Independent Evaluation of *HeadtoHelp* and AMHCs: Final Evaluation Report

Mental Health

1 April 2022

nous

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Glossary

Term	Definition
Community mental health treatment services	State and territory government-funded and -operated specialised mental health care provided by community mental health care services and hospital-based ambulatory care services, such as outpatient and day clinics.
Community support services	Supports or programs that provide non-clinical services to individuals with mental health, alcohol and other drug problems to support their needs and recovery in order to participate in their local community, often provided by non-government organisations (NGOs).
Episode of care	The period between formal entry to and exit from service, during which treatment for presenting concern(s) is provided. This includes treatment for the reason defined at the point of referral and during the treatment period. Formal exit from the service includes formal discharge from the service's Participant Information Management System (CIMS), as the person's episode of care is considered to be open until this process has been finalised.
Lived experience (mental illness)	People with lived experience are people who identify either as someone who is living with (or has lived with) mental illness or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness. People with lived experience are sometimes referred to as participants and support people. Also referred to as "living experience".
Missing middle	Coined by Productivity Commission, this refers to a service gap encountered by people who have multiple needs or symptoms that are too complex to be adequately treated by a general practitioner and the limited Medicare Benefits Schedule-rebated individual sessions with psychologists. Their condition is also not considered severe enough to meet the threshold for access to state or territory funded specialised mental health service.
Participant	A person living with mental illness who uses, has used or may use a mental health service.
Shared-care plan	A shared-care plan is a patient-centred health record that can be shared by many members of a care team, outlining the health and support needs of the participant.
Support person	A person supporting someone with a mental illness.
Warm transfer	The hub or Centre actively communicates with the service to which the individual is connected, to provide essential information about their needs before transferring them. Support is maintained for the individual by the hub or Centre until they are received by the new service.

Abbreviations

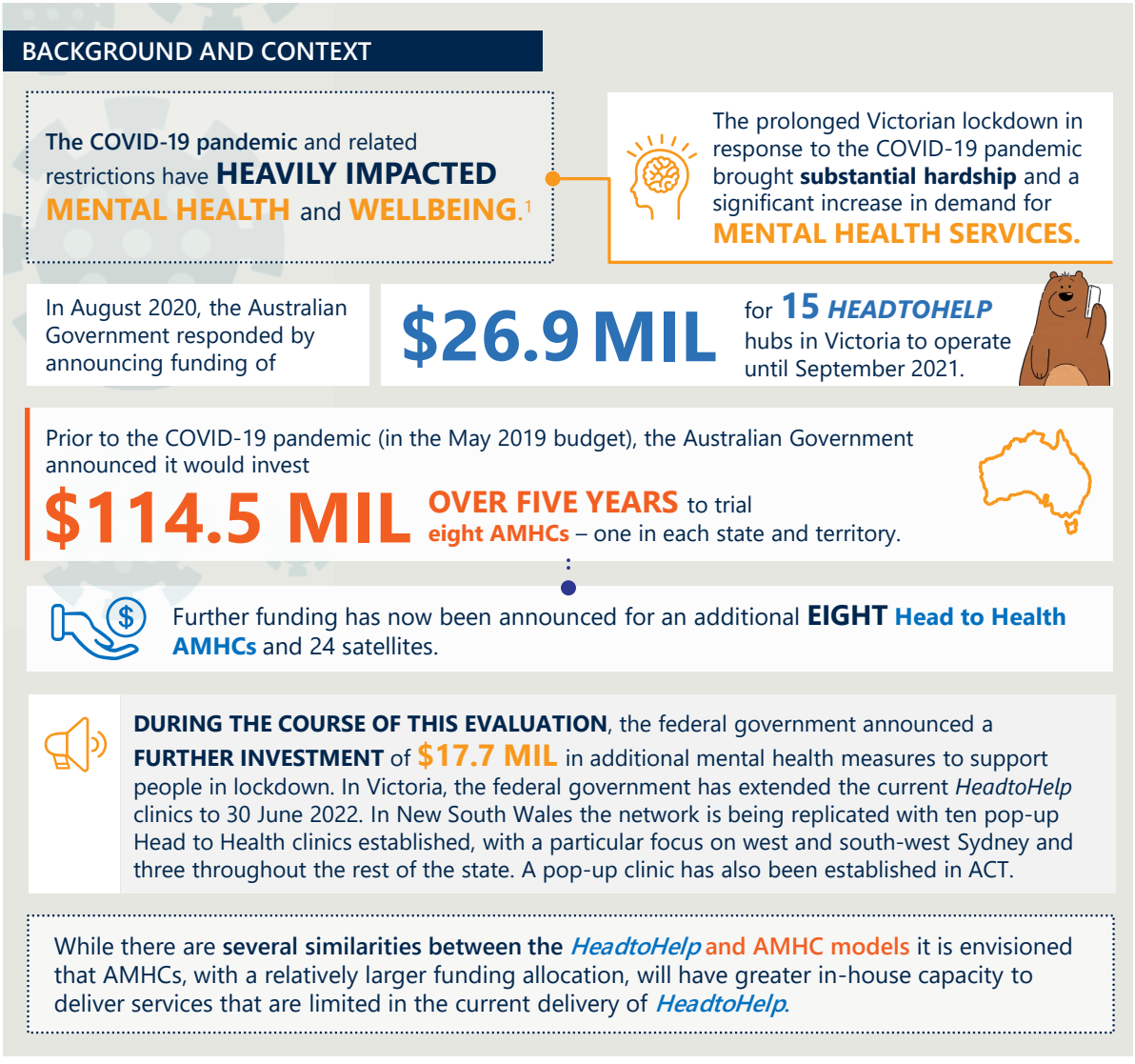
Acronym or abbreviation	Definition
ACCHO	Aboriginal Community Controlled Health Organisation
ACCO	Aboriginal Community Controlled Organisation
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AMHC	Adult Mental Health Centre
AMHS	Area Mental Health Service
AOD	Alcohol and other drugs
CALD	Culturally and linguistically diverse
CAHMS	Child and Adolescent Mental Health Services
CHN	Capital Health Network
DHHS	Department of Health and Human Services
ED	Emergency department
EMPHN	Eastern Melbourne Primary Health Network
EOI	Expression of interest
FAQs	Frequently Asked Questions
FTE	Full time equivalent
GP	General Practitioners
GPHN	Gippsland Primary Health Network
HIE	*HeadtoHelp* Intake Experience survey
IAR	Initial Assessment and Referral
IAR-DST	Initial Assessment and Referral Decision Support Tool
KEQs	Key evaluation questions
KPI	Key performance indicator
LHD	Local Health District
MBS	Medicare Benefits Schedule
MPHN	Murray Primary Health Network
NBMPHN	Nepean Blue Mountains Primary Health Network
NGO	Non-government organisation
NQPHN	Northern Queensland Primary Health Network
NTPHN	Northern Territory Primary Health Network

Acronym or abbreviation	Definition
NWMPHN	North Western Melbourne Primary Health Network
PARCs	Prevention and Recovery Care services
PHN	Primary Health Network
PMHC-MDS	Primary Mental Health Care Minimum Dataset
PMO	Project management office
RCH	The Royal Children's Hospital
RFT	Request for tender
SEMPHN	South Eastern Melbourne Primary Health Network
UMHCC	Urgent Mental Healthcare Centre
WAPHA	WA Primary Health Alliance
WEMWBS	The Warwick-Edinburgh Mental Well-being Scale
WHO	World Health Organization
WVPHN	Western Victoria Primary Health Network
YES	Your Experience of Service survey

Executive Summary

Nous Group (Nous), with support from the University of Sydney, was commissioned by the Australian Government Department of Health to conduct an independent two-part evaluation of the establishment and implementation of the Victorian *HeadtoHelp* initiative, and the establishment of the Head to Health Adult Mental Health Centre (AMHC) trial.

The evaluation ran from January 2021 to March 2022. This Final Report showcases key findings from the evaluation which includes qualitative data collected through interviews and other artefacts, and a quantitative analysis of the Primary Mental Health Care Minimum Dataset (PMHC-MDS) data. Recommendations are provided in relation to intake and use of the Initial Assessment and Referral Decision Support Tool (IAR-DST), the remaining operation of *HeadtoHelp*, as well as the current and future establishment and implementation of the AMHCs across Australia.



1.1 Evaluation findings

Evaluation findings were drawn from comprehensive qualitative and quantitative analysis, including service provider, stakeholder and participant interviews, as well as analysis of the PMHC-MDS, Your Experience of Service (YES) survey and *HeadtoHelp* Intake Experience (HIE) survey findings. Highlights are included below, with detailed analysis in the body of this document.

It is important to note that while this evaluation includes short term outcomes findings for *HeadtoHelp*, findings in relation to AMHCs are limited to the establishment phase. Despite being similar programs, we cannot infer that outcomes achieved through *HeadtoHelp* will be the same as outcomes achieved through AMHC.

1.2 HEADTOHELP FINDINGS

1.2.1 Establishment (Section 3)

How appropriate is the program design to deliver the program outcomes? (Section 3.1)

HeadtoHelp was appropriately designed to increase access to and support navigation of mental health services during a time of heightened need. Specific design features, such as mechanisms to remove barriers to access, use of the IAR-DST and role of multi-disciplinary teams were key to this finding. There were limitations in relation to the opportunity for co-design and the ability of *HeadtoHelp* to operate as a stand-alone response to system fragmentation.

How effective was the establishment of the program? (Section 3.2)

HeadtoHelp hubs were rapidly established in a commendable and highly effective display of Primary Health Network (PHN) collaboration and effort. The approach to commissioning was pragmatic and effective, although some components of contracts could be improved, and the requirement for rapid establishment resulted more in movement for existing staff across the system, rather than a net increase in staff for Victoria. Positively, *HeadtoHelp* drove an unprecedented degree of collaboration – through both governance and goodwill – that PHNs are keen to replicate in other programs. In particular, the shared-service model was positively viewed by stakeholders as a pragmatic, efficient and effective structure to support establishment, that entrenched trust, joint ownership, and collaborative ways of working.

1.2.2 Implementation (Section 4)

How effective has the implementation of the HeadtoHelp initiative been to date and what can we learn from it?

HeadtoHelp is being accessed by the 'missing middle', however, aspects of service use have differed from what was anticipated. Qualitatively, hubs reported that over time, participants were younger, with more severe needs than expected. The level of variation among participants, together with higher than anticipated complexity has posed a significant challenge for each hub's small *HeadtoHelp* workforce and its ability to provide the right level of care and support tailored to each cohort.

Key findings from the service data include:

- Service numbers were concentrated in the regional and remote PHNs – Murray PHN (MPHN) (23 per cent) and Gippsland PHN (GPHN) (23 per cent) accounted for almost half of all *HeadtoHelp* episodes.
- *HeadtoHelp* participants were typically female, English-speaking and aged over 25. While the proportion of clients seen across each age group was broadly similar across PHNs, there were some notable exceptions: approximately a quarter of services in GPHN were delivered to under-18-year-old participants (26 per cent) relative to other PHNs (range of nine to 17 percent).
- Level three Initial Assessment and Referral (IAR) ratings formed the bulk of ratings (ranging from 68 per cent to 81 per cent). There were also more level four and five ratings (15 per cent) relative

to level one and two ratings (10 per cent) across all PHNs. Measuring the severity of psychological distress, the mean K10 scores of clients on entry into the service ranged from 29.5 (MPHN) to 33.4 (Western Victoria PHN (WVPHN)). Scores above 30 on the K10 indicate very high psychological distress, suggesting participants of *HeadtoHelp* were, on average, severely unwell on entering the service.

- Participants and support people sought *HeadtoHelp* services for a variety of reasons – with COVID-19 a primary contributing factor for around two thirds of participants and support persons.
- Psychological therapy and clinical care co-ordination were the most common services delivered by hubs, with six in ten service contacts remote (comprising telephone, video and internet-based). Interestingly, data from the participant and support person interviews contradicted the view often held by service providers that clients overwhelmingly prefer services delivered face-to-face.
- Self and General Practitioner (GP) referrals are the most common pathway to *HeadtoHelp (although the self-referrals are often prompted by GP advice and information).*

Overall, there has been appropriate fidelity to the original service model, although some areas of delivery have differed from what was anticipated – in particular there has been less use of warm referrals (both in and out of the hubs) than anticipated. The average length of service is much longer than the model envisioned, where most participants entering the service continue to be serviced by the hub. The quantitative evidence for this is mixed. Rural and regional PHNs tend to deliver shorter episodes of care, however length of episode care has increased over time. As referrals to *HeadtoHelp* grow, there is a clear risk that it could become another oversubscribed service that is unavailable to community members when they need immediate, accessible, no cost support. In addition, satellite hubs present a potential risk to model fidelity through challenges in ensuring a multi-disciplinary service approach and consistent experience for participants within the constraints of a very small staffing profile. While choice may not be able to be provided in all aspects of service provision, well-funded and well-staffed services will have greater propensity to provide the service and support options participants require.

Other implementation challenges have included service promotion and communication, both with communities and other service providers, and the ability to attract and retain workforce. Specifically, sector-wide workforce competition coupled with short-term contracts for service providers and the associated prolonged uncertainty of *HeadtoHelp's* future has made it extremely challenging for service providers to recruit and retain staff, which is important as participants value the consistency of relationships. Administrative burdens associated with data and reporting has also been a key challenge (though this has improved over time).

These challenges highlight the importance of clear responsibility and remit for service integration, contracts with flexibility and certainty, and the need to manage tension in reporting requirements, as well as build the capability and capacity of the mental health workforce.

Has the HeadtoHelp service implemented effective IAR intake practices?

The roll out of the IAR across *HeadtoHelp* was the first large-scale use of the tool, with largely positive feedback across all stakeholder groups. The IAR has the potential to become a national, standardised approach to conducting an initial intake process for participants of mental health services (except emergency department (ED) presentations in circumstances of severe acute distress where assessment necessarily has a greater focus on risk and timeframe required for stabilisation and treatment). This has important implications for how participants enter and navigate/are referred through the system. There have been some limitations on the extent to which the IAR-DST has reduced 're-telling' of participant stories and opportunities remain to minimise this adverse experience for those seeking treatment and support.

1.2.3 Outcomes (Section 5)

How effective is the program in achieving outcomes for Victorians?

On average, participants experienced a statistically significant reduction in psychological distress, as measured by K10 scores, from the beginning of their engagement with *HeadtoHelp* to the end of service, which indicates reduced psychological distress. It is worth noting that the 10.5 reduction in scores only represents the average change and further analysis reveals that while 84 per cent of participants ultimately had a lower mean post-K10 score, 11 per cent of participants did not see a statistically significant improvement and six per cent had an increase in their post-K10 score. Similarly, based on Kessler 5 assessments, an adaptation of K10 that tends to be used with Aboriginal and/or Torres Strait Islanders, on average, participants experienced a statistically significant improvement in self-reported psychological distress.

Demographic and service factors do not typically impact outcomes of participating in *HeadtoHelp*. Of all factors considered, only three were statistically significant at the 90 per cent significant level: the PHN where the service episode took place, Labour force status (unemployed) and main service contact type (psychosocial[1] support):

- While the relationship between PHNs and change in K10 scores varied among PHNs, the model shows unambiguously that regardless of PHN, participants tended to have statistically significant improvement in outcomes through *HeadtoHelp* (mean difference in K10 scores from pre- to post-episode was 10.5 points).
- For individuals identifying as unemployed, while they still demonstrated an improvement in K10 scores, this was a statistically significant lower improvement relative to those employed.
- For individuals who had a main service contact type of psychosocial support, they similarly experienced a statistically significant lower improvement relative to individuals receiving other main service contact types (e.g., clinical support, referrals to other services). The reasons behind this are unclear but may reflect specific service capabilities and connection to other intersecting service types.

In addition to the quantitative metrics, this evaluation also considered the qualitative benefits of *HeadtoHelp*. Interviews with participants and support people identified a number of benefits for clients including participants being able to think differently, for example, having a better understanding of their mental health situation and being better able to use the services that they need.

What has been and is the likely impact of the implementation of HeadtoHelp?

The majority of participants and support people were satisfied with the service they received. Factors determining high satisfaction included a client-centric system, staff competence and personal qualities, timeliness, cost, proactive communication and follow up, responsiveness to diversity, and the ease with which clients were able to access *HeadtoHelp*. The intake experience was usually positive but depended on the intake clinician. Where clients indicated dissatisfaction with intake this was usually due to what they felt was a superficial intake conversation or an intake staff member who lacked experience or the ability to build rapport.

There were slight differences in satisfaction depending on whether the client received a service at the hub or only a referral, and qualitative data indicated that referrals were often seen as generic or inappropriate. There is evidence of differences in service experience ratings between PHNs.

Interviews with both service partners and participants indicated that integration between *HeadtoHelp* and other services could be improved, and the importance of this for achieving positive outcomes was emphasised by participants. Where service integration was achieved, some success factors included co-location and establishing genuine partnerships to build trust in *HeadtoHelp*.

How efficient is the program?

[1] South Eastern Melbourne PHN defines psychosocial supports as 'a non-therapeutic intervention that can assist people with severe mental illness to participate in their community, manage daily tasks, undertake work or study, find housing, get involved in activities, and make connections with family and friends.'

Noting the limitations of the approach, analysis of costs per service contact and costs per episode of care indicate that while efficiencies are largely dependent on service volumes, some PHNs appear to be more cost efficient than others.

Comparison of overall *HeadtoHelp* efficiency with headspace costs per occasion of service indicates that despite differences in efficiencies between PHNs, *HeadtoHelp* is reasonably efficient across the board.

The slow uptake in service provision is also likely to have impacted the level of confidence in this efficiency analysis. Repeating this analysis with data and service activity from the final December 2021 to June 2022 extension, where funding was distributed based on actuals from the preceding year, would address this limitation and likely to be more reflective of a 'stabilised' service profile.

1.3 AMHC FINDINGS

1.3.1 Establishment (Section 6)

How effective has the establishment of the program been to date and what we can learn from it?

There has been a thorough and robust commissioning processes across the PHNs, with appropriate levels of co-design and funding in place to support effective establishment. While PHNs generally found timelines appropriate, this did not necessarily extend to service providers, many of whom could not meet PHN expectations to open by December 2021. Most major delays to establishment resulted from difficulty in securing the right physical location – recognising an appropriate space as a key feature of the AMHC model and element of co-design.

Workforce recruitment throughout the establishment phase has been effectively managed, with innovative models being adapted for the establishment of peer workforces across services. AMHCs do however, remain concerned about the ability to manage future demand and system-level integration in a complex service and funding environment, particularly in Victoria.

There also remains opportunities to improve collaboration as a complete 'network' of AMHCs.

How appropriate is the IAR intake process that has been developed?

The IAR-DST has been or will be adopted by all the AMHCs in some form, with some states having plans to adopt the tool across state mental health services. Where IAR has already been implemented, for example in the pop-up clinics in NSW, it has received positive feedback. To improve the intake process and ensure consistency for clients, there needs to be further broadening of training in the use of the IAR, as well as consolidation of the intake pathways (phone lines and walk in processes) across AMHCs. The effectiveness of the IAR would increase significantly if supported by an up-to-date directory of services as this would improve the experience of clients and the AMHCs attempting to navigate the mental health system.

How efficiently were AMHCs established?

Funds allocated for the establishment of AMHCs varied across states and territories at the discretion of the Government, appearing to be made on the basis of population size ($10.5 or $14 million across four years). All sites were allocated $1.74 million in establishment costs. Of these establishment costs, the reported expenditure associated with making facilities fit-for-purpose was similar across AMHCs, ranging from $1 million to $1.5 million. Compared with other similar services commissioned, this appears reasonable. In general, PHNs found that establishment funding for the AMHCs was adequate to meet these and other establishment and operating costs such as staffing.

Interviews with AMHC service providers and managers in the early stages of operation have revealed some inefficiencies, partly due to delayed information flow between the Department and service providers, usually due to indirect communications through PHNs. Slow growth in intake numbers during service establishment and maturing also limit efficiency, however many AMHCs have

developed strategies to mitigate this. Efficiency is expected to improve and stabilise as services become more embedded in the community and intake numbers increase to full operating capacity.

It is too early in the roll-out of AMHCs to draw any definitive findings on efficiency. For those services that have commenced operations, initial activity data from December 2021 and January 2022 is both incomplete and inconsistent across centres and is of a too small sample size to draw meaningful conclusions.

Recommendations

This report seeks to assist the Department to make decisions, including about the use of the IAR-DST, transitions for the Victorian *HeadtoHelp* service as well as the current and future roll-out of AMHCs across Australia. At a broader system level, this evaluation seeks to support policy decisions in relation to better integration of services and addressing service gaps, which are relevant to the Australian Government and state governments' National Mental Health and Suicide Prevention Agreement.

A summary of the recommendations in this report is outlined below. Further detail on each is included in Section 7 in this report.

Figure 1 | Summary of Recommendations

1 CENTRALISED INTAKE PROCESSES

- **1.1** Ensure that training is available to support other services in awareness and effective utilisation of the IAR-DST in the context of their service.
- **1.2** Maintain core fidelity of the IAR-DST tool but allow tailoring at the margins for local context.
- **1.3** Evaluate effectiveness of the IAR-DST.
- **1.4** Prioritise investment into continual revision of the IAR-DST, including tailoring for specific cohorts.
- **1.5** The IAR-DST should be amended to include sub-categories of assessments to support the referral of level five clients.
- **1.6** IAR-DST assessment/patient record should be shared with GPs, other referrers and services receiving referrals
- **1.7** The Department should require, and PHNs should ensure, that all continuing *HeadtoHelp* hubs are promoting use of the Victorian single intake contact number only.
- **1.8** The Department should invest in a plan to integrate individual intake processes with the national IAR telephone service when it is implemented in July 2022.
- **1.9** Centralising intake at the PHN regional level should be continued and adopted nationally.
- **1.10** The IAR service needs to be supported by a digital comprehensive service and community resources database that is developed by PHNs as a clinician support tool.

2 REMAINING OPERATION AND WITHDRAWAL OF *HEADTOHELP* HUBS

- **2.1** The Department should extend the operation of existing *HeadtoHelp* hubs until the Victorian Local Mental Health and Wellbeing Centres and subsequent tranches of AMHCs are operational.
- **2.2** Length of stay and impact on access should be closely monitored throughout remaining operation of the hubs.
- **2.3** Evaluation findings should be broadly distributed to PHNs, hubs and intake services. This should include an accompanying guide of best practice features influencing satisfaction.
- **2.4** *HeadtoHelp* PHNs and hubs should review AMHC recommendations and implement where practicable, and benefits will be realised in remaining operation.

3 SUPPORTING SUCCESSFUL *AMHC* IMPLEMENTATION

3.1 Contracts and accountability.

3.1.1 The Department should provide greater guidance on the approach to, and expectations of, performance measurement, and data collection and reporting requirements should be a clear contractual requirement.

3.1.2 The Department should set an expectation of collaboration among both PHNs and commissioned service providers to enable information sharing and continuous improvement.

3.1.3 Performance and outcomes monitoring needs to include specific recovery-oriented individual outcome measurements, including attention to client wellbeing and experience of service.

3.1.4 PHNs' contracts with AMHCs should include specific KPIs for measuring integration to increase accountability

3.1.5 The Department can support timely AMHC establishment through clearer guidance on allocation of time between PHNs and service providers.

3.2 Service model.

3.2.1 Ensure all operating AMHCs have access to appropriate senior clinical expertise.

3.2.2 Ensure adequate training in, and expectations around, use of warm referrals and follow up.

3.2.3 Where existing clinical governance frameworks exist, these should be shared across the AMHC networks.

3.2.4 Funding of AMHCs should seek to maintain accessibility through short waitlists, free services and sufficient capacity.

3.2.5 AMHCs should actively monitor clinical need as the services move more fully into the implementation phase

3.2.6 Ensure all AMHCs have the willingness and capacity to offer and deliver therapeutic telehealth services where that responds to service user preferences.

3.3 Communication, engagement and integration.

3.3.1 Develop a co-designed, comprehensive communications strategy to be adopted by all AMHCs.

3.3.2 As part of an overall communications strategy, AMHCs should be permitted and encouraged to utilise broadcast and social media to connect with local communities.

3.3.3 Clarify and clearly communicate the purpose and intent of AMHCs to manage expectations and ensure there is the capacity and capability to meet those expectations.

3.3.4 AMHCs need to be provided with technical support for system integration.

4 SUPPORTING ESTABLISHMENT AND IMPLEMENTATION OF FUTURE PROGRAMS

4.1 *HeadtoHelp* and the AMHCs have trialled a valuable model for delivering care, that should continue to be delivered and evolved.

4.2 The Department needs to think strategically about how best the Victorian AMHC(s) can interact with the Local Area Wellbeing hubs, and any changes that may be required to the planned roll-out of AMHCs in that jurisdiction.

4.3 Future programs should adopt longer minimum contract durations and adequate minimum periods for renewal prior to contract expiry.

4.4 Future contracts should include dedicated resourcing for relationship building, service integration and promotion and clinical governance.

4.5 Future AMHC locations should be planned in collaboration with state health departments.

4.6 Realise opportunity to inform system design through data.

2 Background to the evaluation

2.1 Purpose of the evaluation

The Australian Department of Health (the Department or Commonwealth) commissioned Nous, supported by the University of Sydney, to conduct an independent evaluation of the Victorian *HeadtoHelp* initiative and the establishment of the Head to Health AMHC trial. Nous partnered with the University of Sydney in undertaking this evaluation. The evaluation commenced in late January 2021 and concluded in March 2022.

The evaluation is being considered in two parts:

- **Part A**, which seeks to assess the establishment, implementation and early outcomes of the *HeadtoHelp* hubs.
- **Part B**, which seeks to understand the effectiveness of the establishment of eight **initial AMHCs**.

During this evaluation the branding of both the *HeadtoHelp* and AMHC programs has or is in the process of transitioning to be known as Head to Health. To reflect stakeholder feedback and avoid confusion, this report uses the terminology of *HeadtoHelp* and AMHC for each program respectively.

This evaluation seeks to understand what has been achieved through these programs to date to enable informed future Commonwealth Government decisions, including about the:

- continuation and/or transition of funding for the Victorian *HeadtoHelp* service and hubs
- current and future roll-out of AMHCs across Australia, including site location, key features of the service, its funding and data to be collected
- extension of the utilisation of the IAR-DST
- addressing of service gaps and navigation
- Commonwealth and state government's national partnership agreement for mental health.

2.2 Evaluation approach

2.2.1 The evaluation focuses on four domains

The domains are:

1. Appropriateness. This looks at whether the approach to establishment and implementation was well-designed, evidence-based and responsive to consultation/co-design within the establishment context.
2. Effectiveness. This includes if the establishment and implementation met stakeholder expectations and planned times, and whether the short-term outcomes were achieved.
3. Efficiency. This assesses if the resources used to set up the services were spent efficiently and if the outcomes achieved represent value for money.
4. Impact. This assesses the likely achievement of the longer-term outcomes expected from the initiatives in the future (as neither services will have been operational long enough to have achieved 'long-term outcomes') and how the initiatives influence the broader service system.

2.2.2 Ten KEQs structured the evaluation and guided data collection and analysis

These key evaluation questions (KEQs) and their alignment to Part A and B of the evaluation is shown in Table 1. Findings in this report are structured around these ten questions.

