.8
General psychologist	70	31.4
Social worker	33	14.8
Occupational therapist	6	2.7
Mental health nurse	38	17
Aboriginal and Torres Strait Islander health/mental health worker	0	0
Low intensity mental health worker	12	5.4
General practitioner	2	0.9
Psychiatrist	1	0.4
Other (medical)	0	0
Other[pp]	28	12.6
None specified	20	9.0
Main setting for delivering services		
Private allied health professional practice	80	35.9
Private psychiatry practice	4	1.8
General medical practice	12	5.4
Private hospital	2	0.9
headspace centre	11	4.9
Early Youth Psychosis centre	0	0
Community-managed community support organisation	52	23.3
Aboriginal health/medical service	1	0.4
State/territory health service organisation	3	1.3
State/ territory health service organisation	0	0
Primary Health Network	5	2.2
Medicare Local	0	0
Division of General Practice	0	0
Virtual clinic	0	0
Other[qq]	33	14.8
Unknown	20	9
Years working in current profession		
Less than 1 year	7	3.1
1-5 years	42	18.8
6-10 years	27	12.1
11-15 years	25	11.2
16-20 years	28	12.6
More than 20 years	73	32.7
Unknown	21	9.4
Age range of mental health practitioners		
20-29 years	11	4.9
30-39 years	36	16.1
40-49 years	66	29.6
50-59 years	54	24.2
60-69 years	29	13
70-79 years	4	1.8
80 years or older	1	0.4
Unknown	22	9.9
Gender of mental health practitioners		
Female	157	70.4
Male	41	18.4
I do not identify with either term	3	1.3
Unknown	22	9.9
Indigenous identification of referrers		
Aboriginal	1	0.4
Torres Strait Islander	1	0.4
Neither Aboriginal nor Torres Strait Islander	199	89.2
Unknown	22	9.9

[pp] ‘Other’ practitioners included accredited mental health social worker (n = 3) and care coordinator (n = 4).

[qq] ‘Other’ settings included private practice (n = 7), community health (n = 6), NGO (n = 5), Not for profit (n = 4) and client’s home (n = 3).

8.3 Engagement as a practitioner

Practitioners were engaged to provide PHN-commissioned services in several different ways: 30% were acting as sole practitioners, 44% were employed by an organisation that was commissioned by a PHN, and 21% were contracted by a commissioned organisation (Table 38).

Table 38. Engagement as a practitioner of PHN-commissioned mental health services

Method of engagement	Freq.	%
Sole practitioner directly contracted by PHN	67	30
Contracted by an organisation that is commissioned by the PHN	47	21.1
Employed by an organisation that is commissioned by the PHN	99	44.4
Other	10	4.5
Total	223	100

8.4 Types of consumers to whom practitioners provide services

Mental health practitioners reported seeing an average of 23 consumers for PHN-commissioned services each month. Practitioners most commonly stated they saw 20 consumers per month, with a reported range of 0 to 210. Eight practitioners indicated that they saw more than 100 consumers, and we are unable to tell from the survey results if these numbers are errors or an accurate reflection of some practitioners' caseloads (e.g., those providing services to groups of consumers).

Most practitioners reported seeing both youth (79%) and adult (89%) consumers, and almost one quarter stated that their consumers included children. When asked to indicate their main consumer group, 80% of practitioners indicated it was adults, 18% indicated youth, and 3% indicated that children were their main consumer group (Table 39).

Table 39. Age of consumers to whom practitioners provide services

Age group	All age groups[rr]		Main age group[bss]	
	Freq.	%	Freq.	%
Children (0-11 years)	54	24.2	6	2.7
Youth (12-25 years)	177	79.4	39	17.5
Adults (26+ years)	199	89.2	178	79.8
Total			223	100

Most practitioners reported seeing consumers of PHN-commissioned services with mild, moderate and severe mental illness, and 38% also indicated they saw consumers who were at risk of developing a mental illness (Table 40). Although most practitioners reported that they saw consumers across the spectrum of illness severity, 61% of practitioners indicated their main consumer group had moderate mental illness, and 22% of practitioners indicated that their main consumer group presented with severe mental illness.

[rr] Multiple responses permitted; therefore, total exceeds 100%.

[ss] Primary age group of consumers seen.

Table 40. Severity of mental health problems for which practitioners deliver service

Severity of mental health problems	All severities[tt]		Main severity[uu]	
	Freq.	%	Freq.	%
At risk (no current mental illness but previous illness or early symptoms)	84	37.7	7	3.1
Mild mental illness	136	61	31	13.9
Moderate mental illness	202	90.6	135	60.5
Severe mental illness	153	68.6	50	22.4
Total			223	100

8.5 Services delivered

As shown in Table 41, 79% of mental health practitioners provided psychological therapy, and close to half provided low intensity psychological interventions. Approximately one third of practitioners provided child- and youth-specific services, and one third, clinical care coordination. Close to two thirds of practitioners indicated that the main focus of services was psychological therapy. Fourteen percent of practitioners indicated that the main focus of their services was low intensity psychological intervention.

Table 41. Focus of services delivered by practitioners

Focus	All service focuses[vv]		Main service focus[ww]	
	Freq.	%	Freq.	%
Psychological therapy	177	79.4	134	60.1
Low intensity	109	48.9	32	14.3
Clinical care coordination	74	33.2	21	9.4
Complex care package	28	12.6	11	4.9
Child and youth	66	29.6	13	5.8
Indigenous	26	11.7	0	0
Other	34	15.2	12	5.4
Total			223	100

Almost all practitioners delivered services face-to-face, and two thirds indicated that they were delivering services by phone (Table 42). However, only 5% of practitioners indicated that the phone was their main mode of service delivery, with the majority indicating that their main mode of service delivery was face-to-face (95%). No practitioners used video or internet as their main mode of service delivery.

Table 42. Modality of services delivered by mental health practitioners

Modality	All modalities[xx]		Main modality[yy]	
	Freq.	%	Freq.	%
Face to face	221	99.1	212	95.1
Telephone	148	66.4	11	4.9
Video (including Skype, Facetime etc.)	33	14.8	0	0
Internet-based	26	11.7	0	0
Total			223	100

[tt] Multiple responses permitted; therefore, total exceeds 100%.
[uu] Primary severity group of consumers seen.
[vv] Multiple responses permitted; therefore, total exceeds 100%.
[ww] Primary service focus.
[xx] Multiple responses permitted; therefore, total exceeds 100%.
[yy] Primary service delivery modality.

8.6 Referral sources

Seventy-one percent of practitioners identified GPs as their main referral source (Table 43), and 97% received at least some of their referrals from GPs. Though not their main referral source, 40% of practitioners received referrals from psychiatrists, a further 40% from social workers, 35% from mental health nurses, and 32% from psychologists. Forty-two percent of practitioners saw consumers who had self-referred.

Table 43. Practitioners' stated source of referrals

Referrer	All referrers[zz]		Main referrers[aaa]	
	Freq.	%	Freq.	%
General practitioner	216	96.9	158	70.9
Psychiatrist	88	39.5	8	3.6
Obstetrician	5	2.2	0	0
Paediatrician	40	17.9	0	0
Other medical specialist	41	18.4	1	0.4
Midwife	6	2.7	0	0
Maternal health nurse	30	13.5	1	0.4
Psychologist	71	31.8	1	0.4
Mental health nurse	77	34.5	2	0.9
Social worker	88	39.5	7	3.1
Occupational therapist	29	13	1	0.4
Aboriginal health worker	23	10.3	1	0.4
Educational professional	39	17.5	1	0.4
Early childhood service worker	15	6.7	0	0
Consumer self-referral	94	42.2	27	12.1
Other (please specify)	46	20.6	15	6.7
Total			223	100

8.7 Support and resources provided by Lead Sites

Half of mental health practitioners undertook professional development, training or workshops with support from their PHN (Table 44). Close to half reported receiving assistance from their PHN with entering minimum dataset information, and one third used written resources from their PHN. Over one quarter received support for stepping consumers up or down, and 23% received assistance with developing referral pathways. A total of 16% of respondents indicated that they had not received support or resources from their PHN.

Table 44. Support or resources received from Lead Sites

Support or resources	Freq.	%
Assistance with developing referral pathways	51	22.9
Options for stepping consumers down or up to other services	61	27.4
Professional development/training/workshop	111	49.8
Clinical supervision	15	6.7
Written resources e.g., guidance or pamphlets	69	30.9
Assistance with entering minimum dataset data	101	45.3
Other	26	11.7
None	35	15.7

Note. Multiple responses permitted therefore total exceeds 100%.

[zz] Multiple responses permitted therefore total exceeds 100%.
[aaa] Primary referral source.

8.8 Providing Lead Site-commissioned services: Perceived impact on consumers

8.8.1 PERCEIVED POSITIVE IMPACT ON CONSUMERS

Positive impacts for consumers of providing PHN-commissioned services were mentioned by 196 respondents (88%). Like referrers (Section 6.5), practitioners viewed the main positive impacts for consumers as relating to access to services (25% commenting on general access). More specifically, they were positive about services being low cost (35%), offering an appropriate number of sessions (17%) and offering an appropriate variety of treatments (10%).

Practitioners also noted improved consumer outcomes and wellbeing (24%), as consumers could engage with services that they may not have previously been able to access, making early intervention possible.

8.8.2 PERCEIVED NEGATIVE IMPACT ON CONSUMERS

Negative impacts for consumers of providing PHN-commissioned were mentioned by 144 respondents (65%). These primarily related to issues of access and insecurity of funding for the program. Practitioners viewed the number of sessions available as being too few for some consumers (26%). Many of these practitioners were frustrated by long waiting times or the central intake process impacting on the timeliness of services (12%). Another negative impact for consumers raised by some practitioners related to the perceived short-term nature of PHN activities and limited funding (11%), leading to insecurity about the future of the program.

8.9 Impact of providing Lead Site-commissioned services on mental health practitioners

8.9.1 POSITIVE IMPACT ON MENTAL HEALTH PRACTITIONERS

A total of 187 practitioners (84%) commented on the positive impacts of providing PHN-commissioned services for themselves. Over one third of responding practitioners commented on the positive impact of improved access to mental health care, with 17% commenting specifically on improved affordability of services. Practitioners also mentioned the positive impact of the referral process with 17% identifying the financial benefit they received by providing a subsidised service and how they now were able to see clients who otherwise may not be able to afford care (and thus they were seeing more clients). Some practitioners (17%) also mentioned the support that they had received in terms of professional development and training opportunities, as well as with decision making.

8.9.2 NEGATIVE IMPACT ON MENTAL HEALTH PRACTITIONERS

One hundred and fifty-one practitioners (67%) noted negative impacts of providing PHN-commissioned services for themselves. These comments were mostly about processes. Practitioners identified an increased administrative burden was being placed upon them (23%), and others pointed to being financially disadvantaged by the referral process (27%). Several practitioners pointed to funding issues, noting concerns that funding had already been exhausted and/or was not secure in the long term (13%).

8.10 Additional suggestions

A total of 143 practitioners (64%) provided additional comments. Comments generally related to the positives and negatives of changes in access to mental health care, communication, training and supervision, and funding. Some practitioners further commented on PHN-commissioned mental health services providing access to care that many consumers would otherwise not be able to access (10%).

Practitioners also suggested that their PHN needed to communicate better (8%), and there was a perception that funding was not secure in the long term (14%). Although many practitioners appreciated the supervision and training opportunities provided, more experienced practitioners felt that these were unnecessary given their high level of expertise (10%).

8.11 Summary and comparison to interim report

The 233 mental health practitioners who completed the survey in Round 2 were providing services for eight Lead Sites. Psychologists were the most commonly represented professional group, and most respondents had 10 or more years' experience in their current profession. Respondents were most commonly employed to work for an organisation commissioned to provide services for the Lead Site and reported seeing, on average, 23 consumers per month for a PHN-commissioned mental health service. Most respondents stated they see both adult and youth consumers, though adults were the main consumer group. Most respondents reported they were providing face-to-face psychological therapy for consumers with moderate mental illness. About half of respondents were providing low intensity services, and two thirds of respondents were delivering some telephone service. GPs were identified as by far the most common source of referrals. Like the referrer survey findings, findings from the practitioner survey mostly inform the overarching Lead Site focus area of stepped care, and to a lesser extent, low intensity and youth services in general.

The most common forms of support provided to practitioners by their PHN were professional development, training and workshops; assistance with entering data into the minimum dataset and written resources. Most practitioners could identify positive effects of the Lead Site-commissioned mental health services for both consumers and themselves, and provision of low cost services was seen as a primary benefit for both groups. Close to two thirds of respondents could also identify negative effects of referring consumers to Lead Site-commissioned services for both consumers and themselves. The primary concern for consumers was the limited number of sessions available, and for themselves their concerns related to financial disadvantages of the referral process and administrative burden.

There were fewer respondents to the mental health practitioner survey in Round 2 (February 2019; 223 from eight Lead Sites) compared with Round 1 (February 2018; 349 from all 10 Lead Sites). Proportionally more mental health nurses and fewer clinical psychologists completed the survey in Round 2. The proportion of practitioner survey respondents employed by a Lead Site-commissioned organisation has increased, and those working as sole practitioners has decreased, over time. Although the trend for most practitioners to most commonly provide services to adults with moderate mental illness was consistent over time, proportionally more practitioners reported providing services to people with severe mental illness in Round 2. Correspondingly, the proportion of practitioners providing clinical care coordination and complex care packages as their main focus of service delivery has also increased since Round 1. Notwithstanding, psychological therapy, followed by low intensity psychological interventions, and child and youth mental health services, remained the most common principal service focuses over time. However, only 6% of respondents endorsed child and youth mental health services as their main service focus. Although there was consistency in practitioners predominantly providing services face to face, there has been an increase in the diversity of service delivery modality in Round 2. Assistance with providing PMHC MDS data and professional development/training/workshops, remained the most common forms of support from Lead Sites, with a proportional increase in the latter in Round 2.

Like referrers, the vast majority of practitioners in both data collection rounds noted positive effects of the Lead-Site commissioned mental health services for consumers, particularly related to increased access to services and improved mental health outcomes. Two thirds or fewer of practitioners across data collection rounds noted some negative effects for consumers that were associated with referral timeliness, limited number of sessions and limited or uncertain funding. Most practitioners also noted positive impacts for themselves, including involvement in decision making and being able to provide services to more, and a variety of, consumers associated with the stepped care model. Just over two thirds of respondents in both rounds mentioned negative impacts for themselves including administrative burden and funding insecurity or inadequacy. Some of the concerns raised in Round 1, such as communication issues with PHNs or referrers and issues associated with lack of care coordination were not raised in Round 2.

9. Consultation with regional and other key stakeholders

9.1 Summary of approach

We asked Lead Sites to review and update the names of, and contact details for, the regional and other key stakeholders in their PHN regions that they had provided us in Round 1 (e.g., drug and alcohol services, youth services, social and community support services, disability support/NDIS services], state/territory policy officers, headspace centres, representatives from clinical councils and community advisory committees, including consumers and carers with lived experience). We consulted with this group of stakeholders in February and March 2019 via:

- Eight focus groups involving 63 participants (five to eight per PHN catchment), using Zoom;
- 11 written responses (from six PHN catchments), which included additional inputs from four focus group attendees.

We asked open-ended questions relating to the four focus areas of the evaluation: service integration and regional planning and service integration; stepped care; low intensity services; and services for youth with, or at risk of, severe mental illness (Appendix 4). Two of us attended each focus groups, with one of us acting as facilitator, and the other, as scribe. All focus groups were recorded using Zoom and notes were taken by one of us. One member of our team listened to the recordings of all focus groups and added to the notes to include all relevant information in writing.

9.2 Sample and demographic information

In total, the regional stakeholder consultations involved input from 70 representatives from all 10 Lead Sites, with a range of five to nine and an average of seven stakeholders per Lead Site. Note that numbers in parentheses in Sections 8.3 to 8.6 refer to the frequency of stakeholders relevant to the emerging themes.

Demographic information was provided by 64 regional stakeholders (91%). The percentages reported are based on this denominator. Almost one third of regional stakeholders were aged 50-59 years (31%), 31% were 40-49 years, 16% were 30-39 years, 17% were 60-69 years and 2% were 70-79 years. Over half (59%) were female and one stakeholder indicated they identified as Aboriginal or Torres Strait Islander (1.6%). Most regional stakeholders were involved with one of the Lead Sites (81%), some with two or three Lead Sites (16%), one with seven Lead Sites (2%) and one with all 10 Lead Sites (2%). Most regional stakeholders (81%) were managers, CEOs or employees from regional service provider agencies (including five LHNs). The remainder included representatives from professional and/or peak bodies, representatives from the local health department and mental health commission, and independent consultants and researchers.

9.3 Regional planning and service integration

Note that numbers in parentheses in Sections 8.3 to 8.6 refer to the frequency of stakeholders relevant to the emerging themes.

9.3.1 REGIONAL PLANNING

9.3.1.1 Involvement in regional planning

Stakeholders from nine Lead Sites noted some form of involvement in the regional planning process by the PHN. Seven stakeholders from five Lead Site regions commented they had a positive and close working relationship with the PHN. However, one of these stakeholders (LHN) also noted their involvement with the Lead Site in its region was experienced as extensive at times.

Twenty-seven stakeholders from eight Lead Site regions noted they were involved in consultations in the form of meetings, workshops and/or forums. Of these stakeholders, two specifically mentioned co-design. One stakeholder noted consultations were undertaken within a limited timeframe, which resulted in limited consumer and/or carer representation. Additionally, two stakeholders from the same region noted that one of the consultations had had an unintended negative impact on the relationship between two service providers due to a mutual misunderstanding of the service deliverables and poor facilitation of the consultation. Furthermore, one stakeholder noted they were part of a consortium and another, that they had been involved developing the regional planning process. Two stakeholders from different regions noted they had only had *some* involvement. Seven stakeholders from five regions commented that their involvement had been very minimal or opportunistic, and three stakeholders reported no involvement.

Six stakeholders from four regions noted different factors that had contributed to improved regional planning. These factors included a stable workforce, local collaboration, and direct contact with the PHN. Involving consumer and carers, linking strategies across the sector, and improving monitoring and reporting of services also contributed to improved regional planning.

> ‘They [PHNs] don’t want to ‘break’ the system – they want to work with it.’

9.3.1.2 Effects of regional planning

Twelve stakeholders from seven regions identified various positive impacts of regional planning for consumers and/or carers, which included: the ability to be more engaged in the planning process and provide input (5), broader support for consumers (2), access to peer workers (1), availability of a child and youth psychiatrist (3), easy referral (2), co-location (3), destigmatising services (2), availability of different modalities (1), more funded services (2) and access to telephone services in remote areas (1).

Seven stakeholders from four regions commented on broader impacts, which included: the ability to respond to consumers/carer voices, flexibility to try new approaches, availability of additional funding, rigorous evaluation, ability to undertake needs assessment, addressing service gaps, defined expectations for improvement, and stronger consumer engagement in both policy and practice.

Four stakeholders from four regions noted negative effects of regional planning, which included: impacts due to transition periods (1), difficult system navigation for new consumers (2), no adequate representation of consumers with relatively low level of need (2) and language barriers for CALD consumers (1). Furthermore, one stakeholder noted a negative effect of the execution of regional plans: a discontinuation of services due to short-term and late notice service contracts (1).

Five stakeholders from three regions identified several gaps in service planning including child and adolescent psychiatry (1), carer support programs (1), services for youth transitioning into adulthood (i.e., 16-17-year olds) (1), mild to moderate services (1) and new emerging gaps due to the loss of federal funding (such as PIR and PHaMS) (1). Three stakeholders felt it was too early to comment on the effects of regional planning (2) or commented there was no evidence of effects at present (1). One stakeholder noted that the effects of planning are impossible to quantify.

9.3.1.3 Improving regional planning

The key themes that emerged in response to how regional planning can be improved in the future were related to communication and consultation processes, commissioning and service implementation processes and others. Stakeholders either articulated challenges or provided suggestions for improvement related to each of these three themes.

9.3.1.3.1 Communication and consultation processes

Several challenges related to the theme of communication and consultation processes emerged. Three stakeholders from two Lead Site regions noted that there was not enough clarity around the PHN vision for regional planning and service integration, and the PHN position within the larger mental health system. Another stakeholder perceived that the Fifth National plan lacks guidance or a theory of change for the PHNs. One stakeholder noted that learnings from the past few years should have better informed the new service model. Two other stakeholders noted tight timelines make it more challenging for the PHNs to achieve comprehensive consultation and insufficient consultation about successful services operating prior to the PHN reforms. Another stakeholder noted a lack of PHN leadership around the transition to the NDIS and a lack of a strategic approach to service planning.

Seven stakeholders from seven regions suggested future improvements for PHN consultation processes, which included: more structured involvement of consumers and carers (2), multiple approaches to involving consumers (1), better representation of consumers and private service providers (1), more focus on low intensity service consumers (2), more input and alignment with other departments (e.g., education) (1), early engagement of local mental health clinical services (1) and involvement of commissioned service providers in service planning (1). One stakeholder advised it is time for PHNs to revisit the population's mental health needs and conduct further consultations with new stakeholders (1).

9.3.1.3.2 Commissioning and service implementation processes

Eleven stakeholders from six Lead Site regions noted challenges associated with short-term funding on the stability and sustainability of a service provider. These challenges included workforce recruitment and retention (5), restricted service planning and improvements (1), lack of time to refine services (2) and consequential confusion across the sector (2) and cynicism of referrers (1). Furthermore, five stakeholders from two regions found that multiple small grants created confusion and fragmentation for service providers. Five stakeholders from two regions agreed that the current commissioning process has created a competitive environment for service providers and does not encourage collaboration. One stakeholder noted that PHNs should review commissioning processes to better support a stepped care model.

> 'You can't just tell people to collaborate, there has to be benefits all round.'

Four stakeholders from one region noted challenges around the tendering process, which included short timeframes, unclear tender requests and a constraining e-tender process (i.e., Tenderlink). Three stakeholders from two regions noted that short term planning and implementation timeframes negatively impact on service providers. They noted this resulted in lack of community consultation (1), insufficient time and resources for community relationship building (1) and setting up proper IT and data collection systems (1). Correspondingly, two stakeholders from one region recommended that established services should be given more time to mature and improve. One stakeholder from another region noted service implementation takes time and the expectations and targets should be more flexible.

> 'It seems like by the time everyone has their head around the system, it's on the next new thing and round of funding and there is no time to bed down and to refine the service.'

9.3.1.3.3 Other challenges or improvements

Two stakeholders from one region noted that there were insufficient services in their areas – one attributed this to funding not being properly directed to where the actual needs are and the other claimed that Commonwealth funding doesn't translate to actual services on the ground at a state-level.

Four stakeholders from two regions suggested that the relationship with GPs needs to be improved in the future as they are a main referral source and are currently insufficiently engaged. Three stakeholders from two regions commented that the evaluation and quality improvement processes can be improved in the future. Specific suggestions were evaluation by a quasi-independent organisation (1), ongoing and real-time feedback from consumers (1), re-evaluation of outcome measures for non-clinical services (1) and benchmarking to track progress and identify challenges (1).

9.3.2 SERVICE INTEGRATION

9.3.2.1 Effects of service integration

Three stakeholders from two Lead Site regions commented on positive impacts for consumer and carers, including improved consumer outcomes (1), a wider range of service options (1) and increased service availability (1).

Twelve stakeholders from seven regions noted broader system impacts of service integration including: increased collaboration (5), cross-partner proposals (1), the promotion of co-location (3), improved consumer focus (1), increased referral pathways (2), establishment of local mental health networks (1), reduced service duplication (1) and service gaps being met (1).

> '... because DHHS and the PHN are starting to work together more closely – you do feel like you are part of a bigger community, working together more effectively.'

Five stakeholders from two regions noted various negative effects caused by service integration activities including the central intake system causing fragmentation (2), recommissioning impacting on former collaborations (1) and the mental health system becoming more complex (3). Two stakeholders from one other region agreed that it is not clear what true integration looks like; they noted that the term integration is not well-defined. Four stakeholders from three regions commented on the lack of an effect of service integration led by PHNs, one of whom noted that service providers are still largely operating in isolation.

9.3.2.2 Improving service integration

Again, in relation to how service integration can be improved, stakeholders mentioned a variety of challenges impacting on integration or provided suggestions for improvement. The key themes related to systemic challenges, strengthening relationships and the role of PHNs.

Two stakeholders from different Lead Site regions noted that it was premature to comment on how service integration could be improved.

9.3.2.2.1 Systemic challenges impacting on service integration

Six stakeholders from five regions noted several challenges related to service integration, which included: difficulty building relationships with the public mental health sector, especially intensive support programs (1); lack of recognition that relationship building and upskilling staff takes time (1); the difference between state and federal funded programs (1); difficulties in navigating the system (2), and siloed funding (1). Three stakeholders commented on the competitive nature of the mental health system, such as funding and tender processes, that limited the extent of service integration. One stakeholder noted that information dissemination about HealthPathways – a web-based portal intended to facilitate integration- was inadequate and it is not optimally used because of the website's inaccessibility, complex processes and insufficient IT support. Another stakeholder from the same region noted the need for a more streamlined and comprehensive needs assessment of consumers, in order to improve referrals to the appropriate care.

9.3.2.2.2 Strengthening relationships

In response to the challenges identified associated with relationship building, five stakeholders from three regions suggested that PHNs need to continuously strengthen communication and relationships with, and between, stakeholders. They noted that stakeholders on whom PHNs should focus their attention are service providers (both PHN- and non-PHN funded), GPs, tertiary clinical services and the broader community (5). One stakeholder provided general comment that the PHN could facilitate more service integration and collaboration, while another stakeholder suggested that PHNs should provide a visual network analysis to improve system navigation.

9.3.2.2.3 Role of the PHNs

There was some discussion of the role and position of the PHN in leading service integration in the mental health sector. Two stakeholders from different regions questioned whether PHNs are best positioned to take on such a role. One of these stakeholders specifically noted that PHNs are not service providers, are highly regulated by the Commonwealth, and that the public mental health sector represents a larger proportion of the entire mental health sector implying the latter may be better positioned to lead service integration.

9.4 Stepped care

9.4.1 INVOLVEMENT IN STEPPED CARE

Eight stakeholders noted they had had some involvement in the implementation of a stepped care approach in their region. Of these, three stakeholders from three Lead Site regions had been involved in early discussions or conversations around stepped care. Three stakeholders from three regions noted more substantial involvement including being involved in forums, being part of an advisory group, and supporting the planning and development of the stepped care approach. Two stakeholders from one region noted more indirect forms of involvement such as defining the step the service should sit within in the request for tender (1) and cross-referencing of consumers between services being defined as a KPI (1). One stakeholder noted they were *informed* of the stepped care approach (as opposed to being consulted). Four stakeholders from four regions noted they had not been involved in the implementation of stepped care.

9.4.2 EFFECTS OF STEPPED CARE

Six stakeholders from five Lead Site regions commented on the positive effects of a stepped care approach for consumer and carers. Specifically, they noted more coordinated care (2), more person-centred care (1), additional access and services for consumers (2), shared care with limited re-admissions (1), better integrated services (2) and services more embedded within GP clinics (1). Additionally, one stakeholder noted more consumers are being reached; specifically, consumers who would not access traditional forms of mental health services and consumers who now access low intensity and online services. One stakeholder commented that a first step had been made in their region towards providing culturally appropriate services for Aboriginal people.

> 'We were able to match and provide a much more coordinated level of care than previously.'
>
> 'It's half a step with Aboriginal people receiving a [service] step from Aboriginal staff.'

Two stakeholders from two regions commented on broader positive impacts of the stepped care approach including a shift to a broader lens of mental health and flexible services that fill gaps.

Five stakeholders from three regions noted negative effects of the stepped care approach, identifying inequitable access to services (1), less services or inaccessible services (1), difficult referral pathways (1), clunky stepping up or down between service providers (1) and lack of incentives to step up or down (2). Furthermore, one stakeholder from another region questioned whether stepped care is providing a trauma-informed approach for young people with attachment issues. This stakeholder noted that continuity of care is not being established when (young) people keep being referred to different service providers or steps.

> 'The way stepped care is commissioned between services creates silos within the steps. The notion is great and can work, but there is no incentive to step up or down outside a service.'
>
> 'Young people have strong connections with services and they can't continue that relationship when being referred. Being passed around when they already have attachment issues…'

9.4.3 IMPROVING STEPPED CARE

Suggestions for improving stepped care related to the theme of increasing service integration and collaboration; or a variety of challenges, most commonly related to the theme of stepping consumers up or down.

9.4.3.1 Improving service integration and collaboration

Eight stakeholders from six Lead Site regions noted that future stepped care efforts should be focused on improving service integration and collaboration. They identified the following strategies or approaches to this end: more time and resources for providers to come together (1), more mechanisms to share best-practices (1), better communication and information sharing between services and GPs (1), an integrated intake system to improve triaging (1), more streamlined services (1), more co-located services (1), integration of national services into the stepped care framework (2), and more consideration of the NDIS and how this will impact on the steps (1). Six stakeholders from four regions commented on the need to improve links between the steps. These stakeholders noted the need for a one-door entry system (1), more integrated and holistic services (2), more equitable services across regions (2), more consistency across the state (1), and the need to include a broader range of social determinants (1) and non-mental health services (1). Three stakeholders expressed that stepped care works best when one service provider can provide a range of services, or when the funding model truly supports a service provider to engage with other services to meet the consumer's needs. Two stakeholders noted there are still major service gaps existing in between the steps. Another stakeholder noted that clinicians need to be given more capacity to exercise their skills and respond to individual needs.

> ‘We have big service gaps, which means we can’t facilitate stepped care.’

9.4.3.2 Stepping consumers up and down

Eight stakeholders from five Lead Site regions noted several challenges around the stepping up and down of consumers. Challenges identified included: difficulty tracking consumers (3), service waitlists (1), stepping up and down still being person-dependent (2), young people with complex needs not wanting to change services (1), absence of steps above high intensity services (1) and absence of (any) stepping up or down (2). Furthermore, one stakeholder noted that many consumers would benefit from a ‘step down’ that focuses on accommodation and social support needs.

> ‘Key sticking point – not a stepped care model until steps talk to each other.’
>
> ‘Stepped care is nice as a model, but time spent on evaluating and tracking in practice… is very difficult.’

9.4.3.3 Other challenges

Four stakeholders from two Lead Site regions commented on marketing and communication from the PHN, including needing better use of social marketing to improve services (2), redirecting focus of communication from GPs towards the broader community sector and other service providers (1), and improving communication with the alcohol and other drugs (AOD) sector (1). Four stakeholders from two regions noted challenges they faced in relation to data collection within the stepped care model including the number of IT-systems being confusing and time consuming (2) and issues with recording consumers’ journeys accurately when the PMHC MDS does not accommodate capturing a consumer receiving services in multiple streams (2). Additionally, two stakeholders from one region noted the burden of assessing outcomes at each session on consumers and clinicians. Another stakeholder noted that the tools, policies and support necessary for the successful implementation of stepped care have not been properly defined.

> ‘The national data collection system doesn’t keep up with reform and commissioning.’

9.5 Low intensity services

9.5.1 INVOLVEMENT IN LOW INTENSITY SERVICES

Thirteen stakeholders from nine Lead Site regions had tendered for low intensity services and/or were involved in a commissioned low intensity service. Two stakeholders from two regions specifically mentioned being involved in a co-design process with the PHN in relation to implementing low intensity services. One of these stakeholders noted that ongoing feedback opportunities during this process were valuable for understanding the aims and objectives of the PHN. Another stakeholder from the same Lead Site noted they had a good partnership with the PHN for developing its service model. Two stakeholders from different regions were involved as advisors on a procurement panel. One stakeholder from another region supported the commissioning of low intensity services by developing and maintaining a communication strategy.

9.5.2 EFFECTS OF LOW INTENSITY SERVICES

Eight stakeholders identified various positive effects of low intensity services for consumers including improved wellbeing or reduced symptoms, improved understanding and awareness of mental health issues, engaging consumers who would otherwise not engage with mental health services, providing a soft entry into mental health care and preventing the need for higher intensity services. Six stakeholders from five regions reported evidence of the effectiveness of low intensity services as demonstrated by improved outcomes on various measures, such as the K10 (4); and qualitative evidence such as positive feedback from consumers or practitioners (2).

Four stakeholders from four regions also mentioned broader impacts of implementing of low intensity services. Specific impacts identified were more collaboration with other services and organisations (e.g., schools and sporting clubs) (1), the introduction of peer-workers as a new workforce (1) and the contribution of low intensity services to prevention (1). It was also noted that more service gaps were being addressed (1).

Three stakeholders from three regions mentioned it was too soon to comment on any concrete outcomes.

9.5.3 IMPROVING LOW INTENSITY SERVICES

In relation to how low intensity services can be improved, stakeholders focussed on a variety challenges, particularly those related to service integration and collaboration, engaging consumers and the community, and service implementation.

9.5.3.1 Service integration and collaboration

Two stakeholders from two Lead Site regions commented on lack of collaboration and difficulty building rapport between service providers in relation to low intensity services. Furthermore, one stakeholder from another region emphasised the importance of integration for seamless step-up and, in turn, low intensity services acting as a soft entry into the mental health service system. Yet another stakeholder perceived lack of national leadership or guidance for the roll out of low intensity services, resulting in fragmented services and a need for more integration. An additional stakeholder noted that low intensity services need to be more strongly embedded in the stepped care model.

9.5.3.2 Community and consumer engagement

Two stakeholders from two Lead Site regions mentioned lack of familiarity and mental health literacy within the community, which in one case was attributed to a change in service name as well as marketing restrictions by the PHN. The other stakeholder highlighted the community's assumption that counselling should be face-to-face, which was exacerbated by service providers' poor understanding of how to promote phone and web services. Four stakeholders from the same region agreed that the language used for 'low intensity services' is not helpful or adequate in describing or promoting the service, sounding like consumers get 'less' rather than capturing the potential these services offer. They suggested an alternative of 'wellbeing' services. One stakeholder noted that the sector is used to engaging with traditional mental health consumers, however low intensity services should engage a much broader market which may be challenging. Furthermore, three stakeholders from two regions agreed that the 'voice' of consumers with relatively low level of need is currently inadequately represented in the sector and so engagement and consultation with them should be strengthened in the future (1).

9.5.3.3 Service implementation issue

Three stakeholders from two Lead Site regions commented on the lack of GP referrals for low intensity services. One of these stakeholders explained that GPs are reluctant about telehealth as a service modality and another noted GPs are reluctant to refer consumers to an interim service while waiting for

MBS services. Two stakeholders from the same region commented that short-term funding and programs are a significant challenge, causing issues with staff and referrers. Correspondingly, one stakeholder noted that improving systems and changing referral behaviours takes time, which is why long-term funding is needed. One stakeholder noted that some professionals felt threatened by the new emerging low intensity workforce, which may interfere service implementation. Two stakeholders noted that consumers of their service present with more complex issues than the service was intended for. One stakeholder referred to the issue of the 'missing middle'; young people with moderate to severe mental health issues that present at low intensity service providers (i.e., headspace centres). As these services do not adequately meet their needs, service providers spend a lot of time triaging instead of providing services. Another stakeholder noted that service providers need more support in the use of technology and the available platforms for delivering low intensity services.

9.5.3.4 Other issues

Three stakeholders from two Lead Site regions noted that monitoring and evaluation need to be improved in order to build more evidence on low intensity programs and workforce (especially the peer-workforce). One stakeholder noted that when planning for low intensity services, PHNs should consider both the potential to reach a large number of people and to prevent people from escalating into higher intensity services. Two stakeholders from one region noted that more funding for low intensity services will decrease service demand in the mild and moderate services in the long run. One stakeholder noted that consumers' needs are dynamic and better outcomes are achieved when a service model is flexible to fit such dynamic needs. Another stakeholder commented that low intensity services can also be very valuable in providing mental health support to consumers in the AOD sector. Other stakeholders suggested several improvements for the future: addressing the lack of services for adolescents (2), expanding the reach of existing programs (1), increasing funding for peer-workers (1) and providing community-based programs to vulnerable and marginalised groups who currently have poor access to mental health services (e.g., consumers form CALD backgrounds). One stakeholder noted that easy access is essential to filling the service gaps existing in low intensity services.

9.6 Services for youth with, or at risk of, severe mental illness

9.6.1 INVOLVEMENT IN SERVICES FOR YOUTH WITH, OR AT RISK OF, SEVERE MENTAL ILLNESS

Eleven stakeholders from five Lead Site regions mentioned having tendered for youth enhanced services and/or being involved in commissioned youth severe services. Two stakeholders from two regions specifically mentioned having a partnership with their PHN. One stakeholder mentioned co-creating their PHN's commissioned youth enhanced service. One stakeholder was involved in pre-commissioning briefings. Two stakeholders from one region mentioned they were involved in child and youth advisory group consultations; and another, being involved in a round table discussion prior to the tendering and commissioning process.

9.6.2 EFFECTS OF SERVICES FOR YOUTH WITH, OR AT RISK OF, SEVERE MENTAL ILLNESS

Fourteen stakeholders from six Lead Site regions noted several positive effects of youth enhanced services, which included: better services (1), availability of a new service (3), easy or improved access (4), access to specialised clinicians or psychiatry (3), destigmatising services (2) and a more comprehensive care approach (1). Furthermore, it was noted that services were reaching young people that are not help-seeking and providing a soft entry into mental health services (1). One stakeholder also reported positive effects of their service for carers of young people with mental health issues (1), such as a huge sense of relief and virtually no drop-outs in the program. Four stakeholders from three regions described evidence that youth enhanced services were having positive effects on young consumers including improved outcomes on various measures, such as the K10 (1), reduced symptomology and emergency department admissions (1) and anecdotal evidence, such as positive feedback from consumers, carers or practitioners (2).

> 'Getting a psychiatrist has proved to be the golden egg.'

Three stakeholders from two regions commented on the broader impact of the implementation of youth enhanced services including collaboration with other services and organisations (2), the introduction of peer-workers (1) and support for the co-location of services (1). One of these stakeholders added that they were very happy that their PHN had moved away from activity-based funding towards outcome-based funding.

> 'The key thing for us is collaboration with other providers (e.g., schools and the justice system). We have better services now than 2 or 3 years ago, because of increased resources.'

One stakeholder stated they were not aware of any evidence or reporting around the impact of youth enhanced services or that these services have been effective in preventing progression into further mental ill-health.

9.6.3 COMPLEMENTING SERVICES FOR YOUTH WITH, OR AT RISK OF, SEVERE MENTAL ILLNESS

Eight stakeholders commented that youth clinical programs in their five regions are part of a wrap-around model, where young people are provided or linked in with complementary services, such as vocational, AOD and family support services. Overall, stakeholders were positive about the ability to provide wrap-around services for young people. One stakeholder noted that the wrap-around approach currently depends on partnerships with other services, which can be challenging with shifting priorities and funding. Three stakeholders from three regions noted that young people were linked to additional non-clinical services if needed. Another stakeholder mentioned the lack of vocational services.

> 'Offering a full suite of services at our centres is critical when considering the holistic needs of young people.'

9.6.4 IMPROVING SERVICES FOR YOUTH WITH, OR AT RISK OF, SEVERE MENTAL ILLNESS

In regard to how youth enhanced services could be improved, stakeholders identified a variety of challenges that require improvement – many of which were similar to those mentioned for low intensity services – including issues with service integration and collaboration, service implementation, workforce and the need for better access and addressing service gaps, and others.

9.6.4.1 Service integration and collaboration

Five stakeholders from three Lead Site regions raised the need for better service integration and collaboration between services in relation to youth enhanced services. Two of these stakeholders specifically identified the need for more collaboration to improve access for homeless young people, with access to accommodation viewed as a critical challenge for service providers. One stakeholder from another region noted the need to engage local mental health clinical services in the planning process. Additionally, two stakeholders from two regions suggested that the relationship with GPs needs to be strengthened in the future. Another stakeholder from a different region commented that the relationship with emergency departments needs to be strengthened, along with development of more direct referral pathways. Yet another stakeholder suggested that the sector needs to rethink its rejection of 'risky' young people (e.g., a history of self-harm). Another stakeholder concurred and added that diversity in service provider thresholds for managing risk is confusing for the community.

9.6.4.2 Service implementation challenges

Three stakeholders from two Lead Site regions mentioned challenges related to reporting and evaluation requirements including data requirements from both the state and the PHN, having to use different data sources, evaluation requirements being disproportionate to funding thereby directing resources away from service provision and the high burden on consumers. Three stakeholders from three regions noted that maintaining adequate youth enhanced funding in the future is imperative. One of these stakeholders noted that longer contracts would also improve stability for the whole sector and region. One stakeholder commented that PHNs need to be responsive and flexible in the development and implementation of services, facilitating evidence-based and best-practice models of care. Another stakeholder noted that more consistency in programs will provide more reliable and holistic care.

9.6.4.2.1 Workforce issues

Seven stakeholders from five Lead Site regions reported having experienced workforce recruitment or retention issues, mainly due to short term funding which leads to short-term contracts and hinders workforce development. Additionally, four stakeholders from three regions specifically identified the need for psychiatrists. One stakeholder viewed the lack of funding for psychiatry as a highly concerning fault in the design and development of the youth enhanced model. One stakeholder noted that services are not funding staff-related indirect costs, including IT upgrades and pay rises which, in turn, exacerbates the challenge of workforce recruitment and retention. Another stakeholder noted that workforce education and support are essential for a successful service. Stakeholders noted that long term funding would assist in attracting the appropriate workforce in the future, including psychologists and psychiatrists.

> 'This [lack of access to psychiatry] has been exceptionally risky for the services, and for clients who are not able to access this essential clinical care element, leaving them at significant risk.'

9.6.4.2.2 Improving access and addressing service gaps

Six stakeholders from six Lead Site regions stated that more or expanded programs are needed to improve access or meet demand in their region. Additionally, one stakeholder from another region noted a lack of resources for engaging families and peers. Several stakeholders identified service gaps that need to be addressed in the future including services for those with more severe and complex issues (2), services for those aged under 18 years (2), programs for parents and carers (1), specialist programs (e.g., complex trauma) (1), support services (e.g., school engagement) (1), suicide prevention (1) and after-hours services (1). Two stakeholders from different regions stated that the discontinuation of the PIR program will leave a gap for young people. Three stakeholders from different regions highlighted the need for prevention or early intervention services, of whom two stakeholders suggested services in schools or targeting school drop-outs would prevent more serious problems down the track. One stakeholder viewed navigation through the current PHN mental health system as too complex for providers, let alone consumers and carers. Another stakeholder noted that providing uncapped sessions and access to a range of support services at all stages of their care pathway would improve access to youth enhanced services.

9.6.4.2.3 Other challenges

One stakeholder highlighted the need for legislative changes to ensure the rights of young people and their carers when interacting with government agencies. Another stakeholder commented that youth enhanced programs need a national approach and funding might be better placed at a federal level.

9.7 Summary and comparison to interim report

In total, 70 regional and other key stakeholders from all 10 Lead Sites participated in Round 2 (February/March 2019) compared with 62 from all 10 Lead Sites in Round 1 (March 2018) consultations. The demographic profile of these stakeholders was similar across the two rounds of data collection. Findings from this data source inform all four of the evaluation focus areas. However, the were some differences in the questions asked in the two rounds of data collection – with Round 1 focusing on implementation processes and Round 2 on early effects and future improvements – which means not all not all responses across the rounds can be compared but comparisons are made where relevant.

Regional planning

In Round 2, stakeholders from nine Lead Sites reported involvement in regional planning in the form of meetings, workshops and/or forums. In general, stakeholders were positive about their involvement – but some viewed their involvement as minimal or opportunistic. Stakeholders identified various positive impacts of regional planning for consumers and/or carers, mostly related to improved service access. Some stakeholders reported negative impacts or current gaps in regional planning, such as difficulties navigating the system or a lack of child and adolescent psychiatry. The key themes that emerged in response to how regional planning can be improved in the future were related to communication and consultation processes, commissioning and service implementation processes and others.

Compared to Round 1, the extent and types of involvement of stakeholders in regional planning were similar across the rounds. Stakeholders in Round 2 were somewhat more positive about their involvement in Lead Sites' regional planning activities and, correspondingly, they raised fewer concerns about, or barriers to, involvement in regional planning activities and meetings.

Service integration

In Round 2, stakeholders reported several positive effects of service integration for consumers and/or carers including improved consumer outcomes, a wider range of service options and increased service availability. Some stakeholders also noted negative effects which were mainly related to service fragmentation and the mental health system becoming more complex. The key themes of how to improve service integration in the future related to systemic challenges; and strengthening relationships with, and between, stakeholders and the role and position of PHNs in the mental health sector.

Compared to Round 1, stakeholders in Round 2 described more detailed and broader positive impacts of service integration that highlighted improved consumer, and to a less extent carer, access to diverse services and outcomes. Similar critical views were expressed by stakeholders in both rounds, relating to integration being fragmented. The need for ongoing communication and the strengthening of relationships with stakeholders to improve regional planning and achieve service integration was a common theme that emerged across both rounds.

Stepped care

Overall, regional stakeholders seemed familiar with, and positive about, the stepped care approach in their region in Round 2. The positive impacts for consumers and/or carers identified were similar to those described for regional planning and service integration. Additionally, stepped care was viewed as contributing to improved service integration. Stakeholders also reported negative effects of the stepped care approach relating to a lack of, or complex, access and challenges in stepping up or down between services. Improving service integration and collaboration was considered to be essential to achieving seamless stepped care.

Compared to Round 1, fewer stakeholders in Round 2 mentioned being involved in the planning or implementation of the stepped care approach in their region. This may be because Lead Sites were no longer in their consultation phase during our Round 2 consultations. Stakeholders in Round 2 seemed more familiar with the stepped care approach and were therefore able to discuss challenges and future recommendations in more detail. A common concern across both rounds was difficult navigation and referral pathways for consumers. Another theme that was consistent across both data collection rounds was the challenge of tracking consumers in the system and across steps, which hindered the ability of providers to ensure consumers were being appropriately stepped up or down.

Low intensity services

Stakeholders in Round 2 reported involvement in the planning and commissioning of low intensity services via a variety of activities. As low intensity services were more established by Round 2, stakeholders were able to comment on their effects, noting their value and the positive impacts they conferred for consumers (e.g., prevention, early intervention and improved outcomes) and providers. Several positive impacts for consumers were reported which related to improved access, mental health literacy and wellbeing. Stakeholders mentioned a variety of challenges which were related to service integration and collaboration, engaging consumers and the community, and service implementation. Specifically, the main barrier that stood out involved the language used for 'low intensity services' not being helpful or adequate in describing or promoting the service.

A similar number of regional stakeholders were involved in the implementation of low intensity services across both data collection rounds. Compared to Round 1, Round 2 regional stakeholders identified a broader range of challenges and future recommendations relating to low intensity service, which is likely to be attributable to more extensive familiarity and involvement with these services over time. The need to increase community, particularly GP, engagement and awareness was consistently raised in both rounds. However, some of the concerns raised in Round 1, such as those about low intensity services replacing higher intensity services, were not mentioned in Round 2.

Youth enhanced services

Stakeholders in Round 2 reported diverse types of involvement in the planning and implementation of youth enhanced services. Stakeholders reported a variety of positive impacts for young consumers which mainly related to improved access and/or services. Overall, stakeholders were very positive about the ability to provide wrap-around services for young people. Challenges of implementing youth enhanced services related to service integration and collaboration, service implementation, workforce recruitment and retention and various service gaps for particularly hard to reach young people (e.g., homeless or at-risk youth) and families.

Compared to Round 1, a similar number of regional stakeholders were involved in the implementation of youth enhanced services. Unlike Round 1 when stakeholders indicated it was too early to notice any effects of this new service type, in Round 2, stakeholders identified a range of positive effects for consumers (i.e., improved access to specialised service and outcomes) and carers (e.g., relief). Regional stakeholders were equally positive about non-clinical youth programs complementing clinical services in both rounds. Compared to Round 1, regional stakeholders noted a broader range of challenges and future recommendations for youth enhanced services in Round 2, which as mentioned for low intensity services, may be due to more extensive familiarity and involvement with youth enhanced services as they have become established over time. Notably, unlike in Round 1, stakeholders in Round 2 did not mention problems associated with lack of guidance and key performance indicators for youth enhanced services.

10. Consultation with consumers

10.1 Summary of approach

We consulted with consumers via an online survey, which included closed and open-ended questions about their experience of service use and its impacts (Appendix 5). The survey was open from 23 November to 21 December 2018. To maximise the response rate, consumers were sent three email or SMS reminders at approximately one-week intervals.

We contacted Lead Sites in early October 2018 and asked them to provide us with a list of consumers (including names and contact information) aged 16+ years, who received services in a four-week census period from 15 October to 9 November 2018 irrespective of whether their episode of treatment was complete. These consumers had provided consent to being contacted for the purpose of research and evaluation. All 10 Lead Sites contributed lists of consumers.

10.2 Sample and demographic information

A total of 310 consumers responded to the survey, 141 (46%) by email and 169 (55%) by mobile phone. Of these, 304 provided useable responses, of which 296 (97%) provided consent for us to provide their Lead Site with aggregate consumer survey results. The number of consumers from each Lead Site region ranged from one to 73.

Table 45 shows the demographic characteristics of consumer respondents. Most consumer respondents were female (68%) and around 4% identified as Indigenous Australians. Most commonly, consumer respondents were aged from 30-39 years to 50-59 years.

Table 45. Characteristics of consumer survey respondents (N = 304)

Characteristic	Freq.	%
Gender		
Female	208	68.4
Male	80	26.3
I do not identify with either term	6	2
Unknown	10	3.3
Indigenous identification		
Aboriginal or Torres strait Islander	11	3.6
Both Aboriginal and Torres Strait Islander	2	0.7
Neither Aboriginal nor Torres Strait Islander	280	92.1
Unknown	11	3.6
Age range		
19 and under	15	4.9
20-29 years	51	16.8
30-39 years	56	18.4
40-49 years	50	16.4
50-59 years	70	23
60-69 years	39	12.8
70-79 years	7	2.3
80 years or older	2	0.7
Unknown	14	4.6

10.3 Service characteristics

10.3.1 SELF-REPORTED SERVICE TYPE AND EPISODE COMPLETION

Table 46 shows consumers' self-reported principal focus of services received and whether they had future sessions booked or planned. Most consumers (61%) reported that they had received psychological therapy, 22% low intensity, 9% clinical care coordination and 7% suicide prevention services. Only four participants received child and youth services, and two participants received Indigenous services. Most consumer respondents indicated that they had a session booked or planned in the future (80%) indicating that their treatment episode was not yet complete.

Table 46. Self-reported service type and continuation

Service characteristic	Freq.	%
Principal focus of service		
Low intensity psychological intervention	66	21.7
Psychological therapy	185	60.9
Clinical care coordination	27	8.9
Indigenous-specific mental health service	2	0.7
Child- and youth-specific mental health service	4	1.3
Suicide prevention service	20	6.6
Future session booked or planned		
Yes	243	79.9
No	51	16.8
Unknown	10	3.3

10.3.2 OTHER SERVICE USE CHARACTERISTICS BY SERVICE TYPE

Table 47 shows consumers' endorsed reason for using the Lead Site-commissioned mental health service, whether this was their first time to use a mental health service and whether they thought they waited longer than reasonable to receive the service. Table 47 outlines all these service characteristics for the overall sample and by service type.

10.3.2.1 Service use reason

Most commonly, consumer respondents indicate their reasons for service use were: they needed professional help (50%), were not coping (49%) and/or they were referred by a health professional (48%) (Table 47). There was some variation according to self-reported service type; for example, referral by a health professional was least common for low intensity services (35%) and most common for suicide prevention (60%).

A total of 32 consumers provided an 'other' response to the question 'Why did you choose to use this mental health service?'. A total of 30 provided useable responses; 10 of these responses reiterated one of the fixed answers given to the service use reason question. Most responses related to symptoms or events as the service use reason. Appendix 13 (Table 106) shows individual themes and subthemes that emerged for this response option by self-reported service type.

Table 47. Service use characteristics

	Low intensity		Psychological therapy		Clinical care coordination		Indigenous[bbb]		Child and youth[ccc]		Suicide prevention		Total	
	n = 66		n = 185		n = 27		n = 2		n = 4		n = 20		N = 304	
	Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**
Service use reason[ddd]														
Not coping	39	59.1	93	50.3	7	25.9	1	50	0	0	10	50	150	49.3
Symptoms worse	25	37.9	73	39.5	5	18.5	0	0	0	0	7	35	110	36.2
Upsetting event	22	33.3	55	29.7	5	18.5	2	100	0	0	6	30	90	29.6
Need professional help	30	45.5	106	57.3	7	25.9	1	50	0	0	8	40	152	50.0
Family/friend suggested	9	13.6	13	7	0	0	0	0	0	0	2	10	24	7.9
Referred by health prof.	23	34.8	92	49.7	14	51.9	2	100	3	75	12	60	146	48.0
Other	7	10.6	18	9.7	2	7.4	0	0	1	25	4	20	32	10.5
First time service use														
Yes, first time	31	47	38	20.5	7	25.9	1	50	3	75	5	25	85	28.0
No, past year	19	28.8	87	47	17	63	0	0	0	0	8	40	131	43.1
No, >1 year ago	16	24.2	60	32.4	3	11.1	1	50	1	25	7	35	88	28.9
Waited longer than reasonable														
Yes	10	15.2	39	21.1	6	22.2	0	0	1	25	7	35	63	20.7
No, did not wait long	56	84.8	146	78.9	21	77.8	2	100	3	75	13	65	241	79.3

[bbb] Multiple responses permitted.
[ccc] Due to small sample size of two, percentages are not informative but have been provided for completion.
[ddd] Due to small sample size of four, percentages are not informative but have been provided for completion.

10.3.2.2 First time service use

Most consumer respondents reported they had used any mental health service in the past year (43%), while almost one third indicated this was the first time they had used mental health services (Table 47). The proportion of consumers who indicated this was their first time to use mental health services was highest for receiving low intensity services (47%) (excluding the two respondents who received Indigenous-specific services) and lowest for those receiving psychological therapy (21%).

10.3.2.3 Waiting time

Most consumers (79%) indicated that they did not wait longer than reasonable for their service (Table 47). This figure was highest for those who self-reported using low intensity services (85%) and lowest for those who self-reported using suicide prevention services.

10.4 Consumers' self-reported outcomes and service rating

Table 48 outlines consumers' self-reported outcomes and service rating. Findings should be interpreted in the context that most respondents had not yet completed their treatment episode.

10.4.1 CHANGE IN HOW CONSUMERS FELT ABOUT THE FUTURE

Most consumer respondents reported they either felt a little better (43%) or much better (37%) about the future after using the mental health service. Some respondents felt the same (16%) and few respondents felt a little or much worse (5%). This trend was consistent irrespective of service type.

10.4.2 CHANGE IN HOW WELL CONSUMERS COULD MANAGE THEIR DAY-TO-DAY LIFE

More than three quarters of consumer respondents (78%) felt that they could manage day-to-day life either a little or much better after using the mental health service. Some respondents felt the same (18%) and few felt a little or much worse (4%). There was some variation according to self-reported service type; for example, compared to those receiving other service types, respondents who received clinical care coordination more often reported they felt the same (33%).

10.4.3 CHANGE IN CONSUMERS' WELLBEING

Three quarters of all consumers (76%) indicated that their wellbeing had improved to differing extents because of receiving services. This proportion was lowest for those receiving suicide prevention services (60%).

10.4.4 MENTAL HEALTH SERVICE RATING

The majority (88%) of all consumers rated services as good or very good (Table 48). This figure was highest for psychological therapy services (91%) and lowest for suicide prevention services (75%).

Table 48. Consumers' self-reported outcomes and service rating

	Low intensity		Psychological therapy		Clinical care coordination		Indigenous[eee]		Child and youth[fff]		Suicide prevention		Total	
Consumer rating	**n = 66**		**n = 185**		**n = 27**		**n = 2**		**n = 4**		**n = 20**		**N = 304**	
	Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**
Feel about the future														
Much worse	2	3	3	1.6	1	3.7	0	0	0	0	1	5	7	2.3
Little worse	1	1.5	4	2.2	1	3.7	0	0	1	25	1	5	8	2.6
Same	8	12.1	30	16.2	5	18.5	0	0	0	0	4	20	47	15.5
Little better	29	43.9	77	41.6	13	48.1	0	0	3	75	8	40	130	42.8
Much better	26	39.4	71	38.4	7	25.9	2	100	0	0	6	30	112	36.8
Change in managing day-to-day life														
Much worse	1	1.5	1	0.5	1	3.7	0	0	0	0	1	5	4	1.3
Little worse	1	1.5	4	2.2	0	0	0	0	1	25	2	10	8	2.6
Same	13	19.7	31	16.8	9	33.3	0	0	0	0	3	15	56	18.4
Little better	23	34.8	88	47.6	14	51.9	1	50	2	50	9	45	137	45.1
Much better	28	42.4	61	33	3	11.1	1	50	1	25	5	25	99	32.6
Change in wellbeing														
Much worse	1	1.5	1	0.5	1	3.7	0	0	0	0	1	5	4	1.3
Little worse	1	1.5	3	1.6	2	7.4	0	0	1	25	2	10	9	3.0
Same	15	22.7	37	20	4	14.8	0	0	0	0	5	25	61	20.1
Little better	24	36.4	76	41.1	15	55.6	1	50	3	75	9	45	128	42.1
Much better	25	37.9	68	36.8	5	18.5	1	50	0	0	3	15	102	33.6
Service rating														
Very bad	0	0	1	0.5	1	3.7	0	0	0	0	2	10	4	1.3
Bad	0	0	3	1.6	1	3.7	0	0	1	0	3	15	8	2.6
Neither	6	9.1	7	3.8	3	11.1	0	0	0	0	0	0	16	5.3
Good	24	36.4	68	36.8	8	29.6	2	100	2	50	8	40	112	36.8
Very good	34	51.5	101	54.6	14	51.9	0	0	1	25	7	35	157	51.6
Unknown	2	3	5	2.7	0	0	0	0	0	0	0	0	7	2.3

[eee] Due to small sample size of two, percentages are not informative but have been provided for completion.

[fff] Due to small sample size of four, percentages are not informative but have been provided for completion.

10.5 Consumers’ qualitative responses about their experience

Consumers were asked three open-ended questions about their experience of receiving services, their responses to which are summarised below.

10.5.1 THE SERVICE WOULD HAVE BEEN BETTER IF…

Consumers were asked to complete the sentence ‘The service would be better if …’. In total, 213 consumers provided relevant responses; the percentages reported are based on this denominator (see Appendix 13, Table 107).

Across all service types, the most common overarching themes related to the sessions (28%), such as the number of sessions (i.e., program length, 14%), session length (6%), frequency of sessions (4%), and the flexibility of session hours (4%). Twenty-one percent of consumers noted they had no comment on how the service could have been better. Other overarching themes included accessibility (20%), staff providing the service (15%), the treatment itself (13%), processes involved in the service (10%) and the infrastructure (3%). A detailed breakdown of responses, by self-reported service type, is provided in Appendix 13.

10.5.2 THE BEST THING ABOUT THE SERVICE WAS…

Consumers were asked to describe what ‘The best thing about the service was …’. A total of 241 answers were included in our analysis of this question; the percentages reported are based on this denominator (see Appendix 13, Table 108).

Across all service types, the most common theme described related to the staff delivering the service (46%); consumers commented on the professional skills and qualities of staff (24%) and on their sentiment towards staff (22%), such as feeling supported, welcomed and safe. Other common themes included the qualities and benefits of the treatment (36%) and the accessibility of the service (34%). Others commented on the sessions (4%), the processes around the service (2%), or commented ‘nothing’ (5%). A detailed breakdown of responses, by self-reported service type, is provided in Appendix 13.

10.5.3 OTHER COMMENTS

Consumers were asked whether they had any other comments about the service. A total of 106 answers were included in our analysis of this question; the percentages reported are based on this denominator (see Appendix 13, Table 109).

Most commonly, consumers reiterated previous comments (39%), either positive (14%) or negative (25%). Any new comments covered similar themes to the previous two questions, including accessibility (15%), the sessions (3%), staff providing the service (17%), the treatment itself (21%), processes involved in the service (4%) and general positive comments about the service (12%).

10.6 Summary and comparison to interim report

In Round 2, 304 consumers completed the online survey (November to December 2018). This represents more than a 100% increase in the number of consumers (n = 150) who completed the online survey in Round 1 (April to May 2018). Around two thirds of Round 2 respondents were female, 4% identified as Indigenous and most were aged 20-59 years; demographic data were not collected in Round 1. Findings from this data source indirectly inform all four of the evaluation focus areas since consumers are the ultimate arbiters of the effects of the PHN-led mental health reforms.

Most consumers who completed the Round 2 survey reported receiving services with a principal focus of psychological therapy or low intensity psychological interventions. This trend was consistent with Round 1 although the proportion of consumers reporting receiving clinical care coordination slightly decreased in Round 2 with a commensurate increase for psychological therapy.

Most commonly, reasons for service use in Round 2 included needing professional help, being referred by a health professional and not coping. For consumers receiving low intensity services, all of the reasons were endorsed more frequently, with the exceptions of family/friend suggestion and 'other' which were somewhat less frequently endorsed. Overall, these service use reasons reported in Round 2 were similar to those in Round 1.

In Round 2, 28% of consumers reported that this was the first time they had used mental health services, which was similar to Round 1. However, in Round 2, there was a notable increase in the proportion of consumers of low intensity services and clinical care coordination who reported this was their first-time service use. Across both rounds, 80% of consumers reported they did not wait longer than reasonable to receive the service. However, the proportion of consumers of suicide prevention services reporting they waited longer than reasonable for their service doubled (to one third, or 7 out of 20) in Round 2.

Around four fifths of Round 2 consumers reported they felt a little better or much better about the future after using the mental health service, which was slightly higher than in Round 1. This increase in the proportion of those feeling better was much more pronounced for consumers of suicide prevention services. Similarly, most consumers in Round 2 reported feeling better to different extents about managing their day-to-day life across both rounds, and there was a notable increase in the proportion of consumers of suicide prevention services reporting feeling better. Again, most consumers across both rounds reported that their wellbeing had improved; and there was an increase in the proportion of consumers of clinical care coordination rating their wellbeing as improved in Round 2. Overall, most consumers in both rounds rated the service received favourably (as good or very good) across all service types.

In Round 2, the most common themes for how the service could have been improved related to session characteristics, such as number, duration and frequency; and staff delivering the services (15%). The most common themes for the best things about the service related to the service providers, the benefits of the treatment and service accessibility. These themes were similar to those from Round 1.

11. Consultation with carers

11.1 Summary of approach

We took a multipronged approach to recruiting carers to maximise the anticipated low response rate of this group. We consulted two groups of carers in November/December 2018: carer representatives involved with the Lead Sites; and carers of consumers receiving PHN-commissioned mental health services.

11.1.1 CARER REPRESENTATIVES

We asked Lead Sites to each identify one to five carer representatives who had participated in stakeholder consultations or were part of a network or committee with their PHN. We consulted carer representatives via focus groups using Zoom, or they provided written responses. The questions we asked were the same open questions as those used for the regional and other key stakeholder consultations and relating to the four focus areas of the evaluation: service integration and regional planning; stepped care; low intensity services; and services for youth with, or at risk of, severe mental illness (Appendix 4).

11.1.2 CARERS

This group of carer participants were recruited via one of two methods. The consumer acted as an intermediary for the first method; that is, the consumer was asked at point of completing the consumer online survey to provide their carer with a link to the carer survey. The service provider acted as an intermediary for the second method by providing the survey link to carers either directly or via consumers. In both cases, the link included a means of identifying which Lead Site the recruitment originated from. We consulted carers via an online survey (Appendix 6), which was open from 23 November 2018 to 2 January 2019. The survey took approximately 15 minutes to complete and comprised mostly closed, and a few open-ended, questions and elicited demographic information. Survey content related to carer views and experiences of the mental health care their significant other had received.

11.2 Sample and demographic information

11.2.1 CARER REPRESENTATIVES

In total, 11 carer representatives were nominated by eight Lead Sites, including one carer nominated by two Lead Sites. One carer representative withdrew during the recruitment period citing a lack of time available to participate, and two did not return responses to written questions. Ultimately, eight representatives from seven Lead Sites participated, with one participant representing two Lead Sites, and two participants representing one Lead Site in two instances. Five participated via two focus groups, consisting of two and three participants, respectively. Three participants provided written responses.

All eight carer representative participants were female, and none identified as Aboriginal or Torres Strait Islander. Four participants (50%) were aged 60 to 69 years; two (25%) were 50 to 59 years, one (12.5%) was 30 to 39 years and one was 20 to 29 years. Carer representatives were asked the name of the organisation they were representing and what their job title or position was. Three of these participants (37.5%) were from peak body carer organisations: two (25%) were CEOs, and the other (12.5%) was a program officer. Two participants (25%) identified as a 'carer representative'; one (12.5%) as a self-employed consultant; and two (25%) responded that this question was not applicable to them.

All eight participants were currently caring for someone. Three participants (37.5%) were caring for their son or daughter, with one of these participants concurrently caring for a friend; two (25%), for their mother or father; one, for their spouse or partner (12.5%); and one for their sibling (12.5%). One participant identified as caring for an ‘other’ person, specifically, as a ‘service provider’.

11.2.2 CARERS

A total of 29 carers consented to complete the family member, partner or friend survey. Of these, four (14%) did not start the survey and nine (31%) responded to demographic questions only and were therefore not included in the analysis. Sixteen carers (55%) provided responses that answered questions about their experiences of PHN-commissioned services. Fifteen respondents were from six Lead Site regions (four were from one, three each from three, and three were from one each). The Lead Site region was unknown for one respondent because the identifying part of the survey link was omitted when entering the web page address.

Of the 16 survey respondents, 11 (68.8%) were female. One respondent (6.3%) identified as Aboriginal. Five respondents (31.3%) were 50 to 59 years, four (25%) were 40 to 49 years, three (18.8%) were 60 to 69 years, two (12.5%) were 20 to 29 years and two (12.5%) were 70 to 79 years.

Characteristics of the consumers for whom the survey respondents were providing care, and of the caring relationship, are shown in Table 49. Eleven respondents (68.8%) were caring for a female consumer. One respondent (6.3%) identified the consumer they were caring for as being of Aboriginal descent. Consumers being cared for by respondents were most frequently aged 19 years and under (31.3%). Most commonly, participants were providing care to a son or daughter, including a step-son or daughter (62.5%), and had been providing care for over 10 years (37.5%).

Table 49. Characteristics of care provided by survey respondents and the consumers for whom they care (N = 16)

Characteristic	Freq.	%
Carer provides support to		
Partner or spouse (including married, de facto)	2	12.5
Son or daughter (including step and in-law)	10	62.5
Brother or sister (including step and in-law)	1	6.3
Friend	3	18.8
Duration of care		
Up to 6 months	1	6.3
1 to 2 years	2	12.5
2 to 5 years	4	25
5 to 10 years	3	18.8
Gender of consumer		
Female	11	68.8
Male	5	31.3
Age of consumer		
Under 19 years	5	31.3
20 to 29 years	4	25.0
30 to 39 years	1	6.3
40 to 49 years	4	25.0
50 to 59 years	1	6.3
60 to 69 years	1	6.3
More than 10 years	6	37.5

11.3 Carer representative responses

11.3.1 REGIONAL PLANNING AND SERVICE INTEGRATION

11.3.1.1 Regional planning

11.3.1.1.1 Involvement in regional planning

Carer representatives were asked how they or their organisations were involved in the regional planning process and some were involved in multiple ways. Six participants reported involvement in workshops or forums, and four reported more formal involvement in various governance structures such as the PHN clinical council. Two carer representatives provided input on the regional plan via a role on an advisory panel, committee or group whose role it is to provide this input. Focuses of these groups also included transitioning to the NDIS and the upcoming rollout of the PHN National Psychosocial Support Measure. One participant was currently involved in a commissioning selection panel.

One carer representative indicated that they had not directly been involved in regional planning activities and did not know of their organisation's involvement. Two were aware of past carer representatives who were involved in co-design, with mention of one Lead Site devoting an entire chapter of their regional plan to carers, which was written by carers.

One carer representative described poor attendance by carers at forums, whilst another cited a short timeframe for planning resulting in carers not being engaged early enough. Two carer representatives stated that PHNs tended to approach 'someone they know' rather than go through peak carer bodies. One carer representative described supporting their PHN to set up a system for engaging carers. Two carer representatives from peak bodies described having a register of carers who have been trained, supported and paid for their time to participate in events such as co-design or information gathering forums.

Three participating carer representatives expressed that PHNs are very inclusive of consumers and carers. Conversely, participants from peak bodies described this inclusiveness as happening at a personal level, but not necessarily at a systemic level. Participants attributed the differences in their experiences to the difference in consultation approaches used by PHNs.