Table 1 | KEQs

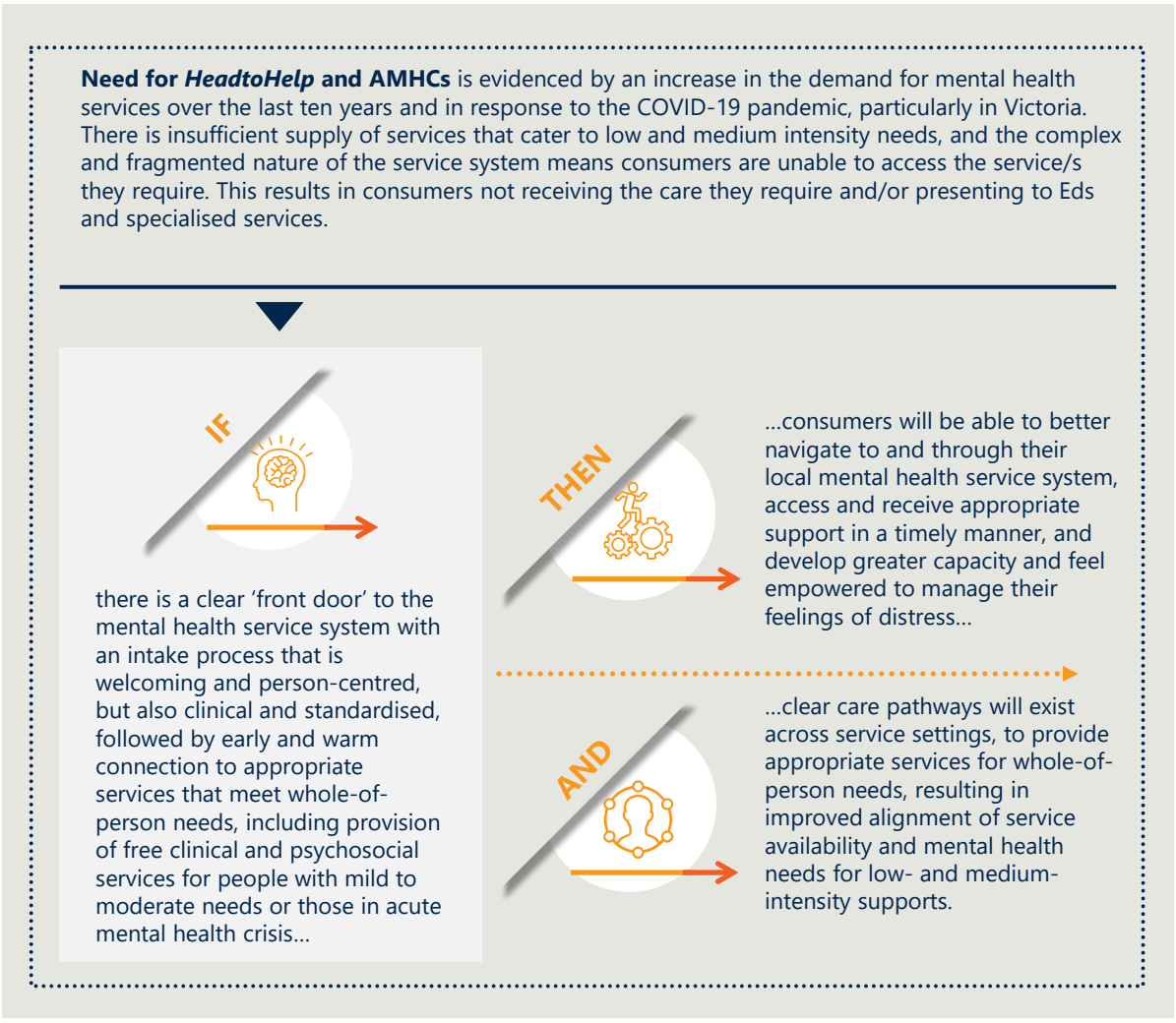
Part A: HeadtoHelp	
Establishment	
1.	How appropriate is the program design to deliver the program outcomes?
2.	How effective was the establishment of the program?
Implementation	
3.	How effective has the implementation of the *HeadtoHelp* initiative been to date and what can we learn from it?
4.	Has the *HeadtoHelp* service implemented effective IAR intake practices?
Outcomes	
5.	How effective is the program in achieving outcomes for Victorians?
6.	What has been and is the likely impact of the implementation of the *HeadtoHelp*?
7.	How efficient is the program?
Part B: AMHC	
8. How effective has the establishment of the program been to date and what we can learn from it?	
9. How appropriate is the IAR intake process that has been developed?	
10. How efficiently were AMHCs established?	

2.3 Methodology

2.3.1 The evaluation was informed by a theory of change and guided by a program logic model

The theory of change for *HeadtoHelp* and the AMHCs is shown in Figure 2. This theory of change is expanded on in the program logics for each program, which can be found in Appendix C of the attached Appendix. The program logics provide further detail on how the *HeadtoHelp* and AMHC activities are intended to achieve the desired outcomes.

Figure 2 | Theory of change for HeadtoHelp and AMHCs



2.3.2 The evaluation involved three data collection stages using a mixed-methods data collection approach

Data collection and analysis activities included consultations and workshops with various *HeadtoHelp* and AMHC stakeholders as well as analysis of survey results and linked data sets. A summary of these activities is given in Figure 3, followed by a summary of the primary and secondary data sources collected by the evaluation. Full details on these sources can be found in the attached Appendix in Sections 1.11 and 1.12.

Figure 3 | Summary of data collection and analysis activities

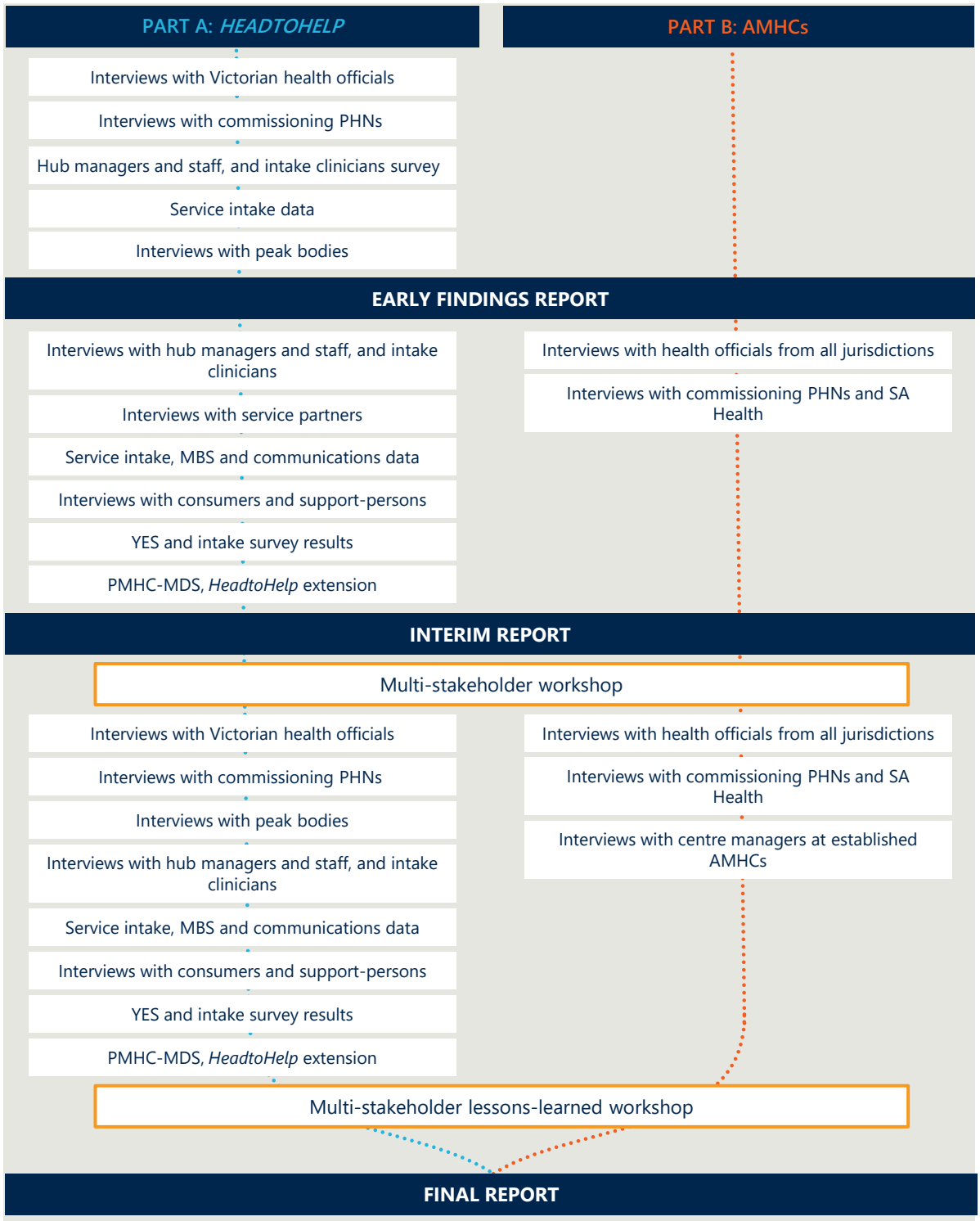


Table 2 | Overview of data sources

	Data Source	Purpose
Secondary Sources	*HeadtoHelp* intake and service data	Understand service delivery trends, including number of participants, referral pathways in and out of *HeadtoHelp,* and episodes of care.
	PMHC-MDS and *HeadtoHelp*	Understand participant demographics, presenting need and

	Data Source	Purpose
	extension	outcomes.
	YES and HIE survey data (when implemented)	Understand participant satisfaction with the service received from *HeadtoHelp*.
	Communications data (e.g., media coverage, website hits, linked calls, Google search, sentiment data)	Understand key awareness raising activities implemented by *HeadtoHelp*.
	MBS data on GP and other service use	Understand historical and current mental health services need.
	Published mental health data on participant, support person and family demand and access	Understand broader trends in mental health service system access.
Primary Sources	Interviews with and surveys of *HeadtoHelp* participants (led by the University of Sydney)	Understand participant experience, outcomes and ideas for improvement.
	Interviews with and surveys of *HeadtoHelp* participants' support people (led by the University of Sydney)	Understand support person experiences and the experience and outcomes of the person they supported, and ideas for improvement.
	Interviews with and surveys of *HeadtoHelp* hubs – managers and staff	Understand what worked well and what was challenging in establishment and implementation, and outcomes being observed for participants.
	Interviews with and surveys of *HeadtoHelp* intake clinicians	Understand how the intake process works, and any challenges and opportunities.
	Interviews with *HeadtoHelp* Service partners and Area Mental Health Services (AMHSs)	Understand how *HeadtoHelp* has integrated with the existing service system, including acting as an effective 'front door', assisting with system navigation and increasing service capacity for people with moderate mental health conditions.
	Interviews with Victorian PHNs for *HeadtoHelp*	Understand establishment and implementation processes, enablers and blockers, and the role of *HeadtoHelp* in the service system.
	Interviews with and surveys of AMHCs – managers and staff	Understand establishment and implementation processes, enablers and blockers, and the role of AMHCs in the service system.
	Interviews with PHNs and SA Health for the AMHCs	Understand establishment and implementation processes, enablers and blockers, and the role of AMHCs in the service system.
	Interviews with officials from the respective state and territory health departments in all jurisdictions	Understand local mental health priorities, operating context for AMHCs and establishment progress, barriers and opportunities.
	Interviews with peak bodies	Understand priorities, role and fit for AMHCs and *HeadtoHelp*, including challenges and opportunities for AMHCs.
	Workshop with multiple stakeholders	Test evaluation insights and findings with staff from PHNs, AMHCs and *HeadtoHelp*, peak bodies and participant representatives, discussing their implication for ongoing and future service establishment, implementation, operation and improvement.

2.3.3 Participant and support people's perspectives for HeadtoHelp were collected in a two-part approach

Participants who participated in interviews and surveys were people who were 16 years and older who had accessed *HeadtoHelp* services, and support people who had been involved with facilitating participants of any age to access or use *HeadtoHelp* services.

The first part of obtaining the perspectives of participants and support people involved qualitative interviews with a purposively selected group, and the second involved primarily quantitative analysis of deidentified participant provided data collected by PHNs as part of their standard service evaluation.

Interview data was analysed using constant comparative analysis, details of which can be found in the accompanying university of Sydney 'Voices of lived Experience' report.

2.3.4 The statistical analysis of the PMHC-MDS data involved two stages

The first stage of the statistical analysis of the PMHC-MDS data was hypothesis testing. This testing helped to determine whether the *HeadtoHelp* service led to a statistically significant effect on the change in the outcome measure (K-10) scores from the start to the end of an episode.

The second stage involved regression analysis to determine the factors that had a statistically significant effect on the change in outcome measure scores from the start to end of an episode. A linear regression was used for simplicity in interpretation with relevant steps taken to ensure the underlying data satisfied assumptions for linear regression, such as no or low collinearity of the chosen factors, homoscedasticity and no or low correlation of residuals. The factors included in the regression model include:

Service[2]

- number of service contacts
- PHN where the episode occurred
- main modality of service contacts
- main type of service contact type.

Demographic

- labour force status
- main language at home
- homelessness
- gender
- age.

2.4 Program context

2.4.1 Background to the HeadtoHelp hubs

Between 9 July and 8 November 2020, metropolitan Melbourne and the Shire of Mitchell re-entered lockdown following a spike in community transmitted cases of COVID-19. The Victorian lockdown in response to the COVID-19 pandemic brought substantial hardship and a significant increase in demand for mental health services.

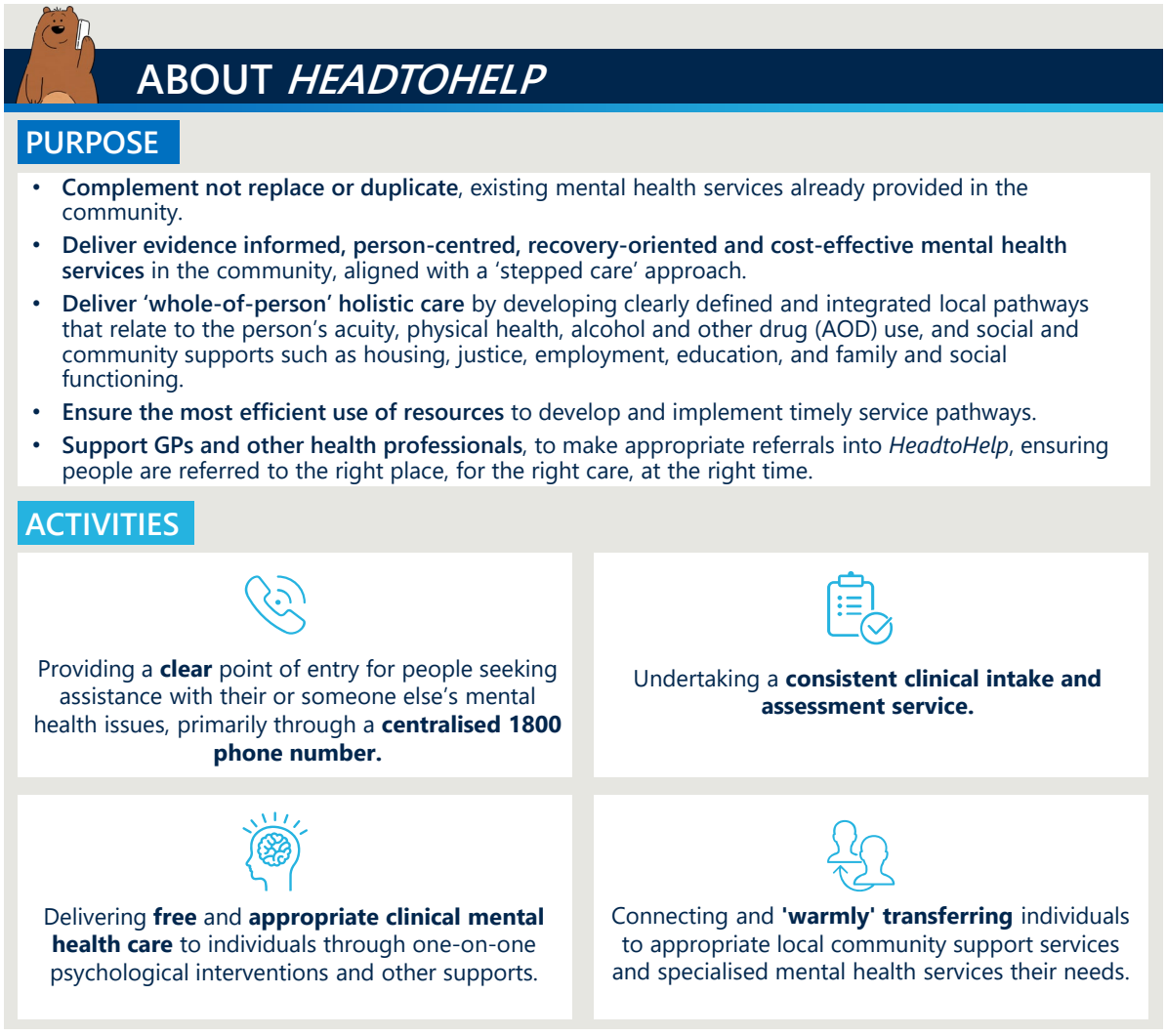
[2] IAR DST-level of care was not considered because participants in GPHN did not have their IAR DST-level of care data in the PMHC-MDS.

HeadtoHelp was established to respond to the urgent and rising mental health need in Victoria, experienced due to this prolonged lockdown. What was unanticipated was that lockdowns would continue as a prominent strategy to contain COVID-19 throughout 2021. In August 2020, the Australian Government responded by announcing funding of $26.9 million for 15 *HeadtoHelp* hubs in Victoria to operate until September 2021. There have been two formal extensions to the program: an initial extension from September 2021 to December 2021 based on underspend and a subsequent successful bid for additional funding for an extension from December 2021 to June 2022.

HeadtoHelp intended to meet mental health needs of Victorians by reflecting system-wide changes in mental health service delivery as outlined by the National Mental Health Commission and Royal Commission into Victoria's Mental Health System.[3] The service aimed to be a 'front door' to the mental health system, providing client-centric, recovery-focused and needs-based care delivered by a multi-disciplinary team.[4] The intent was for Victorians to be able to access services commensurate to their needs, which may have been pre-existing mental health conditions exacerbated by COVID-19 or mental health issues brought on by COVID-19.

The purpose and key activities of the *HeadtoHelp* service and hubs is outlined in Figure 4. Further information on the *HeadtoHelp* service pathway is available in Appendix A.

Figure 4 | Overview of HeadtoHelp



[3] National Mental Health Commission. Monitoring Mental Health and Suicide Prevention Reform: National Report 2019. 2019; Royal Commission into Victoria's Mental Health System. Final Report. February 2021.
[4] Victorian PHN Network. Victorian Mental Health hubs HUB Model of Care. September 2020.

2.4.2 Background to the AMHCs

Prior to the COVID-19 pandemic (May 2019 budget), the Australian Government announced it would invest $114.5 million over five years to trial eight AMHCs – one in each state and territory. The AMHCs have been commissioned in seven states and territories by PHNs, and the final AMHC has been commissioned by the South Australian Government (SA Health). Like *HeadtoHelp*, the Centres aim to make it easier for people to access the mental health advice, information, support and referrals they need in the community. By integrating with other local community services and assisting people to access related health and social services, their aim is to provide a more readily identifiable and accessible 'front door' to the mental health system, as well as immediate treatment and de-escalation of distress or crisis, and support to navigate to other services. The service model is not one of long-term care, however, to 'deliver packages of evidence-based care and family support to cover the short- to medium-term, which could last from a few weeks to several months based on clinical judgement and individual need'.[5]

While there are several similarities between the *HeadtoHelp* and AMHC models, it is envisioned that with the greater amount of funding provided to AMHCs (a range of $2.9 million to $4 million per AMHC per annum compared to $1 million per *HeadtoHelp* hub per annum on average)[6], they will have greater in-house service capacity to deliver services that are limited in the current delivery of *HeadtoHelp* (e.g., medication and psychiatric reviews, telephone de-escalation and walk-in capacity). In addition, *HeadtoHelp* hubs are commonly part of existing services (e.g., GP practices), whereas most AMHCs will be in standalone facilities.

[5] Summarised from the Service Model for Adult Mental Health Centres September 2020.
[6] The figure range for AMHCs was provided by the Australian Government Department of Health in August 2021. The figure for *HeadtoHelp* hubs was provided by the finance lead of the program in April 2021.

Figure 5 | Summary of AMHCs

ABOUT ADULT MENTAL HEALTH CENTRES

PURPOSE

AMHCs seek to address key gaps in the mental health service system. The centres seek to do this by:

- **providing a highly visible and accessible entry point to services** for people experiencing psychological distress, where all feel safe and welcomed
- **offering assessment to match people to the services they need**
- **providing on the spot support, care and advice without needing referral**, prior appointments or out of pocket costs; every interaction should be with the intention of therapeutic benefit
- **offering an episode of care model based on short- to medium-term multidisciplinary care**, aimed at improving psychological wellbeing for people with moderate to high levels of mental health need.

ACTIVITIES

Responding to people experiencing a crisis or in significant distress, including people at heightened risk of suicide, providing support that may reduce the need for ED attendance.

Providing a central point to connect people to other services in the region, including through offering information and advice about mental health and AOD use, service navigation and warm referral pathways for individuals, and their carers and family.

Provide in-house assessment, including information and support to access services, such as completing a biopsychosocial assessment and initial review to ensure people are matched to the services they need.

Evidence-based immediate, and short- to medium-term episodes of care, including medical assessments, psychological therapies, family therapies, connection to culturally appropriate and safe services or services based on presenting need.

3 Establishment of *HeadtoHelp*

This section addresses KEQ 1 (How appropriate is the program design to deliver the program outcomes?) and KEQ 2 (How effective was the establishment of the program?) and is concerned only with the initial design and establishment findings. Adaptations to the model as the program has become more established are addressed in Section 4 (Implementation).

3.1 How appropriate is the program design to deliver the program outcomes?

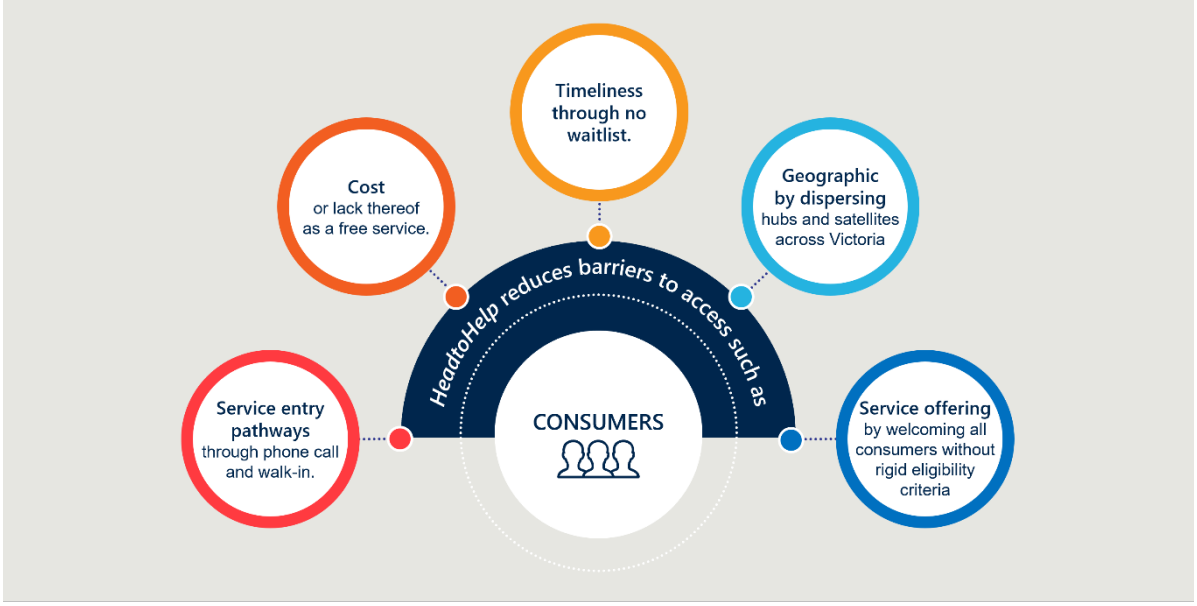
Key findings:*HeadtoHelp* was appropriately designed to increase access to and support navigation of mental health services during a time of heightened need. Specific design features, such as mechanisms to remove barriers to access, use of the IAR-DST and role of multi-disciplinary teams were key to this finding. There were limitations in relation to the opportunity for co-design and the ability of *HeadtoHelp* to operate as a stand-alone response to system fragmentation.

3.1.1 Key design features

HeadtoHelp was appropriately designed to reduce barriers to access

HeadtoHelp was designed to reduce a range of service access barriers that are often experienced by participants. These are detailed in Figure 6.

Figure 6 | Barriers to access



- **Service entry pathways.** Multiple entry pathways (e.g., phone call, walk-in) into the service allows participants to access the service in a way that meets their preferences. Importantly, *HeadtoHelp*

does not require participants to first consult with a GP to develop a mental health plan, which participants have previously reported to the Royal Commission can be a barrier to seeking help.[7]

- **Cost.** Free service was a key feature of *HeadtoHelp*. The Royal Commission identified low socioeconomic status groups as people who have historically been unable to access mental health services due to financial barriers.[8] Participants who would have previously been unable to afford or justify costs of mental health services were able to access services they needed, including people accessing mental health services for the first time.

> "I think the most important thing about *HeadtoHelp* is the financial accessibility of it, like mental health is such a privilege to get support on, it's a humongous privilege that only some people can afford. And when it's financially accessible, when people can actually get long-term help, like it can be such an invaluable service. It can change someone's life." – *Support person*

- **Timeliness.** *HeadtoHelp* aimed for no waitlists and limited time between intake and service delivery. *HeadtoHelp* hubs aimed to contact participants within one day of their intake to organise appropriate services soon after. This recognises that a long waiting time between deciding to seek help and receiving help can be a significant barrier to accessing mental health services.[9] Anecdotally, waiting lists for psychologists in Victoria in late 2020 were between five weeks to six months, and many services no longer had the capacity to accept new referrals.[10]
- **Geographic.** A physical location which provides the option to present for face-to-face was key to meeting the needs and preferences of participants. The importance of physical access to services was emphasised in rural and regional *HeadtoHelp* hubs. Several rural and regional hubs elected to operate an outreach service for participants that could not easily access a hub in person.
- **Service offerings.** *HeadtoHelp* is advertised as welcoming all participants and/or support people that contact the service, in line with the 'no wrong door' approach. Participants were told that *HeadtoHelp* is for 'anyone of any age experiencing emotional distress, crises, mental ill-health and/or addiction along with their families and support people.'[11] Not excluding participants based on their presenting needs (e.g., addiction) heavily reduces barriers to access. This is important considering the many submissions into the Royal Commission that noted the need to integrate the mental health and addiction service systems.[12]

> "If I had to go to Melbourne for something like that, I just wouldn't go because that takes too much out of me and I'm recovering for days just from all the stress of travelling to the city." – *Participant*

[7] Anonymous. 2019 Submission – Royal Commission into Victoria's Mental Health System. Accessed July 2021.
[8] Royal Commission into Victoria's Mental Health System. Interim Report. November 2020. Page 79.
[9] Davey, M. Victoria's mental health royal commission find system in 'crisis mode.' Published March 2020.
[10] Cook, H. Psychologists stretched to limit as virus drives spike in referrals. Published 28 October 2020.
[11] WVPHN. FAQ for participants. September 2020.
[12] Mental health Victoria, Victorian Healthcare Association. Joint Submission to the Royal Commission into Victoria's Mental Health System. July 2019. Page 7.