11.3.1.1.2 Effect of regional planning on carers

Carer representatives were asked what effects PHN regional service planning has had on consumers and carers. Six participants were not able to answer this question or felt it was too early or too hard to tell what effect PHN regional planning had had on carers. However, one of these carer representatives stated that carers are still not included as a member of the care team. Two carer representatives described positive effects including that consumers and carers have a greater understanding of services available, that services now 'identify barriers and seek solutions for the benefit of consumers and carers', and that there are more effective responses to the needs of consumers and carers. Another representative recognised that there had been investment and steps taken to meet priority needs in their region. Two carers from one Lead Site reported that carers are included in the planning process now which is positive, and that the Lead Site had invested in training and support for carer representatives and consumers who are now expected to provide feedback, and where possible, be involved in planning and monitoring services.

11.3.1.1.3 Improving regional planning

Carer representatives were asked how regional planning might be improved in the future. Comments included broadening the scope of consultations by increasing the diversity of carers involved (age or ethnicity), varying the time of day consultations occur or offering a suite of consultation methods, such as online or via telephone or video conference. Two carer representatives from peak bodies also expressed a need for carer input at the higher level in decision making processes. Another carer representative identified the need for consultation to be more organised and systematic, rather than *ad hoc*, and suggested the PHNs develop and use a consultation framework.

Another carer representative expressed a desire for improved communication to carers. This included promotion of opportunities for carers to contribute with enough notice given and clearer indication of what is required of the carer, with less 'jargon'. Two carer representatives suggested Lead Site staff needed to be more aware of the value of carers in the consumer recovery process. Carer representatives in one focus group were interested in what other PHNs were doing to engage with carers. As a result, they suggested that Lead Sites share what they are doing through carer networks.

Four participants praised the role of the Lead Site they were involved with and described an extensive and thorough consultation process. Yet others called for carers to be involved early, particularly in the planning and design process. One carer suggested PHNs push back on unrealistic timelines from the Department of Health that do not allow for thorough engagement. Another noted an opportunity for the role of the carer to be strengthened at the point of making contractual arrangements with service providers. Similarly, another carer called for PHNs to commit to operationalising the parts of the regional plan pertaining to carer engagement and inclusion. Some carer representatives from peak bodies suggested that PHNs should seek carers for consultation through peak organisations (rather than from within their own networks), viewing these carers as better equipped to provide input.

11.3.1.2 Service integration

11.3.1.2.1 Effects of service integration on consumers and carers

Carer representatives were asked what effects they had noticed on integration of mental health services since the commencement of the PHN-led reforms. One carer representative noted that the confusion arising from the mental health reform has led to some people being left without support. Three carer representatives acknowledged that integration may take time, and that PHNs are in a difficult position resulting from the complexities of the reform. As one carer noted, the process of translating theory into practice had not yet occurred. One participant stated that PHNs were not perceived by carers and consumers as the vehicle for integration improvements, and that most people view PHNs as confusing. One participant spoke of personal experience of poor communication between services and a lack of follow-up from providers.

Two participants spoke very positively about the same Lead Site. One viewed the PHN as working closely with the hospitals towards combined objectives. Both had a sense that the PHN's vision for the future includes the carer perspective, and that the PHN was moving towards this future. One participant expressed that there was future potential for increased integration in their PHN regions with some of the programs currently being commissioned.

One carer reported that integration needs to occur with the broader system sectors such as employment, welfare payment, justice and others that impact on consumers' mental health. This carer also noted that physical health needs were not being met for consumers experiencing mental health difficulties.

Four participants perceived no evidence of increased service integration.

11.3.1.2.2 Improving service integration

Carer representatives were asked how service integration might be improved in the future, and four participants highlighted the barriers of siloed health system structures and competitive funding models. They indicated that a cultural shift is required to achieve better service integration:

> 'When there is a cultural shift, the outcome will be improvements for families and carers and loved ones.'

One participant suggested that PHNs should corral and optimise the voice of consumers and carers to put pressure on the health system to work together on integration and care coordination. One carer representative called for provision of resources dedicated to enacting and leading integration, and another highlighted the need for cross-border integration to be considered.

11.3.2 STEPPED CARE

11.3.2.1 Involvement in the implementation of stepped care

Carer representatives were asked how they were involved in the regional implementation of a stepped care approach. One participant was involved in the evolution of stepped care within their Lead Site, another participated in workshops and a planning day, and one was provided with information on stepped care by their Lead Site. Others were not involved due to timing, either because they became involved with the Lead Site later than stepped care planning occurred or because the consultations or workshops were not at a convenient time. Two participants were involved in commissioning of stepped care services.

11.3.2.2 Effect of stepped care on consumers and carers

Carer representatives were predominantly positive about the concept of stepped care. However, most of these carer representatives stated that the public did not have a good understanding of what stepped care is, and that there was no evidence it worked on the ground. Carer representatives were asked about effects of the introduction of stepped care on consumers and carers. Six carers did not feel there was any effect or could not identify any evidence that services were better matched to need. One carer representative expressed that theory had not translated into practice. Only one participant stated that the public is aware of stepped care in their region due to a video produced by carers and consumers.

11.3.2.3 Improving stepped care

When asked how stepped care might be improved in the future, three carer representatives recommended appropriate communication campaigns to the public. One participant stated that the public needs to see where tax payer money is going. Three participants did not know how it could be improved and one participant recommended consulting with carers at the same time as consumers.

11.3.3 LOW INTENSITY SERVICES

11.3.3.1 Involvement in commissioning of low intensity services

Carer representatives were asked about their involvement in commissioning low intensity services, and five indicated they were not involved. One participant complained that the Lead Site had involved consumers in this process, but not carers. One participant was part of a Lead Site-led review of how low intensity services should be delivered. Two carers sat on a tender and selection panel. One of these carers stated that their role on the panel had had the unintentional positive consequence of raising awareness of other panel members about the mental health risks for carers and family members. The same participant indicated that services commissioned because of this awareness were quality-focused rather than cost-focused.

11.3.3.2 Effect of low intensity services on consumers and carers

Carer representatives were asked about the effects of the introduction of low intensity services on consumers and carers. One participant reported there was no impact, and another reported awareness of a broad positive impact but was unaware of specific impacts. One carer representative expressed that online service options were not considered to be useful by consumers or carers, and that other low intensity service options may be useful but limited in terms of the potential outcomes they could achieve. Four participants were not able to comment on this.

11.3.3.3 Improving low intensity services

Carer representatives were asked how low intensity services might be improved in the future and responses included giving carers themselves wellness tools and making low intensity services peer-led. Three carer representatives talked about the importance of carer, family or support person-inclusive practice, with one of these participants suggesting that PHNs advocate for the need for this type of practice to the services they commission. Another carer representative highlighted the need for low intensity approaches to be supported and reinforced by carers to achieve success.

11.3.4 SERVICES FOR YOUTH WITH, OR AT RISK OF, SEVERE MENTAL ILLNESS

11.3.4.1 Involvement in commissioning youth enhanced services

Carer representatives were asked about their involvement in the commissioning of services for youth with, or at risk of developing, severe mental illness. None of the participants were involved in commissioning these services. One participant felt that the introduction of these services has resulted in more attention in the media on youth mental health services.

One carer representative suggested that youth enhanced services could be improved if young consumers and carers were involved in service design. Another carer representative stipulated that service design should occur with the whole person in mind, and therefore incorporate social and vocational support. Similarly, another carer representative suggested that educational and family support programs for carers would be beneficial, particularly if they were the major support provider.

> ‘As a family member, I do not always feel well equipped to support my brother, particularly in crisis situations and when he is at risk of suicide. My parents are in a similar position. Educational and family support programs would be greatly beneficial, considering we are his major support and spend a lot of time with him between clinical appointments.’

Another carer representative highlighted the need for both promotion of available services and after-hours crisis support. One carer was concerned that the youth-carer cohort was being overlooked, and that they are at particularly heightened risk of severe mental illness.

11.4 Carer survey responses

11.4.1 CARER-REPORTED CHARACTERISTICS OF SERVICES RECEIVED

11.4.1.1 Carer-reported service type

Table 50 shows the carer-reported characteristics of services received by their significant other. Around 38% of carers indicated that this was the first time the consumer had used mental health services. Over two thirds of carers (69%) reported that consumers did not wait longer than reasonable to receive services. The service type received by the consumers linked with survey respondents was most commonly psychological therapy (56%) followed by low intensity psychological interventions (25%).

Most carers reported that the consumer they cared for had attended 1-2 or 3-4 appointments (50%) and that the consumer had not yet completed treatment (75%).

Table 50. Carer-reported characteristics of services received by their family member, partner or friend (N = 16)

Service characteristic	Freq.	%
Waited longer than reasonable		
Yes	5	31.3
No, did not wait long	11	68.8
First time service use		
Yes, first time	6	37.5%
No, within past year	2	12.5
No, >1 year ago	8	50
Service type		
Psychological therapy	9	56.3
Low intensity	4	25
Child and youth	2	12.5
Suicide prevention	1	6.3
Number of appointments		
1 – 2	4	25
3 – 4	4	25
5 – 6	2	12.5
8 – 12	3	18.8
Don't know	3	18.8
Treatment complete		
Yes, complete	2	12.5
No, ongoing	12	75
Don't know	2	12.5

11.4.2 CARER-REPORTED CONSUMER OUTCOMES

Table 51 shows the carer-reported consumer outcomes. Most carers (88%) reported that the consumer they cared for felt a little or much better about the future and could manage life a little better or much better following receipt of PHN-commissioned mental health services. Most carers (94%) reported that the consumers' wellbeing was either a little better or much better after using these services.

Table 51. Carer-reported consumer outcomes (N = 16)

Outcome	Freq.	%
Feelings about the future		
Much better	5	31.3
A little better	9	56.3
Same	1	6.3
A little worse	1	6.3
Much worse	0	0
Ability to manage day to day life		
Much better	5	31.3
A little better	9	56.3
Same	0	0
A little worse	2	12.5
Much worse	0	0
Wellbeing		
Much better	5	31.3
A little better	10	62.5
Same	1	6.3
A little worse	0	0
Much worse	0	0

11.4.3 CARER EXPERIENCE OF MENTAL HEALTH SERVICE CONSUMER RECEIVED

Table 52 shows the carers' experience of the mental health service received by the person for whom they cared. Most carers felt involved in the care 'to a great extent' or 'to some extent' (94%) and felt satisfied with the level of their involvement in the consumer's care (81%). Three quarters of carers (75%) indicated feeling confident to support the person they cared for due to information provided by the service the consumer was accessing. Four carers (25%) indicated they had been linked to other information or services by the PHN-commissioned mental health service when they needed them and four (25%) had not. Half of the carers indicated this question was not applicable. Three quarters of carers felt their own life was a little better or much better as a result of the consumer's contact with the PHN-commissioned mental health service. Over 80% of carers rated the PHN-commissioned mental health service the consumer had accessed as either 'very good' or 'good'.

Table 52. Carer experience of mental health service consumer received (N = 16)

Carer experience	Freq.	%
Level of involvement in care of consumer		
To a great extent	10	62.5
To some extent	5	31.3
Not at all	1	6.3
Not applicable/not needed	0	0
Service gave me confidence to support consumer		
To a great extent	8	50
To some extent	4	25
Not at all	3	18.8
Not applicable	1	6.3
Service linked me to information or other services		
Yes	4	25
No	4	25
Not applicable	8	50
Change in carers' family lives/lives	0	0
Much better	4	25
A little better	8	50
Same	2	12.5
A little worse	2	12.5
Much worse	0	0
Service rating		
Very good	5	13.3
Good	8	50
Neither	1	6.3
Bad	2	12.5
Very bad	0	0

11.4.4 THE SERVICE WOULD HAVE BEEN BETTER IF…

Carers were asked to complete the statement: 'The service would have been better if…'. Thirteen participants responded to this question (see Appendix 14, Table 110). Two carers felt the service was excellent and did not require improvements.

Access was the biggest area that was identified as needing improvement. Difficulties with access related to wait periods being too long (n =2), and one of these carers reported they also needed support or help while they were waiting. Others (n = 2) mentioned the need for wider promotion of the PHN-funded mental health service. Three carers wanted more one-on-one sessions, whilst another wanted more group sessions. One carer wanted smaller group sizes. Two carers mentioned that the location of the program could be improved, with one of these calling for more programs in regional areas.

In terms of the treatment received, one carer indicated the consumer's issue had not been resolved by the end of the program and suggested the service would be improved if the carer had an opportunity to provide input during treatment. One person requested clearer resources, or that they be better explained. Another carer recommended a longer program, rather than an intensive program.

Three carers reported the service could be improved with better integration, citing issues with transitioning between levels of care and wait periods, and coordination between the various clinicians such as GPs, psychologists and psychiatrists.

11.4.5 THE BEST THING ABOUT THE SERVICE

Carers were asked to complete the statement, ‘The best thing about the service was…’. Fourteen participants responded to this question (see Appendix 14, 110). Three described the clinicians themselves as caring, compassionate, empathic, warm, engaging, understanding and professional. Two of these carers and another carer also described the therapeutic environment as ‘safe’ or described a level of trust in the clinician. Two carers indicated that positive results were visible in a short time.

A number of carers described the treatment itself as the best aspect of the service. Three carers each mentioned the therapy or program, and one indicated that the skills acquired by the consumer, were the best aspect. Others deemed access as the best thing about the service, with two carers each mentioning the existence of the service, the absence of cost, or its proximal location to their home.

Three carers indicated factors that directly impacted on themselves. For one carer, being linked into a network of other carers was the best thing about the service. Two other carers expressed the feeling of respite through the person they cared for receiving help.

11.4.6 OTHER COMMENTS

Finally, carers were asked whether they had any final comments to make about the PHN-commissioned mental health service the consumer received. Eleven participants responded to this question (see Appendix 14, Table 111). Many participants used this as an opportunity to reiterate what was said in the previous two open-ended questions, and some took the opportunity to specifically praise the service the consumer had attended. One carer emphasised the importance of the client and therapist relationship.

Three carers wanted more connection between the service and the carers. Three different reasons were given for this. One carer felt carers were well placed to inform the therapist of the consumer’s issues from the start. Another described the potential for the carer to support the consumer during therapy or between sessions, and another carer highlighted the opportunity for the carer to continue the work with the consumer following program completion.

Some carers raised critiques of the program. One carer expressed dissatisfaction with follow-up phone calls. Another expressed that online counselling websites require motivation, which the consumer doesn’t always have. One carer highlighted a systemic issue with integration, stating that there is a gap between the mental health clinician and the GP who writes up the observations regarding fitness to return to work.

11.5 Summary

In total 24 carers or carer representatives participated in Round 2 consultations (November/December 2018). Eight were carer representatives from seven Lead Sites – five of whom participated in one of two focus groups and three of whom provided written responses to the focus group questions. Sixteen carers of consumers who had received PHN-commissioned services, completed an online survey. Together, findings from these data sources inform all four of the evaluation focus areas to varying extents. Summary findings are not compared to interim report findings because the equivalent data were not collected in Round 1 in which national or state carer representatives (as opposed to carer representatives from Lead Site regions) provided general input regarding the reforms.

Carer representatives suggested involving carers in regional planning by developing and using a consultation framework and consulting a broader range of carer types using various methods, allowing adequate lead-in time for genuine consultation. Some promoted the services of carer peak organisations or trained carer representatives for consulting with carers. They were interested in finding out the different methods for engaging carers used by all PHNs. Some carers suggested making carer involvement in treatment part of contractual arrangements when commissioning mental health services. They recognised the need for cross sector integration and suggested PHNs build the capacity of consumers and carers to ask for their care to be better integrated and coordinated. Carers suggested they be engaged by low intensity services to extend the work with the consumer beyond the service session, and that this involvement could be mandated within commissioning contracts. None of the eight carer representatives consulted were involved in commissioning youth enhanced services but suggested more after-hours support was needed for this target group.

Nearly 90% of the carers who completed the online survey reported that after receiving PHN commissioned services, the consumer felt better about the future, could manage life better, and their wellbeing was better. Over 90% of carers were involved in the care and nearly 90% were satisfied with their involvement. Carers felt confident to support the person they cared for due to information provided by the service, although only a quarter reported being linked to other information or services. Three quarters of carers indicated their life was better as a result of the consumers' contact with the service. Over 80% of carers reported the service was good or very good. Carers described the clinicians positively but would like to see access improved in terms of location, long wait periods, knowledge of service existence, and integration with other services.

12. Observational and participatory data

12.1 Summary of approach

This part of the evaluation involved a participatory and observational study of Lead Site-specific meetings and PHN workshops. The precise information gleaned from these events depended on the agendas and how they were run. It was anticipated that Lead Sites would share experiences about strategies and approaches that have worked well and challenges they have encountered. Through this approach, we would not only observe from a 'birds eye view' perspective but also participate as evaluators.

As noted in Section 1, the Department of Health has provided a range of tools, resources and guidance materials to support Lead Sites with achieving their remit in relation to planning, commissioning, implementing and integrating stepped care primary mental health services within their local regions. One aspect of this support has been to provide opportunities for knowledge transfer across the PHN network through a variety of forums, including stepped care workshops. In addition, the Department of Health has facilitated face-to-face meetings for Lead Sites to address other aspects of the reforms.

Between June 2018 and March 2019, members of our evaluation team attended three workshops with all PHNs; two Lead Site meetings, one face-to-face and one online video-based; and one face-to-face meeting with the three Lead Sites with a youth enhanced focus (see Table 53). During these meetings, the evaluation team noted key points in relation to the specific focus areas and evaluation questions. Associated documentation such as agendas, minutes, papers and presentation slides were also drawn upon for analysis. Themes were extracted in relation to the focus areas of the Lead Site Project.

Table 53. Forums attended in the context of gathering observational and participatory data

Date	Lead Site meetings
8 June 2018	PHN Mental Health Lead Site face-to-face meeting
15 March 2019	PHN Mental Health Lead Site online conference via Zoom
	PHN workshops
6 and 7 June 2018	The 3rd National Stepped Care Workshop
6 and 7 March 2019	The 4th National Stepped Care Workshop
	Youth enhanced forums
3 September 2018	Orygen youth enhanced Lead Site Meeting
19 and 20 March 2019	Orygen youth enhanced symposium 'Rising to the Challenge'

12.2 Regional planning and service integration

Several of the above forums provided insights into the difficulties around regional planning and service integration. It seemed that since the Lead Sites were further into the activities around regional planning and service integration at this stage, more challenges and difficulties could be identified. Despite this, Lead Sites seemed more adjusted to their responsibilities and approaches to develop a joint regional plan. However, it was generally acknowledged that some PHNs were still struggling with the regional planning framework and engaging with LHNs was challenging for some. This was partly due to the different funding arrangements and priorities. PHNs wanted more support from the Department to address this challenge. Furthermore, there was a shared commitment from both the Lead Sites and the Department to further improve information sharing across PHNs. A Strategic Regional Planning Network was developed to facilitate peer-support for the PHNs, to share approaches and learnings and troubleshoot barriers.

Several issues that had impact on regional planning and service integration were discussed. It was noted by the Lead Sites that there was a lack of GP voices in the guidance documents. Several Lead Sites raised questions around the privacy and consent of consumers relating to aggregated data. Some Lead Sites indicated that the consent guidance documents need to be clearer on this issue, to ensure consumers are more aware of how their data may be used by the PHNs and the Department. Furthermore, concerns were expressed around the transitioning of consumers not eligible for the NDIS and the lack of clarity about their continuity of care. At the fourth Stepped Care workshop (March 2019), the Department of Health indicated they would provide support and guidance on this in the near future. It was also noted that the current reporting templates for the PHNs and the PMHC MDS are not aligned with the work the Lead Sites are doing and do not support service integration.

A number of other challenges around service integration and planning emerged. PHNs reported additional reporting requirements when they pooled funds from different streams (e.g., suicide prevention, services for Indigenous people, drug and alcohol services). They found the short-term funding and contracts being offered a major challenge for the implementation of new PHN services. PHNs saw the intersection with the Drug and Alcohol strategy problematic and it was questioned whether the AOD sector needs to be more involved in order to bring true service integration and break down silos. It was noted that the separate funding created a siloed system, making integration difficult. One of the Lead Sites mentioned collaboration with the AOD sector from the beginning, bringing providers together and linking them to develop partnerships. Two Lead Sites mentioned they facilitated connections by hosting events to bring service providers together. Lead Sites also expressed concerns about the planned downscaling of their Lead Site activity and capacity after December 2018, given the amount of activity and number of staff that are still required.

Several projects and tools were developed by the Department to further assist the PHNs with service integration and related issues. To assist PHNs (as well as LHNs and state health departments) with their regional mental health planning, the University of Queensland developed a tool for more detailed service mapping and planning: The National Mental Health Service Planning Framework (NMHSPF). Several challenges were noted around the use of this tool including training and development of competence needs, commitment and resourcing, the ongoing need for training to use the tool and the varied skills and knowledge of trained staff. In general, most PHNs seemed to have some reservation around the use and benefits of using the NMHSPF. One of the Lead Sites had used this tool on a state-level and had developed a manual in collaboration with the University of Queensland. Furthermore, the National Initial Assessment and Referral in Mental Healthcare Project will assist the PHNs in establishing a nationally consistent, systematic approach to the initial assessment and referrals of consumers who present in their region. The PHNs seemed to be positive about the potential this offers, but it was clear that the PHNs need to familiarise themselves with the tool for successful implementation.

12.3 Stepped care

Two National Stepped Care workshops were held to continue the sharing of information and learnings across PHNs and service providers in relation to the implementation of a stepped care approach. During the Lead Site meeting in June 2018 reflections were shared on the third Stepped Care workshop. Both the government and Lead Sites were overall positive, with the Lead Sites noting they found the workshop the best platform to share experiences and learnings. Lead Sites agreed that it was appropriate for the workshop to remain a closed group and were in favour of finding another forum to include national peak bodies and/or state and territory representatives (e.g. LHD/LHNs). The showcasing of leading work (i.e., Lead Site posters) was found useful for recording information at a point in time, and highlighting strengths and challenges of different approaches. It was discussed that this could include non-Lead Sites in the future. The one-page document on the stepped care models (described in Section 4) was also found useful and it was considered potentially useful to include all PHNs. Again, during the Lead Site meeting in March 2019, the Lead Sites and the Department were positive about the Stepped Care workshop, with some improvements for the future openly discussed with each other to better facilitate information sharing between PHNs.

During the third National Stepped Care workshop the consistency and local variability of the stepped care approach was discussed. It was noted there is no 'off the shelf' stepped care model and PHNs should contribute to the evidence base rather than relying on it. The Department kept a strong focus on the needs of PHNs and how to support them. Several changes to the previous guidance material for PHNs (from 2017) were discussed to better support PHNs. Furthermore, the Department undertook to consider additional resources to assist PHNs with their implementation of a stepped care approach. During the fourth Stepped Care workshop the PHNs appeared well-adjusted and more confident with their role within the mental health reforms. During the panel discussion with some of the Lead Sites it was noted they felt more of a partnership with the Department than ever before:

> '[Lead Sites] felt much more of a partnership with DoH. The Commonwealth is listening to our feedback and learnings and vice versa.'

It was also raised that very few PHNs that were surveyed during the National Assessment and Referral project used a standard assessment tool, and the predominant tool used to provide assistance was HealthPathways. For most PHNs, the referrers were very influential when determining the appropriate service type and intensity within the stepped care model. It was also reported that the stepping up or down of consumers was not occurring as often as it should, and PHNs are not confident in monitoring this.

During the fourth National Stepped Care workshop various reflections were shared between Lead Sites and non-Lead Sites. There was a general sense that the additional funds available to Lead Sites has been very useful and Lead Sites have learned a lot from each other. It was felt valuable learnings and projects have come out of the shared learnings between all PHNs at the Stepped Care workshops (i.e., the National Initial Assessment and Referral in Mental Healthcare Project). Conversely, some non-Lead Sites expressed that they had limited knowledge of the work that Lead Sites are doing. The Department noted they had released the new guidance documents for PHNs, which were developed with the advice and input from the PHN advisory board.

A strong theme throughout the two Stepped Care workshops was the engagement of people with lived experience and their carers, and consumer-centred co-design. Lead Sites were positive about the lived experience representation at the third Stepped Care workshop, however felt improvements could be made. It was noted that only six PHNs had taken the opportunity to organise representatives while there were 15 Government-funded places available. Additionally, more opportunities for youth representatives were needed. People with lived experience were well-represented at the fourth National Stepped Care workshop. The Mental Health Lived Experience Engagement Network (MHLEEN) noted that overall PHNs did well in engaging people with lived experience in their processes, but there was still room for improvement. It was emphasised that there are many resources available for PHNs and that people with lived experience should be involved in the design, tendering and implementation processes. Furthermore, the Mental Health Commission stated they will soon release a practical guide to assist with lived experience engagement.

It is was observed at various PHNs events that there is a growing market for services or tools that facilitate a stepped care approach but the evidence-base for these services or products is ambiguous.

12.4 Low intensity services

Low intensity services were not a main topic of any of the Lead Site meetings or workshops, however some low intensity topics were discussed. During the Lead Site meeting in June 2018 it was noted that most PHNs had struggled with the uptake for low intensity services and that it was a challenge to get sufficient referrals for these services.

During the third Stepped Care workshop, the credentialing project for low intensity services was presented to PHNs. The project works towards accreditation of low intensity services and the accreditation will be a guidance, not a mandate. The key features of low intensity services were articulated as involving prevention and early intervention, support and self-management, fewer resources, cost-efficiency and limited time. It was noted that among the PHNs there were a wide variety of low intensity workers, including non-clinical and peer workers. Questions arose around where clinical responsibilities lie and what clinical governance structures should look like for low intensity services.

During the fourth Stepped Care workshop it was mentioned that the definition, nature and intensity of low intensity services have become clearer over time. At this stage, the Department fully expected low intensity services to be included in joint regional planning and the stepped care approach of the PHNs.

12.5 Services for youth with, or at risk of severe mental illness

Orygen organised a youth enhanced Lead Site meeting in September 2018. During this meeting, learnings from, and updates on, the youth enhanced projects of the three Lead Sites with a youth enhanced focus were shared. As mentioned in Section 4, we accessed a model description that Orygen has collated for this meeting, which described the youth enhanced service models used by the three Lead Sites.

Some of the barriers for implementing these models included the presentation of more complex young people than expected and the work intensity impact on clinicians. Measuring the effects was also problematic since stress levels of young people initially increased during treatment. Lead Sites reported a shortage of psychiatrists, as well as the (lack of) cultural appropriateness of services, and data-sharing issues. Some of the facilitators that were mentioned included outreach capacity, a multi-disciplinary team including a family therapist and peer worker, collaboration with schools, defined specific eligibility criteria, service model flexibility and no session limitations. Upskilling the workforce was also noted as a facilitating factor.

The youth enhanced symposium ‘Rising to the challenge’ held in March 2019 was also organised by Orygen. This event was attended by all but one of the PHNs and many service providers involved in child and youth services. Major overall themes included improving service integration and stepped care for young people, and engagement and co-design with young people with lived experience. Other themes included more complex young people presenting at primary care services (‘missing middle’), as well as workforce issues and the use of technology and ehealth to better support young people.

> ‘We are in the age of digital disruption – it’s gonna happen either way.’ (key-note speaker)

There was some discussion around a state versus a national approach to youth enhanced services. One of the key-note speakers noted that the local approaches by PHNs provides opportunity to reduce competition between services and improve service integration. It was also noted that PHNs have an opportunity to connect and partner with young people to co-design local services.

12.6 Summary and comparison to interim report

Overall, there were fewer Lead Site events in Round 2 (June 2018 to March 2019) compared with Round 1 (February 2017 to March 2018). This is largely attributable to Lead Sites having adapted to their roles and having less need for meetings. It is also partly attributable to a shorter reporting period than that of Round 1, which covered.

Lead Sites were further into regional planning and service integration activities in Round 2 compared to Round 1. A theme which has remained consistent over time is short-term funding and contracts causing challenges for service planning, implementation and integration. The Stepped Care workshops have evolved over time and are recognised as valuable opportunities to share learnings across PHNs, with more comprehensive topics and an increasing engagement of people with lived experience. The nature of low intensity services appears to have become clearer with time. In relation to youth enhanced services, some issues have persisted, such as lack of appropriate workforce (including psychiatry) and issues around data. On the other hand, Lead Sites have commissioned an increasing number of youth enhanced services and are working on local evaluations to monitor and evaluate these services. It is clear that Lead Sites and the Department are identifying challenges along the way and are committed to working together to address these.

13. General input on child and youth mental health services

General input on child and youth services was sought from stakeholders involved with the PHN network more broadly, i.e. headspace National and Orygen: The National Centre of Excellence in Youth Mental Health.

13.1 Summary of our approach

headspace National and Orygen provided written responses to the same set of questions we asked of regional and other key stakeholders regarding the Lead Site Project's four focus areas (Appendix 4). One representative from headspace and Orygen provided a written response on behalf of their respective organisation. The written responses were used as data for qualitative analysis.

13.2 Involvement with PHNs

All 31 PHNs have commissioned headspace services (centres) as part as their mandate in child and youth services more broadly, with some PHNs additionally commissioning headspace centres for specific principal focuses such as low intensity or youth enhanced services. As a broader, national stakeholder, headspace National has been involved as the National Mental Health Foundation providing a range of support services to the headspace network and is contracted to provide advice and support to PHNs when requested. Additionally, headspace National has been involved as a lead agency (i.e., a services provider) for some of the headspace services commissioned by PHNs.

As a key national stakeholder, Orygen has been involved to a greater or lesser extent with all 31 PHNs around their planning and commissioning of services aimed at youth with, or at risk of, severe mental illness. They have been more intensely involved with the three Lead Sites specifically focusing on youth enhanced services. Orygen's work has involved activities such as supporting and facilitating community engagement and co-design workshops, providing input and expert advice on tender documents and evaluation, organising regular networking events, synthesising and disseminating evidence and providing support around service development, implementation and the evaluation of programs.

13.3 Input on child and youth services

headspace National provided input on child and youth mental health services more broadly. It was noted that PHNs variably sought advice and support from headspace National, with some PHNs seeking, and others not seeking, guidance from headspace National. Those who sought guidance did so regarding their regional planning processes, and the development and implementation of their stepped care approach or youth enhanced services.

headspace National identified mostly similar challenges regarding child and youth services as those identified by other stakeholders involved in our consultations. Specifically, the challenges identified were short duration of funding contracts impacting on continuity of care; the recruitment and retention of staff which, in turn, impacts on local service development; the balance of the PHN commissioner/contract manager role and the continuing high demand for headspace services. They also mentioned concerns about added complexity and privacy issues associated with referral and central intake systems and centralised medical records, which they suggested could be improved by developing and implementing systems and tools to facilitate integration.

headspace National provided some general suggestions for improvement of all four Lead Site Project focus areas (i.e., regional planning and integration, stepped care, youth enhanced services, and low intensity services). Suggestions made included: the sharing of evidence, knowledge and learnings across all 31 PHNs; a coordinated and consistent approach across all 31 PHNs; more consultation or involvement of headspace National in service planning, development and integration; more and improved consultation with local service providers, consumers and carers taking a co-design approach; and open and transparent planning and decision-making.

headspace National also provided some suggestions specifically for improving youth enhanced services including providing more wrap-around models of care and more outreach-based services, increased access to psychiatry and clearer parameters for service eligibility criteria.

13.4 Input on youth enhanced services

Orygen provided input specific to youth enhanced services because of their supporting role in regional planning and commissioning of youth enhanced services to varying extents with all 31 PHNs.

Firstly, they noted that service planning seemed to be more effective in addressing service gaps when based on a thorough needs assessment, with current PHN needs assessments varying in quality. Suggestions to improve regional planning in the future comprised: access to good localised data, engagement of stakeholders including consumers in service planning processes, and service specifications informed by learnings from successful service models.

Secondly, Orygen noted that PHNs and service providers experience ongoing challenges around service integration. They stated that integration was difficult to achieve between state and Commonwealth-funded programs, and for services with a lack of clarity around eligibility criteria or appropriateness of programs for specific consumers. They noted that integration has been most successful when formal relationships or agreements between agencies are in place, and when processes are established to facilitate smooth transitions for service providers between programs, services or agencies. Correspondingly, Orygen suggested that improving service integration requires formal relationships and processes across the service system facilitated by PHNs, regional network events facilitated by PHNs, formal agreements and contracts in tender documents, and common electronic records.

Orygen commented that well-designed and quality youth enhanced services have been implemented across PHNs. However, they noted that many programs are at early stages and have not yet been formally evaluated. Orygen reported that in terms of evaluation, PHNs are enthusiastic and several have developed their own evaluation frameworks or have engaged external consultants to undertake formal evaluations. They also stated that clinical care for young people has been complemented by other programs in varying degrees. Integration of clinical and non-clinical programs was observed to be enhanced when services were delivered from a headspace platform or one-stop-shop. Orygen suggested that in the absence of such co-located services, formal relationships and specified referral pathways between clinical services and other youth support programs appear to improve access to complementary services for young people.

Suggestions for improving youth enhanced services included: more support and resources for local evaluation, greater emphasis and guidance on core competencies of the youth mental health workforce, alternative workforce options in areas where recruitment of clinical staff is challenging; and sustainable strategies to improve access to psychiatry, especially in rural and remote areas, including improving access to telehealth and strengthening collaboration with state-funded clinical services.

13.5 Summary and comparison to interim report

In Round 2 headspace National provided more comprehensive input, which was at least partly due to having been given with more time to provide us their response. They made similar suggestions to other stakeholders for improving the four focus areas of the Lead Sites and improving access to mental health services for young people. headspace National's willingness to be involved in PHN-led consultation and planning, particularly for young people aged 12-25 years, has remained consistent over time.

In Round 2, Orygen noted that PHNs have progressed in their planning and implementation of youth enhanced services and they are undertaking local evaluation activities. Some of Orygen's observations were similar across the two data collection rounds such as needs assessments facilitating more effective planning and the need for good localised data to this end, guidance on core competencies of the youth mental health workforce and shared electronic data.

14. Discussion

The Discussion starts with a summary of findings organised by focus areas and primary evaluation questions. It then describes the limitations and strengths of our evaluation and finishes with our recommendations and conclusions.

14.1 Summary of findings by focus areas and primary evaluation questions

14.1.1 REGIONAL PLANNINING AND SERVICE INTEGRATION

14.1.1.1 What approaches were undertaken by Lead Sites to the planning, commissioning, management and delivery of services in the focus area of regional planning and service integration?

We observed, at their meetings and forums, that the Lead Sites had adjusted to their responsibilities of developing their regional plans. They had made more progress with their regional plans in Round 2 than in Round 1. In the focus groups, nine Lead Sites indicated they were at various stages of preparation for drafting their regional plan and one Lead Site had already completed their regional plan and released it as a public document. Importantly, Lead Sites reported using various approaches to building relationships with their LHNs/LHDs, with three noting that they had leveraged their pre-existing strong relationships with LHNs/LHDs to work towards developing their regional plans.

Lead Sites reported that stakeholder consultations and service mapping were the most common means of identifying local service needs in both Rounds 1 and 2. However, by Round 2, Lead Sites were more likely to be using information gathered from Round 1 consultations and mapping to begin their regional planning process. To engage stakeholders, the most common approach was to use established groups and committees to work on the plan. In addition to LHNs/LHDs, these stakeholders included representatives from other PHNs, state government health services, consumers and carers (including peak body representatives), Aboriginal and Torres Strait Islander peak bodies, GPs, the alcohol and other drug sector, the homelessness sector and the NDIS.

Regional and other key stakeholders confirmed that they had mostly been engaged via consultations in the form of meetings, workshops and forums, which they deemed successful in general – but some viewed their involvement as minimal or opportunistic. headspace National reported that PHNs variably sought advice and support from them regarding regional planning and integration of child and youth services.

Lead Sites reported the most common approach to engaging consumers and carers in regional planning was including relevant peak body representatives in regional planning activities and involving consumers and carers in consultations. One Lead Site had devoted an entire chapter of their regional plan to carers, which was written by carers. Carer representatives confirmed their involvement in regional planning through consultations such as workshops or forums, but reported that the consultations were at times poorly attended due to insufficient notice. Some carer representatives described being involved more formally in governance structures. Carer representatives from peak bodies perceived inclusiveness was occurring on an individual level but is yet to occur at a systemic level.

14.1.1.2 What activities and approaches were found by the Lead Sites to be effective in achieving objectives in the focus area of regional planning and service integration?

Although we asked Lead Sites separate questions about the most effective strategies and facilitators for each of the four focus areas, their responses to both questions were similar and were therefore combined for analysis.

Lead Sites most commonly reported that building good relationships with regional stakeholders, especially LHDs, was the most effective strategy or facilitator of regional planning. Other strategies were mentioned by a single Lead Site each and included co-developing the regional plan with stakeholders to foster more buy-in for implementation, undertaking partnership brokerage training, sharing the responsibility for plan implementation with the state government, basing the plan on existing (rather than new) services and on strong needs analysis and service mapping, and having a fully developed stepped care model before undertaking regional planning

Centralised intake was the most commonly reported means of promoting service integration. In addition, some Lead Sites mentioned they facilitated service integration by hosting events to bring together service providers. Some Lead Sites stated that the stepped care model was a key driver of service integration, and some stated that communication with GPs as referrers was essential to achieving integration. Some Lead Sites reported they were currently reviewing existing commissioned services for evidence of integration.

Stakeholders provided anecdotal evidence for the effectiveness of these strategies for regional planning and service integration. Specifically, they described a number of positive impacts and experiences related to regional planning and service integration activities. For example, Lead Sites reported that their regional planning and service integration activities had improved their relationships with their LHN, had created a genuine joint commitment to achieving regional change, and had created opportunities for other collaborations. Regional stakeholders also mentioned several positive impacts for consumers and carers, which were mostly about better engagement/consultation and improved service access. Carer representatives largely viewed Lead Sites' planning and integration intentions positively, reporting improvements in carers' understanding of services available and more effective responses to the needs of consumers and carers. However, they also noted it was premature to observe the effects of planning and integration and that theory was yet to translate into practice.

14.1.1.3 What were the barriers and facilitators to achieving objectives in the focus area of regional planning and service integration?

Barriers

Most Lead Sites experienced some difficulties in developing their regional plan. These included appropriate stakeholder recruitment to, and attendance in, planning groups; reluctance of LHNs to engage due to misaligned boundaries; the changing requirements for the regional plan; and delayed release of the National Mental Health Planning Framework and its limited utility (due to dated data and misalignment with PHN requirements). Lead Sites reported a variety of barriers to service integration, with little consensus. The introduction of the NDIS, and its effects on the primary care mental health workforce, and continued 'siloed' funding streams for mental health services, were seen as the primary barriers to service integration.

Regional and other key stakeholder perceptions of challenges and barriers regarding regional planning included communication issues, such as perceived lack of clarity of the vision of the Lead Sites; a lack of understanding of the position or the role of PHNs in the mental health system; consultations not being fully inclusive of all stakeholders; former learnings not being incorporated into new service models; and a lack of leadership from the Lead Sites during transition. Stakeholders' perceived barriers to commissioning and service implementation processes included uncertainty about the sustainability of PHNs, the fragmentation of small grants and the competitive environment discouraging collaboration. Some also noted the tight timeframes for consultations, tender processes and planning to implementation processes.

Service integration barriers and challenges noted by regional stakeholders were uncertainty about what true integration looks like, the competitive funding climate within the mental health system, the challenge of building relationships with the public mental health sector, and, related to that, the unrecognised time it takes to build relationships and upskill staff. Stakeholders also noted difficulties with service navigation and siloed funding, and differences between federal- and state-funded programs.

headspace National described challenges for the planning and integration of child and youth services, including the short duration of funding contracts impacting on continuity of care; the recruitment and retention of staff, which in turn impacts on local service development; balancing the PHN commissioner/contract manager role with continuing high demand for headspace services; and added complexity and privacy issues associated with referral and central intake systems and centralised medical records.

Other challenges to regional planning and service integration that we observed at Lead Site/PHN gatherings included additional reporting requirements when pooling funds from different streams (e.g., suicide prevention, services for Indigenous people, drug and alcohol services) and the lack of intersection between the Fifth Plan and the Drug Strategy. Some PHNs noted the AOD sector needs to be more involved in order to bring true service integration and break down siloes. Lead Sites also expressed concerns about the planned downscaling of their Lead Site activity and capacity after December 2018, given the amount of activities and staff that are still required.

Facilitators

Facilitators of regional planning and service integration have been described together with effective strategies or approaches in Section 13.1.1.2.

We also observed at forums and workshops that the Department of Health took a collaborative and responsive approach to working with Lead Sites and other PHNs, and that Lead Sites and the Department shared a commitment to further improving information sharing across PHNs. For example, PHNs wanted more support from the Department of Health to address the challenge of engaging LHNs in regional planning. In response, a Strategic Regional Planning Network was developed to facilitate peer-support for the PHNs, to share approaches and learnings and troubleshoot barriers. In addition, the National Initial Assessment and Referral in Mental Healthcare Project commissioned by the Department of Health is intended to assist PHNs in establishing a more effective system for the initial assessment and referral of consumers. The PHNs seemed to be positive about the potential this offers, but they need to familiarise themselves with the tool for successful implementation.

14.1.1.4 What are the implications for future regional planning and service integration activities by PHNs and primary health care reform more generally?

Most Lead Sites were in various preparatory stages of developing their regional plans. Some Lead Sites noted the need for additional funding to better carry out regional planning, and two Lead Sites wanted timely and explicit guidance on developing the plan. Almost half of Lead Sites stated that joint regional planning with the LHN provided an opportunity for greater collaboration and for creating regional change. Good relationships with LHNs and other regional stakeholders are seen as paramount to successfully conducting regional planning.

Some Lead Sites recommended that changes to funding models were necessary to improve service integration, and some stated that the Department of Health needed to make integration fundamental to the national health reform agenda.

Regional and other key stakeholders recommended that PHNs have better representation of consumers and private service providers. One suggested method for achieving this is to take a more structured and multi-modal approach to involving consumers and carers in regional planning activities, with more focus on low intensity services for consumers. Regional stakeholders also suggested more input and alignment with other Commonwealth Departments (e.g., Department of Social Services, Department of Education and Training, Department of Human Services) and early engagement of local mental health clinical services. Some stakeholders wanted commissioned service providers to be part of regional planning. Planning was seen as needing to be a continual process, with new stakeholders constantly included and population mental health needs constantly revisited. Regional stakeholders wanted more time for services to mature and demonstrate improvement, with more flexible expectations and targets. Some stakeholders indicated a need to improve evaluation and quality processes. Regional and other key stakeholders also wanted PHNs to work towards strengthening relationships and communication with, and between, service providers and for PHNs to clearly communicate the role of the PHN in the region.

Carer representatives echoed the views of regional and other key stakeholders regarding approaches to improving regional planning (e.g., broadening the methods and quantity of consultations to involve more diverse carers earlier in design and planning processes) and service integration (e.g., involving other sectors – such as employment, welfare payments, justice, the physical health system – and cross-border partnerships). Some carer representatives recommended PHNs develop an organised and systematic consultation framework with less jargon and better recognise the value of carers in the consumer recovery process (e.g., include carer involvement in treatment as contractual obligation of commissioned providers). Some suggested that PHNs should advocate for more realistic timeframes that allow for adequate consultation with, and engagement of, carers and consumers. Carer representatives involved with peak bodies noted that they have a register of carers who have participated in appropriate training to equip them to sit on committees or participate in planning.

headspace National provided some general suggestions for improvement of all four Lead Site Project focus areas (i.e., regional planning and integration, stepped care, youth enhanced services, and low intensity services). Suggestions made included: the sharing of evidence, knowledge and learnings across all 31 PHNs; a coordinated and consistent approach across all 31 PHNs; more consultation with, or involvement of, headspace National in service planning, development and integration; more and improved consultation with local service providers, consumers and carers taking a co-design approach; and open and transparent planning and decision-making

14.1.2 STEPPED CARE

14.1.2.1 What approaches were undertaken by Lead Sites to the planning, commissioning, management and delivery of services in the focus area of stepped care?

Lead Sites were at different stages of implementing their stepped care model, with six having fully implemented their model and others developing or refining the steps of their model.

The most common strategy to match consumer need to stepped care services was to use intake and assessment procedures. Nine Lead Sites were operating a central intake system for receiving referrals either alone or in combination with commissioned providers receiving direct referrals. The type and extent of assessment or screening undertaken as part of centralised intake in Lead Sites varied from those equipping referrers with digital systems to assess consumer needs and generate appropriate commissioned service options to those with clinical intake teams who conduct telephone-based screening including assessment and eliciting consumer preferences. The centralised intake process included referral to non-PHN commissioned services in four Lead Sites, with a fifth Lead Site planning on incorporating this feature in the future. In the case of the sole Lead Site that was not using a centralised intake system, commissioned providers performed the intake function utilising agreed clinical assessment and triage tools to determine appropriate service delivery. All but one Lead Site procured individual providers (organisations or sole practitioners) across single steps of their stepped care model and another Lead Site procured services across all steps for one of their target groups – Aboriginal and Torres Strait Islander people.

The second most common strategy used to match services to consumer need involved Lead Sites using education and promotion strategies to ensure referral of consumers to the most appropriate services. Lead Sites varied in how they engaged with GPs and other stakeholders to promote stepped care, but strategies included communication plans and strategies, events and education sessions, practice visits, written communication to GPs regarding their patients, and development of HealthPathways.

Data from the 223 mental health practitioner surveys suggest that Lead Sites used mixed approaches to commission stepped care services – 44% of survey respondents were employed by organisations that were commissioned by Lead Sites, 30% were directly commissioned sole practitioners, and 21% were contracted by a commissioned organisation.

Stakeholder groups beyond the Lead Site staff reported limited, if any, involvement in the development of the stepped care approach in their regions.

14.1.2.2 What activities and approaches were found by the Lead Sites to be effective in achieving objectives in the focus area of stepped care?

Seven Lead Sites told us about their most effective strategies for implementing stepped care, but there were no common themes among the strategies. The strategies included use of centralised intake; ongoing provision of support, resources and education for referrers and providers; knowledge transfer about stepped care to regional and other key stakeholders; willingness to adjust the stepped care model as indicated based on feedback; building stepped care requirements into provider contracts; providing psychiatric consultation services; having mental health nurses facilitate stepping up or down; retaining a broad range of services for the catchment; and removing the requirement for a GP Mental Health Treatment Plan.

Indicators of the effectiveness of using these strategies to implement stepped care include uptake of services and consumer outcomes. The impacts and experiences reported by stakeholders are also indicators of effectiveness. These indicators are summarised below.

Our analysis of routinely collected data provided several insights about the implementation of stepped care through Lead Site-commissioned providers in Round 2. The delivery of services across the steps has improved in Round 2 compared with Round 1, with an increase in the proportion of service contacts attended for the lower and higher intensity service type principal focuses of treatment (from 3% to 8% for low intensity psychological interventions and from 2% to 11% for clinical care coordination). The average number of attended service contacts varied appropriately by principal focus of treatment (i.e., from five for low intensity psychological interventions and six for psychological therapy to 13 for clinical care coordination. Consistent with the principles of stepped care, the types of referrers varied ranging from GPs (53%) to self-referral (31%) as did types of mental health practitioners delivering services (e.g., 20% general psychologists, 11% clinical psychologists, 9% low intensity mental health workers, 10% other types of practitioners).

Of the Lead Site episodes in which consumer outcomes were assessed via the K10 (N = 30,938), 38% of episodes were classified as significantly improved (meaning there was a reduction of five points or more in psychological distress from episode start to end). K10 outcome data should be interpreted in the context that only 25% of all Lead Site episodes had episode start and end K10 scores recorded in the PMHC MDS and, of these, 93% were for headspace consumers. the proportion of Lead Site episodes we found to be classified as significantly improved (38%) on the K10 is consistent with those previously published by headspace (36%).[16] However, we also found that the percentage of episodes classified as improved was higher for those who were relatively older (≥ 21 years) (44%); had worse K10 scores at episode start (49%); had a principal focus of psychological therapy (62%), low intensity psychological intervention (64%) or clinical care coordination (58%); and had a greater number of attended service contacts (43% for 6-9, and 45% for >10, service contacts). Of the Lead Site episodes in which consumer outcomes were assessed using the SDQ-PC (N = 63), 48% of episodes were classified as significantly improved.

A few regional and other key stakeholders mentioned broader positive system effects. These included increased collaboration, cross-partner proposals, promotion of co-location, improved consumer-focus, increased referral pathways, establishment of local mental health networks, reduced service duplication and fewer service gaps.

Referrers, mental health practitioners, consumers and carers with whom we consulted mostly expressed favourable views of services. They also felt they had a positive impact on consumers (in terms of access to low cost or free services and improved mental health and wellbeing) and themselves. For example:

- One third of surveyed referrers indicated that the stepped care approach had assisted them in referring consumers to services matched to their needs;

- Mental health practitioners appreciated the support they received from Lead Sites, their involvement in decision making and being able to provide services to more, and a variety of, consumers associated with the stepped care model; and

- Carers were satisfied with their level of involvement in services and indicated that their own lives were better as a result of services their family member partner or friend had received.

Carer representatives were largely positive about stepped care but perceived that the public did not understand the concept. Consistent with their views on regional planning and service integration, carer representatives indicated that stepped care theory had not yet translated into practice.

14.1.2.3 What were the barriers and facilitators to achieving objectives in the focus area of stepped care?

Barriers

Having largely implemented their stepped care models in Round 2, the most common barrier experienced by Lead Sites was that consumers were not being appropriately stepped up or down. Reasons given for this included a lack of clinician knowledge regarding when to step someone up or down, clinicians wanting to provide continuity of care, the financial disadvantage for clinicians of referring consumers to other providers, and consumers not wanting to change service. Regional stakeholders confirmed that they experienced stepping consumers up or down as challenging, attributing this to: difficulties tracking consumers, waitlists of services, stepping up and down continuing to be person-dependent, young people with complex needs not wanting to change services, and absence of steps above high intensity services.

Three Lead Sites noted that referrers and providers have continued to resist the stepped care model. This resistance may be, at least in part, attributable to concerns noted by a minority of referrer survey respondents regarding the variety of services available and the appropriateness of practitioner qualifications. In response to this resistance to change, Lead Sites had undertaken significant change management work such as supporting and resourcing referrers and providers to change, and building and maintaining relationships.

Three Lead Sites perceived misalignment between consumers' needs as assessed by GPs and consumers' actual needs, and this was a significant barrier to implementing stepped care. From the referrer perspective, around one fifth of referrer survey respondents rated the referral process as 'not at all easy' due to excessive processes, paperwork or 'red tape'.

Consistent with responses from the referrer survey, mental health practitioners identified an increased administrative burden was being placed upon them, with some stating that the they were financially disadvantaged by the referral process. Several practitioners expressed concerns that funding had already been exhausted and/or was not secure in the long term.

Regional stakeholders noted that data collection is not aligned with the stepped care approach (i.e., PMHC MDS does not accommodate consumers who are receiving services in multiple streams at one time) and the requirement to assess outcomes at each session may be a burden on both providers and consumers.

Facilitators

The most commonly identified facilitator to the implementation of stepped care, noted by five Lead Sites, was good relationships with stakeholders. This was consistent with responses regarding facilitators to regional planning. Other facilitators to the implementation of stepped care mentioned by Lead Sites are described in Section 13.1.2.2. We have not reported on the facilitators identified by Lead Sites again here because their responses regarding effective strategies and facilitators were largely the same.

Over 40% of surveyed referrers found the referral process to be 'easy' or 'very easy', with the majority mentioning the paperwork was simple to complete and that the process was efficient. Three respondents indicated a mental health nurse helped with the process. By Round 2, referrer survey respondents' awareness of stepped care had improved, which may be attributable to the range of supports with which Lead Sites had provided them (e.g., written resources, attendance at stepped care consultations, options for stepping consumers down or up, professional development/training or workshops, individual feedback on their referrals).

Similarly, surveyed mental health practitioners indicated that Lead Sites had offered them a range of supports. Half of the surveyed mental health practitioners had undertaken professional development, training or workshops with support from their PHN. Close to half reported receiving assistance from their Lead Site with entering minimum dataset information, and one third reported receiving written resources from their Lead Site. Over one quarter sought support from their Lead Site when understanding options for stepping consumers up or down, and 23% received assistance with developing referral pathways.

One carer representative reported that consumers in their region knew about stepped care because of a video about it produced by carers and consumers.

Finally, our own observations were that support and resources from, and the responsiveness of, the Department of Health helped to facilitate the implementation of stepped care by Lead Sites. Support and resources from the Department of Health were in the form of bi-annual stepped care workshops, Lead Site meetings and guidance documents. For example, we observed that Lead Sites, other PHNs, people with lived experience (who were increasingly well represented at the workshops) and the Department of Health were largely positive about the stepped care workshops, with the Lead Sites noting they found the workshop the best platform to share experiences and learnings. At their meetings, Lead Sites reported that the stepped care workshops offered them the opportunity to showcase their leading work (i.e., Lead Site posters) at that point in time, and highlight strengths and challenges of different approaches. They were grateful for the opportunity to have exchanged knowledge and for the additional funds that facilitated innovation in their commissioning of Lead Site activities.

14.1.2.4 What are the implications for future stepped care activity by PHNs and primary health care reform more generally?

Overall, all stakeholder groups were largely positive about stepped care, and four Lead Sites described positive early effects, which included better targeting of services to needs and good clinical outcomes.

Lead Sites' suggestions for how stepped care could be improved varied but included the need to review the stepped care model now that it had been operating for a while, the provision of more support for providers to step consumers up or down when appropriate (e.g., agreed protocols), a system for tracking consumers across the steps, and more communication with stakeholders about the stepped care model. Lead Sites' suggestions regarding additional supports and resources from the Department of Health were similarly varied, but included alignment of state and national funding, more specific guidance on assessment referral, and more time for effective consultation and planning.

The relationship between stepped care and service integration was considered to be reciprocal, with some regional stakeholders observing that stepped care had improved service integration, and others suggesting that stepped care could be improved with better service integration and collaboration. They recommended the following mechanisms for achieving better service integration and collaboration: commissioning individual service providers (organisations or sole practitioners) that can deliver a range of services across the steps, a funding model that truly supports service integration, more opportunities and resources for providers to come together, more mechanisms to share best-practices, improved communication and information sharing between providers and referrers, an integrated intake system to improve triaging, more streamlined services, more co-located services, integration of national services into the stepped care model and more consideration of the NDIS and its impact on the steps.

Like Lead Sites, regional stakeholders identified difficulties in stepping consumers up and down and suggested that these could be addressed by improving links between steps, which is again related to better service integration. Specific suggestions for improving links between the steps were a 'one-door entry system', more integrated and holistic services, more equitable services across regions, more consistency across states/territories and inclusion of complementary non-clinical services.

Finally, regional stakeholders suggested that Lead Sites could improve awareness and acceptance of the stepped care approach through better marketing and communication strategies targeting GPs, the drug and alcohol sector, consumers and the community more broadly. Carers echoed this, specifically mentioning the value of appropriate communication campaigns for the public, as did Lead Sites, noting the importance of communicating the rationale for stepped care.

14.1.3 LOW INTENSITY SERVICES

14.1.3.1 What approaches were undertaken by Lead Sites to the planning, commissioning, management and delivery of services in the focus area of low intensity services?

PHN-commissioned providers are delivering a range of low intensity service types to a variety of target groups. Service types include New Access, brief telephone counselling, group therapy and a social connection group, and Mental Health First Aid. More than half of the Lead Sites had targeted new consumer groups through their low intensity services since Round 1 data collection. These new groups included older people in residential care, CALD groups, LGBTQI people, justice-involved young people, young people aged 12 to 16 years, and Aboriginal and Torres Strait Islander people. Half of the Lead Sites noted directing consumers to various free and paid online mental health services, including free online mental health programs and apps, and the Head to Health Digital Gateway.

Processes used to ensure appropriate targeting of low intensity services include use of a clinical intake tool and the centralised intake function, review of service data for the last 12 months, and making changes to service delivery modalities in response to consumer preference (more face-to-face and less telephone services). Among Lead Sites whose clinical governance frameworks incorporated arrangements for low intensity services, it was still most common for the low intensity providers to have been mandated to document and submit these arrangements to the PHN.

Regional stakeholders reported involvement in the planning and commissioning of low intensity services via a variety of activities. These activities included co-design, feedback opportunities, partnership in model development, participating in a procurement panel, and providing support in the development of a communication strategy. Carer representatives, however, reported little involvement. Those who were involved had participated in a review or selection panel for low intensity services, and some carers wanted their PHN to advocate to their low intensity providers for greater carer involvement in planning and delivery of low intensity services.

14.1.3.2 What activities and approaches were found by the Lead Sites to be effective in achieving objectives in the focus area of low intensity services?

Although all Lead Sites described at least one facilitating factor or effective strategy for the procurement and delivery of low intensity services, these varied widely. This variation may relate to the broad range of low intensity services being delivered to a range of target groups that require differing approaches to their implementation. However, four Lead Sites described close involvement with their chosen providers in implementation of low intensity services as the most effective strategy to achieving their objectives for low intensity services. Other strategies included implementing a service with a good evidence base (e.g., New Access), trialing a range of low intensity services before deciding which ones to retain, co-location of low intensity providers in existing services (e.g., headspace), improving digital health options, using low intensity services to complement face-to-face services, and good relationships among all stakeholders (Lead Sites, low intensity and other commissioned providers, other providers and community organisations, GPs and other referrers).

Some indicators of the effectiveness of using these approaches to implement low intensity services are uptake and outcomes of the services and their impacts on stakeholders. From January 2016 to December 2018, Lead Sites reported 43,507 attended service contacts in which low intensity psychological intervention was the principal focus of treatment. This comprises 8% of all service contacts delivered in that time. This percentage has increased from 3% in Round 1. These low intensity service contacts were delivered within 8,367 episodes of care (6.8% of the total Lead Sites episodes of care). On average, those receiving low intensity services had five service contacts within their episode of care, which is slightly lower than the overall average of six contacts per episode of care. Lead Sites are delivering proportionally more low intensity service contacts and episodes of care than are non-Lead Sites (8.1% vs 4.4% and 6.8% vs 4%, respectively). Of the low intensity psychological intervention episodes (n = 1,282) in which pre- and post-treatment K10 data were available for consumers, 64% significantly improved.

Furthermore, results from our consumer survey showed that those who had received low intensity services were most likely to report that they did not have to wait too long to receive a service. They also reported positive outcomes and satisfaction with services. These outcomes indicated improvements in wellbeing and outlook, and managing day-to-day life. When asked about the best things about the service they received, low-intensity service consumers who completed the survey most commonly stated that the best things were that it filled their personal needs and was helpful; that the service made them feel comfortable, welcome and supported; and the professional skills and qualities of the staff.

Stakeholders also noted a variety of positive effects of low intensity services, including improved wellbeing or reduced symptoms, improved understanding and awareness of mental health issues, engaging consumers who would otherwise not access mental health services, providing a soft entry into mental health care, and preventing the need for higher intensity services.

14.1.3.3 What were the barriers and facilitators to achieving objectives in the focus area of low intensity services?

Barriers

Almost all Lead Sites were experiencing low uptake of at least some of their low intensity services, despite there being a substantial increase in uptake since Round 1. Change management difficulties regarding the introduction of low intensity services were also common. These related to the time needed to establish this new type of service within the sector and understanding and describing the concept of low intensity services. Despite the relatively low uptake of low intensity services, our referrer data showed an increase in the number of referrers who were mainly referring for low intensity services, from 6.6% of referrers in Round 1 to 11.5% in Round 2, showing an increasing trend in referrals to low intensity services. A number of Lead Sites had also experienced workforce challenges, such as attracting and retaining workforce to provide low intensity services, although this had become a less dominant barrier to the delivery of low intensity services than in Round 1.

Regional stakeholders involved in the planning, commissioning or delivery of low intensity services also noted a range of barriers to implementation from their perspective. Chief among these was that the language used for low intensity services is not helpful and adequate in describing or promoting the service, suggesting that the consumers will be receiving a lesser service than they would receive in higher intensity services.

When asked how the low intensity service they received could be better, consumers who completed the consumer survey commonly stated that there could be more sessions available, and that the service could have a broader therapeutic scope.

Facilitators

We have reported on facilitators to achieving objectives related to low intensity services in Section 13.1.3.2.

14.1.3.4 What are the implications for future low intensity activity by PHNs and primary health care reform more generally?

Half of the Lead Sites stated that they were able to see positive effects of the introduction of low intensity services, and a number of Lead Sites had added low intensity services aimed at specific hard-to-reach groups within their communities.

However, as a new type of service being introduced to primary mental health care in Australia, low intensity services are taking some time to embed. As a result, most Lead Sites reported experiencing low uptake of their low intensity services and are therefore undertaking significant education and promotion work to make consumers, referrers and mental health practitioners aware of the availability and benefits of low intensity services. A number of Lead Sites also noted the persisting preference of consumers for face-to-face over telehealth or digital services, which resulted in alterations to low intensity programs to provide more face-to-face services.

To improve the quality and acceptability of low intensity services, engagement and consultation with consumers with relatively low levels of need should be strengthened in the future. Furthermore, if consumers, referrers and other stakeholders are to gain confidence in the utility and effectiveness of low intensity services, there is a need to improve monitoring and evaluation in order to build evidence about whether low intensity programs and the associated, and sometimes peer-led and unaccredited, workforce are a useful type of intervention for those at risk of developing a mental disorder or experiencing mild symptoms. PHNs may also need to consider the language they use to name and describe low intensity services so that it does not inadvertently imply that consumers will receive a ‘lesser’ service than they would receive if they were offered a more traditional service intended for people with relatively higher needs (e.g., psychological therapy).

14.1.4 YOUTH ENHANCED SERVICES

14.1.4.1 What approaches were undertaken by Lead Sites to the planning, commissioning, management and delivery of services in the focus area of youth enhanced services?

PHN-commissioned providers are delivering a range of youth enhanced services and most Lead Sites had commissioned new services or modified their services since Round 1. These included services for young people with co-morbid alcohol or other drug use issues, expansion of services to include 18-to-25-year-olds, assertive outreach, and a functional recovery service for young people with early psychosis, among others. In Round 2, Lead Sites had shifted their focus from identifying the needs of young people in their region to implementing services.

The three youth enhanced Lead Sites had a holistic care approach which combines clinical and non-clinical treatment components. A common approach was to focus on disengaged young people and to include an outreach capacity. Otherwise, approaches to the planning, commissioning and targeting of youth enhanced services varied widely among Lead Sites. For example, headspace National noted that PHNs variably sought advice from them for the development and implementation of their youth enhanced services. Orygen had a supporting role in regional planning and commissioning of youth enhanced services to varying extents with all 31 PHNs. Orygen commented that well-designed and quality youth enhanced services have been implemented across PHNs.

Lead Sites are taking various steps to ensure coordination of care with other youth services. Three Lead Sites stated this was a contractual requirement of their commissioned providers, and two Lead Sites noted strong referral pathways with other services. Funding and working arrangements with headspace varied across Lead Sites. This included providing additional funding to headspace to deliver youth enhanced services, co-location of youth enhanced services within headspace centres, referral to youth enhanced services through headspace intake, and co-locating a low intensity coach within headspace centres.

Regional stakeholders reported diverse types of involvement in the planning and implementation of youth enhanced services, including pre-commissioning briefings and via partnerships and co-creation, youth advisory consultations and round table discussions. None of the carer representatives we consulted were involved in the planning or commissioning of youth enhanced services.

14.1.4.2 What activities and approaches were found by the Lead Sites to be effective in achieving objectives in the focus area of youth enhanced services?

Effective approaches for implementing youth enhanced services varied between Lead Sites. A common and effective strategy identified by four Lead Sites was building their youth enhanced services on existing services. Other strategies mentioned by a single Lead Site each included working closely with providers to troubleshoot problems, implementing assertive outreach to improve access, replicating existing services in new locations, building a strong relationship with the LHN to promote ownership of the service, having a strong clinical governance framework, building the capacity of the workforce (e.g., through training via Orygen), allowing the provider sufficient time to develop the service before commencing service delivery, and co-designing the service with a youth advisory group.

Strategies for building effective linkages with other youth enhanced services varied between Lead Sites. They included co-location of services, having a consortium-led service, and working with other services to build referral pathways. Three Lead Sites described examples of services providing clinical care complemented by vocational, educational and parental support, all of which referred to the headspace model providing wrap-around care.

Orygen noted that service planning seemed to be more effective in addressing service gaps when it was based on a thorough needs assessment. Furthermore, service integration for youth enhanced services were most successful when formal relationships or agreements were in place between agencies, and when processes were implemented to facilitate smooth transitions for consumers (and service providers) between programs, services or agencies. The integration of clinical and non-clinical youth enhanced programs was observed to be enhanced when services were delivered from a headspace platform or one-stop-shop.

Regional stakeholders reported a variety of effective approaches in relation to youth enhanced services, including providing access to specialised clinicians or psychiatry, offering services for carers of young people with mental health issues, and improving access to wrap-around services that include non-clinical programs.

14.1.4.3 What were the barriers and facilitators to achieving objectives in the focus area of youth enhanced services?

Barriers

The most common barrier to implementing youth enhanced services was a lack of available or suitably trained and experienced workforce, which was reported by both the Lead Sites and regional stakeholders. Workforce challenges remained the most commonly noted difficulty for Lead Sites in implementing youth enhanced services in both Round 1 and Round 2.

Four Lead Sites reported having difficulties in collaborating with LHNs, the education sector, or headspace National office, and three Lead Sites experienced difficulties with the minimum dataset requirements. The three youth enhanced Lead Sites reported several additional barriers in relation to the implementation of their youth enhanced models, including a more complex youth cohort than expected, cultural appropriateness of the service, a shortage of psychiatrists, the impact of high intensity work on clinicians, difficulties in accurately measuring outcomes, and data-sharing issues.

Orygen noted that service integration of youth enhanced services was difficult to achieve between state- and Commonwealth-funded programs. In addition, they indicated that unclear eligibility criteria and lack of program appropriateness for specific minority groups of consumers can hinder service integration.

Regional stakeholders also commented on difficulties around reporting and evaluation requirements. This was partly related to differing state and PHN requirements, which resulted in the need to use different data sources. Other barriers reported by regional stakeholders included the complexity of navigation through the mental health system for consumers, carers and service provider staff, and lack of funding for psychiatry.

Facilitators

Facilitators for youth enhanced services have been addressed in the former section (13.4.1.2) under effective approaches. The three youth enhanced Lead Sites reported several additional facilitators, including having an outreach capacity, having a multi-disciplinary team, upskilling the workforce, collaborating with schools, defining specific eligibility criteria, having a flexible service model and not placing a limit on session numbers. Regional stakeholders commented that education and support for the workforce is essential to achieving a successful service.

14.1.4.4 What are the implications for future youth enhanced activity by PHNs and primary health care reform more generally?

Early positive impacts of the implementation of youth enhanced services were reported by five Lead Sites and included improved access for young people, the provision of wrap-around services, and building strong relationships with other services in the sector.

Common across several stakeholder groups (Lead Sites, regional and other key stakeholders, Orygen) was the call for greater integration with other youth services. Orygen suggested that improving service integration requires formal relationships and processes across the service system facilitated by PHNs, regional network events facilitated by PHNs, formal agreements and contracts in tender documents, and common electronic records. Additionally, they suggested that improving regional planning of youth enhanced services requires access to good localised data, engagement of stakeholders including consumers in service planning processes, and service specifications informed by learnings from successful service models.

Recruiting an appropriate workforce for youth enhanced services has been an ongoing challenge in both Rounds 1 and 2. Lead Sites requested more ways to attract appropriately trained and experienced workforce with the support of the Department of Health. Orygen suggested a greater emphasis and guidance around core competencies of the youth mental health workforce and alternative workforce options in locations where recruitment of clinical staff is challenging, and sustainable strategies to improve access to psychiatry, especially in rural and remote areas.

As was the case in Round 1, regional stakeholders called for longer service provider contracts, better service access for young people to address high demand and service gaps, and responsive and flexible development of services.

headspace National suggested PHNs should provide more wrap-around youth enhanced models of care, more outreach-based services, increased access to psychiatry, and provide clearer parameters for the inclusion/exclusion of care. Orygen suggested greater support and resourcing for the local evaluation of youth services.

During the youth enhanced symposium ‘Rising to the challenge’, suggestions to improve youth enhanced services included the use of technology and ehealth to better support young people, reducing competition and improving service integration between services, and connecting and partnering with young people to co-design services.

Carer representatives also offered suggestions for improving youth enhanced services, including involving young consumers and youth carers in service design, focusing on wrap-around services that include social and vocational support, providing after-hours support services, commissioning services for youth carers at-risk of mental illness, and promoting available services.

14.2 Limitations

The above findings should be interpreted in the context of several caveats, most of which relate to the use of routinely collected data and stakeholder consultations.

14.2.1 ROUTINELY COLLECTED DATA

There are a range of limitations associated with using routinely collected administrative data, which have been documented in Section 3. Some of these data limitations are interrelated and may have resulted in under- or over-estimating the quantity of services delivered by PHN-commissioned providers. Examples of such limitations include missing or duplicate data, difficulties in PHNs reliably tracking individuals, and lack of consent by some consumers for their de-identified service use data to be provided to the Department of Health. Another issue is that PHN or provider compliance with data reporting requirements is unknown. However, it is expected that at least some of these issues will be ironed out as the PMHC MDS becomes the single source of data for PHN-commissioned mental health services.