The consistent approach to intake is a transformative component of program design

The IAR-DST was a key part of the design of the intake, assessment and referral process which reflected a stepped care and client-centric approach, matching the level of mental health intervention to the individual's needs.[13] A consistent model at a state level is a significant departure from previous approaches.

Approximately $1.4 million in funding supported the establishment of central intake services, including the 1800 number (see further Section 3.2.3). Participants calling the 1800 number were routed to the appropriate intake team, typically located in the PHN, through a process of geocoding. Intake clinicians then engaged participants, provided assessments and supported service navigation to meet their needs and preferences. In instances where callers were distressed, intake staff reported providing mental health first aid and other supports.

The design of the model includes two options for intake: internal, where intake is conducted entirely in-house, and centralised or external, where intake is conducted for more than one hub by another PHN or external organisation. Hubs applied the intake options differently during establishment and the success, challenges and variations to intake during implementation are discussed in Section 4.2.

Multidisciplinary teams are an ideal design mechanism to support a whole-of-person service response

The *HeadtoHelp* hub model of care was prescriptive with regards to the workforce. The model requires service providers to hire an appropriate mix of qualified staff, with at least one or more clinical workers (e.g., Psychologists, Division 1 Nurses). In all hubs, there is a mix of clinical and non-clinical staff. Some providers varied the model to better meet needs in their local area, such as adding a psychiatrist.

HeadtoHelp also required qualified intake clinicians to perform intake and a multi-disciplinary team to deliver services within the hub. Intake clinicians were required to be registered with an appropriate professional association or possess post graduate education in mental health. Possessing these requirements allows intake clinicians to effectively assess participants using the IAR-DST and provide de-escalation support where participants call in crisis.

Service providers noted the requirement of particular qualifications (e.g., Australian Health Practitioner Regulation Agency (AHPRA) registration) has been a barrier to recruitment, however the expertise of staff is critical to participants' experience. There is also a need to balance the level of prescription of particular roles, versus staffing within local constraints and with a focus on outcomes sought. These points are expanded further in Section 4.1.8.

3.1.2 Design limitations

Short implementation timeframes limited direct involvement of people with lived experience

PHNs recognise there was limited co-design of the *HeadtoHelp* service with people with lived experience and with the local service system. This was entirely due to the timeframes in which the service had to be stood up. While *HeadtoHelp* itself was not co-designed, the clinical design team drew on a rich evidence base from recently conducted co-design activities to include the perspective of people with lived experience as best as possible. With more time, co-design would have been feasible and useful. However, the inputs to the *HeadtoHelp* model, including the Eastern Melbourne PHN (EMPHN) stepped care model, North Western Melbourne PHN's (NWMPHN) planning for mental health, AOD and the AMHC model of care all included extensive co-design processes.

[13] Stepped care represents an approach to deliver the right services, to the right people, at the right time and at the right cost. It is a national priority as outlined in the Fifth National Mental Health and Suicide Prevention Plan. It is also a key priority for the Victorian Government in the redesign of the mental health service system (State of Victoria, Department of Health and Human Services. Victorian Government submission to the Royal Commission into Victoria's Mental Health System. July 2019).

While well-designed, HeadtoHelp is not a stand-alone solution to mental health system fragmentation

Challenges with service navigation in the mental health system are well recognised. The Royal Commission and the Productivity Commission noted the need to have improved access and navigation support for participants.[14] The service model of *HeadtoHelp* enabled it to provide essential service navigation to participants.

HeadtoHelp provided service navigation to participants through various intake functions (e.g., central intake team, dedicated intake clinicians in various hubs) supported by available PHN documentation. Following administration of the IAR, intake clinicians were tasked with identifying appropriate services that matched participants' level of need and access to various services.

PHNs provided navigation support through various means to aid intake clinicians. In some instances, PHNs had detailed service maps that were interactive and greatly supported clinicians in identifying services. Other PHNs had less sophisticated service documentation for their catchment (e.g., an excel document) that forced clinicians to navigate services through any means available to them, such as online search engines.

However, attempting to be a 'front door' was ambitious and required greater consolidation of existing '1800'/'1300' or other purported 'front door' numbers, backed by a stronger promotion campaign. There are numerous services that claim to be the 'front door', Victoria's state-based local community hubs being the latest to announce as such.[15] While multiple services supporting navigation and service access is not an issue in itself, conflicting 'front door' claims may confuse participants and delay the time to which they seek help.

In addition, *HeadtoHelp* needed better promotion to ensure participants and service providers were aware of the service and its offerings. This is discussed further in Section 4.1.7.

3.2 How effective was the establishment of the program?

Key findings: *HeadtoHelp* hubs were rapidly established in a commendable display of PHN collaboration and effort. The approach to commissioning was pragmatic and effective, although some components of contracts could be improved, and the requirement for rapid establishment resulted more in movement of existing staff across the system, rather than a net increase in staff for Victoria. Positively, *HeadtoHelp* drove an unprecedented degree of collaboration – through both governance and goodwill – that PHNs are keen to replicate in other programs. In particular, the shared-service model was positively viewed by stakeholders as a pragmatic and effective structure to support establishment, that entrenched trust, joint ownership and collaborative ways of working.

3.2.1 Hub commissioning and set-up

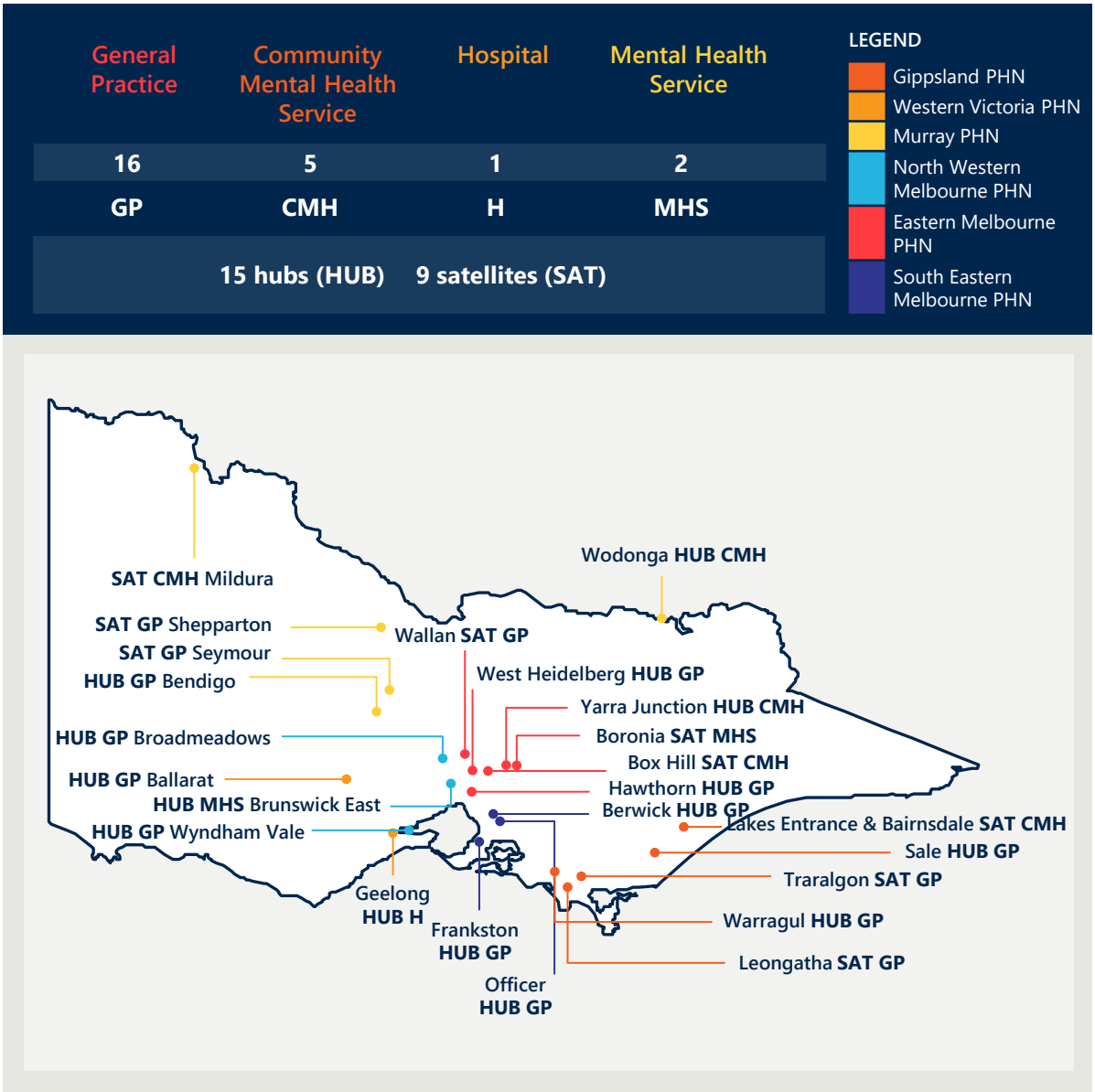
Fifteen HeadtoHelp hubs across six PHNs were stood up in less than four weeks

The Department provided funding for PHNs in metropolitan areas to each establish three hubs and to PHNs in rural/regional areas to each establish two hubs (Figure 7). A total of 15 *HeadtoHelp* hubs were stood up in less than four weeks. Nine satellites were subsequently established based on discretionary spending of a flexible tranche of funding during implementation, see Section 4.1.6.

Hubs were located across four different settings: general practices, community mental health services, hospitals and other mental health service practices, with the majority being located within a general practice setting as illustrated in Figure 7.

[14] Royal Commission into Victoria's Mental Health System. Final Report. February 2021. Page 43.; Productivity Commission. Mental Health Inquiry Report Volume 1. June 2020. Page 74.
[15] Premier of Victoria. Giving Victorians Mental Health Support Close to Home. March 2021.

Figure 7 | Map of HeadtoHelp hubs and satellites



Given the brief timeline, PHNs took a pragmatic approach to commissioning service providers, prioritising providers that already had access to a physical space or were able to co-locate quickly. Commissioning approaches are discussed below.

The service providers that were initially commissioned were a mix between government organisations (tertiary health care, primary health care) and non-government organisations (NGOs) (community health). The type of organisation greatly impacted the ability to stand-up a multidisciplinary workforce rapidly. For example, community health services had relatively less access to a clinical workforce than tertiary health care services and as such could not tap into an existing pool of clinical staff to meet the rapid stand-up required for *HeadtoHelp*. However, they were able to transfer non-clinical/multidisciplinary staff to *HeadtoHelp* from other areas of their services. Establishing the workforce is discussed at the end of this section.

Contracts enabled rapid establishment; but some terms hindered successful operation

The contractual terms for service providers varied across PHNs. Common contractual terms related to clinical and non-clinical staff requirements, and a linking of funding and full time equivalent (FTE) allowances to service volumes through individual hubs.

Contracts also included 14 key performance indicators (KPIs) which were tracked and reported on a monthly basis using a zero-to-two scoring method. The number of KPIs reflected an attempt to meet the needs and preferences of six different PHNs. Following feedback from service providers on the relative burden and value of these metrics, they were subsequently reviewed and reduced to nine indicators (see final KPI list in Appendix G).

Stakeholders reported a number of specific issues with individual contracts, with contract terms being a barrier to effective establishment and operation in some cases. There has been frustration around the short length of contracts, which were initially 12 months, and the short notice provided around changes to contracts, including the extension of the program to June 2022, from both a PHN and hub perspective. Having short and unstable contracts has resulted in challenges including difficulty in recruiting and retaining staff, due to short-term employment contracts raising concerns around job security which compounds the issue of fierce competition for mental health staff in the region. One PHN reported that 'Increasing FTE as business ramps up has been a challenge, as the longitudinal aspect of the program gets shorter when you need more staff.'

Having last-minute communication surrounding contracts has hindered long-term planning. One hub reported being surprised about the extension of the program until June 2022, as they had not received any direct information on this, relying on a media release and word of mouth for information. Another hub reported only being given ten days' notice for having to prepare an exit plan.

There was also a lack of dedicated resourcing for relationship building, service integration, promotion and clinical governance within contracts, despite these being expected and necessary to operate successfully.

The rapid establishment of the services required movement of existing staff across the system, rather than a net increase in staff for Victoria

PHNs managed to stand up their *HeadtoHelp* intake and hub services in four weeks; however, many hubs found the short commissioning timeframes extremely challenging to recruit competent and qualified mental health workers and satisfy the multidisciplinary team requirements of the hub model. These challenges were exacerbated by existing workforce shortages across Victoria. Some hubs noted that they were competing with up to eight other organisations or health services who were recruiting for mental health clinicians and staff at the same time as *HeadtoHelp*.

For hubs that were able to recruit, there was often a considerable time lag between when staff were recruited and when they could start in their new role. Some hub providers already offering PHN programs took a pragmatic approach and were able to second staff to support the establishment of their hubs. Hubs also reported that staff moved from other parts of the service system to the *HeadtoHelp* program, including from AMHSs.

Service providers noted the requirement of particular qualifications (e.g., AHPRA registration) has been a barrier to recruitment. Instead, it has been posed that a flexible approach to commissioning would be preferred (with reference to factors such as local need, evidence-based care, collaboration, clinical governance expectations, clinical treatment expectations, etc).

However, peer workforce is a critical component of mental health services that *HeadtoHelp* was largely unable to achieve in the short stand-up time frame. The Royal Commission has emphasised the need to integrate peer workers and peer-led support into an array of mental health services (community mental health, crisis response, trauma centres).[1] Effective clinical governance measures are required to train and oversee a peer workforce. Where possible, *HeadtoHelp* should be seeking to boost its peer workforce and this has also been a key consideration for the AMHCs.

Challenges around ensuring the model of care is staffed appropriately in terms of clinical expertise is discussed in Section 4.1.8.

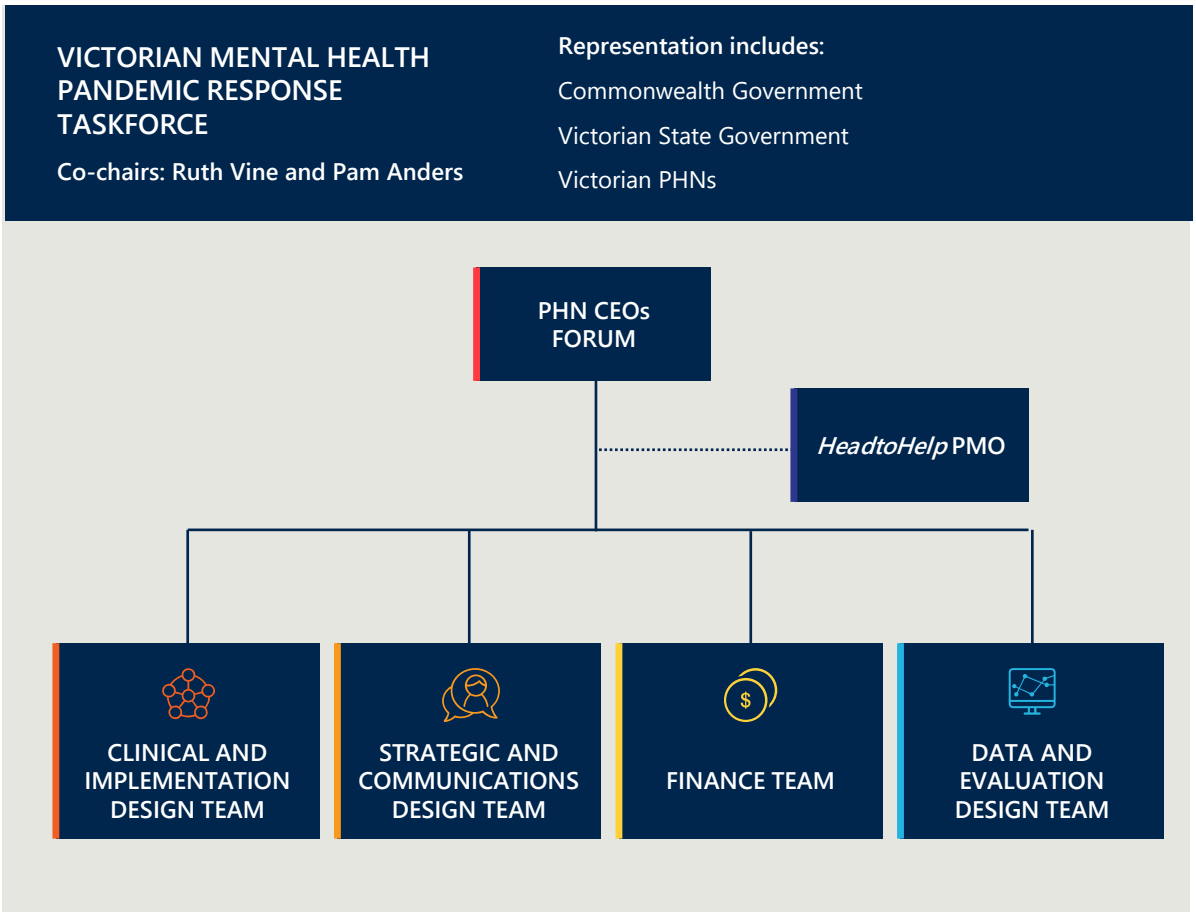
3.2.2 Governance and collaboration

HeadtoHelp drove an unprecedented degree of collaboration – through both governance and goodwill

Following the announcement of *HeadtoHelp*, all six Victorian PHNs worked collaboratively to rapidly coordinate and deliver the *HeadtoHelp* service and hubs. This was formalised through establishment of a clear governance model (Figure 8), which promoted information sharing, pragmatic use of combined resources and joint problem solving.

While supported by governance, PHN CEOs emphasised the level of goodwill that has been critical in establishment success. PHN stakeholders similarly commended the trust and willingness to relinquish control over some aspects of the program, and the deep connections that evolved between PHNs.

Figure 8 | Governance arrangements for HeadtoHelp



The *HeadtoHelp* governance model (Figure 8) had four key features designed to support collaboration:

1. **CEO attention and investment.** The six Victorian PHN CEOs established a CEO forum which met regularly to enable efficient decision making and find solutions to ongoing challenges. During the establishment phase, CEOs had daily 15-minute stand ups. The frequency of the *HeadtoHelp* CEO forum meetings naturally decreased as hubs became more established, but it remains an item on monthly PHN CEO meetings.
2. **Dedicated project management office (PMO) resources.** A PMO was created to establish the *HeadtoHelp* service and hubs. For the first three months there was regular contact between the PMO and CEO groups (commencing with daily updates, before settling to a fortnightly governance meeting and bringing in the stream leads as appropriate). Initially this role was

supported by two project management resources from the Darling Downs and West Moreton PHN before transitioning back to the six Victorian PHNs following recruitment activities, with the PMO role being run out of South Eastern Melbourne PHN (SEMPHN).

3. **Senior government reporting lines.** *HeadtoHelp* establishment and implementation was overseen by the Victorian Mental Health Pandemic Response Taskforce. Discussion on the effectiveness of the Taskforce is included in Section 3.2.2.
4. **An appropriately delegated shared-services model.** The six PHNs developed a shared-services model (Section 3.2.3) to support consistency and efficiency in the establishment and operation of *HeadtoHelp*.

HeadtoHelp has provided a precedent for collaborative working among PHNs

It was initially hypothesized that the PHN collaboration in establishing *HeadtoHelp* was crisis-driven and therefore might be difficult to replicate in other circumstances. However, PHN CEOs and stream leads oppose this view, noting that this collaboration has already begun to extend beyond *HeadtoHelp*. Stakeholders have reflected that the PHN approach to collaboration (governance groups, resource sharing) to establish and operate *HeadtoHelp* can serve as a model for working together on other projects and are determined to retain the efficiencies realised from shared services arrangements to support the progress and outcomes of other PHN activities now and in future.

The Taskforce was a useful mechanism to stand up HeadtoHelp, however its value decreased over time

The Taskforce, comprising of PHN, Commonwealth and Victorian Government representatives was set up to provide advice and oversight during establishment and implementation. The Taskforce was co-chaired by Dr. Ruth Vine, Deputy Chief Medical Officer and Pam Anders, CEO of Mental Health Reform Victoria[16], and worked alongside the Victorian PHN CEO forum to support *HeadtoHelp's* rapid stand up and implementation. In the early stages of *HeadtoHelp*, the Taskforce met weekly, then transitioning to meeting monthly with a broader agenda. The Taskforce receives monthly reporting prepared by the PHN Data and Reporting stream lead and the *HeadtoHelp* PMO.

Joint Victorian and Commonwealth leadership has been a vital governance mechanism to steer the rapid establishment and implementation of *HeadtoHelp*. Stakeholders noted that, initially, the Taskforce was a valuable forum to support decision making and provided a unique opportunity to bring together the Commonwealth and state government for deep collaboration. However, stakeholders reflected the value of the Taskforce has diminished as establishment has progressed, which may be due to a lack of clarity around its ongoing purpose and role after the initial establishment phase. Unfortunately, there is no explicit lived experience representation on the Taskforce. This is a limitation that must be rectified in similar governance mechanisms going forward.

Whilst the Victorian Government was appropriately represented on the Taskforce, in effect it had limited ability to influence, which impacted engagement. Authority and influence sat primarily with the Department, as a result of Commonwealth funding and PHN implementation. The flow of decision making and engagement at an operational level has varied, particularly with AMHSs who did not have representation on the Taskforce. Some stakeholders reflected on the need for greater involvement and action by the Victorian Government to drive the level of coordination and collaboration with state services that was originally envisioned. It was also noted that effective coordination and integration needs to be appropriately resourced, rather than just mandated.

Several stakeholders highlighted the need/opportunity for the Taskforce to focus on integration with the broader mental health service system, which includes identifying alignment between Commonwealth-funded initiatives, state mental health initiatives and royal commission findings.

[16] Note: Mental Health Reform Victoria was subsequently merged into a new Department for Mental Health and Wellbeing within the Victorian Governance.

Some stakeholders noted that a combination of *HeadtoHelp*, local community mental health services (a recommendation of the recently announced Victorian Mental Health Royal Commission), and the additional Head to Health AMHCs and satellites (announced by the Australian Government in the 2021-2022 budget) may only further fragment the Victorian and national mental health service systems, thus exacerbating existing workforce challenges for mental health services and potentially impacting their capacity to support participants with more severe or complex needs.

3.2.3 Shared service model

The shared-service model was a pragmatic and effective structure to support establishment

The six PHNs established a four-stream shared services model, covering clinical and implementation design, strategic and communications design, finance, and data and evaluation. Staffing took a pragmatic approach, with each PHN drawing on its strengths and nominating appropriate staff members to contribute. Insights from each stream are included below.

Feedback on the model adopted was positive, with stakeholders citing previously unseen benefits of collaborative working and relationship building. Pleasingly, this collaborative approach appears to have been sustained as the initial 'crisis phase' of COVID-19 and rapid establishment eased. Some stakeholders did note however, that the consequence of this approach was that responsibility for *HeadtoHelp* stream activities often fell on top of individuals 'day-jobs', with the reflection that there was significant 'out of hours' work put towards establishing *HeadtoHelp*.[17] From this perspective, an alternative option may have been a secondment model – though this would likely have had significant negative implications on the level of collaboration experienced.

The design of a stepped care model for HeadtoHelp leveraged existing insights and highlighted the need to think about system rather than program implementation

PHNs recognise there was limited co-design of the *HeadtoHelp* service with people with lived experience and with the local service system. This was due to the very short timeframes in which the service had to be stood up. While *HeadtoHelp* itself was not co-designed, it drew heavily on the AMHC service model (which did involve co-design) as well as other PHN co-design activities and evidence. With more time, dedicated co-design on the specifics of *HeadtoHelp* would have been feasible and useful.

To mitigate against this, the following inputs that leveraged co-design processes conducted for other programs were drawn on:

- insights from co-design activities in the development of the AMHC service model
- PHN regional planning exercises across the regions with input from people with lived experience
- findings from the design and evaluation of the EMPHN stepped care model
- broader mental health planning undertaken by NWMPHN
- utilising the lived-experienced informed Fifth National Mental Health Plan from the Mental Health Commission of Australia
- drawing on the service platform designed by Eastern Health using co-design with people of lived experience.

The Clinical and Implementation Design team also engaged with other service providers such as Beyond Blue to formalise pathways between *HeadtoHelp* and the Beyond Blue online and low-intensity service offerings. This also enabled an understanding of the flow from Beyond Blue to *HeadtoHelp*, and then to other local PHN commissioned services if required.

[17] Noting there was dedicated roles only for the PMO, not stream activities.

The rapid coming together of the Clinical and Implementation Design group meant that a Victoria-wide alliance was created. This meant PHNs matured from thinking about program implementation towards system integration. Streamlined system integration enables a single point of access through an intake function that allows a person to navigate to the right level of care using the IAR-DST, resulting in coordinated support of the person and timely initiation of treatment. The Clinical and Implementation Design stream see this as an opportunity to enable system reform across Victoria to ensure this concept is built into the system of care, and to realign to what the National Mental Health Plan requires.

The Clinical and Implementation Design stream highlighted several aspects of the establishment and implementation process that could be improved, including:

- Highlighting population segments within mental health and embedding these segments into the system of care. This would assist in ensuring that clients are directed to the correct services for their level of need (i.e., ensure that clients identified by the IAR as level one or two are directed to online resources and services such as headspace, so that clients identified as level three or four have access to the hubs, therefore making the best use of system-wide mental health resources).
- For the same reasons above, agreeing on definitions that separate mental health from mental illness and embedding these into the system of care.
- Engaging subject matter experts in the design and monitoring of the system of care.
- Employing more rigour in the monitoring of performance of outcome measures so that compliance with reporting on the measures designed by the team can be better used to refine services in future.
- Improving collaboration and co-design between Commonwealth and state to work collectively with investment, to reduce the chance of fragmentation and duplication, and to realise administrative efficiencies.

As of December 2021, the Clinical and Implementation Design stream had commenced preparations with local PHNs for the decommissioning of *HeadtoHelp* in June 2022, preparing the gradual transition of clients to relevant local services, such as to Head to Health for adults and youth to headspace. However, a gap in care services for children was highlighted as a continuing problem.

Communication was a major activity to build awareness of HeadtoHelp among participants and service providers; however, effectiveness could have been improved

In order to build awareness of the *HeadtoHelp* service among participants and referrers, PHNs had to establish a coherent communications strategy within four weeks. The PHNs' approach to communications leveraged internal resources to the extent possible and engaged outside sources to compliment.

The total initial program funding for communications was $300,000, which PHNs used to develop:

- **The HeadtoHelp brand**. PHNs engaged Ikon agency to provide brand design.
- **A shared HeadtoHelp platform**. This consisted of a central 1800 number and the *HeadtoHelp* website, developed using internal resources.
- **A targeted marketing campaign for community awareness** that occurred largely in October 2020 and consisted of marketing *HeadtoHelp* on billboards, radio, social media and Google Ads. Given this campaign ran for only one month during the establishment phase, it was very limited in building service awareness among both participants and service providers. A further communications campaign was run in April 2021, which is discussed briefly in Section 4.1.7.