Around 27% of the 122,423 episodes of care provided to consumers through Lead Sites included pre- and post-treatment outcome measurement data that enabled classification of consumer mental health outcomes. This seemingly low proportion of episodes with pre- and post-treatment outcome data may reflect the cross-sectional nature of the data, in which 16% of episodes were still open, 14% were administratively closed and 21% had a missing episode completion status. Having said that, 27% of episodes with pre- and post-treatment outcome measures is an improvement over that reported for Tier 1 ATAPS at 12%.[18]

14.2.2 STAKEHOLDER CONSULTATIONS

Lead Site staff's views may have reflected certain biases, although, the mix of positive and negative views about the various focus areas indicates genuine responses. Furthermore, Lead Sites acted as intermediaries for the recruitment of most of our stakeholder groups consulted, so this may have resulted in the inclusion of stakeholders who are more likely to report more favourable experiences, but again, the mixed views expressed by these stakeholders indicate genuine views. Using Lead Sites as intermediaries for recruitment also meant that the views of other stakeholders not directly affected by the Lead Site Project focus areas were not sought (e.g., referrers, mental health practitioners, other non-commissioned providers in Lead Site regions and consumers without direct experience of PHN-commissioned services). However, this disadvantage was outweighed by the advantage of increasing the likelihood of obtaining input from those with direct experience of PHN-commissioned services and PHN-led regional planning and integration.

A relatively small number of consumers (N = 304) participated in our survey. To counteract this, we supplemented this data source with routinely collected uptake and outcome data for almost 114,000 consumers of Lead Site commissioned services. In addition, the 304 consumers were selected in a way that meant that we could be confident that they had actually received PHN-commissioned services and had done so in the recent past. It is difficult to see how this could have been guaranteed if we had used alternative approaches to recruiting consumers. Another limitation was that some consumers whose first language was not English could not participate in the survey as we did not have the capacity to translate the survey into other languages and the use of interpreters was not feasible.

Although we used multiple methods to maximise the representation of carer views in Round 2 of the evaluation, ultimately, only 24 carers participated – eight carer representatives and 16 carers.

14.3 Strengths

There are two major strengths of the approaches we have taken to evaluating the Lead Site Project – the inclusion of multiple data sources and a range of stakeholders, and repeated measurement.

The first is the inclusion of multiple data sources from a range of stakeholders to assess processes and early outcomes across the four key focus areas. We used routinely collected data from the PMHC MDS, ATAPS MDS and headspace data in combination with surveys, interviews and focus groups to allow us to triangulate findings relating to the evaluation questions. The use of these data sources and data collection methods allowed us to include a large number and range of stakeholders, including consumers, carers, mental health practitioners, referrers, Lead Site staff, and other key stakeholder groups in order to gain a range of perspectives on the evaluation questions. The flexibility of our evaluation approach meant that some stakeholder groups could choose their preferred consultation method, which helped to maximise participation rates. Our collaborative approach with Lead Sites and the Department of Health also helped to maximise participation rates and the potential utilisation of our findings. The result of this broad approach to the evaluation is the reasonable minimisation of bias in the evaluation outcomes and the inclusion of the views of those groups who are affected by these reforms across all points of reform implementation, from planning and commissioning of services to the receipt and outcomes of those services.

The second major strength of our evaluation approach is that we repeated most data collection methods that we used successfully in Round 1, and excluded those Round 1 methods that proved unproductive. The repetition of selected Round 1 methods allowed us to examine progress and changes over time in the implementation of the mental health reforms. By implementing learnings from Round 1, we were also able to improve upon a number of recruitment and data collection methods. For example, we were able to double the number of consumers who completed the consumer survey, and to increase the number of carer representatives with direct experience of the mental health reforms who participated in our consultations. Inclusion of a greater number and diversity of these stakeholders, once again, contributes to more balanced evaluation outcomes.

14.4 Recommendations

This report has highlighted noteworthy achievements of the Lead Sites in leading the primary mental health care reforms. Lead Sites' achievements are evidenced by the significant progress they have made in engaging a diverse range of stakeholders to contribute to regional planning and service integration. They have commissioned a wide range of stepped care services and a variety of services that are low intensity or target youth with, or at risk of, severe mental illness. However, the implementation process has not been without challenges and barriers. Therefore, we have made some recommendations, based on our evaluation findings, that are intended to strengthen activity and progress with primary mental health care reforms across all 31 PHNs.

Ultimately, the goal of PHN-led mental health reforms is to ensure that consumers and carers receive the right, efficient, integrated and effective mental health care at the right time. This is reliant on commissioned mental health providers delivering such services. The following five high level recommendations – and associated actions by PHNs and the Department of Health – are likely to contribute to this goal.

RECOMMENDATION 1: STRENGTHEN ENGAGEMENT AND RELATIONSHIPS WITH REGIONAL AND OTHER KEY STAKEHOLDERS

Key finding 1: Collaboration and strong relationships with regional and other key stakeholders is essential to achieving the goals of regional planning, service integration and stepped care.

PHNs should build/strengthen/maintain effective linkages with and between a broad range of regional and other key stakeholders; and include them in their planning, commissioning and implementation activities. To this end, PHNs could use creative means to encourage collaboration among stakeholders. Approaches that were successful include:

- Joint planning and commissioning arrangements between PHNs and LHNs;
- Co-design of services;
- Commissioning via consortium-led or partnership arrangements; and
- Use of formalised partnership agreements.

The **Department of Health** could contribute to national service integration efforts by strengthening relationships and collaboration with other relevant government departments (e.g., employment, welfare payments, justice) and health services (e.g., state/territory mental health, physical health, non-government organisations providing psychosocial support). Some options for achieving this might include convening a whole of government mental health conference that involves heads from other sectors, establishing an inter-departmental committee that meets at least annually, or developing collaboration arrangements with integrated partnerships between states/territories, LHNs and PHNs.

Key finding 2: PHNs vary in the extent to which they involve consumer and carer stakeholders in commissioning related activities.

PHNs should involve consumers and carers or representatives in all stages of commissioning (from planning to implementation and evaluation). Each PHN should employ and remunerate at least one consumer and carer representative. PHNs could:

- Play a role in resourcing and upskilling consumers and carers in a way that fosters true co-design of services with support from the Australasian international association for public participation (iap2; https://www.iap2.org.au) and the PHN National Mental Health Lived Experience Engagement Network (MHLEEN);
- Seek advice from PHNs, such as Brisbane North, that are already successfully engaging consumers and carers; and
- Use contractual agreements to ensure that providers also involve consumers and carers in their design and delivery of services.

The **Department of Health** could ensure that consumers and carers are involved in all stages of commissioning by including this as a contractual obligation of PHNs and providing funding devoted to this purpose. An existing (e.g., through iap2) or new tool could be used to measure the extent of genuine involvement by people with lived experience, which could be included in the Department of Health mandated KPIs.

RECOMMENDATION 2: IMPROVE STEPPED CARE SERVICE COMMISSIONING, IMPLEMENTATION AND PROMOTION

Key finding 3: A range of innovative, flexible (e.g., type, modality, length) and responsive stepped care services should be commissioned, promoted and governed to meet consumer and carer needs and preferences, and increase access.

PHNs should:

- Commission a broader range of stepped care services, including non-clinical/wrap-around/complementary services (e.g., educational, vocational, social) – particularly for people with higher intensity mental health needs – either through individual or multiple service provider agencies. Commissioned services should use multiple delivery modalities (e.g., face-to-face, phone and ehealth) and help to increase access (e.g., by offering after hours or outreach appointments); and

- Take a flexible, iterative approach to planning, commissioning and implementing services that facilitates changes in response to evolving regional needs.

Key finding 4: Provider and community stakeholder understanding, and implementation of stepped care and low intensity services needs to be improved.

PHNs should:

- Further promote the stepped care model and low intensity services to improve stakeholder awareness and access to services by using clear and ongoing communication and lay language that emphasises the strengths and benefits of stepped care and low intensity services. This communication could be targeted at referrers and other regional stakeholders, particularly GPs. It could also be targeted at the broader community (e.g., through information sessions, communications pieces);
- Offer more support to referrers to help them effectively refer consumers to the intensity of services they need (e.g., through use of central intake);
- Offer more support to providers to step consumers up or down, ensuring that processes are as simple as possible; and
- Incorporate step-up/step-down protocols in contracts with providers.

The **Department of Health** should:

- Play a role in using the lay and strengths-based language (mentioned above) to describe stepped care and low intensity services more broadly across other health services, so that it is understood that this is the health system approach; and
- Explore means of using funding mechanisms to better support stepped care and service integration (e.g., incentivising providers to step consumers up or down as appropriate).

RECOMMENDATION 3: ADDRESS WORKFORCE ISSUES

Key finding 5: There is a notable shortage in access to psychiatry and the capacity of the existing mental health workforce needs to be built and maintained.

PHNs should:

- Explore innovative ways of improving access to psychiatry and GP services for people with higher intensity needs, especially in rural and regional locations (e.g., telehealth) and for young people;
- Build the capacity of the commissioned provider workforce, particularly in the context of youth enhanced and low intensity services (e.g., training mental health practitioners in core competencies for delivering youth enhanced services and peer workers to deliver low intensity services, offering other professional development opportunities), and in rural and regional areas; and
- Offer commissioned providers professional development opportunities and/or use contracts with commissioned providers to mandate clinical supervision so that providers can maintain or build on competencies, receive support and ensure service quality.

The **Department of Health:**

- Should progress the Mental Health Workforce Strategy; and
- Could facilitate PHN efforts to address workforce issues by providing them with funding that may be required to implement these activities or incentivising psychiatrists and GPs to contribute to this type of service delivery.

RECOMMENDATION 4: IMPROVE PHN ACCESS AND CONTRIBUTION TO QUALITY DATA

Key finding 6: PHNs need access to comprehensive, meaningful regional data to inform their needs assessments and commissioning priorities.

PHNs could work with key regional stakeholders, such as LHNs and GPs, to gain access to these data.

The **Department of Health** could facilitate PHN access to regional data on federally funded services (e.g., MBS, PBS) on an ongoing basis (e.g., at contract renewal).

Key finding 7: PHNs need to contribute to the mental health system evidence base by collecting and reporting good quality data on the uptake and outcomes of commissioned services in their regions.

PHNs should:

- Foster commissioned provider awareness of the value of data collection and reporting requirements;
- Build the capacity of providers (e.g., offering PMHC MDS training);
- Incorporate data compliance requirements in contracts with providers; and
- Conduct local evaluations, particularly of new and innovative services.

The **Department of Health** could explore mechanisms for building the capacity of PHNs to conduct local evaluations of new services.

Key finding 8: The PMHC MDS does not adequately capture key elements of the new PHN-commissioned service delivery system.

The **Department of Health** should commission appropriate modifications to the PMHC MDS to capture service delivery system changes (e.g., transition of consumers between steps, consumers simultaneously receiving services across steps, uniform recording of youth enhanced services).

RECOMMENDATION 5: THE CAPACITY OF PHNs TO LEAD THE PRIMARY MENTAL HEALTH REFORMS SHOULD CONTINUE TO BE SUPPORTED

Key finding 9: Department of Health support of PHNs and responsiveness to their needs has facilitated the achievements of PHNs.

The **Department of Health** should continue to:

- Provide resources (funding and guidance) for mental health services commissioned by PHNs;
- Take a collaborative and responsive approach to PHN needs;
- Build the capacity of PHNs at a national level while supporting the flexibility and diversity of PHNs at the regional level. This includes providing guidance materials and commissioning special projects when needed, such as the existing National Initial Assessment and Referral in Mental Healthcare Project; and
- Support PHNs with refining centralised intake (e.g., through the National Initial Assessment and Referral in Mental Healthcare Project) and exploring options for common electronic records to facilitate service integration and tracking consumers across the stepped care approach.

Key finding 10: Key barriers – such as tight timeframes and engaging carers – need to be addressed.

The **Department of Health** could:

- Grant PHNs flexibility with timeframes and contract lengths where possible to facilitate better regional planning and service development; and
- Commission a project to explore carer needs and find out how to better engage carers in the PHN-led primary mental health care reforms.

14.5 Conclusions

PHNs have been charged with a significant undertaking to modify Australia's primary mental health care system by engaging a diverse range of stakeholders in their regions, and planning and commissioning stepped care services to improve the mental health of people in their regions. The services commissioned by PHNs are intended to specifically target hard-to-reach groups and not the entire help-seeking population, which is better served through other components of Australia's mental health system (e.g., the larger-scale Better Access program, state-funded public mental health services and the not-for-profit sector). Lead Sites' efforts appear to be improving access to care and leading to positive outcomes for significant numbers of consumers. The four focus areas of the Lead Site Project – joint regional planning and service integration, stepped care, low intensity psychological interventions and youth enhanced services – are still relatively new elements of the Australian primary mental health care landscape and will continue to mature with time. Together, key stakeholders are investing impressive efforts to improve the mental health of hard-to-reach groups of the Australian population through better regional planning, service integration and ensuring that consumers get the right care at the right time, and importantly, in accordance with their preferences.

References

1. National Mental Health Commission. *The National Review of Mental Health Programmes and Services.* Sydney: National Mental Health Commission; 2014.

2. Australian Government. *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services.* Canberra: Australian Government; 2015.

3. Department of Health. *Primary Health Networks: Grant Programme Guidelines.* Canberra: Australian Government; 2016.

4. Department of Health. *Primary Health Networks: Grant Programme Guidelines: Annexure 1 - Primary Mental Health Care.* Canberra: Australian Government; 2016.

5. Australian Government. *The Fifth National Mental Health and Suicide Prevention Plan.* Canberra: Australian Government; 2017.

6. Department of Health. PHN: An Australian Government Initiative - PHN Tools and Resources. 27 February 2019; http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Tools_and_Resources. Accessed 16 April, 2019.

7. Department of Health. *Regional Planning for Mental Health and Suicide Prevention - A Guide for Primary Health Networks (PHNs). Version 1.01.* Canberra: Australian Government; 2017.

8. The University of Queensland. National Mental Health Service Planning Framework (NMHSPF). http://www.nmhspf.org.au/. Accessed 16 April, 2019.

9. Department of Health. Head to Health. https://headtohealth.gov.au/. Accessed 16/4/19, 2019.

10. Department of Health. *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Low intensity mental health services for early intervention.* Canberra: Australian Government; n.d.

11. Department of Health. *Primary Health Network Mental Health Reform Lead Site Project Evaluation Framework.* Canberra: Australian Government; 2016.

12. Bassilios B, Oostermeijer S, Nicholas A, Williamson M, Machlin A, Harris M, et al. *Primary Health Network Mental Health Reform Lead Site Project (Lead Site Project) - Part A Interim Evaluation Report: Processes and Impacts, July 2016 - December 2017.* Melbourne: Centre for Mental Health, The University of Melbourne; 2018.

13. Slade T, Grove R, Burgess P. Kessler Psychological Distress Scale: normative data from the 2007 Australian National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry.* 2011;45(4):308-316.

14. Coombs T. *Australian Mental Health Outcomes and Classification Network; Kessler -10 Training Manual.* Sydney: NSW Institute of Psychiatry; 2005.

15. youth in mind. SDQ: Information for researchers and professionals about the Strengths & Difficulties Questionnaire. 1/1/12; https://sdqinfo.org/. Accessed 16 April, 2019.

16. Rickwood DJ, Mazzer KR, Telford NR, Parker AG, Tanti CJ, McGorry PD. Changes in psychological distress and psychosocial functioning in young people visiting headspace centres for mental health problems. *Medical Journal of Australia.* 2015;202(10):537-542.

17. Horvarth J. *Review of Medicare Locals: Report to the Minister for Health and Minister for Sport.* Canberra: Department of Health; 2014.

18. Bassilios B, Nicholas A, King K, Reifels L, Fletcher J, Pirkis J. *Evaluating the Access to Allied Psychological Services (ATAPS) and Mental Health Services in Rural and Remote Areas (MHSRRA) programs: Final ATAPS and MHSRRA evaluation report.* Melbourne: Centre for Mental Health, University of Melbourne; 2017.

19. Department of Health. *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Child and Youth Mental Health Services.* Canberra: Australian Government; n.d.

20. Rickwood DJ, Telford NR, Mazzer KR, Parker AG, Tanti CJ, McGorry PD. The services provided to young people through the headspace centres across Australia. *Medical Journal of Australia.* 2015;202(10):533-536.

21. Department of Health. *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative: Fact sheet for allied health professionals.* Canberra: Australian Government; n.d.

22. Australian Institute of Health and Welfare. *Mental health services in Australia: Medicare services.* Canberra: AIHW; 2018.

23. Peer Work Hub. *Employer's guide to implementing a peer workforce.* Sydney: Mental Health Commission of New South Wales; 2016.

24. Integrated Regional Planning Working Group. *Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: A Guide for Local Health Networks (LHNs) and Primary Health Networks (PHNs).* Canberra: Australian Government; 2018.

25. Integrated Regional Planning Working Group. *Joint Regional Planning for Integrated Regional Mental Health and Suicide Prevention Services: A compendium of resources to assist Local Hospital Networks (LHNs) and Primary Health Networks (PHNs).* Canberra: Australian Government; 2018.

26. Department of Health. *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped care.* Canberra: Australian Government; n.d.

27. Peer Work Hub. What is peer work? http://peerworkhub.com.au/what-is-peer-work/. Accessed 16 April, 2019.

28. Department of Health. *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Peer workforce role in mental health and suicide prevention.* Canberra: Australian Government; n.d.

29. Orygen: The National Centre for Excellence in Youth Mental Health. *Young People with Severe Mental Illness Project Brief for Primary Health Networks.* Melbourne: Orygen; n.d.

30. Department of Health. *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Primary mental health care services for people with severe mental illness.* Canberra: Australian Government; n.d.

31. Department of Health. Partners in Recovery: coordinated support and flexible funding for people with severe and persistent mental illness with complex needs (PIR). Accessed 16 April, 2019.

32. Department of Health. Support for Day to Day Living in the Community. http://www.health.gov.au/internet/main/publishing.nsf/content/mental-d2dl. Accessed 16 April, 2019.

33. National Disability Insurance Agency. NDIS: About us. https://www.ndis.gov.au/about-us. Accessed 16 April, 2019.

34. Hawe P, Degeling D, Hall J. *Evaluating Health Promotion: A Health Worker's Guide*. Sydney: MacLennan and Petty; 1990.

35. Quinn Patton M. *Utilization-Focused Evaluation (4th Edition)*. London: Sage Publications; 2008.

36. Shadish W, Cook D, Leviton L. *Foundations of Program Evaluation: Theories of Practice*. London: Sage Publications; 1991.

37. Australian Government Department of Health. PMHC MDS data model and specifications. Accessed 8 May 2019.

38. Australian Bureau of Statistics. Postcode 2017 to Remoteness Area 2016. http://www.abs.gov.au/ausstats/subscriber.nsf/log?openagent&1270055005_cg_postcode_2017_ra_2016.zip&1270.0.55.005&Data%20Cubes&14E68CB22C937EBCCA258251000C8C1B&0&July%202016&16.03.2018&Latest

39. Australian Bureau of Statistics. 2033.0.55.001 Socio-Economic Indexes for Australia (SEIFA), 2016. http://www.abs.gov.au/ausstats/subscriber.nsf/log?openagent&2033055001%20-%20poa%20indexes.xls&2033.0.55.001&Data%20Cubes&DC124D1DAC3D9FDDCA25825D000F9267&0&2016&27.03.2018&Latest.

40. Cohen J. *Statistical power analysis for the behavioral sciences*. New Jersey: Lawrence Earlbaum Associates; 1988.

41. Australian Bureau of Statistics. Errors in statistical data. https://www.abs.gov.au/websitedbs/D3310114.nsf/home/Basic+Survey+Design+-+Errors+in+Statistical+Data. Accessed 8 May, 2019.

42. Schenker N, Gentleman J. On judging the significance of differences by examining the overlap between confidence intervals. *Am Stat.* 2001;55:182-186.

43. Gunn J, Wachtler C, Fletcher S, Davidson S, Mihalopoulos C, Palmer V, et al. Target-D: a stratified individually randomized controlled trial of the diamond clinical prediction tool to triage and target treatment for depressive symptoms in general practice: Study protocol for a randomized controlled trial. *Trials.* 2017;18(1):342.

Appendix 1: Questions for Lead Site staff

The evaluation of the Lead Site Project aims to gather information on the approaches taken by Lead Sites to the planning, integration and delivery of mental health services and to identify the implications for future government policy and the activities of PHNs more generally. The focus is on implementation processes and early outcomes.

Our focus group today is part of our Round 2 data collection, which will inform the second and final evaluation report. Just like last time, we will touch on the four Lead Site Project focus areas: regional planning and service integration, stepped care, low intensity services and youth enhanced services. To avoid duplication, we would like you to focus on any changes or progress made since our last focus group which took place in late 2017 and provide responses that apply to the current year.

We have a total of 46 primary questions, and some additional secondary questions we may ask for further information. We will record the discussion.

*Hardcopy consent forms, and demographic information completed using Qualtrics survey

Low intensity services

1) **Since our first consultation at the end of 2017, has your PHN used any new approaches, strategies or activities to target, commission and deliver low intensity services?**
    a) Any new planning activities specifically to support development of low intensity services?
    b) Any new processes to ensure appropriate targeting, other than the stepped care procedures?
    c) Have you targeted any new (low intensity) consumers?
    d) Any developments in the clinical governance processes to mitigate risk?
    e) Any developments in the use of online services, including the Head to Health Gateway, to complement face-to-face services?

2) **Did the commissioning and implementation of low intensity services happen as planned? Details.**

3) **Overall, which approaches, strategies or activities were most effective for the targeting and delivery of low intensity services in your region? Any evidence that your low intensity services are reaching the target group(s)?**
    a) What arrangements were effective in developing regional workforce capacity to deliver low intensity services?

    b) What approaches were successful in promoting low intensity services to referrers, particularly GPs?

4) **Overall, which approaches, strategies or activities were least effective for the targeting and delivery of low intensity services in your region?**

5) **What (new) factors have helped your PHN in procuring and delivering low intensity services?**

6) **What (new) difficulties has your PHN experienced in procuring and delivering low intensity services?**

7) How has your PHN managed to overcome the main difficulties experienced in procuring and delivering low intensity services?

- a) Did regional services refer appropriately to low intensity services?
- b) Did regional services consider low intensity services to be useful?
- c) Who were the low intensity service providers? Benefits? Challenges?
- d) What initiatives were undertaken to train and retain the necessary workforce?
- a) Were there agreements established with external training providers?

8) What are the (early) impacts of low intensity services?

- b) Are there any negative impacts on your PHN associated with planning, commissioning and implementing low intensity services? Details.

9) How could planning, commissioning and implementing low intensity services be improved in the future?

- a) What factors are considered essential for effective (low intensity) service delivery?
- b) Do you need different types of supports or resources from the Department?

Youth enhanced services

10) Since our first consultation at the end of 2017, has your PHN used any new approaches, strategies or activities for developing, commissioning and targeting youth enhanced services?

- a) Any new planning activities specifically to support development of youth enhanced services?
- b) Any new planning arrangements set up with other youth service providers in the region?
- c) Any new processes to ensure appropriate targeting/ meeting service gaps?
- d) What selection criteria were developed to inform referrers?
- e) Any new promotion strategies to encourage service use?
- c) Any new strategies to coordinate care with other service providers?

11) Did the commissioning and implementation of youth enhanced services happen as planned? Details.

12) Lead Sites have commissioned headspace **to deliver some youth mental health services. For which types of services has your PHN commissioned** headspace**?**

- a) Are these low/moderate services, or youth enhanced specific?
- b) Is this the 'basic' headspace funding or does this involve any additional commissioned services?

13) Overall, which approaches, strategies or activities were most effective for the targeting and delivery of youth enhanced services in your region? Any evidence that your youth enhanced strategies are reaching the target group(s)?

- a) Any examples of where clinical care is being effectively complemented by vocational, educational and parental support programmes?

- d) What effective linkages were formed with other regional youth-specific services, including those provided by states and territories, headspace, schools and other educational institutions?

14) Overall, which approaches, strategies or activities were least effective for the targeting and delivery of services to young people with, or at risk of, severe mental illness?

15) **What (new) factors have helped your PHN in procuring and delivering youth enhanced services?**

16) **What (new) difficulties has your PHN experienced in procuring and delivering youth enhanced services?**

17) **How has your PHN managed to overcome the main difficulties experienced in procuring and delivering youth enhanced services?**

18) **What are the (early) impacts of youth enhanced services?**
    a) Are there any negative effects on your PHN associated with planning, commissioning and implementing youth enhanced services? Details.

19) **How could planning, commissioning and implementing youth enhanced services be improved in the future?**
    a) What factors are considered essential for effective youth enhanced service delivery?
    b) Do you need different types of supports or resources from the Department?

Regional planning and service integration

REGIONAL PLANNING

20) **At what stage is your joint regional mental health and suicide prevention plan?**

21) **Since our first focus group discussion, what additional or new regional planning approaches, strategies or activities have you used?**
    a) Activities to understand local MH care needs and service gaps;
    b) Arrangements and partnerships with LHNs;
    c) Approaches to engage regional and other key stakeholders.

22) **Since our first consultation, has your PHN used any new approaches to engage consumers and carers in regional planning? Details. What about for the planning of low intensity services?**

23) **Overall, which approaches, strategies or activities were most effective for regional planning? Any evidence that regional planning process was effective in advancing service implementation?**

24) **Overall, which approaches, strategies or activities were least effective for regional planning?**

25) **What (new) factors have helped your PHN in relation to regional planning?**

26) **What (new) difficulties has your PHN experienced in relation to regional planning?**

27) **How has your PHN managed to overcome the main difficulties experienced in relation to regional planning?**
    a) Any new tools and resources used to guide regional planning?

28) **What are the (early) impacts of the regional planning activities?**
    a) In hindsight, have the planning activities you undertook for commissioning services been effective?
    b) Are there any negative impacts for your PHN associated with your regional planning activities?

29) How could regional planning be improved in the future?

a) What factors are considered essential for effective planning?
b) Do you need different types of supports or resources from the Department?

INTEGRATION

In round 1 we asked Lead Sites to describe the strategies they had used to integrate their mental health services with other regional services – but for most Lead Sites it was still early days.

30) Has your PHN used any new approaches, strategies or activities to integrate your commissioned mental health services with other regional services?

a) What partnership arrangements were put in place with other regional service providers?
b) How was regional service integration supported by shared policies and procedures, joint care pathways and protocols or other similar documentation?
c) To what extent were plans developed for co-commissioning of services with LHNs?
d) Did governance arrangements support engagement of key players?

31) Overall, which approaches, strategies or activities were most effective for achieving regional service integration? Any evidence that services are more integrated in your region?

32) Overall, which approaches, strategies or activities were least effective for achieving regional service integration?

33) What (new) factors have helped your PHN achieve regional service integration?

34) What (new) difficulties has your PHN experienced in relation to achieving regional service integration?

35) How has your PHN managed to overcome the main difficulties experienced in achieving regional service integration?

36) What are the (early) impacts of your regional service integration activities?

a) Are there any negative impacts on your PHN associated with your regional service integration activities?

37) How could regional service integration be improved in the future?

a) What factors are considered essential for achieving effective service integration?

Stepped care

In round 1 we asked Lead Sites to describe what arrangements were put in place to promote a stepped care approach - that matched services offered to the level of each consumer's need.

38) At what stage of development or implementation is your stepped care model currently?

E.g., mostly development, early/late stage of implementation, or fully developed?

b) How are services targeted?
c) What processes are used for initial assessment, triage and review of consumers?
d) How were referral pathways developed, particularly with GPs, state/territory community and other mental health services?

39) Since our first consultation, has your PHN used any new approaches, strategies or activities to match services to consumer needs? Details.

a) What (new) strategies are being used to engage referrers and other stakeholder groups to promote a stepped care model? GPs?
b) What (new) activities have been undertaken to maximise the central role of GPs in building a stepped care model?
c) What (new) procedures are in place for follow-up of clients and new referrals?
d) Have regional targets been set for an optimal mix of services?
e) How has funding been allocated to services at different steps?

40) Overall, which approaches, strategies or activities have been most effective for implementing stepped care? Any evidence that this has been effective in implementing stepped care?

41) Overall, which approaches, strategies or activities were least effective for implementing stepped care?

42) What (new) factors have helped your PHN develop and implement a stepped care approach?

a) What tools and resources were used to guide development of an approach suited to regional needs?
b) How are you using technology to help with implementing a stepped care approach?

43) What (new) difficulties has your PHN experienced in relation to developing and implementing a stepped care approach?

44) How has your PHN managed to overcome the main difficulties experienced in relation to developing and implementing stepped care?

45) What are the (early) impacts of stepped care approach?

a) Are there any negative impacts on your PHN associated with your approach to developing and implementing stepped care?
b) What evidence is there that consumers received services more appropriate to their MH needs?

46) How could stepped care be improved in the future?

a) What factors are considered essential for successfully implementing stepped care?
b) Do you need different types of supports or resources from the Department?

Appendix 2: Referrer survey

Thank you for agreeing to complete this survey. It will take you approximately 10 minutes. Your responses will be confidential. If you don't want to continue with the survey, you may stop at any time.

You are being approached because you are referring patients to mental health services commissioned by XXXX Primary Health Network (PHN). We are interested in your views and experiences of referring patients to receive these services from **1 March 2018 to the present**.

XXXX PHN has sent you this survey on behalf of the University of Melbourne evaluators, but your responses will go to the evaluators only. **If you work across more than one PHN, please ensure your responses relate only to XXXX PHN.**

The following questions relate to your experiences of referring patients for mental health services commissioned by XXXX PHN.

1. On average, since 1 March 2018, how many patients have you referred for these services **each month?**

[ ] Patients

2a. What is the focus of the (PHN-commissioned) mental health services for which you refer patients?

Service focus	**a. Select all focuses that apply**	**b. Select the main focus**
Psychological therapy	[ ]	[ ]
Low intensity psychological intervention	[ ]	[ ]
Clinical care coordination	[ ]	[ ]
Complex care package	[ ]	[ ]
Child and youth-specific mental health services	[ ]	[ ]
Indigenous-specific mental health services	[ ]	[ ]
Other (please specify):		

2b. Which of the following patient groups do you refer for (PHN commissioned) mental health services?

Patient group	**a. Select all patient groups that apply**	**b. Select the main patient group**
Children (0-11 years)	[ ]	[ ]
Youth (12-25 years)	[ ]	[ ]
Adults (26+ years)	[ ]	[ ]

2c.How would you rate the severity of the mental health problems of these patients?

Severity of the mental health problems	**a. Select all severities that apply**	**b. Select the main severity**
At risk (no current mental illness but previous illness or early symptoms)	[ ]	[ ]
Mild mental illness	[ ]	[ ]
Moderate mental illness	[ ]	[ ]
Severe mental illness	[ ]	[ ]

2d. Please rate the ease of the referral process for the main service focus.

0 – not at all easy
1 – somewhat easy
2 – neither easy nor difficult
3 – easy
4 – very easy

2e. Please indicate why you have selected this response.

A stepped care approach, matching services offered to the level of patient need, has been a key component of mental health reforms led by PHNs.

3. How has the stepped care approach influenced the referrals you have made?

[ ] I don't know what the stepped care approach is
[ ] The stepped care approach has made no difference to my referrals
[ ] The stepped care approach has assisted me in referring patients to services matched to their needs
[ ] Other, please specify: ____

4. Have you received support or resources, either from the PHN or your organisation, to help you implement a stepped care approach to mental health referrals?

[ ] Yes (go to Q5)
[ ] No (go to Q6)

5. What support did you receive, either from the PHN or your organisation, to help you implement a stepped care approach to mental health referrals? [Select all that apply]

[ ] Involved me in consultations about developing stepped care
[ ] Provided options for stepping patients down or up to less or more intensive services
[ ] Professional development/training/workshop
[ ] Written resources
[ ] Provided individual feedback on my referrals to encourage a stepped care approach
[ ] Other, please specify: _______________________________

6. What, if any, are the positive impacts for <u>patients</u> of your being able to refer to PHN-commissioned mental health services?

7. What, if any, are the negative impacts for <u>patients</u> of your being able to refer to PHN-commissioned mental health services?

8. What, if any, are the positive impacts for <u>you</u> of being able to refer patients for PHN-commissioned mental health services?

9. What, if any, are the negative impacts for you of being able to refer patients for PHN-commissioned mental health services?

10. Please provide any other comments you'd like to make about referring patients for PHN-commissioned mental health services?

Finally, here are some questions about you.

11. Which of the following best describes the main setting in which you currently work?

[ ] General practice
[ ] Medical specialist consulting rooms
[ ] Private practice
[ ] Public mental health service
[ ] Public hospital
[ ] Private hospital
[ ] Emergency department
[ ] Community health centre
[ ] Drug and alcohol service
[ ] Community support organization NFP
[ ] Indigenous health organization
[ ] Child and maternal health
[ ] Nursing service
[ ] School
[ ] Other (specify):___________________

12. What is your main current profession?

[ ] General Practitioner
[ ] Psychiatrist
[ ] Obstetrician
[ ] Peadiatrician
[ ] Other Medical Specialist
[ ] Midwife
[ ] Maternal Health Nurse
[ ] Psychologist
[ ] Mental Health Nurse
[ ] Social Worker
[ ] Occupational Therapist
[ ] Aboriginal Health Workers
[ ] Educational professional
[ ] Early childhood service worker
[ ] Other(please specify):___________________________

13. How long have you been working in this profession?

[ ] Less than 1 year
[ ] 1-5 years
[ ] 6-10 years
[ ] 11-15 years
[ ] 16-20 years
[ ] More than 20 years

14. What is your age range?

[ ] 19 years or younger
[ ] 20-29 years
[ ] 30-39 years
[ ] 40-49 years
[ ] 50-59 years
[ ] 60-69 years
[ ] 70-79 years
[ ] 80 years or older

15. What is your gender?

[ ] Female
[ ] Male
[ ] I do not identify with either term

16. Do you identify as Aboriginal and/or Torres Strait Islander?

[ ] Aboriginal
[ ] Torres Strait Islander
[ ] Both Aboriginal and Torres Strait Islander
[ ] Neither Aboriginal nor Torres Strait Islander

Thank you for participating in the survey.

Appendix 3: Mental health practitioner survey

Thank you for agreeing to complete this survey. It will take you between 15 and 20 minutes. Your responses will be confidential. If you don't want to continue with the survey, you may stop at any time.

You are being approached because you have been commissioned to provide mental health services for XXXX Primary Health Network (PHN). We are interested in your views and experiences of providing these services from **1 March 2018 to the present**.

XXXX PHN has sent you this survey on behalf of the University of Melbourne evaluators, but your responses will go to the evaluators only. **If you work across more than one PHN, please ensure your responses relate only to XXXX PHN.**

The following questions relate to your experiences of providing PHN-commissioned mental health services.