As in other streams, activities were founded on collaborative efforts. PHNs worked together to create a repository of Frequently Asked Questions (FAQs) for both participants and service providers. Most PHNs locally adapted communications to their community by adjusting generic FAQs to their

catchment. For example, NWMPHN translated material to cater to key CALD communities at its own cost and shared this among the PHNs.

Additional funding has been provided for specific activities and in line with program extensions:

- In early 2021, an additional $200,000 in funding was provided for marketing, some of which was reserved specifically for Aboriginal and culturally and linguistically diverse (CALD) communities, for example, a number of targeted ads were created in CALD languages. Views of effectiveness have been mixed. It was suggested that the service may have benefited from a dedicated communications expert, particularly someone responsible for social media posts, which has been found to be effective for engaging Aboriginal and CALD communities.
- Funding extensions have also included some additional investment in strategic and communications design – $50,000 for the September to December 2021 extension and $216,000 for the December to June 2022 extension.

Responding in part to the feedback above, combined PHN communications funding from the September to December 2021, and December 2021 to June 2022 extension funding has been used to hire a part-time dedicated resource, situated within SEMPHN to support more structured and ongoing strategic communications activity. Key activities have included development of a 'base pack' of the new Head to Health branding and materials for each hub, and an upgrade of the **HeadtoHelp website (now headtohealthvic.gov.au).** In addition, the PHNs have continued to contract Ikon to manage brand tracking through website traffic and communications.

There is an opportunity during the transition to Head to Health to rectify the branding and marketing issues experienced by *HeadtoHelp*.

Throughout the establishment of Head to Health, stakeholders have consistently complained of confusion between *HeadtoHelp* and Head to Health, noting both the name similarities, as well as ambiguity around the services and purpose of each program.

Furthermore, it is difficult to find information on the *HeadtoHelp* hubs, the new Head to Health satellites and the AMHCs on the federal Head to Health website (the name of which further exacerbates the confusion), which is why the *HeadtoHelp* website has been redeveloped and maintained as "headtohealthvic" even as the transition approaches.

As the full transition takes place, there is an opportunity to manage the brand transition in such a way as to help to reduce the ambiguity of and promote Head to Health's services, including by ensuring clarity between federal and state websites, and promote ease of access to practical user-friendly information for consumers.

At the time of this evaluation, no communications funding has been announced for the exit strategy of *HeadtoHelp*, however a resource has been allocated for three days a week for four weeks in June 2022 to provide marketing support around the transition. The communications stream expressed some frustration around not having a clear view of the broader Commonwealth plan and timeframes for this transition.

The funding model was established rapidly with limited data and evolved over time, using additional data as it became available

The Finance stream established a funding model for *HeadtoHelp* in approximately two weeks, enabling hub operation within four weeks. Given the timeframe, the Finance stream was unable to prepare extensive prospective modelling to inform funding requirements for each PHN. Under the circumstances for initial establishment, the Finance stream created a fit-for-purpose model based on limited available data to enable *HeadtoHelp* to effectively deliver services. Initial funding was estimated on the number of participants a *HeadtoHelp* hub would see per week and a unit price per

occasion of service was determined. The funding model was set up to provide three funding tranches over the contract, where second and third tranches of funding were released when occasions of service KPIs were achieved.[18]

Several stakeholders noted concerns with the tranche funding approach – in particular, some hubs reported that the number of referrals to hubs and resulting occasions of service was slower to build than initially anticipated by PHNs and the target referral figure stipulated in provider contracts. Consequently, some hubs were unable to access the next funding tranches within the allocated timeframes, missing out on access to funding and hence ability to recruit additional FTE to hit subsequent targets on time – ending up in a cycle of hitting targets late, continually preventing or delaying access to further funds. These challenges have now been overcome, and all remaining operating hubs have access to their full funding allocation.

Funding from the first round was distributed through a shared cost model, through four areas: clinic establishment, intake services, hub running costs and program support services (Figure 9). There was an additional tranche of flexible funding available for each PHN to use with discretion following establishment (including in clinic running costs). Some PHNs elected to use the discretionary funding to establish satellites, embed an intake person within the service, or add to the stipulated core workforce.

In total, $26.9 million was allocated for the establishment and running of *HeadtoHelp* between September 2020 and 31 December 2021, of which $17.2 million was for hub establishment and operations and the remainder was flexible funding for PHN operations. Details of the initial funding model for hubs are provided in Figure 9 below.

Figure 9 | Initial funding model

HUB ESTABLISHMENT	INTAKE SERVICE	HUB RUNNING COSTS	PROGRAM SUPPORT SERVICES
$340,000 or **$510,000** per PHN*	Approximately **$1.2 MIL** for state-wide intake service	**$1.7 MIL** or **$2.5 MIL** per PHN*	Approximately **$815,000** for communications and marketing, training and IAR, legal, data and PMO

*Amount reflective of PHN catchment/population size

There were two extensions to the funding model – during which the model has evolved to be more evidence-based.

- **September to December 2021 extension.** This extension was based on underspend and used the same funding model as in the first round. Underspend funding was reallocated across all PHNs to ensure equitable distribution across all.
- **December 2021 to June 2022 extension.** Funding has been redistributed according to costs/need in different regions, rather than allocating the same amount of funding to every region – this was possible due to having greater data available on the actual spend/underspend, staffing requirements of each hub and trend analysis, which assisted in the calculation of unit pricing with low month on month growth. Further, under the December 2021 to June 2022 extension, the funding model is less prescriptive, with PHNs having greater flexibility in the use of allocated funding themselves, as long as they meet contract conditions.

Across the shared services, the greatest cost has been in developing and managing data storage, management and reporting. Other shared costs have included project management, the 1800 phone line, communications and budget to cover finance costs previously managed out of PHN resources.

[18] The measure of occasions of service contacts was used as a KPI to release the second and third tranches of funding. These tranches of funding aimed to provide 'performing' hubs with additional funding to increase their FTE. The initial target occasion of service for each hub to release tranche two funding was 3,000. However, hubs had different ways of measuring this. Note: the modelling completed for each PHN was different and exact occasions of service targets may vary.

Communications allocation was notably higher in the June extension bid due to the brand transition to Head to Health.

Critical to the success of *HeadtoHelp* has been the ability to be flexible around funding over the course of implementation, particularly in adjusting the shared services funding to meet needs at the local level of delivery. Strong governance and collaboration among the PHNs underpinned efficient and needs-based financial decision-making. The finance model was however complicated – some stakeholders reflected that the simplest cost-management process would have been to provide one PHN with all the funding, which could then be allocated across other PHNs as required using an invoicing system. The clear disadvantage of this is that it would have resulted in reduced cross-collaboration, which has been a defining feature of the *HeadtoHelp* establishment experience, and one that future programs should seek to replicate.

An extensive data system was set up to enable data collection and analysis

A significant amount of work was undertaken by the Data and Evaluation Design stream to stand up the data and reporting systems to support *HeadtoHelp*. This stream developed three key components for *HeadtoHelp* (detail on the data ecosystem is in Appendix D):[19]

- **the centralised intake system** – enabled the use of the IAR-DST via a secure web-form
- **shared data analytics workspace** – to collect intake data, PMHC-MDS hub activity data, participant experience data, and intake and hub contract/KPI reporting.
- **participant experience survey platform** – to collect participant feedback on their experience of intake (HIE survey) and service at the hub (YES).

The data system was developed to collect data about *HeadtoHelp* participants, the services they receive and their experience of that service. The data system is a robust state-wide linked data set that tracks the participant's journey through the system from referral to the completion of their episode of care. This is the first time that it has been possible to view state-wide unit record mental health data and it provides a complete picture of those who contact the intake service, whereas the PMHC-MDS data only reflects a proportion of the data that is useful for understanding the actual needs and profiles in the region.

This system also specifically enabled the 'warm transfer' process through the sharing of information related to a participants' needs. A central repository from which hub managers and staff can access information collected at intake limits the number of times a participant needs to re-tell their story. Further, in some cases, the data system enabled the sharing of information with providers outside of the *HeadtoHelp* service where required and consented.

Additionally, stakeholders have reported that a data-driven quality improvement approach was taken, from which the *HeadtoHelp* service delivery staff have been able to learn and adapt the model of care. For example, a quality user improvement user group for intake, including representatives from ACT and NSW was established to discuss incoming data and its implications. In addition, at the PHN PMO and stream level, data from the Data and Evaluation Design stream could continually be fed into the Clinical and Implementation Design stream, to continue to refine the model.

This data system provides a unique opportunity to understand the flow of referrals into and out of the *HeadtoHelp* and AMHC hubs. This could be utilised to understand the demand for services and the current supply, thus identifying the types of services that require expansion to meet that demand.

[19] May 2021 Taskforce Report.

4 Implementation of *HeadtoHelp*

This section addresses KEQ 3 (How effective has the implementation of the *HeadtoHelp* initiative been to date and what can we learn from it?) and KEQ 4 (Has the *HeadtoHelp* service implemented effective IAR intake practices?). Findings have been informed by program documentation, insights from qualitative data collection and analysis of the PMHC-MDS data.

4.1 How effective has the implementation of the HeadtoHelp initiative been to date and what can we learn from it?

Key findings: *HeadtoHelp* is being accessed by the 'missing middle', however, aspects of service use have differed from what was anticipated – in particular the time taken to build up referrals, and participants being both younger and more complex than initially envisaged. Key findings from service data include:

- Service numbers were concentrated in the regional and remote PHNs – MPHN (23 per cent) and GPHN (23 per cent) accounted for almost half of all *HeadtoHelp* episodes.
- *HeadtoHelp* participants were typically female, English-speaking and aged over 25. While the client proportions across each age group were broadly similar across PHNs, there were some exceptions: approximately a quarter of services in GPHN were delivered to under-18-year-old participants (26 per cent) relative to other PHNs (range of nine to 17 percent).
- Level three IAR ratings formed the bulk of ratings (68 per cent to 81 per cent). There were also more level four and five ratings relative to level one and two. Mean K10 scores[20] of clients on entry into the service ranged from 29.5 (MPHN) to 33.4 (WVPHN), suggesting participants of *HeadtoHelp* were, on average, severely unwell on service entry.
- Participants and support people sought *HeadtoHelp* services for a variety of reasons – with COVID-19 a primary contributing factor for around two thirds of participants and support persons.
- Psychological therapy and clinical care co-ordination were the most common services delivered by hubs, with six in ten service contacts remote. Interestingly, data from the participant and support person interviews contradicted the view often held by service providers – that clients overwhelmingly prefer services delivered face-to-face.
- Self and GP referrals are the most common pathway to *HeadtoHelp* (although the self-referrals are often prompted by GP advice and information.

Overall, there has been appropriate fidelity to the original model, although some areas of delivery have differed from what was anticipated – in particular there has been less use of warm referrals (both in and out of the hubs) than anticipated. Further, length of episode care has increased overall during service delivery, and rural and regional PHNs tend to deliver shorter episodes of care.

Particular implementation challenges have included service promotion and communication, both with communities and other service providers, ability to attract and retain workforce, and administrative burden (though this improved over time). This highlights the importance of clear remit for integration, contracts with flexibility and certainty, and the need to both manage tension in reporting requirements, as well as build capability in the sector.

Note – much of this section discusses activity data associated with use of the *HeadtoHelp* service. It does not imply a connection between volume of activity and quality or outcomes of service received. A discussion of the participant outcomes resulting from engagement with *HeadtoHelp* is included in Section 5.1.1.

[20] Scores above 30 on the K10 indicate very high psychological distress

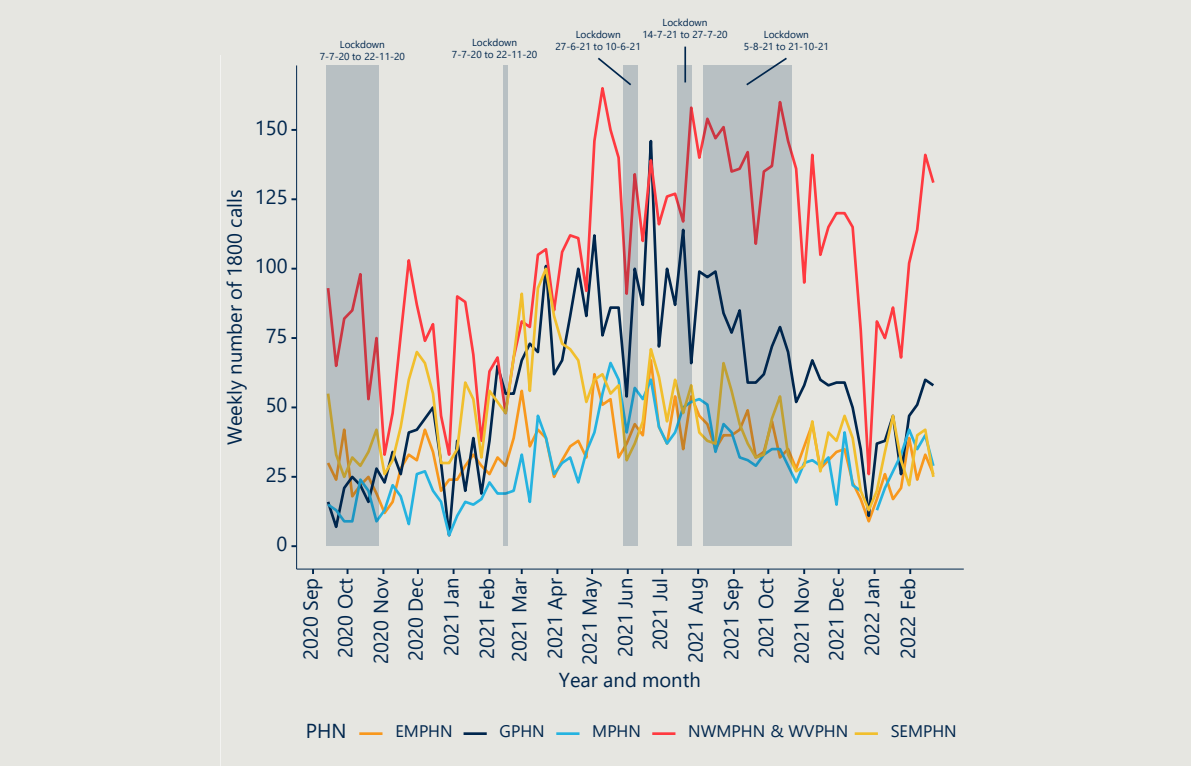
4.1.1 Volume of service use

Since program inception, over 20,600 people have called the 1800 number

From 14 September 2020 to 28 February 2022, 20,641 calls were made by participants and support people to the 1800 intake telephone line (see Figure 11). Over 76 weeks, this amounts to an average of approximately 272 calls per week, virtually unchanged from the 267 calls per week identified in the Interim Evaluation report. The call data varies considerably each month and is difficult to draw firm conclusions from. Key points to note are:

- After relatively low call numbers for the first few months of operation, all PHNs experienced rapid growth in calls in the first half of 2021. The significant growth in GPHN over this time period likely reflects capacity expansion of three additional satellites on 11 January 2021.
- Most PHNs experienced a gradual decline in average number of calls after reaching a peak a few weeks after the June 2021 lockdown. Interestingly SEMPHN hit their peak earlier than other PHNs, in April 2021.
- GPHN, EMPHN, WVPHN and NWMPHN experienced subsequent call peaks in the weeks just before the August 2021 lockdown.
- As is commonly experienced across mental health services in late December 2021/early January 2022, call volumes fell substantially. However, average weekly call volumes began to increase in late January, with most PHNs returning to similar call levels as experienced prior to the Christmas/New Year period.
- NWMPHN and WVPHN continue to have the highest number of 1800 calls in by participants and support people through September 2020 to February 2022. However, this is unsurprising given that this is a combined intake service for two catchments. Call volume for each of the two PHNs is broadly comparable to other PHNs.

Figure 10 | Average number of 1800 calls by PHN per week from 9 September 2020 to 28 February 2022



The evaluation is unable to determine whether there is a definitive correlation between Victorian COVID-19 lockdowns and the average number of 1800 calls by PHN per week. Figure 10 shows an increase in calls made one to three weeks following a Victorian lockdown (with the exception of the August 2021 to October 2021 lockdown which experiences peaks throughout – likely given its duration). There are also a number of other reasons that call volume may have dropped in some PHNs in the second half of 2021 – including that as capacity for new clients in *HeadtoHelp* decreased, other service providers (in particular GPs) may have stopped advising individuals to call the 1800 number. In addition, it appears that *HeadtoHelp* advertising deceased over this period (both due to reduced funding and emphasis on advertising after the initial service launch), and because some hubs made a deliberate decision to stop advertising as they could not handle the demand.

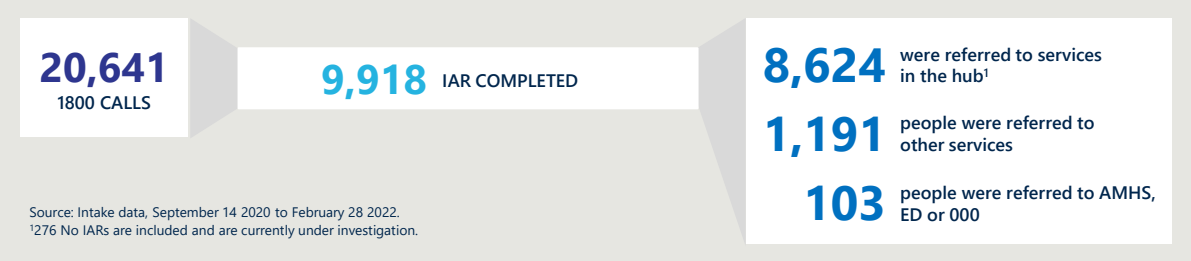
Approximately half of the calls resulted in a completed IAR

For participants who completed an IAR, 87 per cent of participants and support people are referred to the hub, whereas 12 per cent are referred to PHN funded or other services and one per cent are referred to a local AMHS, ED or triple zero (see Figure 11). Intake clinicians noted that where calls received by the 1800 number do not progress to referrals, callers may be calling for information, be transferred directly to another service, escalated to an acute service, or decide to discontinue with seeking *HeadtoHelp* service.

More than half (52 per cent) of calls did not result in a completed IAR. Intake clinicians noted that reasons for some 1800 calls not progressing to referral included:

- participants or support people may be calling in for more information or want to discuss their situation with someone neutral and elect not to proceed
- participants or support people may learn that services are unable to meet their needs (e.g., require higher acuity services)
- participants or support people may decide not to engage in an IAR and pursue further services.

Figure 11 | Intake and referral snapshot



Over 9,964 people received support through HeadtoHelp, with more participants in rural and regional PHNs

The 9,964 distinct participants were linked to 10,590 episodes.[21] At least 523 participants have more than one intake episode, suggesting they have returned to *HeadtoHelp* for additional episodes of care.[22] For participants returning for multiple episodes of care, there is a mean of approximately 109 days (3.5 months) between episodes.[23] Participants with multiple intake episodes do not appear clinically different than other participants, with similar distributions of IAR levels of care (three quarters of participants with IAR level three) and mean entry K10 scores. Rate of participants

[21] See Appendix E for episode data detail. There are three kinds of episodes: intake episode with no episode of care; intake episode with episode of care; episode of care with no intake episode. The slight discrepancy from the number of completed IARs above (9,964) is attributed to the different data sources for this figure – PHN intake data vs PHMC-MDS data.
[22] An episode of care is a period of health care (e.g., a series of occasions of service) with a defined start and end
[23] For people with more than two episodes, each gap between services was included in this analysis. For example, the number of days between the first and second episodes, and the number of days between the second and third episodes were included.

returning for additional episodes of care were highest for EMPHN (30 per cent, up from 14 per cent in the Interim Evaluation Report) and lowest for WVPHN (one per cent).

MPHN (23 per cent, n=2,260) and GPHN (23 per cent, n=2,220) accounted for almost half of all *HeadtoHelp* episodes. Furthermore, each of these regions had only two hubs each, as opposed to the three hubs in most other PHNs, further emphasising the skew in volume of delivery in rural and regional settings.

Higher episodes in these PHNs are likely a combination of the fact that these PHNs saw more participants, participants had lower average service contacts per episode, and episodes were shorter (discussed further in Section 4.1.6). Higher numbers of participants accessing rural and regional hubs aligns with qualitative insights that there are less available services in these regions, and that affordability is a significant barrier in accessing other forms of care.

Figure 12 | Open and closed episodes by PHN

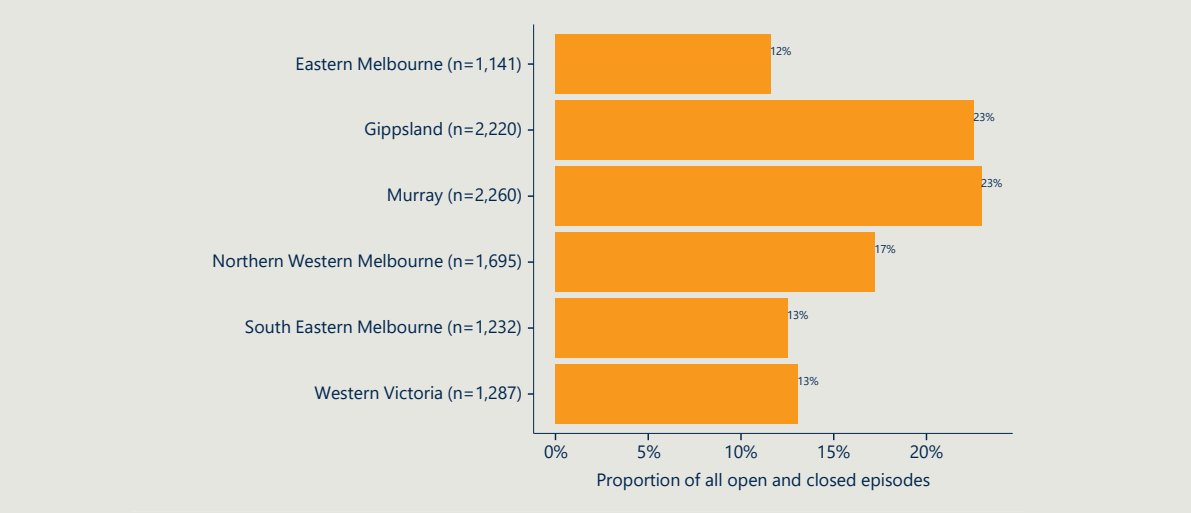
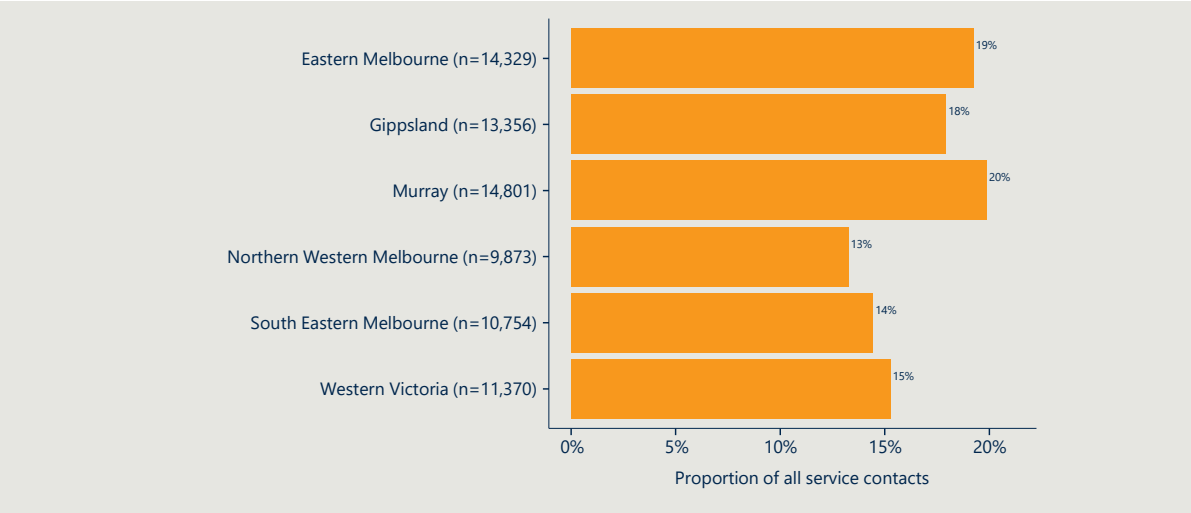


Figure 13 | Service contacts by PHN for open and closed episodes



There were 74,483 service contacts in total in closed and open episodes, with the highest proportions of service contacts coming from EMPHN, GPHN and MPHN (Figure 13).

Figure 14 and Figure 15 illustrate time trends in the number of first service contacts and overall service contacts during the duration of the *HeadtoHelp* program. For both figures, we attribute the sharp drop in service contacts in February 2022 to the time-lag between service delivery and recording data.

Figure 14 shows that first service contacts increased steadily from September 2020 to May 2021 before decreasing slowly from May 2021 to February 2022. This reflects the broad pattern of decline in calls to the 1800 number in Figure 10.