1. How are you engaged by the PHN?

[ ] Sole practitioner directly contracted by PHN
[ ] Contracted by an organisation that is commissioned by the PHN
[ ] Employed by an organisation that is commissioned by the PHN
[ ] Other (please specify):

2. On average since July 2017, how many clients did you see for PHN-commissioned mental health services each month?

[ ] Clients

3. Which of the following client groups do you deliver services to for the PHN?

Client group	**c. Select all client groups that apply**	**d. Select the main client group**
Children (0-11 years)	[ ]	[ ]
Youth (12-25 years)	[ ]	[ ]
Adults (26+ years)	[ ]	[ ]

4. How would you rate the severity of the mental health problems of these clients?

Severity of the mental health problems	**c. Select all severities that apply**	**d. Select the main severity**
At risk (no current mental illness but previous illness or early symptoms)	[ ]	[ ]
Mild mental illness	[ ]	[ ]
Moderate mental illness	[ ]	[ ]
Severe mental illness	[ ]	[ ]

5. What is the focus of the PHN-commissioned mental health services you deliver?

Focus of service	**c. Select all focuses that apply**	**d. Select the main focus**
Psychological therapy	[ ]	[ ]
Low intensity psychological intervention	[ ]	[ ]
Clinical care coordination	[ ]	[ ]
Complex care package	[ ]	[ ]
Child- and youth-specific mental health services	[ ]	[ ]
Indigenous-specific mental health services	[ ]	[ ]
Other (please specify):		

6. How do you deliver PHN-commissioned mental health services?

Modality	**a. Select all modalities that apply**	**b. Select the main modality**
Face-to-face	[ ]	[ ]
Telephone	[ ]	[ ]
Video (including skype, facetime etc.)	[ ]	[ ]
Internet-based	[ ]	[ ]

7. Who has referred clients to you for PHN-commissioned mental health services?

Referrer type	**a. Select all referrers that apply**	**b. Select the main referrer**
General Practitioner	[ ]	[ ]
Psychiatrist	[ ]	[ ]
Obstetrician	[ ]	[ ]
Paediatrician	[ ]	[ ]
Other Medical Specialist	[ ]	[ ]
Midwife	[ ]	[ ]
Maternal Health Nurse	[ ]	[ ]
Psychologist	[ ]	[ ]
Mental Health Nurse	[ ]	[ ]
Social Worker	[ ]	[ ]
Occupational Therapist	[ ]	[ ]
Aboriginal Health Worker	[ ]	[ ]
Educational professional	[ ]	[ ]
Early childhood service worker	[ ]	[ ]
Client self-referral	[ ]	[ ]
Other (please specify):		

8. What support or resources have you received from the PHN to assist you with delivering mental health services? [Select all that apply]

[ ] Assistance with developing referral pathways
[ ] Options for stepping clients down or up to other services
[ ] Professional development/training/workshop
[ ] Clinical supervision
[ ] Written resources e.g., guidance, pamphlets
[ ] Assistance with entering minimum dataset data
[ ] Other (please specify):____________________
[ ] None of the above

Thinking about the period from 1 July 2017 to the present:

9. What, if any, are the positive impacts for <u>clients</u> of your being commissioned by the PHN to provide mental health services?

10. What, if any, are the negative impacts for <u>clients</u> of your being commissioned by the PHN to provide mental health services?

11. What, if any, are the positive impacts for <u>you</u> of being commissioned by the PHN to provide mental health services?

12. What, if any, are the negative impacts for <u>you</u> of being commissioned by the PHN to provide mental health services?

13. Please provide any other comments or suggestions you'd like to make about being commissioned by the PHN to provide mental health services.

Finally, here are some questions about you.

14. Which of the following best describes the main setting in which you <u>currently</u> deliver services for the PHN?

[ ] Private Allied Health Professional Practice
[ ] Private Psychiatry Practice
[ ] General Medical Practice
[ ] Private Hospital
[ ] headspace Centre
[ ] Early Youth Psychosis Centre
[ ] Community-managed Community Support Organisation
[ ] Aboriginal Health/Medical Service
[ ] State/Territory Health Service Organisation
[ ] Drug and/or Alcohol Service
[ ] Primary Health Network
[ ] Medicare Local
[ ] Division of General Practice
[ ] Virtual clinic
[ ] Other (please specify):____________________________________

15. What is your main <u>current</u> practitioner category for providing mental health services for the PHN?

[ ] Clinical Psychologist
[ ] General Psychologist
[ ] Social Worker

[ ] Occupational Therapist
[ ] Mental Health Nurse
[ ] Aboriginal and Torres Strait Islander Health/Mental Health Worker
[ ] Low Intensity Mental Health Worker
[ ] General Practitioner
[ ] Psychiatrist
[ ] Other Medical
[ ] Other (please specify):

16. How long have you been working in this profession?

[ ] Less than 1 year
[ ] 1-5 years
[ ] 6-10 years
[ ] 11-15 years
[ ] 16-20 years
[ ] More than 20 years

17. What is your age range?

[ ] 19 years or younger
[ ] 20-29 years
[ ] 30-39 years
[ ] 40-49 years
[ ] 50-59 years
[ ] 60-69 years
[ ] 70-79 years
[ ] 80 years or older

18. What is your gender?

[ ] Female
[ ] Male
[ ] I do not identify with either term

19. Do you identify as Aboriginal and/or Torres Strait Islander?

[ ] Aboriginal
[ ] Torres Strait Islander
[ ] Both Aboriginal and Torres Strait Islander
[ ] Neither Aboriginal nor Torres Strait Islander

Thank you for participating in the survey.

Appendix 4: Questions for other Lead Site regional stakeholders and carer representatives

We are interested in the views of stakeholders / carer representatives on changes to primary mental health care service delivery led by Primary Health Networks (PHNs). These changes are a result of revisions to Federal Government policy and funding of services.

ROUND TWO QUESTIONS

SERVICE PLANNING AND INTEGRATION

PHNs are required to undertake service planning activities. These activities aim to ensure the primary mental health services they commission help to meet the mental health needs of people within their catchment. PHNs also need to ensure these services are integrated with existing services in the region. That is, that they complement existing services and encourage cooperation between services to better support consumers and carers.

SERVICE PLANNING

1. How were you or your organisation involved in PHN regional mental health planning?
2. What effects has PHN service planning had on consumers and carers?
3. How might this service planning be improved in the future?

SERVICE INTEGRATION

4. Since the commencement of PHN-led mental health reforms in June 2016, what effects have you noticed on integration between mental health services (e.g., service gaps, transition between services for carers and consumers, communication between services)?
5. How might regional service integration be improved in the future?

STEPPED CARE

As part of the PHN-led mental health reforms, a ‘stepped care’ approach was introduced in order to match services offered to the level of each consumer’s need. With the stepped care approach, PHNs are required to commission a range of evidence-based treatments from low intensity options, like group and online programs, to high intensity options, such as case management and intensive counselling programs. The type and intensity of the intervention is matched to the level of need of the consumer at the time. Commissioning involves selection and contracting of service providers through a competitive selection process.

6. How were you or your organisation involved in PHN regional implementation of the stepped care approach?
7. What effects has the introduction of the stepped care approach had on consumers and carers?
    a. Since the introduction of the stepped care approach in June 2016, have you seen any evidence that consumers have received services that are better matched to their mental health needs?
8. How might regional implementation of stepped care be improved in the future?

LOW INTENSITY SERVICES

As part of the introduction of the stepped care approach, low intensity services were commissioned by PHNs in order to meet the mental health needs of consumers with mild mental health problems or consumers who are at risk of developing mental health problems. Examples of low intensity interventions include group mindfulness programs, short-term coaching for stress and anxiety management, peer-support programs, online programs for managing stress and anxiety, and short-term one-on-one counselling.

9. How were you or your organisation involved in PHN commissioning low intensity services?
10. What effects has the introduction of the new low intensity services had on consumers and carers?
    a. Have you seen any evidence that low intensity services have been effective in preventing further progression of mental health problems? If so, please elaborate.
11. How might low intensity services be improved in the future?

SERVICES FOR YOUTH WITH OR AT RISK OF SEVERE MENTAL ILLNESS

PHNs are also required to commission primary mental health care services for children and young people who have, or are at risk of developing, a mental illness, and who are being managed in primary care. As well as headspace centres, examples of other services commissioned by PHNs for these young people include an assertive outreach program for those who have stopped attending school; a counselling program to assist young people who have experienced complex trauma; and an eating disorders program.

12. How were you or your organisation involved in PHNs commissioning services for youth with, or at risk of, severe mental illness? For which PHN/s?
13. What effects has the introduction of the new services for young people with, or at risk of, severe mental illness had on consumers and carers?
    a. Have you seen any evidence that services for young people with, or at risk of, severe mental illness have been effective? If so, please elaborate.
14. How has clinical care for young people with, or at risk of, severe mental illness been complemented by other programs important for young people, such as vocational, educational and parental support programs?
15. How might services for young people with, or at risk of, severe mental illness be improved in the future?

Demographic questions (to be provided by participants with consent form for focus groups and interviews, or as part of survey for participants providing written responses).

To help us contextualise your responses, please provide responses to the following questions and return this form with your signed consent form. [Written responses, participants in focus group or interviews]

1. **What is your age range?**

[ ] 19 years or younger
[ ] 20-29 years
[ ] 30-39 years
[ ] 40-49 years
[ ] 50-59 years
[ ] 60-69 years
[ ] 70-79 years
[ ] 80 years or older

2. **What is your gender?**

[ ] Female
[ ] Male
[ ] I do not identify with either term

3. **Do you identify as Aboriginal and/or Torres Strait Islander?**

[ ] Aboriginal
[ ] Torres Strait Islander
[ ] Both Aboriginal and Torres Strait Islander
[ ] Neither Aboriginal nor Torres Strait Islander

4. **What is the name of the organisation you are representing?**

5. **What is your job/position title?**

6. **With which PHN regions have you or your organisations organisation been involved?**

  [ ] Central and Eastern Sydney
  [ ] North Coast
  [ ] Murrumbidgee
  [ ] North Western Melbourne
  [ ] Eastern Melbourne
  [ ] South Eastern Melbourne
  [ ] Brisbane North
  [ ] Perth South
  [ ] Tasmania
  [ ] Australian Capital Territory

Appendix 5: Consumer Survey

Thank you for agreeing to complete this survey. It will take you between 5 and 15 minutes. Your responses will be confidential. If you don't want to continue with the survey, you may stop at any time.

You have been invited to complete this survey because you received a mental health service funded by the Australian Government through Primary Health Networks (PHNs) and we are interested in your experience of this service. These services are often provided by health professionals who directly offer people counselling, support and information, or arrange for them to receive care from other sources. We're only looking at services where PHNs are involved, and not services that are covered by Medicare.

We'd like you to think about the last PHN mental health service you received in October/November 2018. When we say "service", we mean all of the sessions that made up that service, noting that you may still have some sessions to go. For example, if you had four sessions with a psychologist in February 2018 and still had others booked, we'd like you to think about the "service" as these four sessions.

Please answer the following questions *__with your last PHN mental health service in mind__*.

1. Please indicate the 'type' of service you received [Check one only]

- Low intensity psychological intervention (these services are evidence-based psychological interventions, but are often delivered by non-tertiary qualified providers under the supervision of clinicians. Examples include group mindfulness programs, short term coaching or counselling, peer-support programs and online programs)
- Psychological therapy (these services are evidence-based psychological interventions delivered by tertiary qualified clinicians, such as psychologists, social workers and occupational therapists)
- Care coordination services (these services are often delivered by mental health nurses supporting the coordination of a range of clinical care needs)
- Indigenous focused service
- Child and/or youth focused service
- Suicide prevention service

2. Why did you choose to use this mental health service? [Check all that apply]

- I felt I was not coping
- My symptoms were getting worse
- I experienced an event that was very upsetting
- I felt I needed professional help
- A family member/friend suggested it
- A health professional referred me
- Other (specify):___________________________

3. Is this the first time you have ever used a mental health service? [Check one only]

- Yes, this is the first time
- No, I have used a mental health service in the past year
- No, I have used a mental health service in the past, but more than one year ago

4. Did you wait longer than you felt was reasonable to be able to use this mental health service? [Check one only]

- Yes - I waited longer than I felt was reasonable
- No – I did not have to wait too long

The next three questions are about changes that you may have experienced because of this mental health service.

5. After using this mental health service, which of the following best describes any change in how you feel about your future? [Check one only]

- Much worse
- A little worse
- About the same
- A little better
- Much better

6. After using this mental health service, which of the following best describes any change in how well you can manage your day-to-day life? [Check one only]

- Much worse
- A little worse
- About the same
- A little better
- Much better

7. After using this mental health service, which of the following describes any change in your wellbeing? [Check one only]

- Much worse
- A little worse
- About the same
- A little better
- Much better

8. Overall, how would you rate this mental health service? [Check one only]

- Very bad
- Bad
- Neither good nor bad
- Good
- Very good

Please complete the next two sentences in your own words:

9. The service would have been better if …

10. The best thing about the service was …

11. Do you have any other comments about the last PHN mental health service you received in February 2018?

Just a few more questions about you and the service you received to help us contextualise your responses.

12. **Your gender [Check one only]**

    - Female
    - Male
    - I do not identify with either term
    - Other (specify):

13. **Your age: _____________(years)**

14. **Do you identify as Aboriginal and/or Torres Strait Islander?**

    - Aboriginal
    - Torres Strait Islander
    - Both Aboriginal and Torres Strait Islander
    - Neither Aboriginal nor Torres Strait Islander

15. **How many sessions have you attended? __________(number of sessions)**

16. **Do you have any further sessions booked or planned for the near future? [Check one only]**

    - Yes
    - No

17. **What is your postcode?**

Finally, we are also interested in opinions of support people (e.g., family members, partners, friends) about the service you received. If you have such a support person who think might be interested and you would like them to receive an invitation to participate in an online survey, please type in their email address and click 'send invitation'. You can send this invitation to more than one person if you choose. This person or people will then receive the following invitation to participate in an online survey.

Are you providing support to someone using mental health services?

We need your opinion to help improve mental health services in Australia

We are contacting you because your family member/partner/friend received mental health services in October/November 2018 that were funded wholly or in part by their Primary Health Network (PHN) and your family member/partner/friend has provided your email address as a contact for our evaluation of the mental health services they received. Mental health services can include services such as individual or group counselling/psychological therapy, web-based programs or a health provider organising your access to multiple services to improve your overall wellbeing.

The University of Melbourne has been funded by the Australian Government Department of Health to evaluate how PHNs plan and deliver mental health services for their community and what that might mean for government policy and future PHN activities.

As part of this evaluation, we are conducting a survey that focuses on your experiences of the PHN-funded mental health care your family member/partner/friend received in October/November 2018. We are interested in your experiences of this service regardless of whether your family member/partner/friend has finished or is still receiving these services. The survey will take about 15 minutes. You do not have to participate in this survey [click here if you wish to opt out]. If you agree to participate, your responses are confidential, and you are free to withdraw from the survey at any stage. All data will be de-identified, meaning it will not be linked with your name or contact information.

For more information about the survey, to provide informed consent and to complete the survey, please click on the following link:

[link to PLS and informed consent process].

We appreciate your contribution to this important evaluation.

Kind regards

The University of Melbourne evaluation team

THANK YOU FOR PARTICIPATING IN THE SURVEY

Appendix 6: Carer survey

Thank you for agreeing to complete this survey. It will take you approximately 15 minutes. Your responses will be confidential. If you don't want to continue with the survey, you may stop at any time.

You have been invited to complete this survey because your family member/partner/friend received a mental health service funded by the Australian Government through Primary Health Networks (PHNs) and we are interested in your experience of this service as their support person. These services are often provided by health professionals who directly offer people counselling, support and information, or arrange for them to receive care from other sources. We're only looking at services where PHNs are involved, and not services that are covered by Medicare.

We'd like you to think about the PHN mental health service your family member/partner/friend received in October/November 2018. When we say "service", we mean all of the sessions that made up that service, noting that they may still have some sessions to go. For example, if your family member/partner/friend had four sessions with a psychologist in October/November 2018 and still had others booked, we'd like you to think about the "service" as these four sessions.

First, we would like to ask some questions about you and your family member/partner/friend so we can contextualise your responses.

1. **Your gender [Check one only]**

    - Female
    - Male
    - I do not identify with either term
    - Other (specify):

2. **Your age: _____________years**

3. **Do you identify as Aboriginal and/or Torres Strait Islander?**

    - Aboriginal
    - Torres Strait Islander
    - Both Aboriginal and Torres Strait Islander
    - Neither Aboriginal nor Torres Strait Islander

4. **Your postcode: _____________**

5. **What is your relationship to the family member/partner/friend who received the mental health service and who you provide support to? The person I support is: [Check one only]**

    - My partner or spouse (including married, defacto)
    - My son or daughter (including step and in-law)
    - My mother or father (including step and in-law)
    - My brother or sister (including step and in-law)
    - A friend
    - Other, specify:_________________

6. **How long have you been supporting your family member/partner/friend with their mental health?**

- Up to 6 months
- 6 months to 1 year
- 1 to 2 years
- 2 to 5 years
- 5 to 10 years
- Over 10 years

7. **The gender of your family member/partner/friend [Check one only]**

- Female
- Male
- My family member/partner/friend does not identify with either term
- Other (specify):

8. **The age of your family member/partner/friend [Check one only]**

9. **Does your family member/partner/friend identify as Aboriginal and/or Torres Strait Islander?**

- Aboriginal
- Torres Strait Islander
- Both Aboriginal and Torres Strait Islander
- Neither Aboriginal nor Torres Strait Islander
- I don't know

10. **Your family member's/partner's/friend's postcode:** ______________

Please answer the following questions *<u>with your family member's/partner's/friend's PHN mental health service in mind</u>*.

11. **Please indicate the 'type' of service your family member/partner/friend received [Check one only]**

- Low intensity psychological intervention (these services are evidence-based psychological interventions, but are often delivered by non-tertiary qualified providers under the supervision of clinicians. Examples include group mindfulness programs, short term coaching or counselling, peer-support programs and online programs)
- Psychological therapy (these services are evidence-based psychological interventions delivered by tertiary qualified clinicians, such as psychologists, social workers and occupational therapists)
- Care coordination services (these services are often delivered by mental health nurses supporting the coordination of a range of clinical care needs)
- Indigenous focused service
- Child and/or youth focused service
- Suicide prevention service
- I don't know

12. **In total, how many appointments has your family member/partner/friend attended?**

13. Has your family member/partner/friend completed their treatment? [Check one only]

- Yes
- No
- Don't know

14. Is this the first time your family member/partner/friend has ever used a mental health service? [Check one only]

- Yes, this is the first time
- No, they have used a mental health service in the past year
- No, they have used a mental health service in the past, but more than one year ago

15. In your opinion, did your family member/partner/friend wait longer than you felt was reasonable to be able to use this mental health service? [Check one only]

- Yes – my family member/partner/friend waited longer than I felt was reasonable
- No – my family member/partner/friend did not have to wait too long

The next three questions are about changes that your family member/partner/friend may have experienced because of this mental health service.

16. After using this mental health service, which of the following best describes any change in how your family member/partner/friend feels about their future? [Check one only]

- Much worse
- A little worse
- About the same
- A little better
- Much better

17. After using this mental health service, which of the following best describes any change in how well your family member/partner/friend can manage their day-to-day life? [Check one only]

- Much worse
- A little worse
- About the same
- A little better
- Much better

18. After using this mental health service, which of the following describes any change in your family member's/partner's/friend's wellbeing? [Check one only]

- Much worse
- A little worse
- About the same
- A little better
- Much better

The next five questions are about <u>your</u> experience of the mental health service that your family member/partner/friend received.

19. I was involved in the care of my family member/partner/friend. [Check one only]

- Not at all
- To some extent
- To a great extent
- Not applicable/not needed

20. I was satisfied with my level of involvement in the mental health service provided to my family member/partner/friend. [Check one only]

- Not at all
- To some extent
- To a great extent

21. The service provided enough information for me to feel confident in supporting my family member/partner/friend. [Check one only]

- Not at all
- To some extent
- To a great extent
- Not applicable

22. The service linked me to other information or services when I needed them for myself. [Check one only]

- Yes
- No
- Not applicable

23. Because of my family member's/partner's/friend's contact with the service, my family life/my life is: [Check one only]

- Much worse
- A little worse
- About the same
- A little better
- Much better

24. Overall, how would you rate your experience as a support person with this mental health service? [Check one only]

- Very bad
- Bad
- Neither good nor bad
- Good
- Very good

Please complete the next two sentences in your own words:

25. The service would have been better if..

26. The best thing about the service was …

27. Do you have any other comments about the mental health service your family member/partner/friend received in October/November 2018?

Thank you for participating in the survey.

Appendix 7: Mental health practitioner characteristics

Table 54. Mental health practitioner characteristics, overall and by Lead Site status (July 2016 – December 2018)

		Lead Sites (n = 5,212)		**Non-Lead Sites (n = 7,677)**		**Total (N = 12,889)**	
Characteristic		**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**
Source	ATAPS	1,095	21.0	2,349	30.6	3,444	26.7
	headspace	1,511	29.0	2,132	27.8	3,643	28.3
	PMHC	2,606	50.0	3,196	41.6	5,802	45.0
Practitioner category	Clinical psychologist	583	11.2	743	9.7	1,326	10.3
	General psychologist	1,025	19.7	1,315	17.1	2,340	18.2
	Social worker	313	6.0	520	6.8	833	6.5
	Occupational therapist	54	1.0	99	1.3	153	1.2
	Mental health nurse	318	6.1	379	4.9	697	5.4
	Aboriginal and Torres Strait Islander health/mental health worker	12	0.2	69	0.9	81	0.6
	Low Intensity mental health worker	445	8.5	608	7.9	1,053	8.2
	General practitioner	89	1.7	96	1.3	185	1.4
	Psychiatrist	47	0.9	26	0.3	73	0.6
	Other medical	23	0.4	27	0.4	50	0.4
	Other	512	9.8	992	12.9	1,504	11.7
	Psychosocial support worker	1	0.0	0	0.0	1	0.0
	Peer support worker	0	0.0	2	0.0	2	0.0
	Not stated	1,790	34.3	2,801	36.5	4,591	35.6

		Lead Sites (n = 5,212)		Non-Lead Sites (n = 7,677)		Total (N = 12,889)	
Characteristic		**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**
Gender	Male	457	8.8	634	8.3	1,091	8.5
	Female	1,737	33.3	2,147	28.0	3,884	30.1
	Other	4	0.1	9	0.1	13	0.1
	Not stated/inadequately described	3,014	57.8	4,887	63.7	7,901	61.3
ATSI Status	Aboriginal but not Torres Strait Islander origin	15	0.3	95	1.2	110	0.9
	Torres Strait Islander but not Aboriginal origin	1	0.0	0	0.0	1	0.0
	Both Aboriginal and Torres Strait Islander origin	8	0.2	11	0.1	19	0.1
	Neither Aboriginal or Torres Strait Islander origin	1,719	33.0	2,069	27.0	3,788	29.4
	Not stated/inadequately described	3,469	66.6	5,502	71.7	8,971	69.6
Cultural Training	Yes	923	17.7	1,303	17.0	2,226	17.3
	No	914	17.5	790	10.3	1,704	13.2
	Not required	4	0.1	60	0.8	64	0.5
	Missing / not recorded	3,371	64.7	5,524	72.0	8,895	69.0
Actively Delivering Services	Inactive	547	10.5	222	2.9	769	6.0
	Active	4427	84.9	7,231	94.2	11,658	90.4
	Missing	238	4.6	224	2.9	462	3.6
Age Group	16-25	83	1.6	80	1.0	163	1.3
	26-35	319	6.1	531	6.9	850	6.6
	36-45	439	8.4	506	6.6	945	7.3
	46-55	478	9.2	600	7.8	1,078	8.4
	56-65	343	6.6	465	6.1	808	6.3
	66-85	112	2.1	118	1.5	230	1.8
	Missing	3,438	66.0	5,377	70.0	8,815	68.4

Table 55. Types of practitioners delivering psychological therapy overall and by Lead Site status (July 2016 – December 2018)

Practitioner category	Lead Sites (n = 2,968)		Non-Lead Sites (n = 4,684)		Total (N = 7,652)	
	Freq.	%	Freq.	%	Freq.	%
Clinical psychologist	277	9.3	301	6.4	578	7.6
General psychologist	895	30.2	1,243	26.5	2,138	27.9
Social worker	209	7.0	298	6.4	507	6.6
Occupational therapist	22	0.7	57	1.2	79	1.0
Mental health nurse	200	6.7	220	4.7	420	5.5
Aboriginal and Torres Strait Islander health/mental health worker	1	0.0	24	0.5	25	0.3
Low intensity mental health worker	12	0.4	16	0.3	28	0.4
General practitioner	5	0.2	4	0.1	9	0.1
Psychiatrist	0	0.0	4	0.1	4	0.1
Other medical	1	0.0	3	0.1	4	0.1
Other	68	2.3	279	6.0	347	4.5
Not stated	1,278	43.1	2,235	47.7	3,513	45.9

Table 56. Types of practitioners delivering low intensity psychological interventions, overall and by Lead Site status (July 2016 – December 2018)

Practitioner category	Lead Sites (n = 558)		Non-Lead Sites (n = 746)		Total (N = 1,304)	
	Freq.	%	Freq.	%	Freq.	%
Clinical psychologist	48	8.6	40	5.4	88	6.7
General psychologist	164	29.4	149	20.0	313	24.0
Social worker	48	8.6	95	12.7	143	11.0
Occupational therapist	5	0.9	16	2.1	21	1.6
Mental health nurse	65	11.6	114	15.3	179	13.7
Aboriginal and Torres Strait Islander health/mental health worker	0	0.0	18	2.4	18	1.4
Low intensity mental health worker	84	15.1	47	6.3	131	10.0
General practitioner	41	7.3	25	3.4	66	5.1
Psychiatrist	0	0.0	2	0.3	2	0.2
Other medical	1	0.2	5	0.7	6	0.5
Other	33	5.9	214	28.7	247	18.9
Not stated	69	12.4	21	2.8	90	6.9

Table 57. Types of practitioners delivering clinical care coordination, overall and by Lead Site status (July 2016 – December 2018)

Practitioner category	Lead Sites (n = 500)		Non-Lead Sites (n = 310)		Total (N = 810)	
	Freq.	%	Freq.	%	Freq.	%
Clinical psychologist	9	1.8	7	2.3	16	2.0
General psychologist	43	8.6	22	7.1	65	8.0
Social worker	61	12.2	16	5.2	77	9.5
Occupational therapist	5	1.0	1	0.3	6	0.7
Mental health nurse	219	43.8	177	57.1	396	48.9
Aboriginal and Torres Strait Islander health/mental health worker	15	3.0	1	0.3	16	2.0
Low intensity mental health worker	13	2.6	0	0.0	13	1.6
General practitioner	4	0.8	1	0.3	5	0.6
Psychiatrist	3	0.6	0	0.0	3	0.4
Other medical	3	0.6	1	0.3	4	0.5
Other	111	22.2	56	18.1	167	20.6
Peer worker	1	0.2	0	0.0	1	0.1
Not stated	13	2.6	28	9.0	41	5.1

Table 58. Types of practitioners delivering complex care packages, overall and by Lead Site status (July 2016 – December 2018)

Practitioner category	Lead Sites (n = 49)		Non-Lead Sites (n = 60)		Total (N = 109)	
	Freq.	%	Freq.	%	Freq.	%
Clinical psychologist	12	24.5	2	3.3	14	12.8
General psychologist	11	22.4	8	13.3	19	17.4
Social worker	2	4.1	2	3.3	4	3.7
Mental health nurse	22	44.9	38	63.3	60	55.0
Aboriginal and Torres Strait Islander health/mental health worker	0	0.0	3	5.0	3	2.8
Low intensity mental health worker	0	0.0	2	3.3	2	1.8
Other	1	2.0	4	6.7	5	4.6
Not stated	1	2.0	1	1.7	2	1.8

Table 59. Types of practitioners delivering child and youth specific mental health services, overall and by Lead Site status (July 2016 – December 2018)

Practitioner category	Lead Sites (n = 2,369)		Non-Lead Sites (n = 3,445)		Total (N = 5,814)	
	Freq.	%	Freq.	%	Freq.	%
Clinical psychologist	334	14.1	492	14.3	826	14.2
General psychologist	256	10.8	184	5.3	440	7.6
Social worker	133	5.6	227	6.6	360	6.2
Occupational therapist	31	1.3	45	1.3	76	1.3
Mental health nurse	59	2.5	72	2.1	131	2.3
Aboriginal and Torres Strait Islander health/mental health worker	7	0.3	13	0.4	20	0.3
Low Intensity mental health worker	364	15.4	546	15.8	910	15.7
General practitioner	42	1.8	67	1.9	109	1.9
Psychiatrist	47	2.0	21	0.6	68	1.2
Other medical	22	0.9	19	0.6	41	0.7
Other	396	16.7	567	16.5	963	16.6
Psychosocial support worker	1	0.0	0	0.0	1	0.0
Not stated	677	28.6	1,192	34.6	1,869	32.1

Table 60. Types of practitioners delivering Indigenous specific mental health services, overall and by Lead Site status (July 2016 – December 2018)

Practitioner category	Lead Sites (n = 358)		Non-Lead Sites (n = 990)		Total (N = 1,348)	
	Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**
Clinical psychologist	17	4.7	37	3.7	54	4.0
General psychologist	56	15.6	110	11.1	166	12.3
Social worker	17	4.7	31	3.1	48	3.6
Occupational therapist	4	1.1	6	0.6	10	0.7
Mental health nurse	15	4.2	27	2.7	42	3.1
Aboriginal and Torres Strait Islander health/mental health worker	5	1.4	46	4.6	51	3.8
Low intensity mental health worker	1	0.3	2	0.2	3	0.2
General practitioner	4	1.1	0	0.0	4	0.3
Psychiatrist	0	0.0	1	0.1	1	0.1
Other medical	0	0.0	5	0.5	5	0.4
Other	2	0.6	30	3.0	32	2.4
Not stated	237	66.2	695	70.2	932	69.1

Table 61. Types of practitioners delivering other mental health services, overall and by Lead Site status (July 2016 – December 2018)

Practitioner category	Lead Sites (n = 1,109)		Non-Lead Sites (n = 1,509)		Total (N = 2,618)	
	Freq.	%	Freq.	%	Freq.	%
Clinical psychologist	53	4.8	35	2.3	88	3.4
General psychologist	302	27.2	132	8.7	434	16.6
Social worker	60	5.4	58	3.8	118	4.5
Occupational therapist	7	0.6	5	0.3	12	0.5
Mental health nurse	86	7.8	62	4.1	148	5.7
Aboriginal and Torres Strait Islander health/ mental health worker	1	0.1	19	1.3	20	0.8
Low intensity mental health worker	2	0.2	9	0.6	11	0.4
General practitioner	3	0.3	0	0.0	3	0.1
Psychiatrist	0	0.0	1	0.1	1	0.0
Other medical	0	0.0	3	0.2	3	0.1
Other	43	3.9	69	4.6	112	4.3
Peer worker	0	0.0	1	0.1	1	0.0
Not stated	552	49.8	1,115	73.9	1,667	63.7

Appendix 8: Episode characteristics

Table 62. Episode data source, overall and by Lead Site status (January 2016 – December 2018)

Episode data source	Lead Site (n = 122,423)		Non-Lead Site (n = 237,708)		Total (N = 360,131)	
	Freq.	%	Freq.	%	Freq.	%
ATAPS	13,728	11.2	49,338	20.8	63,066	17.5
headspace	60,776	49.6	99,380	41.8	160,156	44.5
PMHC	47,919	39.1	88,990	37.4	136,909	38.0

Table 63. Episode completion status, overall and by Lead Site status (January 2016 – December 2018)

Episode completion status	Lead Sites (n = 122,423)		Non-Lead Sites (n = 237,708)		Total (N = 360,131)	
	Freq.	%	Freq.	%	Freq.	%
Episode open	19,213	15.7	39,284	16.5	58,497	16.2
Episode closed - treatment concluded	60,385	49.3	106,676	44.9	167,061	46.4
Episode closed administratively - client could not be contacted	2,132	1.7	4,964	2.1	7,096	2.0
Episode closed administratively - client declined further contact	2,239	1.8	4,487	1.9	6,726	1.9
Episode closed administratively - client moved out of area	331	0.3	957	0.4	1,288	0.4
Episode closed administratively - client referred elsewhere	1,502	1.2	2,941	1.2	4,443	1.2
Episode closed administratively - other reason	11,305	9.2	8,864	3.7	20,169	5.6
Missing	25,316	20.7	69,535	29.3	94,851	26.3

Table 64. Average number of all service contacts per episode by principal focus, overall and by Lead Site status (January 2016 – December 2018)

Principal focus	Lead Sites (n = 122,423)				Non-Lead Sites (n = 237,708)				Total (N = 360,131)			
	n	range	mean	S.D.	n	range	mean	S.D.	n	range	mean	S.D.
Psychological therapy	36,075	1-113	6.3	5.4	93,389	1-165	5.4	4.9	129,464	1-165	5.7	5.0
Low intensity psychological intervention	8,367	1-84	6.0	5.6	9,437	1-112	5.4	6.2	17,804	1-112	5.7	6.0
Clinical care coordination	4,464	1-371	14.4	19.7	8,903	1-245	9.2	15.6	13,367	1-371	11.0	17.2
Complex care package	181	1-72	9.3	11.3	981	1-110	7.5	11.7	1,162	1-110	7.8	11.7
Child and youth-specific mental health services	66,127	1-245	5.5	8.3	110,115	1-286	5.1	7.2	176,242	1-286	5.2	7.7
Indigenous-specific mental health services	1,256	1-109	5.3	6.5	6,486	1-146	5.7	7.7	7,742	1-146	5.6	7.5
Other	5,953	1-77	6.3	5.7	8,397	1-98	6.7	6.2	14,350	1-98	6.5	6.0
Overall	**122,423**	**1-371**	**6.1**	**8.2**	**237,708**	**1-286**	**5.5**	**7.0**	**360,131**	**1-371**	**5.7**	**7.4**

Table 65. Average number of attended service contacts per episode by principal focus, overall and by Lead Site status (January 2016 – December 2018)

Principal focus	Lead Sites (n = 122,423)				Non-Lead Sites (n = 237,708)				Total (N = 360,131)			
	n	range	mean	S.D.	n	range	mean	S.D.	n	range	mean	S.D.
Psychological therapy	36,075	1-113	5.8	5.1	93,389	1-165	5.4	4.9	129,464	1-165	5.7	5.0
Low intensity psychological intervention	8,367	1-82	5.2	6.0	9,437	1-112	5.4	6.2	17,804	1-112	5.7	6.0
Clinical care coordination	4,464	1-348	12.9	17.8	8,903	1-245	9.2	15.6	13,367	1-371	11.0	17.2
Complex care package	181	1-67	8.1	10.4	981	1-110	7.5	11.7	1,162	1-110	7.8	11.7
Child and youth-specific mental health services	66,127	1-245	5.5	8.3	110,115	1-286	5.1	7.2	176,242	1-286	5.2	7.7
Indigenous-specific mental health services	1,256	1-102	4.9	6.0	6,486	1-146	5.7	7.7	7,742	1-146	5.6	7.5
Other	5,953	1-74	5.9	5.6	8,397	1-98	6.7	6.2	14,350	1-98	6.5	6.0
Overall	**122,423**	**1-348**	**5.9**	**7.9**	**237,708**	**1-286**	**5.2**	**6.7**	**360,131**	**1-348**	**5.4**	**7.1**

Table 66. Episode referral source, overall and by Lead Site status (January 2016 – December 2018)

Referral Source	Lead Sites (n = 237,708)		Non-Lead Sites (n = 122,423)		Total (N = 360,131)	
	Freq.	%	Freq.	%	Freq.	%
General practitioner	64,877	53.0	147,154	61.9	212,031	58.9
Psychiatrist	2,141	1.7	1,040	0.4	3,181	0.9
Obstetrician	4	0.0	22	0.0	26	0.0
Paediatrician	329	0.3	638	0.3	967	0.3
Other medical specialist	264	0.2	274	0.1	538	0.1
Midwife	12	0.0	125	0.1	137	0.0
Maternal health nurse	295	0.2	307	0.1	602	0.2
Psychologist	862	0.7	1,465	0.6	2,327	0.6
Mental health nurse	463	0.4	1,448	0.6	1,911	0.5
Social worker	613	0.5	1,322	0.6	1,935	0.5
Occupational therapist	46	0.0	103	0.0	149	0.0
Aboriginal health worker	56	0.0	330	0.1	386	0.1
Educational professional	238	0.2	534	0.2	772	0.2
Early childhood service worker	67	0.1	129	0.1	196	0.1
Other	7,708	6.3	14,863	6.3	22,571	6.3
N/A - self referral	38,190	31.2	58,633	24.7	96,823	26.9
Not stated	6,258	5.1	9,321	3.9	15,579	4.3

Table 67. Episode referrer organisation, overall and by Lead Site status (January 2016 – December 2018)

Referrer organisation	**Lead Sites (n = 122,423)**		**Non-Lead Sites (n = 237,708)**		**Total (N = 360,131)**	
	Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**
General practice	45,873	37.5	90,338	38.0	136,211	37.8
Medical specialist consulting rooms	730	0.6	398	0.2	1,128	0.3
Private practice	983	0.8	1,715	0.7	2,698	0.7
Public mental health service	849	0.7	1,665	0.7	2,514	0.7
Public hospital	829	0.7	852	0.4	1,681	0.5
Private hospital	15	0.0	32	0.0	47	0.0
Emergency department	76	0.1	72	0.0	148	0.0
Community health centre	1,588	1.3	1,063	0.4	2,651	0.7
Drug and alcohol service	37	0.0	224	0.1	261	0.1
Community support organisation NFP	1,091	0.9	2,173	0.9	3,264	0.9
Indigenous health organisation	654	0.5	2,720	1.1	3,374	0.9
Child and maternal health	109	0.1	157	0.1	266	0.1
Nursing service	15	0.0	48	0.0	63	0.0
Telephone helpline	10	0.0	14	0.0	24	0.0
Digital health service	266	0.2	120	0.1	386	0.1
Family support service	128	0.1	170	0.1	298	0.1
School	555	0.5	732	0.3	1,287	0.4
Tertiary education institution	18	0.0	73	0.0	91	0.0
Housing service	31	0.0	106	0.0	137	0.0
Centrelink	5	0.0	17	0.0	22	0.0
Other	7,067	5.8	12,954	5.4	20,021	5.6
N/A - self referral	38,190	31.2	58,633	24.7	96,823	26.9
Not stated	23,304	19.0	63,432	26.7	86,736	24.1

NFP. Not for profit.