Figure 14 | First service contacts by date for closed and open episodes

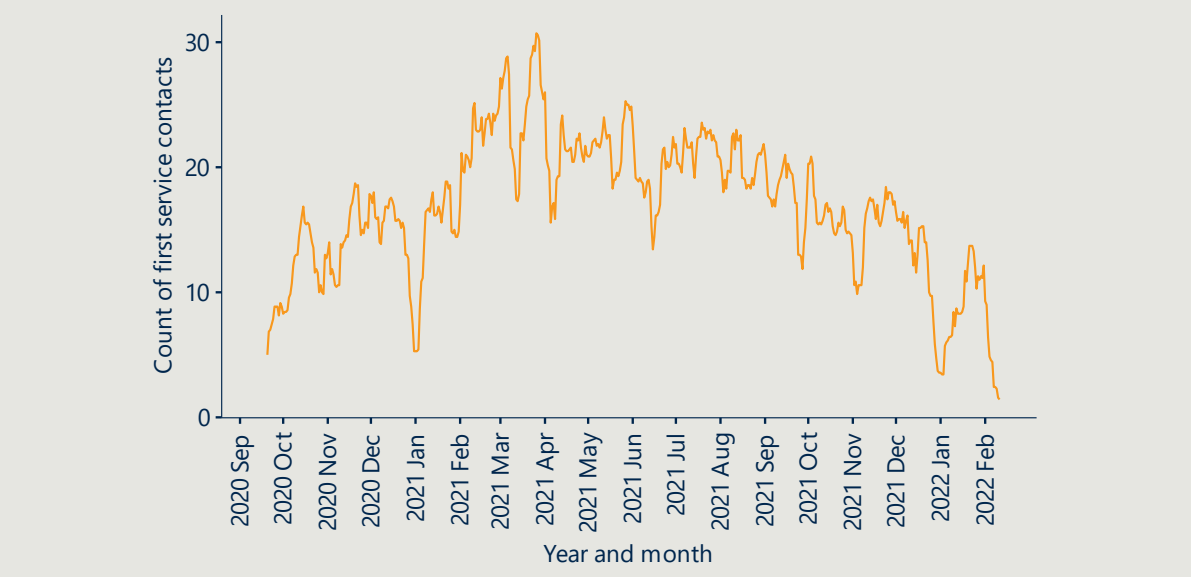
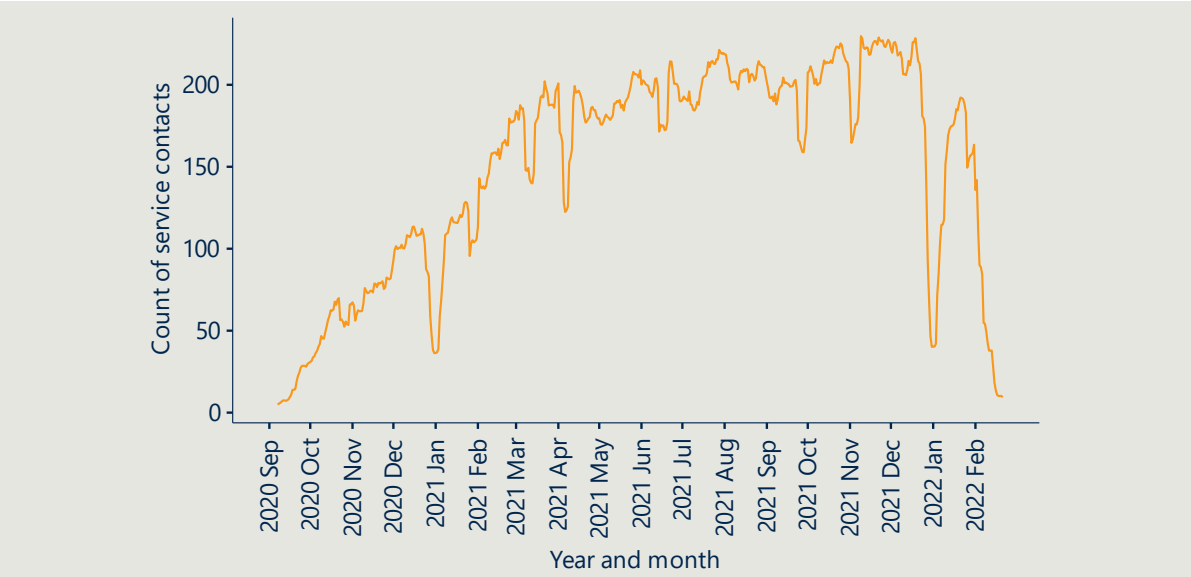


Figure 15 | Service contacts by date for closed and open episodes

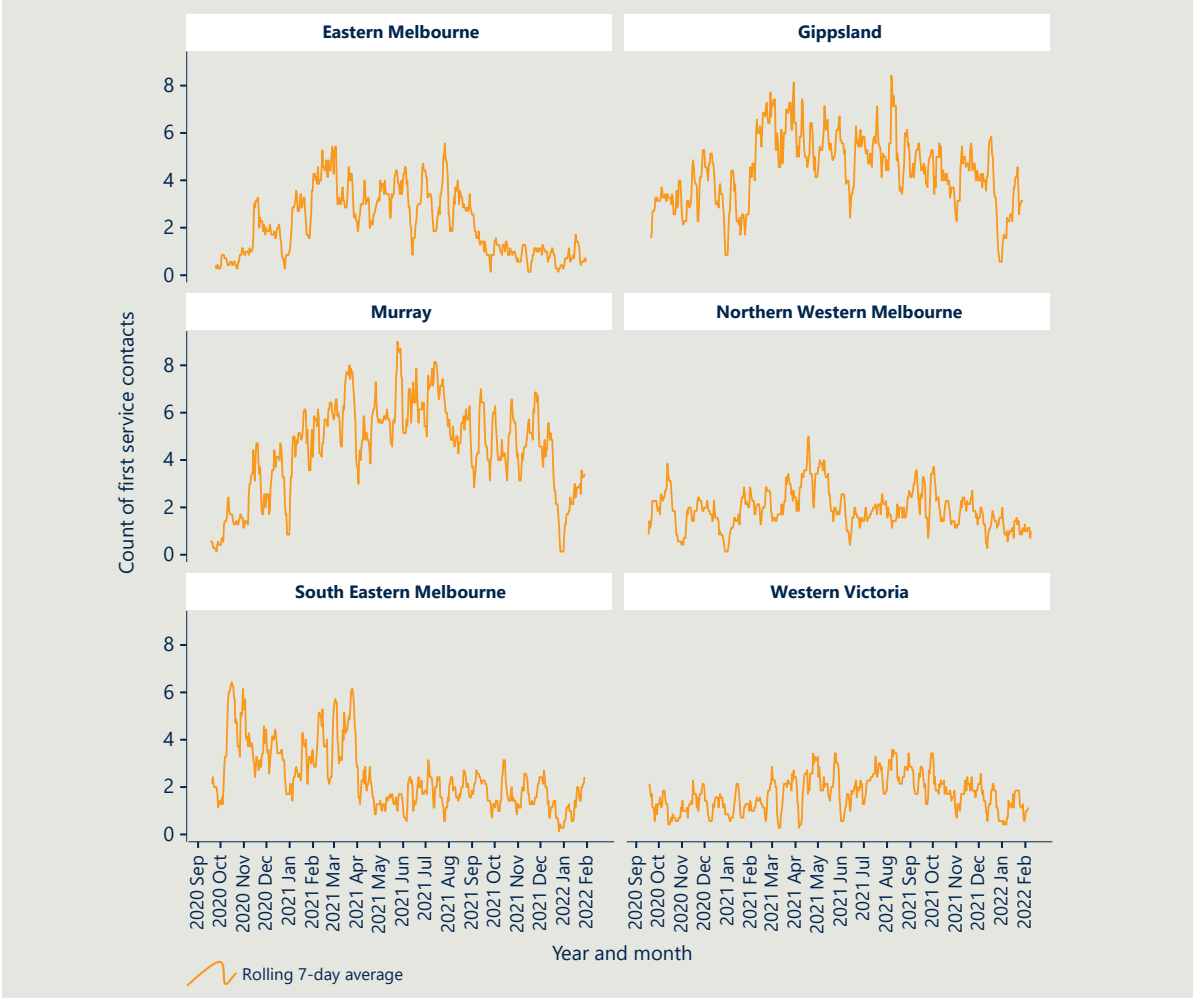


In contrast, when comparing the number of first service contacts with the total number of service contacts (Figure 15), there is no observed peak in the total number of service contacts. In fact, service contacts continue to increase slightly from April 2021 before peaking around November and December 2021. This suggests that the average number of service contacts per participant has increased from April 2021. Further analysis (see Figure 13) on the number of service contacts per episode confirms that the average number of service contacts for closed episodes has increased from 5.4 from the interim evaluation to 7.6. **This indicates that while there are less new clients entering into HeadtoHelp, the hubs are increasingly busy and operating at capacity**. This also supports the hypothesis above that number of calls to the 1800 number are in decline as referrers know the hubs are at capacity.

Looking at the volume of first service contacts by PHN, there are three broad trends occurring (Figure 16). There is an increase in first service contacts in EMPHN, GPHN and MPHN from September 2020, peaking in March 2021 for EMPHN and GPHN and in June 2021 for MPHN, before showing a steady decrease to February 2022. It should also be noted that from October 2021, EMPHN saw rolling seven-day average of less than two first service contacts, meaning that the PHN had less than two new clients on average every day from October 2021. SEMPHN shows service contacts peaking in October 2020 and April 2021 before plateauing at a lower level from May 2021 to February 2022. Finally, service contacts in NWMPHN and WVPHN have remained fairly consistent from September 2020 to February 2022.

It should be noted that EMPHN has almost doubled its proportion of total service contacts since the Interim Evaluation Report (ten per cent to 19 per cent). This can be attributed to the high number of service contacts per episode in EMPHN relative to the other PHNs. EMPHN has the second highest number of service contacts per closed episodes (10.4) and the highest number of episodes longer than 45 days, along with the episode with the highest number of contacts (154). See Figure 16 for more details.

Figure 16 | Count of first service contacts by PHN



4.1.2 Headtohelp participants

Headtohelp participants were typically female, English-speaking and aged over 25

Participants' demographics were evaluated based on the following variables:

Gender	Age	Aboriginal and/or Torres Strait Islander status	Language spoken at home

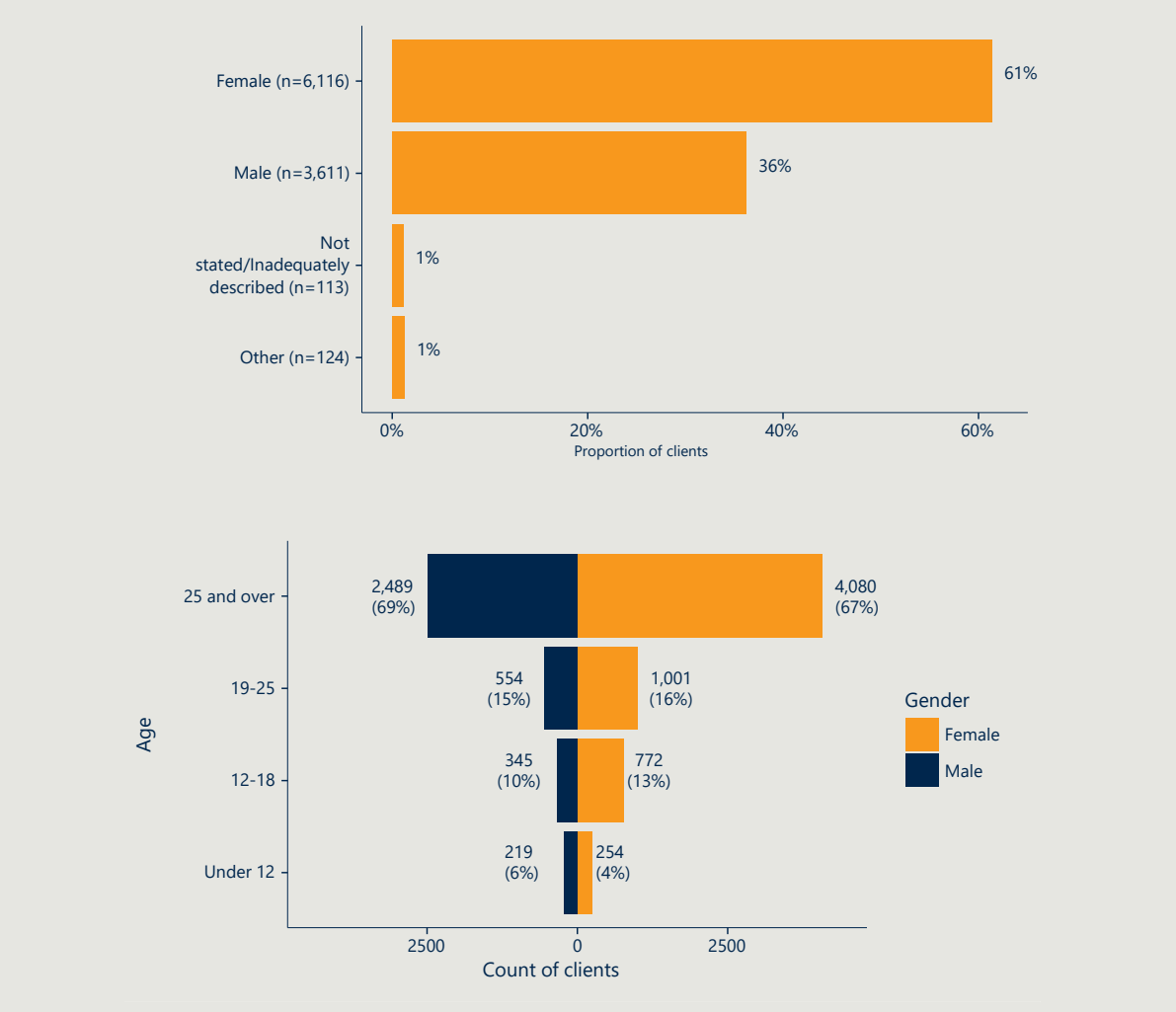
Gender Participants are mostly female (61 per cent, n=6,116), with almost twice as many female participants as male participants (36 per cent, n=3,611) (see Figure 17). A further 237 participants did not state their gender or did not identify as male or female. The higher proportion of women aligns with the fact that women are typically more likely than men to seek help for mental health issues and twice as likely to present for depressive symptoms, than men.[24] Women over the age of 25 accounted for 67 per cent of all female participants (n=4,080) or 41 per cent of all participants.

Age[25]. The majority of participants were adults (25+, 67 per cent, n=6,679). Sixteen per cent of participants were youth (19 to 25, n=1,609), 12 per cent were adolescents (12 to 18, n=1,181), and five per cent were children (under 12, n=482). There were approximately twice as many females across these age groups seeking help, mirroring what was seen in the adult age groups. Qualitatively, hubs and clinicians report that meeting needs for children, adolescents and youth posed a significant challenge, largely since the child and youth mental health workforce is extremely limited and it was difficult to recruit for this position.

[24] World Health Organization. Mental health and substance use. https://www.who.int/teams/mental-health-and-substance-use/gender-and-women-s-mental-health

[25] The age of 446 participants were missing in the data and omitted from any analysis involving participants' age.

Figure 17 | Proportion and count of clients by age and gender[26]



The proportion of clients seen in each age group was similar across the PHNs. Notably, WVPHN delivered services to more under-12 participants (eight per cent, n=97) relative to other PHNs (range of one per cent to seven per cent of total participants) and GPHN delivered services to more 12- to 18-year-olds (20 per cent, n=418), more than double compared to other PHNs (range of eight per cent to ten per cent). Overall, approximately a quarter of services in GPHN were delivered to under-18 participants (26 per cent, n=537) relative to other PHNs (range of nine per cent to 17 per cent). One hub in GPHN reported prioritising integration with the local headspace clinic, which may have led to the increase in young people seen by *HeadtoHelp* in this region. The reasons behind both WVPHN and GPHN seeing high numbers of children and young people requires further investigation but reflect findings from the respective PHN 'Need Assessments', which identify low accessibility of services for young people in these regions, relative to the rest of the state.[27] The lack of financial barriers to entry was likely to also be a significant contributing factor for parents and young people, to seek care through *HeadtoHelp* in these regions.[28]

[26] Note the totals may not add up between the two charts. Participants who did not state their gender or did not identify as male or female were omitted from the pyramid chart.

[27] In the WVPHN 2019 needs assessment, parents and carers identified accessibility of services as one of two main barriers for the treatment of people aged four to 17, of which 32.6 per cent were able to access mental health treatment when needed compared to 41.6 per cent Victoria-wide. WVPHN. Needs Assessment Report 2019. December 2019. https://westvicphn.com.au/wp-content/uploads/2020/03/WVPHN-Needs-Assessment-2019.pdf; In the 2019-2022 needs assessment, GPHN found that less than half of parents surveyed would be able to afford the support they would need for themselves or their children if they were experiencing a mental health issue. GPHN. Needs assessment 2019-2022. November 2018. https://www.gphn.org.au/wp-content/uploads/2019/02/GPHN-Needs-Assessment-Report-July-2019-June-2022.pdf

[28] Ibid.

Aboriginal and/or Torres Strait Islander. Approximately four per cent of participants identified as Aboriginal and/or Torres Strait Islander (n=440), which is higher than the relative proportion in the Victorian population (0.8 per cent).[29] In 2018-19, an estimated 24 per cent (187,500) of Indigenous Australians reported a mental health or behavioural condition, with a higher rate among females than males (25 per cent compared with 23 per cent, respectively).[30] In comparison to non-Indigenous Australians, Indigenous Australians are more than twice as likely to report 'high or very high' psychological distress.[31] With consideration of the prevalence of mental health disorders relative to the rest of the Australian population, there appears some evidence that *HeadtoHelp* was effective in increasing service access for Aboriginal and Torres Strait Islander people. Discussion of outcomes and satisfaction is included in Section 5.

Language spoken at home. The total proportion of people accessing *HeadtoHelp* who do not speak English at home is eight per cent (n=758), which although an increase from the Interim Report (six per cent), remains significantly below the proportion of people who do not speak English at home in Australia (21 per cent).[32] NWMPHN and SEMPHN have more than ten per cent of participants who do not speak English at home (15 per cent and 13 per cent respectively). Both GPHN and MPHN both have one per cent of participants who do not speak English at home. Where English is not spoken at home, the languages most often spoken at home were more likely to be an Asian language than any other languages. Some hub clinicians reflected that the *HeadtoHelp* service was designed and better able to meet 'mainstream'/normative populations in Australia (i.e., Caucasian and English speaking).

4.1.3 Social and clinical complexity

Participants were typically more complex than initially anticipated

Participants social and clinical complexity were evaluated based on the following variables:

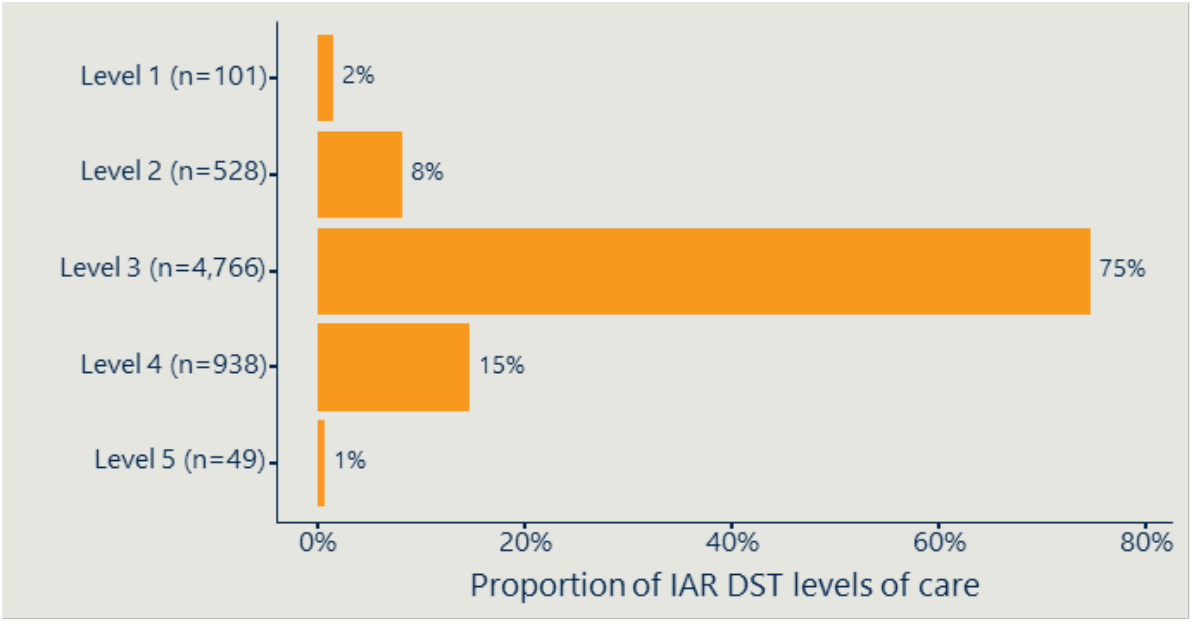
- IAR level of care
- K10 scores on entry
- prescribed medication
- principal diagnoses
- labour force status
- accommodation
- comorbid health diagnoses.

IAR LEVEL OF CARE. Across PHNs, level three IAR ratings formed the bulk of ratings (ranging from 68 per cent to 81 per cent). There were also more level four and five ratings relative to level one and two ratings across all PHNs suggesting participants were moderately to severely unwell and potentially presenting with more severe symptoms than anticipated. However, there is a chance that level one and two participants were triaged to more suitable services, such as online resources, before completing the IAR, and so would not have been captured in the data.

Notably, NWMPHN saw the highest proportion of level four and five ratings, forming more than a fifth of all ratings (22 per cent, n=309). At the other end of the scale, all PHNs saw approximately a tenth of ratings at level one and two (ranging from eight per cent to 11 per cent).

[29] Noting that this is from the 2016 census. Australian Bureau of Statistics. 2071.0 – Census of the Population and Housing: reflecting Australia – Stories from the Census, 2016.
[30] Ibid.
[31] Australian Institute of Health and Welfare. Indigenous health and wellbeing. https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing
[32] Noting that this data is from the 2016 census and is likely to be higher in 2021. Australian Bureau of Statistics. 2071.0 Census of Population and Housing: Reflecting Australia – Stories from the Census, 2016. June 2017.

Figure 18 | Proportion of IAR-DST by level (all PHNs)



K10 SCORES ON ENTRY. K10 scores are typically measured following intake and on entry to the service. Mean K10 scores ranged from 29.5 (MPHN, n=1,245) to 33.4 (WVPHN, n=428). Scores above 30 on the K10 indicate very high psychological distress, suggesting participants of *HeadtoHelp* were, on average, severely unwell on entering the service.[33] This strengthens the interpretation on IAR levels of care, suggesting that participants were moderately to severely unwell and potentially presenting with more severe symptoms than anticipated. It also aligns with qualitative insights on participant severity of need.

PRINCIPAL DIAGNOSES.[34] The vast majority of participants presented with symptoms (e.g., anxiety symptoms) rather than pre-existing diagnoses (e.g., major depressive disorder), suggesting many clients may have been accessing mental health services for the first-time. It may also reflect the large number of self-referrals, and that these individuals may be more likely to present with symptoms rather than a diagnosis, regardless of past interactions with the mental health system. Anxiety symptoms, depressive symptoms, mixed anxiety and depressive symptoms and stress-related symptoms made up more than half of 'principal diagnosis' at the time of intake. This aligns with the predicted connection between COVID-19 and mental health. The World Health Organization (WHO) has previously reported increasing levels of anxiety, depression and stress related to the COVID-19 pandemic.[35] An Australian study also found that between March to June 2020, risk factors for depression and anxiety symptoms were elevated for participants experiencing COVID-19 related social impairment and financial distress, an existing mental disorder diagnosis, or were younger in age.[36]

PRESCRIBED MEDICATION. Three quarters (73 per cent) of participants were not prescribed any medication prior to intake. Participants are typically prescribed medication when other interventions have not been effective, or they are experiencing moderate to severe mental health needs and/or

[33] People seen in primary care who score 30 and over on the K10 are likely to have very high psychological distress. This is, however, a screening instrument and practitioners are expected to make clinical judgements. Australian Institute of Health and Welfare. Adults with very high levels of psychological distress, 2018. 2018.
[34] The diagnostic categories within the PMHC-MDS data include a mix of diagnostic and symptom categories to reflect the fact that people who do not meet full diagnostic criteria can access services (rather than that their diagnosis is unavailable).
[35] World Health Organization, COVID-19 disrupting mental health services in most countries, WHO survey. October 2020. https://www.who.int/news/item/05-10-2020-covid-19-disrupting-mental-health-services-in-most-countries-who-survey
[36] Herrman, H & Kieling, C. Symptoms of depression and anxiety during the COVID-19 pandemic: implications for mental health. Medical Journal of Australia; 214 (10). June 2021. https://www.mja.com.au/journal/2021/214/10/symptoms-depression-and-anxiety-during-covid-19-pandemic-implications-mental

persistent and chronic mental health needs.[37] The most common medications prescribed prior to intake were antidepressants (22 per cent, n=2,373), followed by antipsychotics (five per cent n=522) and anxiolytics (four per cent n=460)[38]. The Australian Commission on Safety and Quality in Health Care found that there is wide variation in the quality of prescribing of medications for mental health, as well as confusion about the responsibilities of different clinicians.[39] Given the very limited number of hubs with psychiatrists in the workforce, it should be considered how *HeadtoHelp* facilitates medication reviews for participants during their episode of care, potentially coordinating with the participants primary physician. Both EMPHN and MPHN had the highest proportion of participants who were prescribed medication (41 per cent) compared to other PHNs (range of 12 to 29 per cent).

LABOUR FORCE STATUS, ACCOMMODATION AND COMORBID HEALTH DIAGNOSES. The PMHC-MDS contains other demographic variables that may be risk factors for mental disorders, such as employment/labour force participation, accommodation and comorbid health diagnoses that affect mental health. Of *HeadtoHelp* participants, 31 per cent were not in the labour force[40] (n=3,297), which suggests that the program's purpose as a COVID-19 response was appropriate, noting that the pandemic has had a substantial impact of employment of individuals in a number of sectors. Five per cent are in short-term or emergency accommodation or sleeping rough or in non-conventional accommodation (n=448).

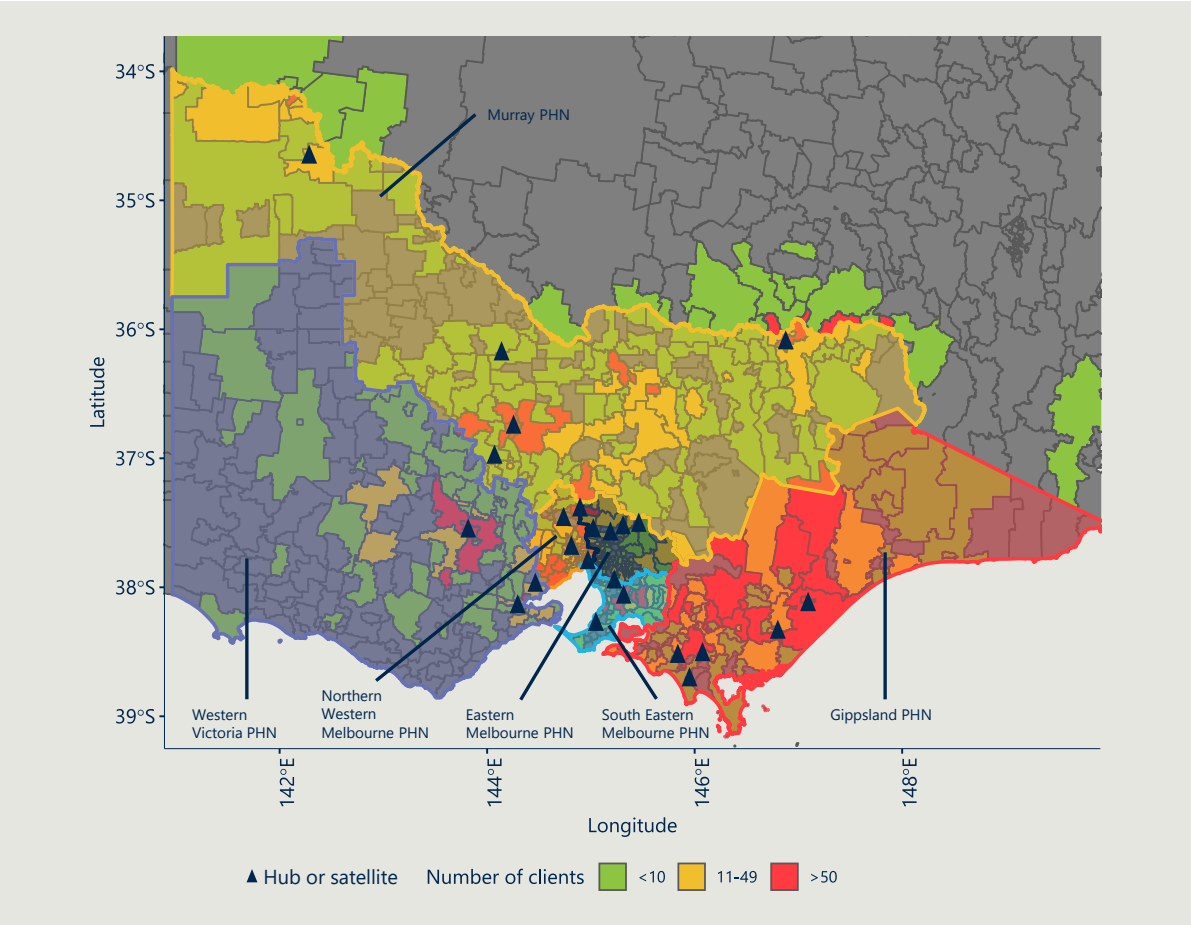
Participants were dispersed across Victoria, with particularly high uptake in border and regional communities

Participants were dispersed across Victoria (and in New South Wales, in some cases). Figure 19 displays the count of participants by postcode. High case numbers (e.g., >50 clients per postcode) tend to be seen near hub locations (e.g., Bendigo, West Heidelberg, Wyndham Vale, Ballarat, Sale). The areas with the highest growth in participants also tend to be around hub locations. This suggests that a brick-and-mortar service improves service awareness and access in that community, relative to other areas that can access the service via telephone or video call.