Appendix 9: Person-level consumer characteristics

Table 68. Socio-demographic consumer characteristics, overall and by Lead Site status (January 2016 – December 2018)

Characteristic		Lead Sites (n = 113,974)		Non-Lead Sites (n = 215,095)		Total (N = 329,069)	
		Freq.	%	Freq.	%	Freq.	%
Data source	ATAPS	12,901	11.3	45,447	21.1	58,348	17.7
	headspace	54,833	48.1	88,455	41.1	143,288	43.5
	PMHC	46,240	40.6	81,193	37.7	127,433	38.7
Gender	Not stated/Inadequately described	5,808	5.1	7,124	3.3	12,932	3.9
	Male	40,694	35.7	79,239	36.8	119,933	36.4
	Female	66,333	58.2	127,391	59.2	193,724	58.9
	Other	1,139	1.0	1,341	0.6	2,480	0.8
Indigenous status	Aboriginal but not Torres Strait Islander origin	6,466	5.7	21,464	10.0	27,930	8.5
	Torres Strait Islander but not Aboriginal origin	206	0.2	677	0.3	883	0.3
	Both Aboriginal and Torres Strait Islander origin	472	0.4	1,308	0.6	1,780	0.5
	Neither Aboriginal or Torres Strait Islander origin	86,413	75.8	155,663	72.4	242,076	73.6
	Not stated/inadequately described	20,417	17.9	35,983	16.7	56,400	17.1
Country of birth	Australia	69,834	61.3	129,606	60.3	199,440	60.6
	England	1,517	1.3	2,292	1.1	3,809	1.2
	New Zealand	1,169	1.0	2,106	1.0	3,275	1.0
	China (excludes SARs and Taiwan)	612	0.5	557	0.3	1,169	0.4
	South Africa	324	0.3	525	0.2	849	0.3
	Philippines	297	0.3	522	0.2	819	0.2
	India	274	0.2	367	0.2	641	0.2
	United States of America	323	0.3	335	0.2	658	0.2
	Other	3,503	2.2	3,716	1.3	7,219	1.5
	Unknown	36,121	31.7	75,069	34.9	111,190	33.8

Characteristic		Lead Sites (n = 113,974)		Non-Lead Sites (n = 215,095)		Total (N = 329,069)	
		Freq.	%	Freq.	%	Freq.	%
Main language	English	89,501	78.5	181,525	84.4	271,026	82.4
	Arabic	630	0.6	990	0.5	1,620	0.5
	Mandarin	848	0.7	727	0.3	1,575	0.5
	Vietnamese	598	0.5	575	0.3	1,173	0.4
	Spanish	379	0.3	465	0.2	844	0.3
	Other Australian Indigenous Languages, NEC	178	0.2	650	0.3	828	0.3
	Cantonese	453	0.4	369	0.2	822	0.2
	Italian	287	0.3	283	0.1	570	0.2
	Greek	327	0.3	205	0.1	532	0.2
	Aboriginal English, so described	17	0.0	514	0.2	531	0.2
	Hindi	171	0.2	312	0.1	483	0.1
	Tagalog	141	0.1	245	0.1	386	0.1
	Turkish	163	0.1	146	0.1	309	0.1
	German	112	0.1	165	0.1	277	0.1
	French	127	0.1	150	0.1	277	0.1
	Japanese	108	0.1	167	0.1	275	0.1
	Korean	122	0.1	119	0.1	241	0.1
	Afrikaans	60	0.1	152	0.1	212	0.1
	Russian	123	0.1	85	0.0	208	0.1
	Serbian	76	0.1	97	0.0	173	0.1
	Persian (excluding Dari)	59	0.1	105	0.0	164	0.0
	Samoan	58	0.1	99	0.0	157	0.0
	Macedonian	84	0.1	58	0.0	142	0.0
	Tamil	15	0.0	118	0.1	133	0.0
	Polish	60	0.1	53	0.0	113	0.0
	Other	480	0.0	973	0.0	1,453	0.0
	Unknown	18,797	16.5	25,748	12.0	44,545	13.5

NEC. Not elsewhere classified.

Characteristic		**Lead Sites (n = 113,974)**		**Non-Lead Sites (n = 215,095)**		**Total (N = 329,069)**	
		Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**
Proficiency English	Not applicable (persons under 5 years of age or who speak only English)	70,453	61.8	119,525	55.6	189,978	57.7
	Very well	17,096	15.0	52,823	24.6	69,919	21.2
	Well	3,068	2.7	15,583	7.2	18,651	5.7
	Not well	934	0.8	1,683	0.8	2,617	0.8
	Not at all	300	0.3	248	0.1	548	0.2
	Not stated/inadequately described	22,123	19.4	25,233	11.7	47,356	14.4
Number of episodes	1	106,341	93.3	196,125	91.2	302,466	91.9
	2	6,904	6.1	16,200	7.5	23,104	7.0
	3	652	0.6	2,205	1.0	2,857	0.9
	4	70	0.1	384	0.2	454	0.1
	5	6	0.0	117	0.1	123	0.0
	6 or more	1	0.0	64	0.0	65	0.0

Appendix 10: Episode-level consumer characteristics

Table 69. Episode-level consumer age, overall and by Lead Site status (January 2016 – December 2018)

Age (years)	Lead Sites (n = 122,423)		Non-Lead Sites (n = 237,708)		Total (N = 360,131)	
	Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**
0-11 years	6,728	5.5	15,039	6.3	21,767	6.0
12-25 years	76,670	62.6	132,152	55.6	208,822	58.0
26-35 years	10,377	8.5	24,822	10.4	35,199	9.8
36-45 years	9,633	7.9	21,461	9.0	31,094	8.6
46-55 years	8,986	7.3	21,512	9.0	30,498	8.5
56-65 years	5,818	4.8	13,681	5.8	19,499	5.4
66+ years	3,634	3.0	7,938	3.3	11,572	3.2
Missing	577	0.5	1,103	0.5	1,680	0.5

Table 70. Episode-level consumer characteristics, overall and by Lead Site status (January 2016 – December 2018)

Characteristic		Lead Sites (n = 122,423)		Non-Lead Sites (n = 237,708)		Total (N = 360,131)	
		Freq.	%	Freq.	%	Freq.	%
Homelessness	Sleeping rough or in non-conventional accommodation	696	0.6	1,204	0.5	1,900	0.5
	Short-term or emergency accommodation	1,629	1.3	2,665	1.1	4,294	1.2
	Not homeless	82,796	67.6	150,769	63.4	233,565	64.9
	Not stated / missing	37,302	30.5	83,070	34.9	120,372	33.4
Labour force status	Employed	27,840	22.7	46,842	19.7	74,682	20.7
	Unemployed	20,995	17.1	39,892	16.8	60,887	16.9
	Not in the labour force	31,752	25.9	59,238	24.9	90,990	25.3
	Not stated / inadequately described	41,836	34.2	91,736	38.6	133,572	37.1
Employment participation	Full-time	6,999	5.7	14,676	6.2	21,675	6.0
	Part-time	20,570	16.8	30,923	13.0	51,493	14.3
	Not applicable - not in the labour force	51,750	42.3	97,392	41.0	149,142	41.4
	Not stated / inadequately described	43,104	35.2	94,717	39.8	137,821	38.3
Source of income	N/A - client aged less than 16 years	22,028	18.0	47,004	19.8	69,032	19.2
	Disability Support Pension	4,011	3.3	6,844	2.9	10,855	3.0
	Other pension or benefit (not superannuation)	13,450	11.0	28,486	12.0	41,936	11.6
	Paid employment	24,500	20.0	40,297	17.0	64,797	18.0
	Compensation payments	156	0.1	327	0.1	483	0.1
	Other (e.g., superannuation, investments etc.)	548	0.4	978	0.4	1,526	0.4
	Nil income	3,095	2.5	4,760	2.0	7,855	2.2
	Not known	13,426	11.0	24,565	10.3	37,991	10.5
	Not stated/inadequately described	41,209	33.7	84,447	35.5	125,656	34.9

Characteristic		Lead Sites (n = 122,423)		Non-Lead Sites (n = 237,708)		Total (N = 360,131)	
		Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**
Health care card	Yes	16,200	13.2	31,238	13.1	47,438	13.2
	No	8,410	6.9	16,972	7.1	25,382	7.0
	Not known	4,774	3.9	13,459	5.7	18,233	5.1
	Not stated	93,039	76.0	176,039	74.1	269,078	74.7
NDIS participant	Yes	610	0.5	1,309	0.6	1,919	0.5
	No	22,557	18.4	49,270	20.7	71,827	19.9
	Not stated / inadequately described	99,256	81.1	187,129	78.7	286,385	79.5
Marital status	Never married	12,370	10.1	25,702	10.8	38,072	10.6
	Widowed	852	0.7	1,563	0.7	2,415	0.7
	Divorced	2,144	1.8	4,269	1.8	6,413	1.8
	Separated	2,299	1.9	5,567	2.3	7,866	2.2
	Married (registered and de facto)	6,582	5.4	16,877	7.1	23,459	6.5
	Not stated / inadequately described	98,176	80.2	183,730	77.3	281,906	78.3
Remoteness area	Inner regional Australia	24,437	20.0	64,429	27.1	88,866	24.7
	Major cities of Australia	88,675	72.4	118,712	49.9	207,387	57.6
	Outer regional Australia	7,837	6.4	41,432	17.4	49,269	13.7
	Remote Australia	403	0.3	7,368	3.1	7,771	2.2
	Very remote Australia	28	0.0	4,402	1.9	4,430	1.2
	Missing	1,043	0.9	1,365	0.6	2,408	0.7
IRSD	1 (greatest disadvantage)	19,724	16.1	60,486	25.4	80,210	22.3
	2	24,713	20.2	58,921	24.8	83,634	23.2
	3	24,579	20.1	53,395	22.5	77,974	21.7
	4	22,707	18.5	36,013	15.2	58,720	16.3
	5 (least disadvantage)	29,639	24.2	27,496	11.6	57,135	15.9
	Missing	1,061	0.9	1,397	0.6	2,458	0.7

IRSD. Index of Relative Socio-economic Disadvantage.

Table 71. Episode-level GP Mental Health Treatment Plan, overall and by Lead Site status (January 2016 – December 2018)

GP Mental Health Treatment Plan	Lead Sites (n = 122,423)		Non-Lead Sites (n = 237,708)		Total (N = 360,131)	
	Freq.	%	Freq.	%	Freq.	%
Yes	44,296	36.2	85,018	35.8	129,314	35.9
No	7,554	6.2	11,655	4.9	19,209	5.3
Unknown	43,613	35.6	78,701	33.1	122,314	34.0
Not stated / inadequately described	26,960	22.0	62,334	26.2	89,294	24.8

Table 72. Episode-level suicide referral flag, overall and by Lead Site status (January 2016 – December 2018)

Suicide referral flag	Lead Sites (n = 122,423)		Non-Lead Sites (n = 237,708)		Total (N = 360,131)	
	Freq.	%	Freq.	%	Freq.	%
Yes	6,814	5.6	15,197	6.4	22,011	6.1
No	47,840	39.1	110,756	46.6	158,596	44.0
Unknown	67,769	55.4	111,755	47.0	179,524	49.8

Table 73. Episode-level diagnosis, overall and by Lead Site status (January 2016 – December 2018)

Diagnosis	Lead Sites (n = 122,423)		Non-Lead Sites (n = 237,708)		Total (N = 360,131)	
	Freq.	%	Freq.	%	Freq.	%
Anxiety disorders	18,759	15.3	36,793	15.5	55,552	15.4
Affective disorders	19,628	16.0	38,053	16.0	57,681	16.0
Substance use disorders	1,230	1.0	2,076	0.9	3,306	0.9
Psychotic disorders	1,633	1.3	2,296	1.0	3,929	1.1
Childhood and adolescence disorders	2,331	1.9	5,147	2.2	7,478	2.1
Other mental disorders	4,076	3.3	7,659	3.2	11,735	3.3
Subsyndromal problem	16,257	13.3	28,052	11.8	44,309	12.3
Other	24,892	20.3	67,090	28.2	91,982	25.5
Missing	33,617	27.5	50,542	21.3	84,159	23.4

Table 74. Episode-level additional diagnosis, overall and by Lead Site status (January 2016 – December 2018)

Additional diagnosis	Lead Sites (n = 122,423)		Non-Lead Sites (n = 237,708)		Total (N = 360,131)	
	Freq.	%	Freq.	%	Freq.	%
No additional diagnosis	10,060	8.2	32,390	13.6	42,450	11.8
Anxiety disorders	10,326	8.4	18,563	7.8	28,889	8.0
Affective disorders	4,230	3.5	8,136	3.4	12,366	3.4
Substance use disorders	1,347	1.1	2,535	1.1	3,882	1.1
Psychotic disorders	302	0.2	397	0.2	699	0.2
Childhood and adolescence disorders	876	0.7	1,861	0.8	2,737	0.8
Other mental disorders	1,946	1.6	4,601	1.9	6,547	1.8
Subsyndromal problem	8,096	6.6	15,382	6.5	23,478	6.5
Other	5,496	4.5	31,749	13.4	37,245	10.3
Missing	79,744	65.1	122,094	51.4	201,838	56.0

Table 75. Episode-level medications, overall and by Lead Site status (January 2016 – December 2018)

Medication		Lead Sites (n = 122,423)		Non-Lead Sites (n = 237,708)		Total (N = 360,131)	
		Freq.	%	Freq.	%	Freq.	%
Antipsychotics (N05A)	Yes	3,346	2.7	6,141	2.6	9,487	2.6
	No	38,823	31.7	103,581	43.6	142,404	39.5
	Unknown	80,254	65.6	127,986	53.8	208,240	57.8
Anxiolytics (N05B)	Yes	3,788	3.1	6,447	2.7	10,235	2.8
	No	38,056	31.1	102,928	43.3	140,984	39.1
	Unknown	80,579	65.8	128,333	54.0	208,912	58.0
Hypnotics and sedatives (N05C)	Yes	2,373	1.9	4,992	2.1	7,365	2.0
	No	38,836	31.7	103,182	43.4	142,018	39.4
	Unknown	81,214	66.3	129,534	54.5	210,748	58.5
Antidepressants (N06A)	Yes	14,631	12.0	35,479	14.9	50,110	13.9
	No	29,132	23.8	75,817	31.9	104,949	29.1
	Unknown	78,660	64.3	12,6412	53.2	20,5072	56.9
Psychostimulants and nootropics (N06B)	Yes	528	0.4	1,136	0.5	1,664	0.5
	No	25,347	20.7	51,134	21.5	76,481	21.2
	Unknown	96,548	78.9	185,438	78.0	281,986	78.3

Appendix 11: Service contact characteristics

Table 76. Service contact type, overall and by Lead Site status (July 2016 – December 2018)

Service contact type	Lead Site (n = 534,127)		Non-Lead Site (n = 1,009,718)		Total (N = 1,543,845)	
	Freq.	%	Freq.	%	Freq.	%
Assessment	102,738	19.2	174,528	17.3	277,266	18.0
Structured psychological intervention	292,009	54.7	604,274	59.8	896,283	58.1
Other psychological intervention	47,904	9.0	53,775	5.3	101,679	6.6
Clinical care coordination/liaison	30,537	5.7	63,655	6.3	94,192	6.1
Clinical nursing services	20,281	3.8	16,374	1.6	36,655	2.4
Child or youth specific assistance NEC	13,905	2.6	32,556	3.2	46,461	3.0
Suicide prevention specific assistance NEC	6,159	1.2	14,249	1.4	20,408	1.3
Cultural specific assistance NEC	847	0.2	12,990	1.3	13,837	0.9
Psychosocial support	46	0.0	129	0.0	175	0.0
ATAPS	19,701	3.7	37,188	3.7	56,889	3.7

NEC. Not elsewhere classified.

Table 77. Service contact modality, overall and by Lead Site status (July 2016 – December 2018)

Service contact modality	Lead Site (n = 534,127)		Non-Lead Site (n = 1,009,718)		Total (N = 1,543,845)	
	Freq.	%	Freq.	%	Freq.	%
Face-to-face	467,060	87.4	890,710	88.2	1,357,770	87.9
Telephone	53,177	10.0	95,947	9.5	149,124	9.7
Video	1,584	0.3	3,250	0.3	4,834	0.3
Internet-based	12,306	2.3	19,811	2.0	32,117	2.1

Table 78. Service contact participants, overall and by Lead Site status (July 2016 – December 2018)

Service contact participants	Lead Site (n = 534,127)		Non-Lead Site (n = 1,009,718)		Total (N = 1,543,845)	
	Freq.	%	Freq.	%	Freq.	%
Individual client	468,186	87.7	902,789	89.4	1,370,975	88.8
Client group	23,152	4.3	40,379	4.0	63,531	4.1
Family / client support network	19,717	3.7	34,662	3.4	54,379	3.5
Other health professional or service provider	9,248	1.7	26,378	2.6	35,626	2.3
Other	841	0.2	2,749	0.3	3,590	0.2
Not stated	12,983	2.4	2,761	0.3	15,744	1.0

Table 79. Service contact venue, overall and by Lead Site status (July 2016 – December 2018)

Service contact venue	Lead Site (n = 534,127)		Non-Lead Site (n = 1,009,718)		Total (N = 1,543,845)	
	Freq.	%	Freq.	%	Freq.	%
Client's home	15,220	2.8	21,948	2.2	37,168	2.4
Service provider's office	131,468	24.6	256,095	25.4	387,563	25.1
GP practice	20,084	3.8	62,178	6.2	82,262	5.3
Other medical practice	1,599	0.3	3,833	0.4	5,432	0.4
headspace centre	10,662	2.0	5,365	0.5	16,027	1.0
Other primary care setting	8,316	1.6	11,017	1.1	19,333	1.3
Public or private hospital	1,755	0.3	6,728	0.7	8,483	0.5
Aged care centre	545	0.1	1,472	0.1	2,017	0.1
School or other educational centre	4,593	0.9	6,971	0.7	11,564	0.7
Client's workplace	355	0.1	436	0	791	0.1
Other	8,637	1.6	17,172	1.7	25,809	1.7
Aged care centre - non-residential	0	0	58	0	58	0
Not applicable (service contact modality is not face-to-face)	47,589	8.9	78,636	7.8	126,225	8.2
Not stated	283,304	53.0	537,809	53.3	821,113	53.2

Table 80. Duration, overall and by Lead Site status (July 2016 – December 2018)

Duration	Lead Site (n = 534,127)		Non-Lead Site (n = 1,009,718)		Total (N = 1,543,845)	
	Freq.	%	Freq.	%	Freq.	%
1-15 mins	51,343	9.6	59,771	5.9	111,114	7.2
16-30 mins	39,685	7.4	74,302	7.4	113,987	7.4
31-45 mins	16,421	3.1	27,434	2.7	43,855	2.8
46-60 mins	327,446	61.3	649,269	64.3	976,715	63.3
61-75 mins	60,339	11.3	126,698	12.5	187,037	12.1
76-90 mins	12,355	2.3	25,780	2.6	38,135	2.5
91-105 mins	11,601	2.2	19,591	1.9	31,192	2.0
106-120 mins	4,856	0.9	14,167	1.4	19,023	1.2
over 120 mins	10,029	1.9	12,600	1.2	22,629	1.5
Missing	52	0.0	106	0.0	158	0.0

Table 81. Client participation, overall and by Lead Site status (July 2016 – December 2018)

Client participation	Lead Site (n = 534,127)		Non-Lead Site (n = 1,009,718)		Total (N = 1,543,845)	
	Freq.	%	Freq.	%	Freq.	%
Yes	524,197	98.1	978,716	96.9	1,502,913	97.3
No	9,930	1.9	31,002	3.1	40,932	2.7

Table 82. Interpreter, overall and by Lead Site status (July 2016 – December 2018)

Interpreter	**Lead Site (n = 534,127)**		**Non-Lead Site (n = 1,009,718)**		**Total (N = 1,543,845)**	
	Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**
Yes	5,166	1.0	7,725	0.8	12,891	0.8
No	249,943	46.8	426,835	42.3	676,778	43.8
Not stated	279,018	52.2	575,158	57.0	854,176	55.3

Table 83. Copayment, overall and by Lead Site status (July 2016 – December 2018)

Co-payment	**Lead Site (n = 534,127)**		**Non-Lead Site (n = 1,009,718)**		**Total (N = 1,543,845)**	
	Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**
No	533,434	99.9	995,657	98.6	1,529,091	99.0
Yes	693	0.1	14,061	1.4	14,754	1.0

Table 84. Final service contact, overall and by Lead Site status (July 2016 – December 2018)

Final service contact	**Lead Site (n = 534,127)**		**Non-Lead Site (n = 1,009,718)**		**Total (N = 1,543,845)**	
	Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**
No further services are planned for the client in the current episode	14,516	2.7	27,412	2.7	41,928	2.7
Further services are planned for the client in the current episode	355,717	66.6	638,621	63.2	994,338	64.4
Not known at this stage	163,894	30.7	343,685	34.0	507,579	32.9

Appendix 12: Analysis of PMHC MDS outcomes

A12.1 Data Integrity

There were 360,131 in-scope episodes supplied by all 31 PHNs. Of these, 122,423 (34%) were episodes supplied by the 10 PHN Lead Sites, and are the focus of analysis of consumer mental health outcomes.

Table 85 shows that, for Lead Sites, the majority of in-scope episodes came from the headspace (49%) and PMHC (39%) data sources.

Table 85. In-scope episodes supplied by Lead Sites by data source

Lead Site Project	Source			
	ATAPS	headspace	PMHC	Total
Yes	13,728	60,776	47,919	122,423

Of the 122,423 in-scope episodes supplied by Lead Site PHNs, 49,041 (40%) had no outcome data recorded. Conversely, there were 73,382 unique episodes (60% of the 122,423) with outcome data recorded. Of the 73,382 unique in-scope episodes with outcome data recorded, there was a total of 117,840 outcome collection occasions reported, noting that an episode of care can have multiple outcome collection occasions. These 117,840 outcome collection occasions comprised 115,099 K10 measures, 675 K5 measures, 1,192 SDQ-PC measures, 542 SDQ-PY measures, and 332 SDQ-YR measures.

Table 86 shows the 117,840 outcome measures supplied, by measure and data source (i.e., ATAPS, headspace or PMHC). It shows that headspace only reports the K10 and that, overall, 72% K10 data comes from headspace. The K5 is only reported by the PMHC data source. Approximately 90% of data for each of the three SDQ measures is reported by the PMHC data source.

Table 86. Measures supplied by PHN Lead Sites by data source (%)

Measure	Freq.	Source			Total
		ATAPS	headspace	PMHC	
K10	115,099	2.0	73.4	24.6	100.0
K5	675	.	.	100.0	100.0
SDQ-PC	1,192	12.0	.	88.0	100.0
SDQ-PY	542	4.6	.	95.4	100.0
SDQ-YR	332	7.8	.	92.2	100.0
Total	117,840	2.1	71.7	26.2	100.0

‘ . ’ indicates no records.

Data integrity checks were undertaken with both the episode record details and the outcome measures. At the episode level, the number and percentage of records were identified with: missing values or anomalous episode attributes; missing values on selected episode-level domains; missing or anomalous information regarding outcome measure collection occasions; and missing or anomalous information regarding outcome measure scores. The selected episode-level domains were: socio-demographic variables (gender, age, remoteness, and IRSD quintile), clinical variables (principal diagnosis, outcome score category at baseline), treatment variables (principal focus of treatment plan, number of attended service contacts) and system-related variables (referrer profession and year of referral) [ggg].

Data integrity checks for the five outcome measures included validation of the total score, specifically whether the supplied total score was within the range of valid scores for that measure and, where measure specific items were supplied, whether the supplied total score reconciled with the derived total score. There were some additional checks relevant only to the SDQ measures. With respect to the SDQ measures, checks were undertaken to test whether the 'baseline' version was reported at episode start and whether the 'follow-up' version was reported at review or episode end. Tests were also undertaken to check that the appropriate version specific to the consumer's age was reported. In order to account for the censored nature of the sampling frame (i.e., the consumer's age is recorded at episode start), SDQ measure-specific age bands allowed for lower age range less than 1-year and an upper range 2-years greater than the usual restriction: for the SDQ-PC, an acceptable measure was for a child consumer aged between 3 and 12 years; for the SDQ-PY and SDQ-YR, an acceptable measure was for a consumer aged between 10 and 19 years.

Table 87 shows the percentage of records that failed each check. Of note:

- Approximately one-fifth of K10 and SDQ-YR records, one-third of SDQ-PC and SDQ-PY, and one-tenth of K5 records were missing Principal Diagnosis;
- Between 7% and 14% of K5 and all three SDQ measure records were missing Referrer Profession;
- For the K10, K5 and the two SDQ youth measures, 6-13% of episode records included a Collection Occasion occurring before the Episode Start Date;
- There were no outcome scores for 19% of K5 records; and
- For all three SDQ measures, 9-13% of records had anomalies relating to Version and Collection Occasion Reason; 22% of SDQ-PY records and 5% of SDQ-YR records had anomalies relating to Version and Client Age.

It was possible for a record to 'fail' more than one check. Records that failed each check were excluded if the amount of missing data was negligible (i.e., less than 5% for each of the five outcome measures); this means that records with missing Principal Diagnosis and missing Referrer Profession were retained. After implementing the data integrity checks:

- The percentage of supplied outcome measure records that met minimum data integrity requirements and were retained for subsequent analysis and reporting was approximately 60% for the SDQ-PY, 70% for the K5, SDQ-PC and SDQ-YR, and 90% for the K10; and
- The total number of records retained for analysis was 104,999 (86% of total supplied records).

[ggg] We selected episode-level domains from the broader array available from the routinely collected data sources. Domains were selected if they were available for all data sources and; the overall level of missing data was < 25%. Referrer Organisation met these criteria but was not selected because Referrer Profession was more comprehensively reported.

Table 87. Percentage of records that failed integrity checks, by measure (%)

Data integrity checks[hhh]	K10	K5	SDQ-PC	SDQ-PY	SDQ-YR
Supplied: (N)	115,099	675	1,192	542	332
No Episode Record	0.1	0.1	0.4	.	.
Missing: Episode Referral date	0.5	0.1	0.4	.	.
Missing: Episode Start Date	0.1	0.1	0.4	.	.
Date anomaly: Episode Start before Referral	0.2	0.7	2.4	2.8	2.4
Date anomaly: Episode Start after Episode End	0.0	.	0.1	.	.
Missing: Client Gender	0.3	0.3	0.5	0.6	0.9
Missing: Client Age	0.2	0.6	0.4	.	.
Missing: Remoteness Area	0.4	0.7	0.8	.	0.3
Missing: IRSD Quintile	0.5	0.7	0.8	.	0.3
Missing: Principal Diagnosis[iii]	19.1	10.2	37.2	29.7	19.0
Missing: Principal Focus of Treatment Plan	0.1	0.1	0.4	.	.
Missing: Referrer Profession[jjj]	2.5	6.8	10.9	14.0	7.5
Missing: Year of Referral	0.5	0.1	0.4	.	.
Missing: Collection Occasion date	0.3	.	4.3	2.4	1.2
Date anomaly: Collection Occasion before Episode Referral	0.1	.	0.7	0.6	0.3
Date anomaly: Collection Occasion before Episode Start	6.3	11.1	4.5	5.7	13.0
Date anomaly: Collection Occasion after Episode End	0.0	.	0.2	.	0.3
No Outcome Scores	2.0	19.4	4.7	1.7	2.4
Invalid Outcome Scores	0.0	.	2.5	1.3	1.5
Multiple Outcome Measures-per day	1.0	0.3	1.0	1.8	1.2
Anomaly: SDQ Measure & Collection Occasion Reason	.	.	12.7	10.1	9.0
Anomaly: SDQ Measure & Client Age	.	.	3.8	21.8	5.1
Retained: (N) Valid Outcome Measures	103,125	492	832	322	228
Retained: (%) Valid Outcome Measures	89.6	72.9	69.8	59.4	68.7

‘.’ indicates no data and ‘0’ indicates the percentage is greater than 0 and less than 0.05. IRSD, Index of Relative Socio-economic Disadvantage.

Table 88 shows the 104,999 outcome measures retained, by measure and data source. When compared to the patterns of measures supplied (Table 86), the exclusion of records failing the integrity checks did not appear to introduce any important bias in the data available for analysis.

Table 88. Measures retained by and data source (%)

Measure	**Freq.**	**Source**			**Total**
		ATAPS	**headspace**	**PMHC**	
K10	103,125	1.9	76.2	22.0	100
K5	492	.	.	100.0	100
SDQ-PC	832	16.3	.	83.7	100
SDQ-PY	322	5.0	.	95.0	100
SDQ-YR	228	7.5	.	92.5	100
Total	104,999	2.0	74.8	23.2	100

‘ . ’ indicates no records.

[hhh] Integrity checks are not reported for Baseline outcome score because episodes without outcome collection occasions have already been deemed out of scope.

[iii] Records missing Principal Diagnosis and Referrer Profession were retained. All other records failing integrity check were excluded.

[jjj] Records missing Principal Diagnosis and Referrer Profession were retained. All other records failing integrity check were excluded.

A12.2 Analysis cohort: Episode types

The outcome measure records that met minimum levels of data integrity (N = 104,999) were included in analyses of consumers' mental health status and, where possible, mental health outcomes. Note that outcome analyses are only possible where there are at least two measures per consumers within an episode of care. Further, to assess outcomes at the end of treatment, it is necessary to identify matched pairs of measures corresponding to the Start and End of treatment.

We first examined whether outcome collection occasions were 'singletons' (i.e., a single outcome measurement for the entire episode of care) or formed part of a 'sequence' of multiple ratings. Table 89 shows that the majority of ratings for the K10 (69%) formed part of a sequence of multiple ratings per episode, whereas the majority of K5 ratings and SDQ ratings (64%-74%) were single ratings per episode. Overall, of the 104,999 ratings, 33,738 were single ratings (32%) and thus can have no outcome 'status'. Therefore, only the 71,261 multiple ratings per episode were further considered.

Table 89. Measure by number of ratings

Measure	Single		Multiple		Total	
	Freq.	%	Freq.	%	Freq.	%
K10	32,438	31.5	70,687	68.5	103,125	100
K5	314	63.8	178	36.2	492	100
SDQ-PC	596	71.6	236	28.4	832	100
SDQ-PY	238	73.9	84	26.1	322	100
SDQ-YR	152	66.7	76	33.3	228	100
Total	33,738	32.1	71,261	67.9	104,999	100

Among the multiple ratings, we then identified those that were the first or the last in the sequence, and those that were 'others' (i.e., occurred between the first and the last). Table 90 shows that, for the K10, SDQ-PC and SDQ-PY, approximately 95% of ratings were the first or the last in a sequence; for the K5 and SDQ-YR, the percentage was nearing 90%. Overall, of the 71,261multiple ratings, 3,183 ratings (5%) occurred between the first and the last; these were excluded from further analysis. The remaining 68,078 ratings were 34,039 'matched' pairs, which were further considered.