Interestingly, while there are high case numbers in border communities in MPHN, particularly in Mildura and Albury/Wodonga, there has been little growth in these border communities since the Interim Evaluation Report. Our hypothesis is that border communities were at particular risk of mental health concerns because of early COVID-19 related border closures as services, workplaces, friends and family may be dispersed across the border. However, border closures with NSW were not a feature of the COVID-19 pandemic response by both states from June 2021[41] and hence, people might have experienced lower mental health risk as a result. Figure 19 also indicates some areas of high need that are not particularly close geographically to a hub – including near Shepparton, and across the Gippsland region, which may be important to inform future locations for AMHCs.

[37] National Institute for Health and Care Excellence. Common mental health problems: identification and pathways to care. May 2011.
[38] It should be noted that an average of 42 per cent of participant's prescription history in each of the medication subgroups antidepressants, antipsychotics, anxiolytics, hypnotics and psychostimulants as prescribed in the PMHC-MDS was not known.
[39] Australian Commission on Safety and Quality in Health Care. Medication safety in mental health. June 2017.
[40] The four options for this statement where: employed, unemployed, not in the labour force, not stated/inadequately stated. Australian Government Department of Health. PMHC-MDS data specification-Episode labour force status. 2019.
[41] https://www.parliament.vic.gov.au/publications/research-papers/download/36-research-papers/14010-chronology-of-victorian-border-closures-due-to-covid-19

Figure 19 | Number of clients by postcode



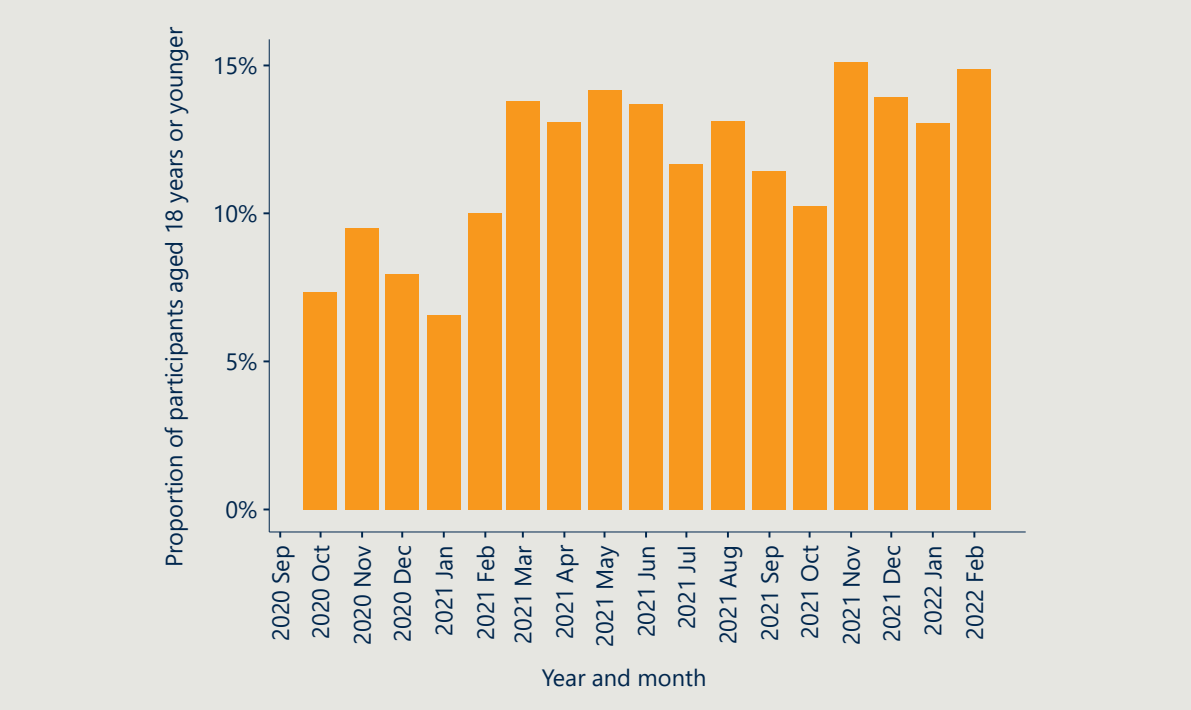
Qualitatively, hubs reported that over time participants appeared younger, with more severe needs

Most hubs report that many of their participants are the 'missing middle'. That is, people who have multiple needs or symptoms that are considered too complex to be adequately treated by a GP, however, not severe enough to meet the threshold for access to the state funded specialised mental health service (i.e., AMHS).

Initially, participants were presenting with COVID-19 related situational distress that could be managed by psychosocial supports (e.g., financial advice, relationship counselling). Over time, participants have presented with more severe and acute mental illnesses that have been exacerbated by COVID-19 (related restriction, ambiguity and uncertainty). Many hub staff reflected that they are working with participants who have never sought help from mental health services before.

Over the second half of operation, many intake clinicians and hub providers qualitatively observed the *HeadtoHelp* cohort that is referred to and is utilising the service is becoming younger. Many clinicians highlighted that it is becoming common for external providers such as AMHSs, headspace or community children and youth services to attempt to refer participants, particularly youth and children (under the age of 12) to the service. The evaluation is aware there is a substantial gap in the services available for these cohorts and as a result *HeadtoHelp* is viewed as an alternative option by external providers. The variability in cohort for the service, particularly age, introduces a significant challenge for each hub's small *HeadtoHelp* workforce and its ability to provide the right level of care and support tailored to each cohort.

Figure 20 | Proportion of participants aged 18 years or younger by episode referral date

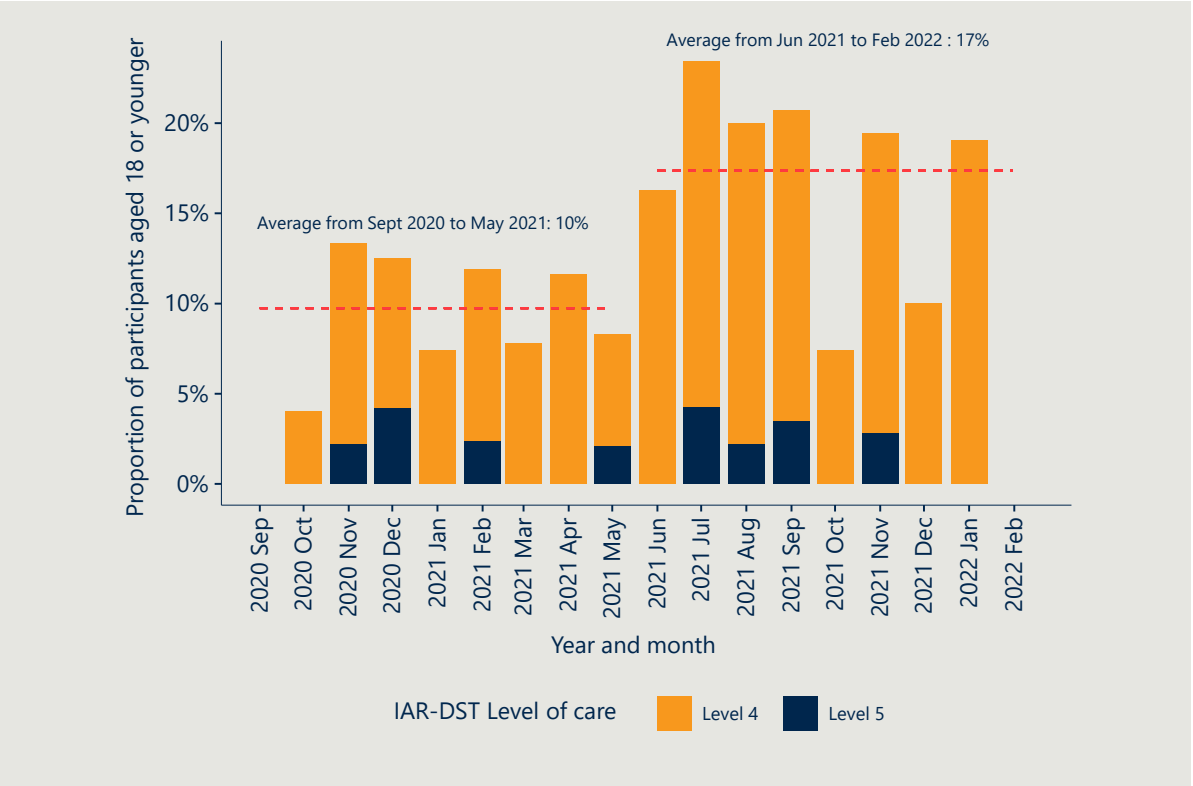


This qualitative insight is confirmed by analysis of the PMHC-MDS data. The data shows that the proportion of participants aged 18 years or younger has steadily increased from less than ten per cent at the start of the program to just under 15 per cent.[42]

Looking again at the participants aged 18 or younger and their IAR-DST levels of care at intake also shows the proportion assessed at Level four or five, indicating severe psychological stress, has increased over time, averaging ten per cent between September 2020 to May 2021, before increasing to 17 per cent from June 2021 to February 2022. It is interesting to note that the peak in both referrals and IAR levels of care in November 2021 which coincides with the emergence of the Omicron COVID-19 variant. Additionally, there is a peak in the IAR levels of care in July 2021 coinciding with the most recent Delta outbreak in NSW and Victoria. This may reflect mental and stress anxieties caused by COVID-19 among young people.

[42] By way of comparison, 23 per cent of the Australian population is aged 18 and under (ABS, Population by age and sex – national, as at 30 June 2021). While on face value, this would appear that younger people are under-represented, given the existence of specialist child and youth services, in particular as headspace, this could be considered a reasonable representation in the *HeadtoHelp* service. https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release

Figure 21 | Proportion of participants aged 18 or younger with IAR-DST levels of care four and five at intake



4.1.4 Service use

Participants and support people sought HeadtoHelp services for a variety of reasons – with COVID-19 a primary contributing factor

Participants and support people approached *HeadtoHelp* to support a range of different issues. Almost all wanted counselling and psychological services, and some reported seeking help for drug and alcohol issues, domestic violence, relationships, grief, medication review, housing and financial issues, work stress, and coping with experiences of anxiety and depression. Support people sought help when they observed changes in their loved one's behaviour or mental state, including worsening symptoms of a diagnosed mental health issue, noticing symptoms for the first time, or observing that the person was struggling with stressors such as school transitions.

The HIE survey indicated that for around two thirds of participants and support people COVID-19 had contributed, at least slightly, to their need to contact *HeadtoHelp*. Very similar percentages were reported by interview participants, with around a third of people reporting that COVID-19 made no contribution to the reason for engaging with *HeadtoHelp*, and around 12 per cent attributing the contact primarily to COVID-19.

The ways in which COVID-19 and the associated lockdowns contributed to mental health issues were varied, and included:

- losing work and the financial implications of that
- having to work more hours
- fear of contracting the virus
- strained relationships with family or housemates
- escalation of domestic violence
- being isolated from family and friends
- being bored with nothing to do

- increased drug and alcohol consumption
- dealing with other people's stress and panic
- the disruption to daily life
- feeling locked up
- feeling that there was nothing to look forward to.

For example, one participant sought support with family conflict which was 'obviously… exacerbated by COVID', while another described how being bored during lockdown had worsened his substance use issues. Support people who reported that COVID-19 had influenced their loved one's mental state most commonly reported increased anxiety due to fear of COVID-19 or to having spent a long period not getting out and socialising with friends. As one pointed out: 'She needed that social contact because being away from school heightened that anxiety'. Several participants also attributed difficulty accessing other services and long waiting times to the extra demand for mental health services related to COVID-19. Eight people stated that COVID-19 made it difficult to access *HeadtoHelp*, as well as the services that *HeadtoHelp* referred them to.

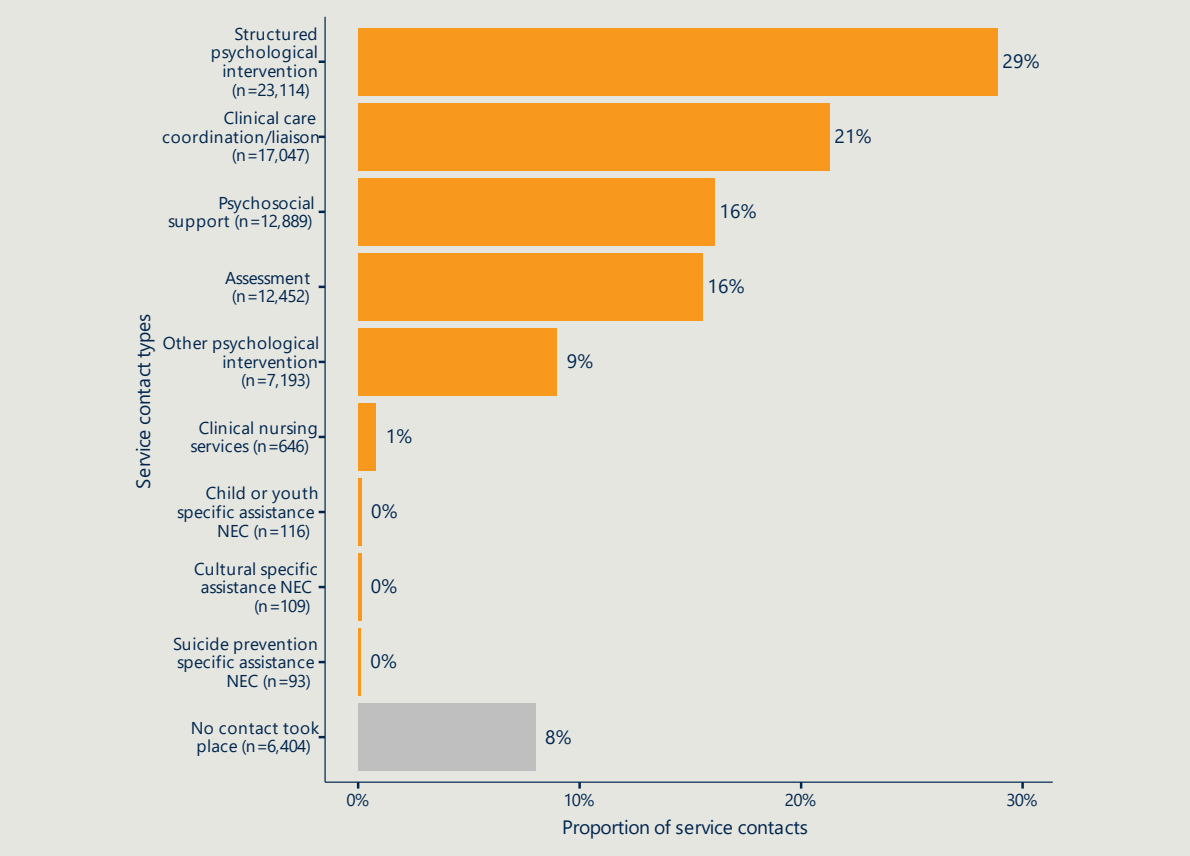
Eleven per cent of people reported that COVID-19 did not play a part in why they contacted *HeadtoHelp* for mental health assistance.

Psychological therapy and clinical care co-ordination were the most common services delivered by hubs

Structured psychological intervention (29 per cent, total n=23,114) and clinical care coordination/liaison (21 per cent, n=17,047) were the most common types of service contacts. The least common types of service contact were suicide prevention specific assistance (n=93), cultural specific assistance (n=109) and child or youth specific assistance (n=116). The low number of child or youth specific assistance and cultural specific assistance is likely due to the fact that most hubs were recording data as other intervention types (e.g., structured psychological intervention), as we know that greater numbers of children or youth were provided assistance. There were no notable differences across PHNs in terms of the types of service contact.

Participant interviews highlighted this concentration of service types. This is not surprising given that *HeadtoHelp* participants requested psychology or counselling given that 'talking therapy' is what is most known by lay people to alleviate mental distress. Further these were the interventions most frequently offered and provided. However, *HeadtoHelp* and comparable programs are uniquely placed to link to, and provide through the hubs, a wider range of evidence-informed modalities beyond talking therapies, in particular to respond to other wellbeing challenges such as financial, social and relational health issues.

Figure 22 | Total service contact types by volume



Six in ten service contacts were remote

Remote contact (comprising telephone, video and internet-based) formed the majority (61 per cent) of all service contact modalities (Figure 23). Service contacts, which do not include the initial call to the 1800 number, were most commonly delivered through telephone (47 per cent, n=37,401), followed by face-to-face (30 per cent, n=23,855). Service contacts by video and telephone peaked during periods where stay-at-home orders are enforced. Given *HeadtoHelp* was intended as a COVID-19 response, it follows that a high proportion of service contacts were not face-to-face to prevent transmission of COVID-19.

Hub clinicians and staff reported that many users preferred face-to-face, particularly in rural and regional communities, so the service modalities may not reflect participant preferences. The video modality is used less frequently than telephone, which was not expected given the global shift to videoconferencing because of COVID-19 restrictions across other sectors.[43] Anecdotally, this has also been the experience across primary care more broadly. Most age groups had a higher proportion of telephone service contacts versus face-to-face service contacts, except in the under-12 age groups.

> Interview findings challenge service provider assumptions about the value of telehealth
>
> Interestingly, data from the participant and support person interviews challenged the views often held by service providers – that clients overwhelmingly prefer face-to-face services. Of 45 participants who commented on their preference regarding telehealth, 21 participants said that they preferred in-person services, 16 said that they preferred telehealth services and eight described merits of both modes of service delivery and appreciated a combination.

[43] Forbes. How videoconferencing and COVID-19 may permanently shrink the business travel market. November 2020.

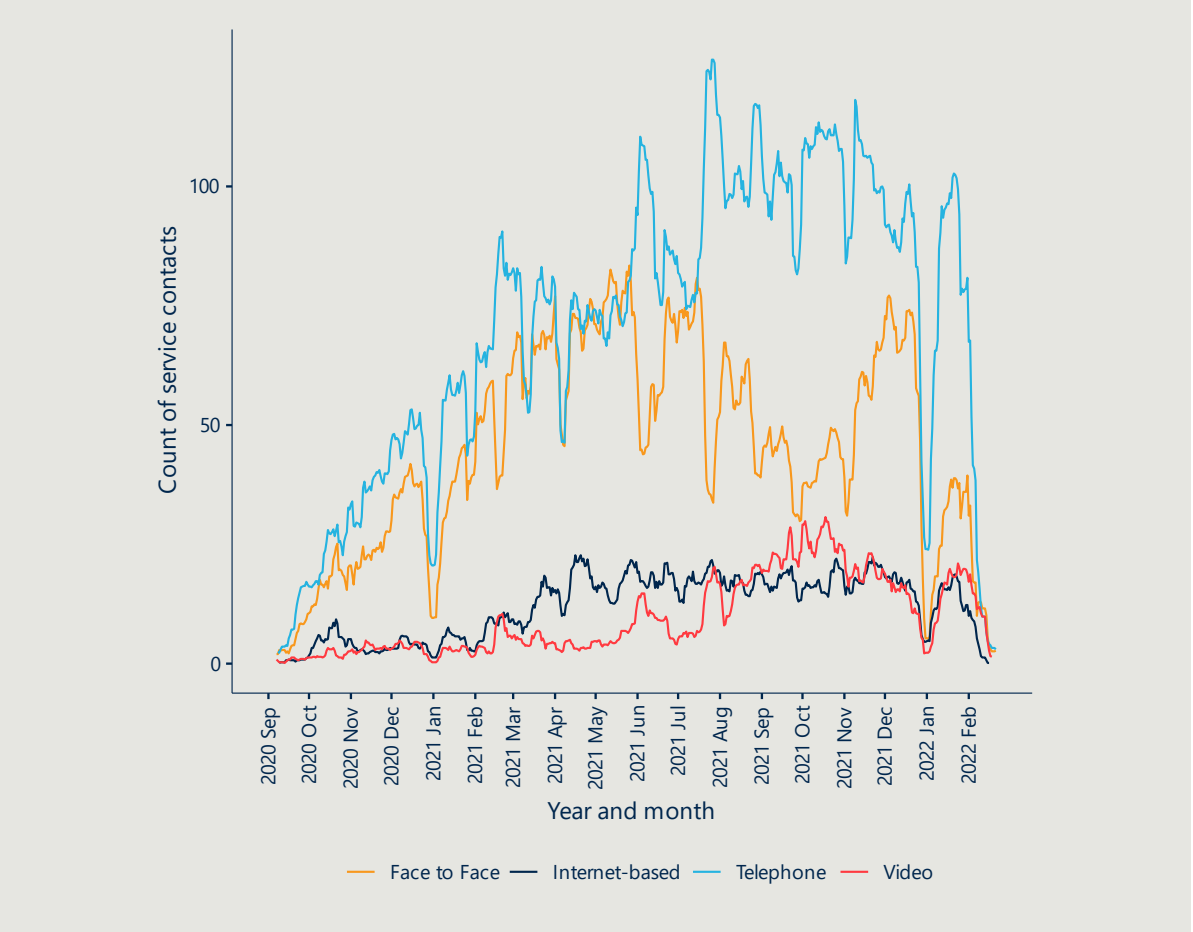
Direct experience of telehealth services appeared to influence participants' preferences for telehealth vs in-person services. People who had only received in-person services, where they expressed a preference, preferred in-person services. However, people who had experienced telehealth were more likely to prefer telehealth or see benefits of both. A lower proportion of participants who had only experienced telephone services preferred telehealth compared to people with at least some experience with service via videoconferencing.

Those who preferred in-person services most commonly cited the belief that personal human contact and connection was superior in in-person settings. However, sometimes it also appeared to be attributable to the clinician's lack of skills with the format, rather than the format itself. Participants who preferred telehealth services or a combination described a range of benefits of telehealth, predominantly the convenience: being able to access services despite busy work schedules and family responsibilities, and not needing to travel. Participants who valued a mix of service types suggested that different formats may suit different people at different times.

It is important to recognise that the above findings are based on a limited sample size. Several studies into consumer preferences for mental health service delivery via in person versus telehealth or online services indicate that the COVID-19 pandemic has altered traditional attitudes towards mental health treatment via telehealth and online services. The rise in the use of this delivery format has increased awareness of its benefits, including increasing access to (e.g., remote communities), and the lower cost of online and telehealth services. However, the majority of research indicates that people do still tend to prefer in-person services when presented with the choice , , . Therefore, it is important that face-to-face services are made available wherever possible to meet participant preferences and achieve better outcomes, however telehealth and online services should continue to be adopted where they may be more useful (e.g., where they make services affordable for those who cannot afford in-person services, or accessible for those in remote areas). The expansion of these delivery methods also provides important preparation for possible future events that prevent physical attendance, such as a pandemic or natural disaster.

Service contacts between 46 to 60 minutes are the most frequent duration and has been increasing in proportion of the total, growing from 29 per cent to around 43 per cent of all service contacts from September 2020 to February 2022. The reasons for this are unclear.

Figure 23 | Service contact by modality and date



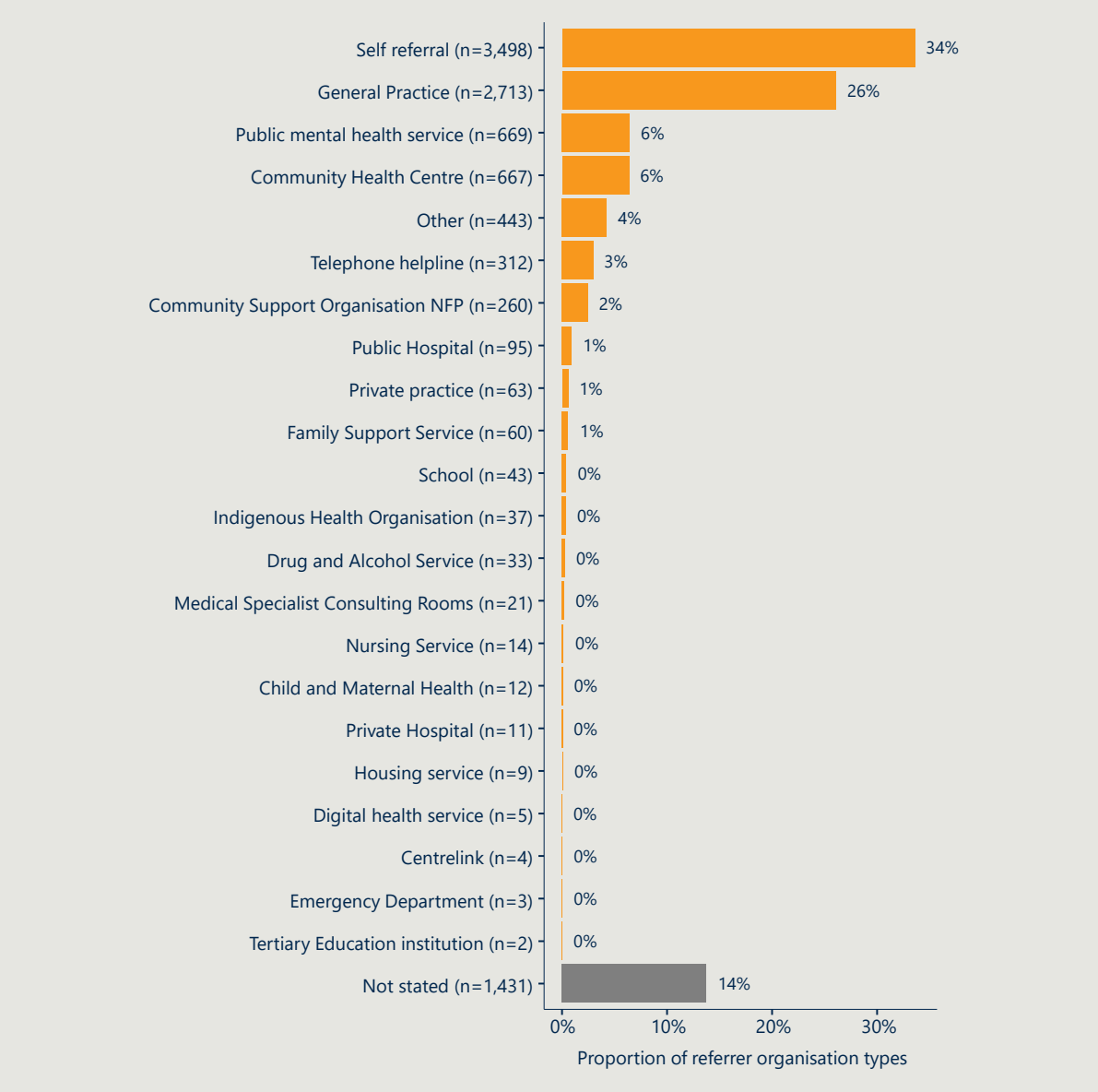
4.1.5 Service pathways

Self and GP referrals are the most common pathway to HeadtoHelp

Self-referrals (34 per cent, n=3,498) and GP referrals (26 per cent, n=2,713) form the majority of referrals[44] into the *HeadtoHelp* service. Having high levels of self-referral can be viewed as a positive impact of the service, as it may indicate that some participants are seeking and finding *HeadtoHelp* prior to reaching crisis or presenting to an AMHS or ED. Conversely, it may suggest that *HeadtoHelp* is not as well connected to other services as would be desirable. Interestingly, several stakeholders reported AMHSs and EDs are more likely to refer to GPs than to *HeadtoHelp* directly. Potential reasons for this are discussed in Section 5.2.3.