Table 90. Measure by rating type

Measure	First or Last		Other		Total	
	Freq.	%	Freq.	%	Freq.	%
K10	67,550	95.6	3,137	4.4	70,687	100
K5	160	89.9	18	10.1	178	100
SDQ-PC	222	94.1	14	5.9	236	100
SDQ-PY	80	95.2	4	4.8	84	100
SDQ-YR	66	86.8	10	13.2	76	100
Total	68,078	95.5	3,183	4.5	71,261	100

Among the matched pairs of ratings, we then examined which were 'valid' pairs (e.g., a rating with a collection occasion reason recorded as Start followed by a rating recorded as a Review within the same episode of care) and those that were 'invalid' pairs (e.g., a rating with a collection occasion reason recorded at the End followed by a rating made at the Start within the same episode of care). Table 91 shows that, for all measures, the vast majority of matched pairs were valid. Overall, of the 34,039 matched pairs, only a small number (449 or 1%) was invalid; these pairs were excluded from further analysis. The remaining 33,590 valid pairs were further considered.

Table 91. Measure by valid pairs

Measure	Valid pair		Invalid pair		Total	
	Freq.	%	Freq.	%	Freq.	%
K10	33,344	98.7	431	1.3	33,775	100
K5	73	91.3	7	8.8	80	100
SDQ-PC	106	95.5	5	4.5	111	100
SDQ-PY	37	92.5	3	7.5	40	100
SDQ-YR	30	90.9	3	9.1	33	100
Total	33,590	98.7	449	1.3	34,039	100

Among the valid pairs, we then identified which were ‘completed’ episodes (i.e., comprised a Start rating and an End rating). Table 92 shows that the majority (93%) of matched pairs for the K10 and approximately half of matched pairs for the three versions of the SDQ (49-59%) were completed episodes. In contrast, for the K5, more than half of matched pairs (52%) were a Start rating followed by a Review rating (i.e., a ‘right’ censored episode that was ‘incomplete’ within the sampling frame 1 July 2016 to 31 December 2018). Overall, of the 33,590 valid pairs, the majority (31,051 or 92%) were completed episodes.

Table 92. Measure by episode type

Measure	Start > Review		Start > End		Review > Review		Review > End		Valid pair	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
K10	1,718	5.2	30,938	92.8	490	1.5	198	0.6	33,344	100
K5	38	52.1	17	23.3	12	16.4	6	8.2	73	100
SDQ-PC	33	31.1	63	59.4	3	2.8	7	6.6	106	100
SDQ-PY	12	32.4	18	48.6	2	5.4	5	13.5	37	100
SDQ-YR	10	33.3	15	50.0	4	13.3	1	3.3	30	100
Total	1,811	5.4	31,051	92.4	511	1.5	217	0.6	33,590	100

Table 93 shows the measure, by data source, for the 31,051 completed episodes. Overall, 93% of episodes with K10 measures came from headspace and 7% from the PMHC data source. For the K5, 100% of episodes came from the PMHC data source. For the SDQ measures, 71-87% of episodes came from the PMHC data source and 13-29% from ATAPS.

Table 93. Completed episodes by measure, Lead Site project and source

Measure	Freq.	Source			Total
		ATAPS	headspace	PMHC	
K10	30,938	.	93.1	6.9	100
K5	17	.	.	100.0	100
SDQ-PC	63	28.6	.	71.4	100
SDQ-PY	18	22.2	.	77.8	100
SDQ-YR	15	13.3	.	86.7	100
Total	31,051	0.1	92.8	7.1	100

‘ . ’ indicates no data.

A12.3 Analysis cohort: Descriptive profile of completed episodes

For the remainder of the analyses, we focus on the 31,051 matched pairs of measures from completed episodes. In this section, we provide a descriptive profile of the completed episodes according to selected episode-level domains: socio-demographic variables (gender, age, remoteness, and IRSD quintile), clinical variables (principal diagnosis, baseline outcome score category), treatment variables (principal focus of treatment plan, number of attended service contacts) and system-related variables (referrer profession and year of referral).

Table 94 shows the gender mix of consumers, by measure, for completed episodes. Between 60% and 70% of K10, K5 and SDQ-YR completed episodes were for females, while 80% of SDQ-PY and 50% of SDQ-PC completed episodes were for males.

Table 94. Completed episodes for the K10, K5 and SDQ measures (%), by gender

Measure	Freq.	Gender			Total
		Male	Female	Other	
K10	30,938	36.5	61.5	1.9	100
K5	17	29.4	70.6	.	100
SDQ-PC	63	50.8	47.6	1.6	100
SDQ-PY	18	77.8	22.2	.	100
SDQ-YR	15	33.3	66.7	.	100
Total	31,051	36.6	61.5	1.9	100

‘ . ’ Indicates no data.

Table 95 shows the distributions of consumers’ age, by measure, for completed episodes. As expected, the vast majority of K10 episodes were for consumers aged 15 to 21 years (the interquartile range), most SDQ-PC episodes were for consumers aged 7 to 9 years, most SDQ-PY episodes were for consumers aged 11 to 13 years, and most SDC-YR measures were for consumers aged 13 to 16 years. K5 episodes spanned a broader age range, with most episodes for consumers aged 30 to 52 years.

Table 95. Completed episodes for the K10, K5 and SDQ measures (%), by age

Measure	Freq.	Mean	SD	p10	p25	p50	p75	p90
K10	30,938	19.7	8.4	14	15	18	21	24
K5	17	40.3	18.5	13	30	48	52	61
SDQ-PC	63	8.0	1.7	6	7	8	9	10
SDQ-PY	18	11.9	1.4	11	11	11	13	14
SDQ-YR	15	14.0	1.7	11	13	14	16	16

SD = standard deviation; p = percentile.

Table 96 shows the percentage of completed episodes, by measure, according to remoteness area category. For the K10, K5 and SDQ-YR, the highest percentage (67-82%) of completed episodes were for consumers residing in major cities of Australia. For the SDQ-PC and SDQ-PY, the highest percentages were for consumers residing in in inner regional Australia (48-67%).

Table 96. Completed episodes for the K10, K5 and SDQ measures (%), by remoteness area

Measure	Freq.	Remoteness area Major cities of Australia	Inner regional Australia	Outer regional/ remote/ very remote Australia	Total
K10	30,938	75.5	20.1	4.3	100
K5	17	82.4	11.8	5.9	100
SDQ-PC	63	31.7	47.6	20.6	100
SDQ-PY	18	22.2	66.7	11.1	100
SDQ-YR	15	66.7	13.3	20.0	100
Total	31,051	75.4	20.2	4.4	100

Table 97 shows the percentage of completed episodes, by measure, according to quintile of relative socio-economic disadvantage. Episodes for consumers rated using the K10 were fairly evenly distributed across IRSD quintiles. Episodes for consumers rated using the K5, SDQ-PC and SDQ-PY tended to be concentrated in the middle quintiles (2 to 4). Episodes for consumers rated using the SDQ-YR were concentrated further towards areas with relatively less disadvantage (4 and 5).

Table 97. Completed episodes for the K10, K5 and SDQ measures (%), by quintile of relative socio-economic disadvantage

Measure	Freq.	IRSD quintile[kkk] 1	2	3	4	5	Total
K10	30,938	12.7	19.8	22.6	19.5	25.4	100
K5	17	11.8	5.9	35.3	35.3	11.8	100
SDQ-PC	63	11.1	34.9	31.7	12.7	9.5	100
SDQ-PY	18	11.1	27.8	38.9	16.7	5.6	100
SDQ-YR	15	.	13.3	20.0	40.0	26.7	100
Total	31,051	12.7	19.8	22.6	19.5	25.4	100

IRSD, Index of Relative Socio-economic Disadvantage.

Table 98 shows the percentage of completed episodes, by measure, according to consumers' principal diagnosis group. Patterns varied across measures but should be interpreted in light of high rates of missing data for SDQ-PC and SDQ-PY episodes, and large percentages across all measures classified as 'other'.

[kkk] IRSD quintiles range from 1 (greatest disadvantage) to 5 (least disadvantage)

Table 98. Completed episodes for the K10, K5 and SDQ measures (%), by principal diagnosis group

Measure	Freq.	Diagnosis group					Total
		Anxiety disorders	Affective disorders	Other mental disorders[lll]	Other[mmm]	Missing	
K10	30,938	26.3	21.9	8.9	26.2	16.7	100
K5	17	47.1	5.9	.	35.3	11.8	100
SDQ-PC	63	6.3	1.6	9.5	19.0	63.5	100
SDQ-PY	18	16.7	.	11.1	16.7	55.6	100
SDQ-YR	15	20.0	6.7	.	53.3	20.0	100
Total	31,051	26.2	21.8	8.9	26.2	16.8	100

Table 99 shows the percentage of completed episodes, by measure, according to consumers' outcome score category at episode start. Psychological distress scores at episode start were classified as high or very high for the 80% of episodes in which consumer outcomes were rated using K10 and 100% of consumer outcomes were rated using the K5. SDQ total difficulties scores at episode start were classified as high for the majority (53-67%) of episodes in which consumer outcomes were rated using SDQ-PC, SDQ-PY or SDQ-YR.

Table 99. Completed episodes for the K10, K5 and SDQ measures (%), by outcome score category at episode start

Measure	Freq.	Outcome score category				Total
		Low	Moderate	High	Very high	
K10[nnn]	30,938	7.0	13.5	28.1	51.5	100
		Low/ Moderate	High/ Very high			100
K5[booo]	17	.	100.0			100
		Close to average	Slightly raised	High		100
SDQ-PC[ppp]	63	22.2	15.9	61.9		100
SDQ-PY[qqq]	18	27.8	5.6	66.7		100
SDQ-YR[rrr]	15	13.3	33.3	53.3		100

' . ' indicates no data. Shaded cells=category not relevant to the measure

Table 100 shows the percentage of completed episodes, by measure, for each principal focus of treatment plan. Almost all episodes in which consumer outcomes were rated using the K10 (93%) had 'Child- and youth-specific mental health services' as the principal focus; this reflects the fact that the majority (75%) of all K10 records come from headspace (see Table 88). For episodes in which consumer outcomes were rated using the K5, 'Psychological therapy' was the principal focus for the majority of episodes (88%). For the SDQ-PC and SDQ-PY measures 'Psychological therapy' and 'Child- and youth-specific mental health services' comprised the majority of principal foci. For

---

[lll] . 'Other mental disorders' includes substance use disorders, psychotic disorders, childhood and adolescence disorders, adjustment disorders, eating disorders, somatoform disorders, personality disorders and other mental disorders.

[mmm] 'Other' includes subsyndromal problems or other (with no further specification).

[nnn] K10 total score categories: 10-15 (Low); 16-21 (Moderate); 22-29 (High); 30-50 (Very high).

[ooo] K5 total score categories: 5-11 (Low/Moderate); 12-25 (High/Very high).

[ppp] SDQ total difficulties score categories for the parent-completed versions: 0-13 (This score is close to average - clinically significant problems in this area are unlikely); 14-16 (This score is slightly raised, which may reflect clinically significant problems); 17-40 (This score is high - there is a substantial risk of clinically significant problems in this area).

[qqq] SDQ total difficulties score categories for the parent-completed versions: 0-13 (This score is close to average - clinically significant problems in this area are unlikely); 14-16 (This score is slightly raised, which may reflect clinically significant problems); 17-40 (This score is high - there is a substantial risk of clinically significant problems in this area).

[rrr] SDQ total difficulties score categories for the self-completed version: 0-15 (This score is close to average - clinically significant problems in this area are unlikely); 16-19 (This score is slightly raised, which may reflect clinically significant problems); 20-40 (This score is high - there is a substantial risk of clinically significant problems in this area).

episodes in which consumer outcomes were rated using the SDQ-YR, ‘Psychological therapy’ was the most common focus, followed by ‘Low intensity psychological intervention’ and ‘Child- and youth-specific mental health services’.

Table 100. Completed episodes for the K10, K5 and SDQ measures (%), by principal focus of treatment plan

Measure	Freq.	Principal focus of treatment plan							Total
		Psychol-ogical therapy	Low intensity psychol-ogical intervention	Clinical care coordin-ation	Complex care package	Child- and youth-specific mental health services	Indigenous-specific mental health services	Other	
K10	30,938	2.2	4.1	0.3	0.0	93.2	0.0	0.1	100
K5	17	88.2	11.8	.	.	.	.	.	100
SDQ-PC	63	52.4	4.8	.	.	42.9	.	.	100
SDQ-PY	18	50.0	.	5.6	.	44.4	.	.	100
SDQ-YR	15	46.7	20.0	6.7	.	26.7	.	.	100
Total	31,051	2.4	4.2	0.3	0.0	93.0	0.0	0.1	100

‘ . ’ Indicates no data.

Table 101 shows the percentage of completed episodes, be measure, according to number of attended service contacts. Episodes in which consumer outcomes were rated using the K10 or K5, similar percentages had 3 or less, 4-5, 6-9 and 10 or more attended service contacts. For episodes in which consumer outcomes were rated using the SDQ measures, the vast majority had 6 or more attended service contacts.

Table 101. Completed episodes for the K10, K5 and SDQ measures (%), by number of attended service contacts

Measure	Freq.	Number of attended service contacts				Total
		≤ 3	4-5	6-9	≥ 10	
K10	30,938	29.1	19.9	26.6	24.4	100
K5	17	23.5	17.6	29.4	29.4	100
SDQ-PC	63	.	11.1	36.5	52.4	100
SDQ-PY	18	.	11.1	44.4	44.4	100
SDQ-YR	15	.	6.7	26.7	66.7	100
Total	31,051	29.0	19.9	26.6	24.5	100

‘ . ’ Indicates no data.

Table 102 shows the percentage of completed episodes, by measure, according to referrer profession. GPs were common sources of referral across all episodes; self-referral was also common for episodes in which consumer outcomes were rated using the K10 and referral from other professionals was common for episodes in which consumer outcomes were rated using the SDQ-YR. High rates of missing data for SDQ-PC and SDQ-PY episodes should be taken into account when interpreting these patterns.

Table 102. Completed episodes for the K10, K5 and SDQ measures (%), by referrer profession

Measure	Freq.	Referrer profession				Total
		GP	Other	N/A - Self-referral	Not stated	
K10	30,938	44.9	10.5	43.6	1.1	100
K5	17	70.6	17.6	.	11.8	100
SDQ-PC	63	49.2	15.9	1.6	33.3	100
SDQ-PY	18	38.9	11.1	.	50.0	100
SDQ-YR	15	33.3	40.0	6.7	20.0	100
Total	31,051	44.9	10.5	43.4	1.2	100

‘ . ’ Indicates no data.

Table 103 shows the percentage of completed episodes, by measure, according to year of referral. For all measures, the percentage of all completed episodes was higher in 2017 than in 2016 or earlier. The percentage of all completed episodes was higher again in 2018 or later than in 2017 for the K5, SDQ-YR and SDQ-PY; these increases were large for the K5 and SDQ-YR and more modest for the SDQ-PY. The percentage of all completed episodes was somewhat lower in 2018 or later than in 2017 for the K10 and SDQ-PC.

Table 103. Completed episodes for the K10, K5 and SDQ measures (%), by year of referral

Measure	Freq.	Year of referral			Total
		≤ 2016	2017	≥ 2018	
K10	30,938	17.9	42.1	40.0	100
K5	17	.	23.5	76.5	100
SDQ-PC	63	20.6	42.9	36.5	100
SDQ-PY	18	22.2	33.3	44.4	100
SDQ-YR	15	13.3	26.7	60.0	100
Total	31,051	17.9	42.1	40.0	100

‘ . ’ Indicates no data.

A12.4 Outcome classification for completed episodes

Mental health outcomes - that is, the difference or ‘change’ between episode start and episode end scores - were classified using Cohen’s Effect Size metric.[sss] For each measure, a ‘medium’ effect size threshold was set at half a standard deviation of the score. This was calculated from <u>all in-scope episodes supplied by Lead Sites at episode Start</u>, separately for each measure.

Table 104 shows that, for episodes in which consumer outcomes were rated using the K10, this corresponded to an absolute threshold of change score of 5. Mental health outcomes on the K10 were then classified as ‘significant improvement’ if the change score was 5 or more, ‘no significant change’ if the change score was between -4 and 4, and ‘significant deterioration’ if the change score was -5 or less.

For episodes in which consumer outcomes were rated using the K5 and SDQ-PY, the absolute threshold of change score was 3. Mental health outcomes on the K5 were classified as ‘significant improvement’ if the change score was 3 or more, ‘no significant change’ if the change score was between -2 and 2, and ‘significant deterioration’ if the change score was -3 or less.

For episodes in which consumer outcomes were rated using the SDQ-PC and SDQ-YR, the absolute threshold of change score was 4. Mental health outcomes on the SDQ measures were classified as ‘significant improvement’ if the change score was 4 or more, ‘no significant change’ if the change

---

[sss] Cohen J. Statistical power analysis for the behavioural sciences. New Jersey: Lawrence Earlbaum Associates; 1988.

score was between -3 and 3, and 'significant deterioration' if the change score was -4 or less. Note that the change thresholds were calculated for each version separately; it is coincidental that they were the same across all three versions.

Table 104. Cohen's d medium effect size thresholds by measure

Measure	SD	Freq.[ttt]	Absolute threshold of change score [a]	Interval of change scores for 'significant improvement'		Interval of change scores for 'no significant change'		Interval of change scores for 'significant deterioration'	
				Max.	Min.	Max.	Min.	Min.	Max.
K10	8.9	59,954	5	40	5	4	-4	-5	-40
K5	4.4	241	3	20	3	2	-2	-3	-20
SDQ-PC	6.5	577	4	36	4	3	-3	-4	-36
SDQ-PY	6.0	225	3	40	3	2	-2	-3	-40
SDQ-YR	6.1	145	4	34	4	3	-3	-4	-34

SD = standard deviation; Max.=maximum; Min.=minimum.

Outcome analyses were stratified on a number of episode-level domains. Two sets of age bands - median splits and quartile splits - were reported. Quartile splits provide a finer level of detail, but sometimes only a median split is possible due to the small number of episodes. The thresholds for the age splits were calculated from all in-scope episodes supplied by Lead Sites for each measure, using the consumers' age at episode start (see Table 105).

Table 105. Distribution of age by measure

Measure	Freq.	mean	S.D.	p10	p25	p50	p75	p90
K10	59,954	22.7	12.1	14	16	19	23	40
K5	241	34.5	19.4	11	19	33	49	60
SDQ-PC	577	7.7	2.0	5	6	8	9	10
SDQ-PY	225	12.3	1.8	11	11	12	13	15
SDQ-YR	145	14.0	2.0	11	12	14	15	17

SD = standard deviation; p=percentile.

[ttt] Represents all in-scope episode Start scores (i.e., not just the matched pairs).

Appendix 13: Themes and quotes from consultation with consumers

Table 106. Consumer survey: Themes for responses to the question, 'Why did you choose to use this mental health service? Other, please specify (n = 30)

Themes	Subthemes	Low intensity	Psychological therapy	Care coordination	Indigenous focused	Child and youth	Suicide prevention	Total
Number of respondents		**n = 7**	**n = 16**	**n = 3**	**n = 0**	**n = 1**	**n = 3**	**n = 30**
Reiterated fixed answers		3	6	0	0	0	1	10
Costs	Can't afford a psychologist	1						1
Referral								4
	Referred by teacher		1					
	Court ordered/ parole		2					
	Suggested by housing service, subsequently got a GP referral		1					
Symptoms or events								9
	Angry and not happy with myself		1					
	Need someone to talk to	1						
	Complex and multiple mental health issues		1					
	Upset and depressed by issues with Centrelink		1					
	Had been admitted to psychiatric ward twice		1					
	Relapsed						1	
	Child with mental health issues		1			1		
Lack of support	No other social support available		2					2
Part of another program								2
	As part of a mental health care plan			1				
	A part of the Redress program						1	
Other								3
	Earlier experience with service and staying on top of mental health issues			1				
	Choose this service rather than a psychologist	1						
	Due to advertisement/ flyer	1						

Table 107. Consumer survey: Themes for responses to the question ‘The service would have been better if …’ (n = 213)

Themes	**Subthemes**	**Low intensity**	**Psychological therapy**	**Care coordination**	**Indigenous focused**	**Child and youth**	**Suicide prevention**	**Total**	**Sample quotations[a]**
Number of respondents		**n = 51**	**n = 131**	**n = 19**	**n = 1**	**n = 1**	**n = 10**	**n = 205**	
Accessibility								43	
	More accessible location and/or less travel time	3	4	0	0	0	0	7	
	Less waiting time	2	13	2	0	0	1	18	‘I had been able to see a psychologist sooner. By the time I was able to see someone, my mental health had deteriorated substantially’ (PT)
	Other and/or more modality options	1	1	0	0	0	0	2	
	Less costs	0	5	0	0	0	0	5	‘……The New Start Allowance doesn't pay much per fortnight especially when food, rent and other bills are taken out, so I'm at a disadvantage, I need to see a psychologist long term, but can't pay for their service.’ (PT)
	Ongoing care/ continuity	1	4	1	0	0	0	6	
	Outreach available	0	1	0	0	0	0	1	
	More direct access to medication	0	1	0	0	0	0	1	
	Choice of provider/ clinician	0	2	0	0	0	0	2	
	More programs available	0	1	0	0	0	0	1	
Sessions								59	
	More sessions/ longer period (program length)	6	23	0	0	0	0	29	
	More frequent sessions	1	7	0	0	0	0	8	
	Longer sessions (session length)	2	9	2	0	0	0	13	
	More flexible hours/ after-hours	1	6	1	1	0	0	9	‘Opening/Closing hours were earlier/later as some sessions I missed out on because of education commitments. (PT)
Staff								31	
	More/ improved professional skills or qualities of staff	3	9	8	0	1	3	24	‘My daughter was able to connect with her councillors better’ (PT)
	Expert staff needed (e.g. psychiatrist)	0	1	0	0	0	0	1	
	More staff available	0	7	0	0	0	0	7	

Themes	Subthemes	Low intensity	Psychological therapy	Care coordination	Indigenous focused	Child and youth	Suicide prevention	Total	Sample quotations[uuu]
Treatment								26	
	A wider therapeutic scope	9	9	1	0	0	2	21	'It wasn't so CBT based' (PT)
	Improve qualities of treatment	0	0	0	0	0	2	2	
	More/fewer other people in group	2	0	0	0	0	0	2	
	More clarity on treatment and outcomes	1	0	0	0	0	0	1	
Processes								21	
	Better referral processes	0	4	0	0	0	0	4	
	Easier management of appointments	1	2	0	0	0	0	3	
	Better communication between staff and or health services	1	1	0	0	0	0	2	
	More advertisement/ promotion of service	4	2	1	0	0	1	8	'I could have known of its availability rather than finding out about it by chance' (LI)
	Less paperwork/ questionnaires	1	2	0	0	0	0	3	
	Better worksheets	1	0	0	0	0	0	1	
Infrastructure								7	
	Sound proof rooms	0	1	0	0	0	1	2	
	More appropriate/ comfortable spaces	2	1	1	0	0	0	4	
	Disability access	0	1	0	0	0	0	1	
Other		1	0	0	0	0	0	1	'I have had access when I was experiencing more severe problems' (LI)
Nothing		9	30	3	0	0	2	44	

Note. Some consumers have given answers with multiple themes or sub-themes, as such number per theme/sub-theme do not add up to total number of consumers. In total, 17 consumers gave 1 additional answer, 2 consumers gave 2 additional answers and 1 consumer gave 3 additional answers (n = 20).

[uuu] Quotes per service-type indicated as: LI= low intensity services; PT= psychological therapy; CC= care coordination; SP= suicide prevention.

Table 108. Consumer survey: Themes for responses to the question ‘The best thing about the service was…’ (n= 241)

Themes	**Subthemes**	**Low intensity**	**Psychological therapy**	**Care coordination**	**Indigenous focused**	**Child and youth**	**Suicide prevention**	**Total**	**Sample quotations**[vvv]
Number of respondents		**n = 56**	**n = 146**	**n = 23**	**n = 1**	**n = 2**	**n = 13**	**n = 241**	
Accessibility								82	
	Distance/ location	3	7	1	0	0	1	12	
	Promptness	4	10	1	0	0	1	16	‘The efficiency and ease of access once my application was processed. I got my first appointment within a month of submitting the application and it was a huge weight off my shoulders…..’ (PT)
	Modality / modality options	2	3	0	0	0	0	5	
	Costs/ free	6	14	1	0	0	0	21	
	Ongoing care/ continuity	1	6	1	0	0	0	8	‘having something constant in my life.’ (PT)
	Outreach	2	3	3	0	0	0	8	
	Ease of access/ General availability	1	7	3	0	0	0	11	
	Access to medication	0	0	0	0	0	1	1	
Sessions								10	
	Amount of sessions/period (program length)	0	0	0	0	0	1	1	
	Frequency of sessions (weekly/monthly)	2	3	1	0	0	0	6	
	Session length/ time	0	1	0	0	0	0	1	
	Flexible hours/ after-hours	2	0	0	0	0	0	2	‘Being the mum of a six month old baby this was really important to me and indeed it was the only service I could find that provided that flexibility.’ (LI)
Staff								112	
	Professional skills and qualities of staff	13	38	4	1	0	2	58	‘Feeling welcome, supported with no judgement.’ (PT)
	Client sentiment (support, welcoming, safe space etc.,)	12	36	2	0	1	3	54	‘I felt safe’ (SP)

[vvv] Quotes per service-type indicated as: LI= low intensity services; PT= psychological therapy; CC= care coordination; SP= suicide prevention.

Themes	**Subthemes**	**Low intensity**	**Psychological therapy**	**Care coordination**	**Indigenous focused**	**Child and youth**	**Suicide prevention**	**Total**	**Sample quotations[a]**
Treatment								86	
	Beyond the scope/ fills other needs (holistic, other than MH)	0	0	1	0	0	1	2	
	Fills personal needs/ helpful	19	39	9	0	0	1	68	'It was tailored to my specific requirements.' (CC)
	Outcomes: behavioral changes / learnings	6	8	0	0	0	0	14	'Skills finally equipped enough to work for my life..'(PT)
	Meeting others with similar condition/problems	0	2	0	0	0	0	2	
Processes								6	
	Fast/prompt referral	0	1	0	0	0	0	1	
	Easy to schedule appointment	0	0	1	0	0	0	1	
	Collaboration with other services	0	1	0	0	0	0	1	
	Follow-ups	2	0	0	0	0	0	2	
	Outcome measures/ tracking personal change	1	0	0	0	0	0	1	
Other		1	1	0	0	0	0	2	'The facilities and programs' (PT) 'First time [I] could be open to a male councillor' (LI)
Nothing		2	6	1	0	1	3	13	

Note. Some consumers have given answers with multiple themes or sub-themes, as such number per theme/sub-theme do not add up to total number of consumers. In total, 60 consumers gave 1 additional answer, 8 consumers gave 2 additional answers and 2 consumers gave 3 additional answers (n = 70).

Table 109. Consumer survey: Themes for 'other comments' about the service (n = 106)

Themes	Subthemes	Low intensity	Psychological therapy	Care coordination	Indigenous focused	Child and youth	Suicide prevention	Total	Sample quotations[a]
Number of respondents		**n = 25**	**n = 63**	**n = 10**	**n = 0**	**n = 0**	**n = 8**		
Reiterates previous comments								41	
	Positive	1	9	1	0	0	4	15	
	Negative	10	15	0	0	0	1	26	
Accessibility								16	
Negative/ improvements	Waiting time	2	1	0	0	0	0	3	
	Costs	1	2	0	0	0	0	3	
	Ongoing car/continuity	0	2	0	0	0	0	2	
	Number of programs available	1	2	0	0	0	0	3	'I wish there were more groups so my friends and family could do it'(LI)
Positive	Promptness	0	1	0	0	0	0	1	
	Costs/ free	1	0	0	0	0	0	1	
	Ongoing care/ continuity	1	0	0	0	0	0	1	
	Ease of access/ General availability	1	1	0	0	0	0	2	
Sessions								3	
Negative/ improvements	Amount of sessions/ program length	0	1	0	0	0	0	1	
	Session frequency	1	1	0	0	0	0	2	
Staff								18	
Negative/ improvements	Professional skills or qualities of staff	0	1	0	0	0	0	1	'I am Aboriginal and I only wish more psychologists could connect with members of my community the way mine has with me and more Aboriginal psychologists need to be employed.' (PT)
	Amount of staff available	0	2	0	0	0	0	2	
Positive	Professional skills and qualities of staff	2	3	0	0	0	0	5	
	Client sentiment (support, welcoming, safe space etc.)	2	5	1	0	0	2	10	

Themes	**Subthemes**	**Low intensity**	**Psychological therapy**	**Care coordination**	**Indigenous focused**	**Child and youth**	**Suicide prevention**	**Total**	**Sample quotations**[www]
Treatment								22	
Negative/ improvements	Therapeutic scope	0	2	0	0	0	0	2	'…..I wish there was a more holistic or spiritual counselling available ….' (PT)
	Qualities of treatment	0	1	0	0	0	0	1	
	Clarity on treatment outcome	0	0	1	0	0	0	1	
Positive	Beyond the scope/ fills other needs (holistic, other than MH)	0	0	1	0	0	0	1	
	Fills personal needs/ helpful	1	1	0	0	0	1	3	
	Outcomes: behavioral changes / learnings	1	9	4	0	0	0	14	'It has been life changing and kept me out of prison' (CC) '…It was transformative for me.' (PT)
Processes								4	
Negative/ improvements	Amount advertisement/ promotion of service	0	1	1	0	0	0	2	
Positive	Collaboration with other services	0	1	1	0	0	0	2	
General positive comment on service		3	10	0	0	0	0	13	
Other		1	0	0	0	0	0	1	I still do not know how [it] works, whether it covers me for 12 sessions a year, and if I could bring it forward to the following year if I have not used them up [….]. (LI)

Note. Some consumers have given answers with multiple themes or sub-themes, as such number per theme/sub-theme do not add up to total number of consumers. In total, 11 consumers gave 1 additional answer, 1 consumer gave 2 additional answers (n = 12).

[www] Quotes per service-type indicated as: LI= low intensity services; PT= psychological therapy; CC= care coordination; SP= suicide prevention.

Appendix 14: Themes and quotes from consultation with carers

Table 110. Carer survey: Themes for responses to the question, ‘The service would have been better if…’ (n = 13)

Themes	Subthemes	Freq.	Sample quotations[xxx]
Access was improved		11	
	More programs in regional areas	1	
	More psychologist sessions were offered	2	
	More one-on-one programs (rather than group or online)	1	
	Location of programs better	2	‘It was a little closer to home.’(PT)
	Wait was less	2	
	Help was offered to carer while waiting	1	‘…I would really have appreciated some help with this…’ (LI)
	Programs were promoted more widely	2	
Treatment was improved		4	
	There was resolution of difficulties by end of program	1	
	Groups were smaller	1	
	Resources were explained better	1	
	Longer duration program	1	
Service integration was better		4	
	Transition between levels of care took too long	2	
	More coordination between clinicians (GP, Psych etc)	2	
Carer Input	Carer input during treatment	1	
None	The service does not need improvement	2	‘The service was excellent and so was the professional’ (CY)

Note. Some carers have given answers with multiple themes or sub-themes, therefore, the number of responses per theme/sub-theme do not add up to total number of carers. In total, 9 carers gave an answer with a single theme/sub-theme, 1 carer gave an answer with 2 themes/sub-themes, 2 carers gave an answer with 3 themes/sub-themes and 1 carer gave an answer with 5 themes/sub-themes (n = 22).

[xxx] Quotes per service-type indicated as: LI= low intensity services; PT= psychological therapy; CY = child and youth; SP= suicide prevention

Table 111. Carer survey: Themes for responses to the question 'The best thing about the service was …' (n = 14)

Themes	Subthemes	Total	Sample quotations[yyy]
Access		6	
	Cost	2	
	Location	2	'The clinic is also very close to our home and my daughter can walk there as she doesn't have her licence.' (PT)
	Existence of the service	2	
Treatment		11	
	Therapy	3	
	Skills acquired	1	
	Consumer awareness of own issues	2	
	Trust in clinician or therapeutic environment safe	3	
	Results visible quickly	2	
Clinician attributes (good, empathic, warm engaging, caring, understanding, compassionate, professionalism		3	'The psychologist is warm and engaging.' (PT) '…the compassion and caring understanding and professional help we received.' (CY)
For carers		3	
	Carers network	1	
	Respite	2	'My sister is getting her shit together which means I can start focusing on my life.'(PT)

Note. Some carers have given answers with multiple themes or sub-themes, therefore, the number of responses per theme/sub-theme do not add up to total number of carers. In total, 9 carers gave an answer with a single theme/sub-theme, 3 carers gave an answer with 2 themes/sub-themes and 2 carers gave an answer with 4 themes/sub-themes (n = 23).

[yyy] Quotes per service-type indicated as: LI= low intensity services; PT= psychological therapy; CY = child and youth; SP= suicide prevention.

Table 112. Carer survey: Themes for 'other comments' about the service received (n = 11)

Themes	Subthemes	Freq.	Sample quotations[zzz]
Praise		7	
	Service	4	'This service is amazing. My son was out of control. He is now working hard to reach his goals.' (CY)
	Clinician	1	
	Therapy	1	
	Connection between clinician and consumer	1	
Engagement with carer		3	
	Carer knows issues	1	
	Carer supporting consumer during treatment	1	'…a great contribution to this program is having a family member or friend available as well who is familiar with these programs…' (PT)
	Carer training to continue the work	1	'Follow up and ongoing involvement to support my friend would be helpful in sustaining the constructive process commenced at the sessions.' (PT)
Criticisms		3	
	Follow-up phone calls not helpful	1	
	Online counselling not appropriate (requires motivation)	1	
	Systemic gap / integration	1	'…there is a gap between this treatment and the GP who is writing up observations about fitness to return to work…' (LI)
Reiteration of previous question answers		3	
None		1	

Note. Some carers have given answers with multiple themes or sub-themes, therefore, the number of responses per theme/sub-theme do not add up to total number of carers. In total, 7 carers gave an answer with a single theme/sub-theme, 2 carers gave an answer with 2 themes/sub-themes and 2 carers gave an answer with 3 themes/sub-themes (n = 17).

[zzz] Quotes per service-type indicated as: LI= low intensity services; PT= psychological therapy; CY = child and youth; SP= suicide prevention.