[44] Note that the total number of identified referral pathways (n=4,131) does not equal to the distinct number of participants (n=5,013). See Appendix E for more details on how these were derived.

Figure 24 | Referral pathways for HeadtoHelp



Members of the Taskforce had expected the number of referrals from AMHSs to be higher than the five per cent that has been observed. It is possible that AMHSs, EDs or other services are providing the *HeadtoHelp* 1800 number to participants, who then call the number and may be recorded as a 'self-referral'. Feedback from AMHSs has also indicated that their primary referral pathway is to GPs.

The counterview to this, is that a low portion of referrals from AMHSs and EDs (see Figure 24) can be viewed as poor engagement and integration between *HeadtoHelp* and Victorian mental health services. Appropriate referrals are contingent on strong communication (and consequently, strong relationships) between *HeadtoHelp* and service partners. This is discussed in further Section 5.2.3.

Referral sources differed among PHNs, which was expected. There is a strong link between the *HeadtoHelp* service setting and the referring organisation. For example, those hubs co-located with GP clinics have higher proportions of clients referred by GPs. Interestingly, co-location with a GP clinic did not appear to result in greater referrals overall – hubs co-located with GPs (of which there were 11 of 15, 73 per cent) only accounted for approximately 53 per cent of intakes overall. Likewise, those hubs co-located with community health organisations[45] have higher proportions of

[45] Unless otherwise specified, this includes referrer organisations classed as 'community health centre' and 'community support organisation not for profit.'

participants referred by community health organisations. The following differences were noted by PHN:

- SEMPHN hubs are all co-located in GP clinics. In SEMPHN, over half of referrals were from GPs (56 per cent). A third (33 per cent) of referrals were self-referrals, whereas only two per cent of referrals originated from 'community support organisation'. Most of the GP referrals went to the Officer Medical Centre for services, suggesting that this clinic either experienced many referrals from GPs in the area and/or a high proportion of walk-ins, which may have been coded as 'GP referral' given that they presented to a GP directly.
- EMPHN hubs are co-located in community health centres. EMPHN saw a significantly higher number of referrals from community health organisation referrals (36 per cent) as compared to GP referrals (11 per cent).[46]
- Relative to other PHNs, MPHN had the most varied referral sources (31 per cent from GP, 23 per cent self-referral, nine per cent from community health organisations), including a significant amount from public mental health services (nine per cent). This suggests hubs in MPHN were better able to integrate with AMHSs in the catchment (e.g., by having a clinician that sat in both the *HeadtoHelp* service and tertiary service).
- Gippsland hubs (like SEMPHN) are co-located in GP clinics. Despite having majority GP hubs and satellites, GPHN received a relatively similar amount of referrals from GPs (40 per cent) and self-referral (37 per cent), which may suggest that there is a weaker link between service setting and referring organisation in rural and regional hubs given the greater mental health need and limited access to services, relative to the rest of Victoria. GPHN also saw a significant amount of referrals from public mental health services (12 per cent)

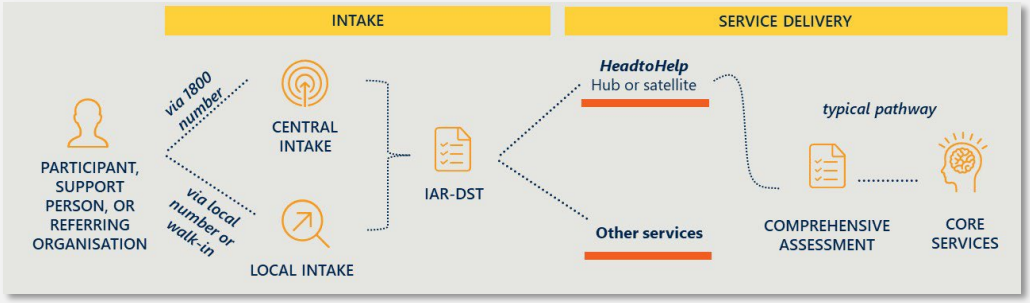
Unfortunately, the majority of referrals in WVPHN and NWMPHN were recorded as 'not stated' (60 per cent and 38 per cent respectively) so much of the data could not be analysed in a meaningful and accurate way.

Most participants received services just over two weeks after a referral

The average number of days from intake referral [47] to comprehensive assessment[48] is approximately 11 days (up from an average of seven days from the Interim Evaluation Report), peaking in April 2021 at 18 days (see Figure 25 for a diagram of a typical participant journey). This may reflect longer processing times due to an increase in participant numbers.

[46] A caveat to this analysis is that referral organisation type and provider organisation data appeared missing or incomplete for EMPHN, which has at least three hubs and three satellites. When episode data was linked to service contact data, data was available for only Access Health and Banyule Community Health.
[47] Intake referral is when a participant has completed intake and, typically, also completed the IAR and has been referred to *HeadtoHelp* services.
[48] Comprehensive assessment does not refer to the IAR but to mental health assessments made in addition to the IAR. Assessments typically occur in the first session of service delivery.

Figure 25 | Typical participant journey



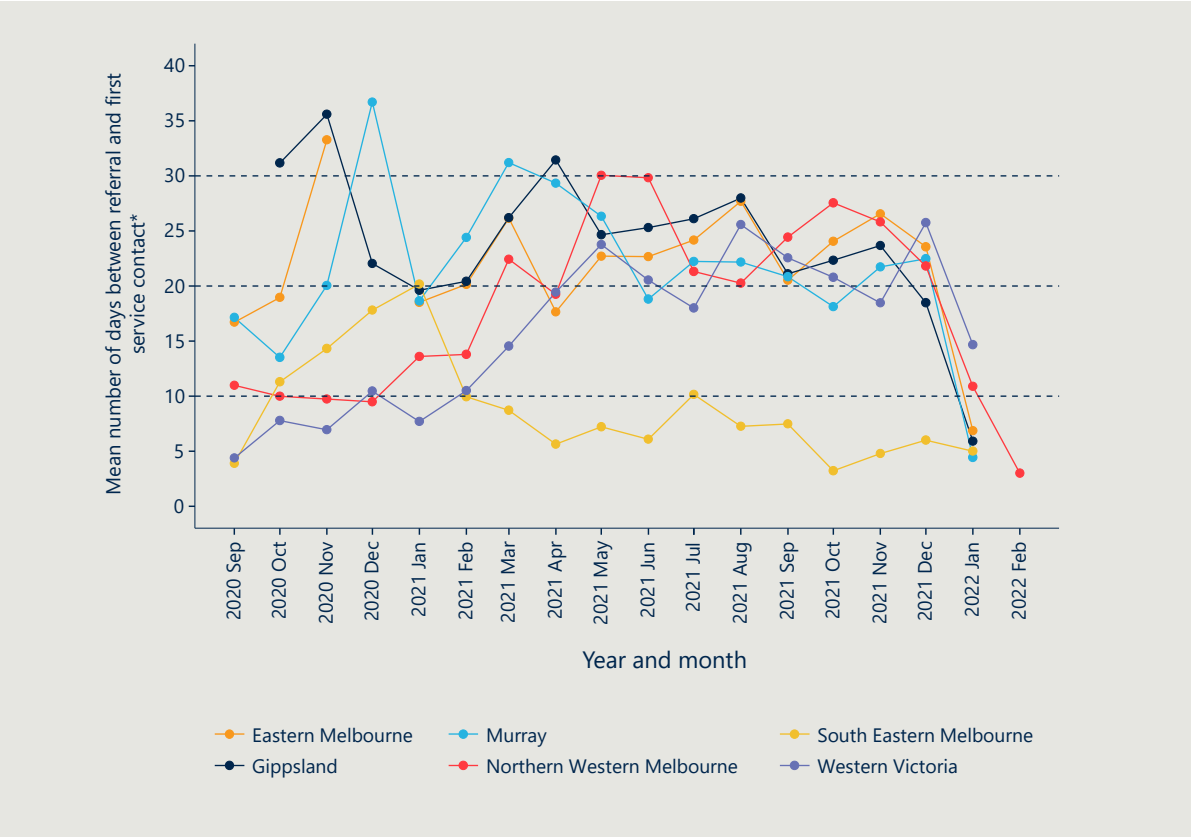
As the Interim Evaluation Report covered data until 30 June 2021, this suggests that the average number of days from intake referral to comprehensive assessment has increased in July 2021 to February 2022. This is noteworthy as participants and support people have indicated that one of the aspects of *HeadtoHelp* that they value most highly is the immediacy of the service. There were no major differences seen in the mean wait time by IAR level of care. It is worth noting that despite the increase since the Interim Evaluation Report, these wait times remain considerably lower than anecdotally reported elsewhere in the sector.[49]

Average waiting time between referral to a core service (which does not include assessment or care coordination) was approximately 20 days (up from an average of 17 days from the Interim Evaluation Report).

All PHNs, except SEMPHN, had average waiting times in the ranges of 17 days to 26 days. These PHNs generally had rising average waiting times from September 2020 to April 2021 before stabilising between 20 to 30 days from April 2021 to December 2021. On the other hand, SEMPHN had an average waiting time of ten days and maintained an average waiting time below ten days from February 2021 onwards.

[49] Cook, H. Psychologists stretched to limit as virus drives spike in referrals. Published 28 October 2020.

Figure 26 | Mean number of days between referral and first service contact by PHN



Some service partners were hesitant to refer to HeadtoHelp

Some service partners, including AMHSs, children and family services, and headspace, report feeling frustrated and fatigued from the rejection of seemingly appropriate referrals to *HeadtoHelp* hubs in their local areas. Service partners report that they have referred participants or families who in their view, fit the broad risk profile of *HeadtoHelp*, however find their local *HeadtoHelp* hub is hesitant or unqualified to take the referral on. Service partners that primarily support children and youth, report this is a common experience for the cohort they service. This has greatly impacted service partners' perceptions of the *HeadtoHelp* service and its perceived value as a front door, with some stating they are no longer comfortable referring their participants to *HeadtoHelp*. This feedback is also consistent with feedback from hub staff, who have noted they have found it challenging to recruit staff or upskill staff with expertise to adequately meet the needs of young people.

This hesitancy from service partners highlights the importance of *HeadtoHelp* (and any mental health initiative) clearly articulating the purpose of the service and level of risk the service has the ability to manage, including the capacity and capability of the service, to mitigate against fatigue from referrals being rejected. While the extent of this hesitancy varied across partners and locations, it was a strong theme in the consultations, and requires focused effort to overcome.

4.1.6 Alignment of delivery with intended design

Anecdotally, the average length of service is much longer than the model envisioned, where most participants continue to be serviced by the hub

Hub staff report that the *HeadtoHelp* funding model estimated hubs would provide between six and eight occasions of service per participant. However, staff report the average length of care is much longer than the model anticipated. Quantitative evidence on this point varies – see analysis of the PMHC-MDS data below.

Hub staff report that there are likely a range of factors that have contributed to this:

- **Agreed definition of occasion of service.** Many hubs report they do not have a clear definition within their contract of what contributes to an 'occasion of service' (i.e., the type of service/interaction and length of time). There was often a discrepancy between hubs, where some reported administrative tasks as an occasion of service and others did not. This is evident in the level of variability between hubs.
- **Complexity of HeadtoHelp cohort.** As outlined earlier, most hubs reported that the presenting cohort to *HeadtoHelp* (i.e., the 'missing middle') is much more complex than originally envisioned. As a result, this has often translated into a greater or longer intervention to meet the participant needs, whilst sometimes awaiting referral to another service. This was corroborated by participants who indicated that their needs could not be met in a short period of time.
- **Lack of senior clinicians who are comfortable to discharge participants.** Managing participant throughput in the *HeadtoHelp* hubs continues to be a challenge for many hubs. This may be attributed to the level of experience hub staff bring, where inexperienced staff are overly concerned about discharging a participant at the risk of something going wrong. Some hubs may also lack sufficient clinical guidance or reviews from senior clinicians which limits their ability to safely discharge participants from the service in a timely way.
- **Capacity of other services to take on referrals from HeadtoHelp.** Several hubs and service partners noted that the capacity of existing community and tertiary services was limited. This impacted the hubs' ability to promptly refer participants out of the hubs to receive either more appropriate or additional services. Many hub managers report that a lack of capacity in other services has limited their ability to transition participants out of the *HeadtoHelp* hub.

Many stakeholder groups, including hubs, PHNs and service partners, raised concern over the impact of the lengthy hub service delivery. There are major concerns that the length of service is leading *HeadtoHelp* hubs to fill up quickly and reach capacity, thus being 'just another service' in the mental health service system, rather than act as a front door to the system with throughput to other services.

Length of episode care has increased overall, and rural and regional PHNs tend to deliver shorter episodes of care

The average number of days between first[50] and last service contact (or episode length) for closed episodes of care was approximately 70 days, an increase from 46 days from the Interim Evaluation Report. This increased episode length was observed across all PHNs (Figure 28). GPHN and MPHN had the lowest mean episode length at approximately 57 days, with the other PHNs having mean episode lengths of greater than 70 days. SEMPHN had the highest mean episode length at 94 days. Reduced episode lengths at MPHN reflected qualitative feedback that demand was exceeding capacity and there was a need to adhere to a fixed number of sessions.

Based on closed episodes only, the mean number of service contacts for participants is approximately 7.4, an increase from 5.6 from the Interim Evaluation Report. GPHN had the lowest mean number of service contacts per participant at 4.5, while WVPHN has the highest mean number of service contacts per participant with 13. Interesting, four of the six PHNs were able to keep mean number of service contacts within the anticipated range of six-to-eight. WVPHN's high number of service contacts per participant may be in part explained by the fact that this PHN has the second highest mean K10 score on entry (33.4), suggesting most participants have very high psychological distress and therefore require more care. However, this relationship does not hold for GPHN, which had the highest mean K10 score on entry (33.6).

[50] Note that the first service contact does not include the intake service contact and refers to the first service contact where care was administered.

Interpreting violin plots

The next two diagrams contain violin plots, which are a standardised way of displaying the distribution of data based on the 25th quartile, median, 75th quartile, interquartile range and outliers, as well as visualising the frequency of data through the 'violin', where the width of the shape corresponds to the frequency of data points at that value. Violin plots enable easy comparison across PHNs as well as better visualise skewness or lack thereof in data than a standard boxplot.

Figure 27 | Illustration of a violin plot

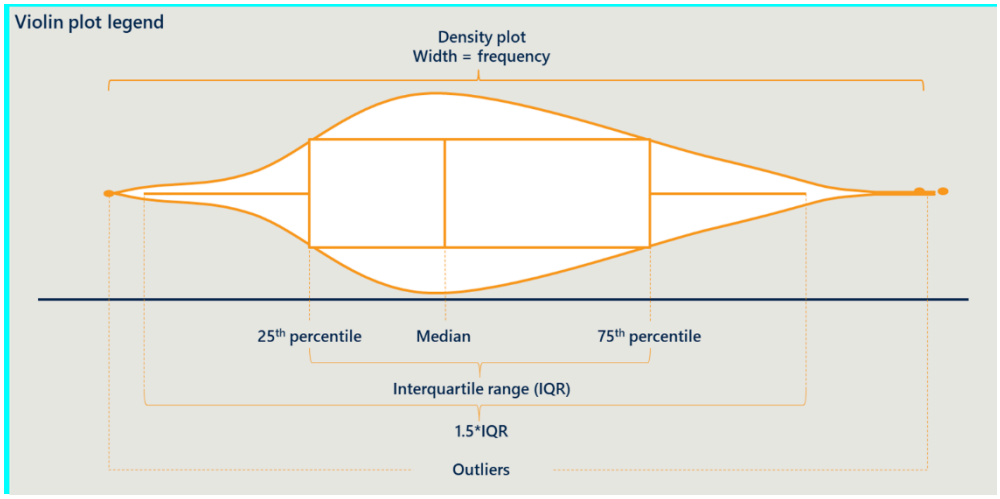
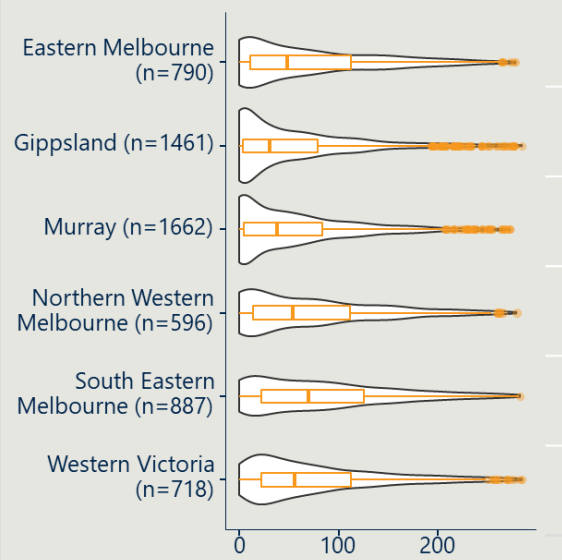
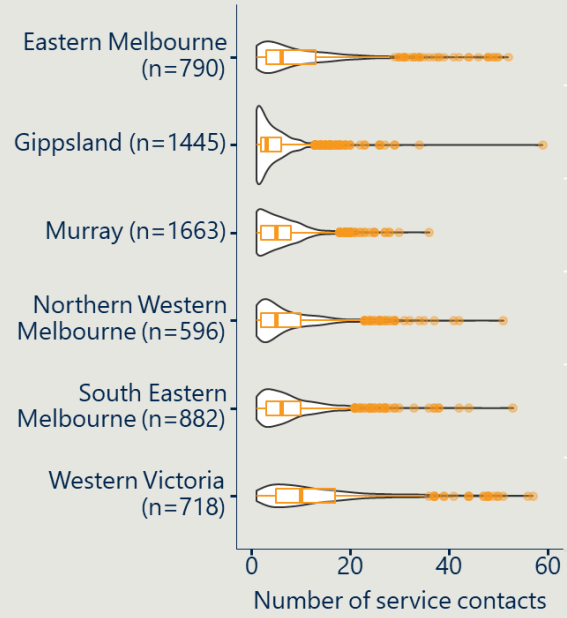


Figure 28 | Length of episodes by PHN for closed episodes of care



	Min	25th percentile	Median	Mean	75th percentile	Max
Eastern Melbourne (n=790)	0	11	49.0	76.1	121	420
Gippsland (n=1461)	0	4	32.0	57.3	84	378
Murray (n=1662)	0	4	39.0	57.0	85	406
Northern Western Melbourne (n=596)	0	15	61.0	81.2	125	448
South Eastern Melbourne (n=887)	0	24	74.0	93.9	138	472
Western Victoria (n=718)	0	22	56.5	77.6	117	316

Figure 29 | Number of service contacts by PHN for closed episodes of care[51]



	Min	25th percentile	Median	Mean	75th percentile	Max
Eastern Melbourne (n=790)	1	3	6	10.4	13	154
Gippsland (n=1445)	1	2	3	4.5	6	88
Murray (n=1663)	1	2	5	6.0	8	36
Northern Western Melbourne (n=596)	1	2	5	7.4	10	51
South Eastern Melbourne (n=882)	1	3	6	7.8	10	53
Western Victoria (n=718)	1	5	10	13.0	17	130

While the data is not conclusive it is suggestive that the decreasing number of first service contacts (see Figure 14) combined with the increasing length of episode care suggests that it is getting harder to get into hubs as demand for the service outstrips service supply. As referrals to *HeadtoHelp* grow, there is a clear risk that it could become another oversubscribed service that is unavailable to community members when they need immediate, accessible, no cost support. Availability and rapid access for all, regardless of economic status is critical and these must remain essential design features, with concomitant funding. This will need to be closely monitored for AMHCs to avoid service blockages and losing the critical ease of access feature. This is especially important given their role as a transitional service, as if clients are required to wait for a transitional service the value is lost, and they may bypass it completely.

There has been less use of 'warm referrals' than anticipated

Warm referrals are key to reducing the number of times participants and support people have to tell their story, ensuring that they meet the service offerings and risk profile of the intended service and providing interim support to people while they are waiting for their referral to be accepted and actioned. Warm referrals can be critical for the engagement of potential service users who are hesitant or anxious to contact a service themselves. Low use of warm referrals has been seen both by *HeadtoHelp* staff, as well as services referring into *HeadtoHelp*:

- For individuals referred to services outside of the hub[52], less than half of these were warm referrals, where *HeadtoHelp* contacted the service provider directly. This contrasts with the intent of *HeadtoHelp* in providing warm referrals to other services. Warm referral figures differed between PHNs, with NWMPHN and WVPHN reporting 30 per cent warm referrals, and SEMPHN

[51] The high number of maximum service contacts for closed episodes of care for EMPHN and WVPHN make them outliers. For EMPHN, 94% of all service contacts were clinical care coordination/liaison, and for WVPHN, 66% of all service contacts were clinical care coordination/liaison, compared to a 35% average across PHNs. This indicates that the overuse of the clinical care coordination/liaison service contact type may be the reason for the high maximum service contact number for these PHNs.
[52] A total of 19 people reported being referred to other services, of which eight were given warm referrals.

reporting just over five per cent[53]. Of the participants who reported being pleased with their referral, all but one had received a warm referral.

- Of the participants and support people engaged for this evaluation, only half reported that they received warm referrals to services outside of the hub. Support people were particularly frustrated by the lack of warm referral, reflecting that they feel 'bounced around' between services. Some participants commented that the current mental health system is fragmented and difficult to navigate, with a lack of linkages between different mental health services and between mental health, addiction and other health services. Further integration between *HeadtoHelp* and AMHSs should enable warm referrals between services and therefore improve the experience for participants and support people.
- **Many hubs also reported that they do not receive warm referrals from service partners,** particularly AMHSs in their area, with many participants often told to call the service directly or approach their GP to be referred to the hub. This is likely because the default discharge pathway following an admission to an AMHSs is to a GP. Some hub staff reflect that 'cold' referrals into the service has resulted in some participants approaching the service in crisis, exceeding the level support *HeadtoHelp* can provide. Hubs often attributed this to lack of awareness or understanding of the purpose of *HeadtoHelp* or the stepped care model. Participant and support person interviews also indicated that cold referrals may have resulted in a number of potential participants not contacting the hub at all, due to being anxious or hesitant to make the phone call.

Satellite hubs were stood up to extend the reach of HeadtoHelp; however, they present a potential risk to model fidelity

Satellites have been established to extend the geographical reach of face-to-face services in some regions. Using discretionary spending under the flexible tranche of *HeadtoHelp* funding, some PHNs have elected to stand up satellite hubs, whilst others used this to support their intake teams.

Three of the six PHNs established satellite hubs to better service people with mental health needs in their region. Two of these PHNs (MPHN and GPHN) oversee large rural and regional areas where service access is often a challenge. Additionally, these regions are broken down into four sub-regions, and the provision of services to only half of the region was problematic both for service access and perceptions of equity. Stakeholders reported that the design of satellite hubs were in part informed by participants' hesitancy to engage in telehealth services (i.e., they prefer to receive services in person).

Co-location of hubs with existing services has been raised as a key enabler (and barrier, in some instances) for the stand-up of the services. Of the nine satellites currently operating, services have been co-located in general practices (four) and community health services (five).

The approach to standing up satellites has differed and has implications for the fidelity of the *HeadtoHelp* model. There have been two approaches taken to establish satellites:

1. Sending an existing hub workforce to the satellite on a part-time or as needed basis.
2. Engaging a third-party provider to deliver the service.

The PHN that engaged a third-party service provider emphasised the need to work in partnership with existing service providers across the community, to build engagement and strengthen referral pathways into and out of the satellite.

Most satellites are characterised by a much smaller staffing profile. This reduces ability to deliver a multi-disciplinary and/or clinical approach for participants and has been raised as a concern for model fidelity and participant experience by some stakeholders. While choice may not be able to be

[53] For NWMPHN, 5 out of 17 participants reported warm referrals, for WVPHN, 3 out of 10 participants reported warm referrals. SEMPHN reported 1 warm referral out of 18 participants.

provided in all aspects of treatment, well-funded and well-staffed services will have greater propensity to provide options.

4.1.7 Service awareness and promotion

Broader promotion of HeadtoHelp could enable greater access

HeadtoHelp appears to be predominantly accessed by people already connected to services delivered or supported through the PHNs such as GPs and other government services (see Figure 30). Few people found out about *HeadtoHelp* through advertising and 16 interviewees spontaneously commented that they thought that *HeadtoHelp* was not well known or promoted and that they had been lucky to stumble upon it. This situation did not appear to have improved over time.

> "I was just sort of surprised to learn that that kind of service existed and that I wasn't at all aware of it… If I had of known… we could have perhaps done it, you know, before we got to as bad a position that we were in." – *Support person*

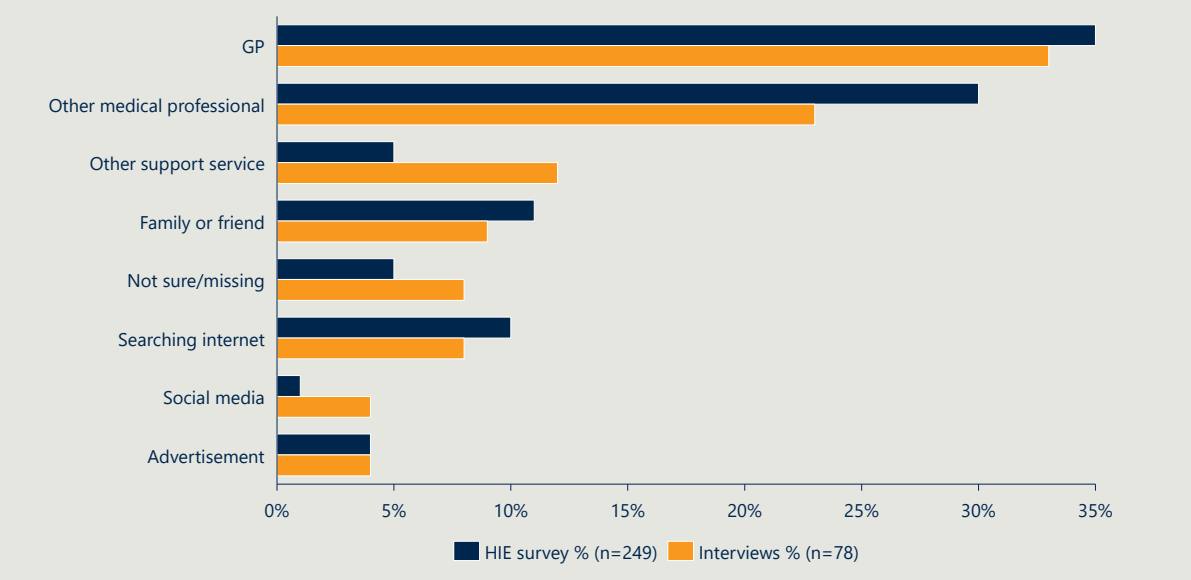
> "I had never heard of them… I don't know how they advertised themselves but clearly for someone that's vaguely aware of this stuff, yeah, the fact I'd never heard of them was probably – maybe they could do a bit more promotion." – *Participant*

It should also be noted that there was sometimes a lack of understanding about the nature and purposes of *HeadtoHelp*. Thirty *HeadtoHelp* participants showed evidence of having an incomplete or incorrect understanding of *HeadtoHelp* and its functions or processes, including thinking of *HeadtoHelp* as a referral line, that it was crisis or telephone counselling and that it only offered psychology services. Some reported thinking that a mental health plan was required, and others were confused about which health workers were part of *HeadtoHelp* and which were external, as well as having misunderstandings about the assessment process.

These participant's understandings were based on their own experience – the level of care they were assessed as needing and the support they received. Another talked about being assessed at a particular 'level', however, not understanding what these levels meant. A lack of overall understanding of *HeadtoHelp* may mean that in future, if people's needs changed, they might not recontact *HeadtoHelp*.

Broader promotion of the *HeadtoHelp* program using a range of advertising channels, including social media, is needed to achieve more equitable access.

Figure 30 | Channels through which people found out about HeadtoHelp



Many stakeholders felt the level of service promotion and community engagement was underdone

Following the establishment of *HeadtoHelp*, the communications team ran a four-week campaign from early April, timed for when JobKeeper ended. The campaign included paid Google search, radio advertisements, print and online media, and various social media platforms.

Many hubs felt frustrated with how the *HeadtoHelp* service was promoted and noted that the level of community engagement or tailored communication was limited, resulting in less initial referrals to the service. Staff highlighted three components of the *HeadtoHelp* branding and promotion that likely contributed to this:

- **The HeadtoHelp Bear** (see right). Views on the *HeadtoHelp* bear were mixed. Some hubs felt the bear did not 'hit the mark' and failed to communicate the purpose and offering of *HeadtoHelp* clearly to particular cohorts, such as men and Aboriginal people, and appeared to market the service as a child service. One hub described the bear as a barrier to community knowledge of the service and questioned why an animal that is not native to Australia had been selected.

- **Lack of tailored promotion to the local community context.** Several regional hubs highlighted the methods used to promote *HeadtoHelp* (e.g., commercial radio and billboard advertisements) were more appropriate and likely more effective within a metropolitan context rather than a regional setting. Staff from regional hubs noted a more effective promotion method may have been promoting the service through local agencies or community social media pages.
- **Confusion between HeadtoHelp and Head to Health**. The similarity in names and ambiguity about the differences in the service offerings and purpose of *HeadtoHelp* and Head to Health have created confusion amongst service providers and consumers which has increased with the roll out of Head to Health. Some participants actually referred to *HeadtoHelp* as Head to Health or mentioned the confusion between the similar sounding services.

Many hubs reported it was unclear whether they were responsible for the ongoing promotion of service or if their PHN was. In addition, hubs often felt there was no time available for hub staff to promote the service because they were already at capacity, and

> "I think the doctor referred to them as Head to Health and at least one other person has called them that as well…I'm looking up Head to Health, but I'm like 'Head to… it's just, is that what I'm looking for?" – *Participant*

this is a continuous balance they are trying to strike. Some hubs stopped promoting their service as they were at capacity and already had long waitlists.

Building service awareness among providers still needs work

Awareness among referring service providers requires further cultivation. Hub and intake staff noted that while some services are aware of *HeadtoHelp* and refer frequently (e.g., co-located GPs), others have limited awareness and consequently limited referrals into *HeadtoHelp* (e.g., AMHS).

Service awareness is heavily contingent on the PHN's relationship or *HeadtoHelp* hub managers relationship with other providers in the area. Some PHNs have strong relationships and established communication channels with AMHSs, Local Health Districts (LHDs) and community mental health programs.

Providing further clarity on the future of *HeadtoHelp* is key to the success of building service awareness. As a result, the Australian Government need to provide a plan for services to either continue with additional funding or transition to other services that the Australian Government (or Victorian Government) seek to establish.

4.1.8 Workforce

Challenges to recruit the envisioned multi-disciplinary hub workforce has impacted the capacity and capability of *HeadtoHelp*.

The funding approach and service contracts did not support retention of a qualified workforce

The confluence of short service contracts and conditional funding for staff have created workforce challenges for *HeadtoHelp*. Service contracts were only for 12 months of operation and included funding for 3.5 FTE. Funding for additional FTE was tied to volume of service occasions (see Appendix G) that, once met, would allow *HeadtoHelp* to recruit additional staff.

As discussed, the consequence of the short contracts is that (anecdotally) staff are leaving *HeadtoHelp* due to limited job security. Considering the limited extension of services from September to December 2021, retention has been made even more challenging. A three-month extension is neither enough to incentivise current staff to remain with the service, nor enough to attract new staff to the service.

The most common challenge shared by service providers was the ability to meet the 'all ages' remit set out by the *HeadtoHelp* model of care. Recruiting clinicians with the qualifications for and confidence to deliver services to toddlers, children and youth was hampered due to the limited pool of clinicians. Stakeholders had shared that there are many options available with greater job security to specialised mental health staff, particularly those experienced in child and youth mental health.

Stakeholders indicated that the contracts are not long enough and pose risks to participants as the service is nearing the end of the contract. The lack of funding for clinical governance and other activities (e.g., promotion, relationship building, service integration, overseeing provisionally registered staff) has meant that current staff are time poor and under pressure to deliver.

The issues arising from difficulties in retaining staff from a participant perspective were highlighted in interviews, as participants found it very important to have a regular contact person and a consistent therapist. Eleven support people described a change in therapist as a disruptive experience, either because they had to start building trust and rapport again and retell their story, because there was a gap or delay in service, or because the replacement staff member was not a good fit for them.

Workforce shortages and the uncertainty of HeadtoHelp's future has made it challenging to recruit and retain staff

The mental health workforce continues to be insufficient to meet demand in Victoria, as highlighted by the recent Royal Commission into Victoria's Mental Health System[54]. As outlined earlier in establishment, recruitment of a competent and qualified mental health workforce has continued to be an ongoing challenge for *HeadtoHelp* hubs.

Hub managers noted that the current inability to adequately recruit and retain appropriate mental health staff will significantly impact the delivery of *HeadtoHelp*, including the ability to take on new participants and manage their existing patient load and the breadth of the service offering due to the capability of staff. Several hub managers noted that there are three additional factors hindering recruitment and retention of staff, in addition to Victoria's state-wide (and also national) shortage. These included:

- **a lack of awareness of the HeadtoHelp hubs** and their intended purpose and role within the Victorian mental health system
- **failure to assure job security** due to the uncertain and short-term nature of the *HeadtoHelp* hubs, noting that short-term contracts are unappealing to existing and potential recruits, particularly when they are in high demand across the mental health service system
- anecdotally, an inability to provide a competitive salary to clinicians, compared to other services
- some participants reported that they would like *HeadtoHelp* to be both better funded and have guaranteed future funding to ensure its sustainability, increased reach and service offerings, and integration with other services.

A lack of qualified child and youth mental health workers has also impacted *HeadtoHelp's* ability to service this cohort. Several hubs reported an observed increase in youth and child referrals to hubs, however, many hubs were uncomfortable with these referrals as they did not have the appropriate staff and therefore rejected these referrals. The NWMPHN has sought to mitigate this by forming a partnership with The Royal Children's Hospital (RCH) and *HeadtoHelp* hubs to ensure hub staff are appropriately supervised by a clinician with experience working with youth and children (see Section 5.2.3 for further details).

Most hubs have been unable to establish a peer workforce as the original model intended

The *HeadtoHelp* model of care envisioned the hub workforce to be inclusive of peers. However, many hubs noted that they did not have capacity for a peer workforce citing the requirement of seven FTE with mental health or allied health qualifications, funding tranches and limited peer workforce governance and training as barriers to recruiting a peer workforce.

All hubs noted that they wanted more people with lived experience in their hub teams and there was a clear intention to hire this workforce should *HeadtoHelp* be continued.

Many hub managers shared the perception that the clinical governance requirements to supervise and manage a peer workforce were costly and complex. One PHN stakeholder noted that there is a huge risk that the intent and role of the peer workforce is open to interpretation and there needs to be some form of standardised approach across PHNs for building peer workforce capability. However, consultations with SA Health in relation to the AMHC identified ways in which this was managed effectively by the service provider (see Section 6 for further details).

In addition, several stakeholders noted that for a peer workforce to be effective in the *HeadtoHelp* hubs and more broadly across other mental health programs, there needs to be a cultural shift within organisations, including by mental health clinicians, to embrace, collaborate and coordinate with the peer workforce, to allow them to be effective.

[54] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Parl Paper No. 202, Session 2018-21.

4.1.9 Data and reporting

Information collected about *HeadtoHelp* imposes a high administrative burden on service providers.

Collecting correct and sufficient data has been a significant challenge

Hub staff are supportive of the need to collect data to understand how the service is working, for whom and what outcomes are being achieved. However, all hubs have found the data and reporting requirements to be onerous, duplicative and somewhat greater than initially envisioned or outlined in the service contracts.

All hubs reported that the existing systems (i.e., Fixus and IAR-DST) do not integrate with each other and as a result create further work for staff to input data from one system to another. Hub managers noted that the salaries and position descriptions are not inclusive of this level of administrative requirement.

Hub staff reported that the extensive data collection and reporting requirements are impacting participant contact hours, which many hub managers consider has limited their ability to achieve KPIs. Anecdotally, the burden of data collection has also impacted retention of staff at some hubs. One hub did not retain a psychologist due to the perceived amount of administrative data required for the program. This clinician had previously worked in similar PHN mental health programs that did not have intensive data requirements.

In addition to the difficulty of data collection within hubs, there has been very low uptake of the YES and HIE surveys sent out by PHNs to clients, with response rates of only ten per cent and 14 per cent, respectively. For the YES survey, reasonable data was only available for three PHNs, with one providing minimal data and no data available for two PHNs. The lack of YES survey responses from some PHNs is due to several issues including consent concerns resulting in invitations being sent to a limited number of clients, no invitations being sent from one PHN and very few, late invitations sent from another due to system difficulties. Full details on survey participation rates and the characteristics of survey respondents can be found in Appendix E.

With HeadtoHelp functioning as a front door to the mental health service system has enabled PHNs to have a state-wide view of participants' pathways

Collection of service and 'front door' data through new data collection tools (i.e., HIE survey) and use of existing datasets (i.e., PMHC-MDS and *HeadtoHelp* extension) has provided PHNs with a state-wide view of mental health, that has never been achieved before. The six Victorian PHNs established a framework for a data-driven quality improvement approach (see Section 3.2.3) from which it was intended that service delivery teams would be able to learn and adapt the model of care based on this information.

PHNs noted that historically the planning and delivery of PHN mental health services has been informed by the review of actual service utilisation data as there was limited data captured at the 'front door'. The introduction of the use of the PMHC-MDS and *HeadtoHelp* extension has created a robust state-wide linked data set which seeks to track the participant journey through the system from when they first reach out for support to when they complete their care with a provider (i.e., the *HeadtoHelp* hub). Data collected through the HIE survey also allows PHNs to understand the participant's experience of the 'front door'.

4.2 Has the HeadtoHelp service implemented effective IAR intake practices?

Key findings: The roll out of the IAR across *HeadtoHelp* was the first large-scale use of the tool, with largely positive feedback across all stakeholder groups. The IAR has the potential to become a national, standardised approach to conducting an initial intake process for participants of mental

health services. This has important implications for how participants enter and navigate/are referred through the system. There have been some limitations on the extent to which the IAR-DST has reduced 're-telling' of participant stories.

4.2.1 Experience of use

The IAR has provided service providers with a level of consistency and structure not previously seen in PHN-funded programs

The IAR-DST has been described by intake clinicians as a highly effective, client-centric tool that ensures clinicians understand the needs of a person more deeply and reduces the potential for clinicians to refer to the same services based on habit or what they know. Most intake clinicians noted that the IAR has supported them to make decisions on referrals to appropriate services.

Several service partners noted that the IAR-DST provided a new and holistic perspective of a participants needs and provided a different structure to the state triage tool, which is often used as a 'yes' or 'no' assessment of eligibility for the service rather than directing the participant to a service or support that best suits their needs.

Intake clinicians and hub staff were regularly trained in the IAR-DST. Some staff have attended multiple sessions to consolidate learning. Many stakeholders commented that the training provided in the tool was very useful and helped to develop their confidence to use the tool. Some intake clinicians noted that the training could be further adapted to include information on how to use the IAR webform and PowerBI[55] tools.

Many hub staff noted that for the tool to be successful, the use of the IAR requires knowledge of mental health and wellbeing, the social determinants of health, suicide, relapsing illness and the knowledge of services within the community. Consequently, there can be variability in the outcome and quality of the IAR depending on the application of the tool by the intake clinician or referrer and highlights the need for effective and consistent training in the tool. Insights on participant experience with the IAR-DST provided in Section 5.2.2 highlight the importance of this training, as participant experience is highly dependent on the experience and rapport building skills of the clinician conducting the intake process.

While the IAR is fulfilling its purpose for service providers, participants have continued to tell their stories more than once and have varying expectations of the HeadtoHelp hub

> "Well, that's just traumatising to me. It's just like, they haven't even listened … you're just repeating yourself and then no-one's listening, so it actually triggered trauma for me." – *Participant*

Several *HeadtoHelp* participants report they have continued to tell their stories throughout their experience with *HeadtoHelp*. Some people were accepting of this repetition, but others found it annoying or upsetting. Stakeholders report a range of reasons that have contributed to this:

- **Lack of warm handovers** between AMHSs and *HeadtoHelp*.
- Use of service provider specific intake tools to re-triage patient.
- **Lack of trust between PHN intake teams and providers**. Providers are not confident that all necessary information on the client has been gathered by *HeadtoHelp*.
- **Need for service providers to manage clinical risk**. Once a client is handed over to a service provider, the provider is responsible for them, and many providers are reluctant to assume the clinical risk associated with client responsibility unless they have undertaken their own assessment and are confident in the assessment information.

[55] Power BI is an interactive data visualisation software product from Microsoft, with a primary focus on business intelligence.

- **Occasional operational/staff drivers**. Such as administrative glitches, poor record keeping, or a therapists' failure to review records before sessions.

> As well as being hesitant to accept IAR data from *HeadtoHelp* as the complete story of a patient, some service partners, particularly AMHSs, are hesitant to use the IAR as their own assessment tool. The rationale often provided by AMHSs is they already have an assessment process in place and therefore do not need to take on another process. However, the AMHS process indicates urgency based on risk, rather than assessment of the level of care required, and some AMHSs identified there was additional value to be drawn from the IAR and have worked with hubs and PHNs to organise training for their staff to upskill in the IAR-DST.

This highlights that there is a lack of continuity between services and a lack of fidelity to the primary intent of the centralised intake process. That is, to provide 'warm' connection to ensure continuity of care and support, and limit repetition of participant story telling. Of the participants and support people interviewed for the evaluation, only half of those receiving services outside of the hub received warm referrals.

This is a difficult issue to resolve. Many stakeholders observed that in practice, a treating clinician will always want to make their own assessment, noting it remains important to ask and clarify questions with participants about their experience to ensure clinicians have all the information they need when working with participants and can manage risk. Some hub staff reflected that often there is no way to reduce these questions at a hub level. Rather the objective needs to be to create an environment where the next clinician has as much information as possible, and confidence in that information, such that it can be relied on, and reduce the extent to which a person needs to retell their story. Interestingly, where *HeadtoHelp* hubs were co-located with a GP clinic or tertiary service, staff noted that there was a reduced need for participants to re-tell their story.

There is an underlying tension between the consistency and efficiency of centralised intake versus the need for a more localised approach

Hub staff report varying experiences of intake into their hub. Intake can range from completely centralised, (i.e., intake for all hubs occurs at a central, national level) to entirely localised, where each hub conducts its own intake. The benefit of a completely centralised intake function is that it is extremely efficient, whereas an entirely localised approach would be extremely inefficient for the system. However, a more localised approach allows for local knowledge of important elements such as referral services, which is important for quality of care. Some hubs primarily use referrals from the centralised intake function (i.e., state-wide 1800 number), whilst others have introduced a localised approach (e.g., promoting contact via a direct number to the service) as they feel the centralised intake phone number does not work for their location, particularly for regional communities.

The benefits and challenges of each intake approach are outlined in Table 3.

Balancing the need for a consistent approach to intake to support a single 'front door' into the mental health system with the importance of local knowledge, this evaluation concludes that *HeadtoHelp* should maintain a centralised intake at the PHN level as this appears to be the most effective method to find this balance.

Table 3 | Benefits and challenges of each intake approach

	Benefits identified by stakeholders	Challenges identified by stakeholders
Centralised intake approach	• Provides a clear point of entry for people seeking assistance with their or someone else's mental health issues, thus avoiding confusion among participants attempting to access the service and referrers attempting to refer to the	*Challenges observed relate to PHNs delivering the centralised intake on behalf of another PHN.* • When performed by intake clinicians who are not in the local PHN catchment, clinicians may lack knowledge about geographic area and/or

	Benefits identified by stakeholders	Challenges identified by stakeholders
	service. • Some participants appreciate speaking with someone 'neutral' or unknown to them to tell their story. • Supports a 'system-wide' approach.	what is available to participants to best support their needs leaving participants feeling frustrated or lacking confidence in the service. • Centralised intake number not always helpful in regional context.
Localised intake approach	• Intake clinicians have knowledge of geographic area, available supports and waiting times. • Participants within the community may know the person and be more comfortable to access and use the service.	• People may have to re-tell their story as local intake is not connected to centralised intake. • Intake clinician and/or hub staff may not have a picture of participants service usage. • Intake requires a significant amount of administrative work, and therefore an extra staff member dedicated to intake.

Some service providers are also undertaking additional activities that deviate from the centralised intake function. For example, some hubs undertake a re-triage/intake process following the referral of a participant to their hub. Some hubs use their own triage or assessment tools to support this process. Hubs report this additional function is completed for three reasons:

1. Referrals from the relevant PHN centralised intake team are not comprehensive and do not provide a clear picture about the individuals entire mental health journey.
2. Referrals do not reflect understanding of the local context (as completed by a different PHN to where the participant is located).
3. Service providers have ultimate liability for their clients' clinical safety and therefore want to ensure they have full knowledge of the clinical risk associated with each client, especially as many of their staff are provisional or new to the workforce.

4.2.2 Limitations

The IAR is not appropriate for children, youth or Aboriginal and Torres Strait Islander people

Most intake clinicians and hubs noted the IAR-DST is not practical for use in child or youth cohorts and is inappropriate for Aboriginal and Torres Strait Islander people. While the IAR is currently being used in some Aboriginal Medical Services, clinicians need to be aware of any cultural sensitivities and services that might be more appropriate when using the current version. More work is required to ensure a tool that is both culturally and age appropriate is designed to effectively triage these cohorts. Many hub staff also see an opportunity to make the IAR-DST more user friendly for CALD communities.

To address these limitations, different versions of the IAR-DST are currently in development. The Commonwealth has developed child and adolescent versions and is working on a version for Older Adults. Adaptations of the tool will be undertaken by the Commonwealth in 2022-23 for Aboriginal and Torres Strait Islander Peoples, in 2023-24 for CALD people, and in 2024-25 for veterans and people with co-occurrences.

The IAR does not currently integrate with existing systems which limits hub views of the participant's mental health journey

Early consultations with hub staff reported that the completion of the IAR-DST and subsequent 'rating' is completely dependent upon what participants report at the time of intake, which impacts staff's ability to form a clear picture about what other services may already be involved in the participants care (e.g., presentations to an ED, using other community health services, accessing

counselling). This demonstrated the need for greater integration of the IAR-DST with existing health record information (e.g., myhealthrecord) to support clinicians' knowledge of patient history).

As *HeadtoHelp* evolved, the functionality of the PHN IT systems improved to allow IAR DST assessments to be sent as part of the referrals. Intake teams are still required to contact services to inquire on referral capacity, but automatic data transfer occurs regularly throughout each day.

There would also be value in ensuring all PHN mental health programs are using the IAR-DST to support cross-referrals between programs and to provide the history of a participant's journey without them having to repeat their story.

5 Short-term outcome findings

This section addresses KEQ 5 (How effective is the program in achieving outcomes for Victorians?), KEQ 6 (What has been and is the likely impact of the implementation of the *HeadtoHelp*?) and KEQ 7 (How efficient is the program?).

It is important to note that while this evaluation includes short term outcomes findings for *HeadtoHelp*, findings in relation to AMHCs are limited to the establishment phase. Despite being similar programs, we cannot infer that outcomes achieved through *HeadtoHelp* will be the same as outcomes achieved through AMHC.

5.1 How effective is the program in achieving outcomes for Victorians?

Key findings:

On average, participants experienced a statistically significant reduction in K10 scores from the beginning of their engagement with *HeadtoHelp* to the end of service, which reflects an improvement in psychological distress. It is worth noting that the 10.5 reduction in scores only represents the average change and further analysis reveals that while 84 per cent of participants ultimately had a lower mean post-K10 score, 11 per cent of participants did not see an improvement and six per cent had an increase in their post-K10 score. Similarly, on average, participants experienced a statistically significant reduction in K5 scores, or an improvement in self-reported psychological distress. K5 tends to be used with Aboriginal and/or Torres Strait Islanders, though not exclusively.

Demographic and service factors do not typically impact outcomes of participating in *HeadtoHelp*. Of the factors considered, the PHN where the episode took place, labour force status (unemployed) and main service contact type (psychosocial support) were all statistically significant at the 90 per cent significant level. While the relationship between PHNs and change in K10 scores varied among PHNs the model shows unambiguously that regardless of PHN, participants tended to have better outcomes through *HeadtoHelp*. For individuals identifying as unemployed, or who had a main service contact type of psychosocial support, they experienced a less positive outcome at the end of service relative to individuals not displaying these factors. The reasons behind this are unclear but may reflect specific service capabilities and connection to other intersecting service types.

In addition to the quantitative metrics, this evaluation also considered the qualitative benefits of *HeadtoHelp*. Interviews with participants and support people identified a number of benefits for clients including participants being able to think differently, for example, having a better understanding of their mental health situation, and being better able to use the services that they need.

Section 5.1 looks at the participant **outcomes** of receiving services from *HeadtoHelp*. Participant **experience** with the service is discussed in Section 5.2.

5.1.1 Participant outcomes

Approximately 74 per cent of service episodes have been closed

At time of analysis, approximately 74 per cent of episodes were closed. Almost a third (32 per cent) of episodes were closed because service concluded. The remaining 68 per cent of episodes were closed for administrative reasons, with 35 per cent of the participants referred elsewhere or the

participant moved out of the area, 16 per cent could not be contacted, eight per cent declined further contact and ten per cent were closed for other reasons.

Participant and support person interviews highlighted that completion of service is a critical aspect and needs to be better and more consistently addressed within the *HeadtoHelp* program, including through discharge planning, agreed timing for service completion, follow-up and 'keeping an open door'.

On average, participants experienced an improvement in levels of psychological distress post-engagement with HeadtoHelp

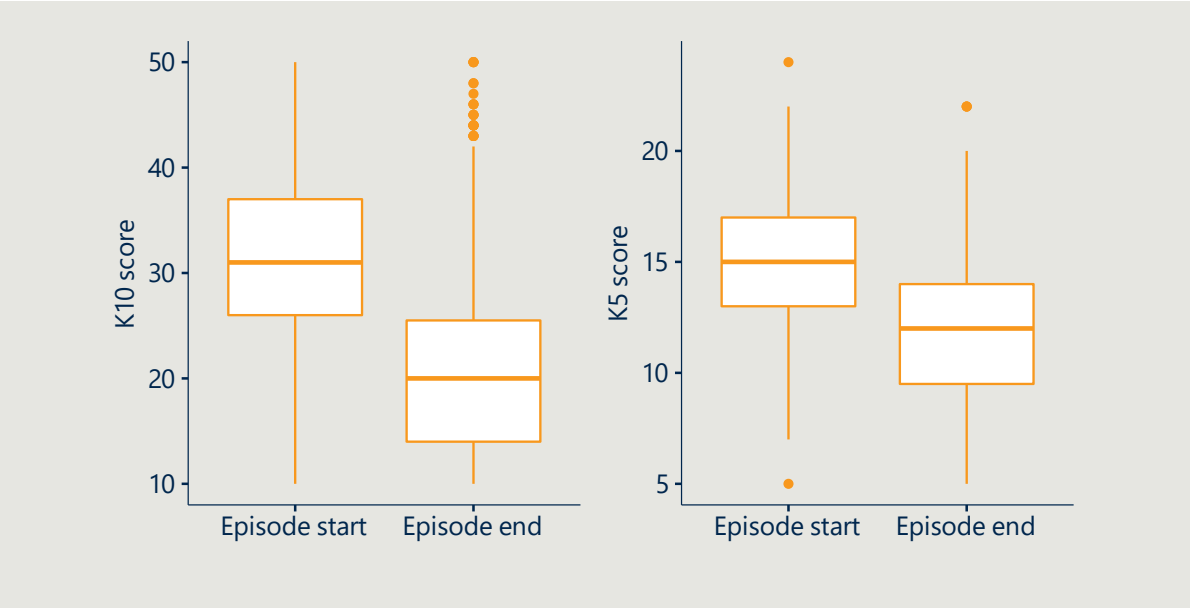
On average, participants experienced a statistically significant reduction on K10 or K5 scores from start of service to end of service, which reflects an improvement in psychological distress (Figure 31). A paired t-test was used to investigate the differences from pre- to post-service K10 and K5 scores. Only participants with a valid pre- and post-service K10 or K5 were included in the respective analyses. For the K10 analysis, the sample size was 1,411 participants while the K5 analysis had a sample size of 183 participants.

K10. On average, participants experienced a statistically significant reduction in K10 scores, or an improvement in self-reported psychological distress in all PHNs. The mean difference in K10 scores from pre- to post-episode was 10.5 points on the K10 (P <0.0001, 95 per cent CI: -11, -9.9), a reduction from a mean entry score of 31.6.[56, 57] This extent of change was consistent with the findings of the Interim Evaluation Report (average 10.6 point change). At an average of 21 points on the K10 at the end of service, this suggests that participants typically conclude service with moderate psychological distress. It is worth noting that the 10.5 reduction in scores only represents the average change and further analysis reveals that while 84 per cent of participants ultimately had a lower mean post-K10 score, 11 per cent of participants did not see an improvement and six per cent had an increase in their post-K10 score. It appears that GPHN had the largest positive difference in K10 scores from pre- to post-episode, reflecting a greater reduction in psychological distress on average. This is particularly noteworthy, given GPHN had the lowest average number of service contacts.

K5. On average, participants experienced a statistically significant reduction in K5 scores, or an improvement in self-reported psychological distress. K5 tends to be used with Aboriginal and/or Torres Strait Islanders, as changes were made to K10 items to enhance understanding in an Indigenous context, however not exclusively.[58] The mean difference in K5 scores pre- to post-episode was 3.5 points (P <0.0001, 95 per cent CI: -4.1, -3), a reduction from a mean entry score of 15.5[59,60]. However, the mean post-episode score of 12 is still a high level of psychological distress – albeit at the bottom end of this range.[61]

[56] People seen in primary care who score 30 and over on the K10 are likely to have very high psychological distress.' This is, however, a screening instrument and practitioners are expected to make clinical judgements. Australian Institute of Health and Welfare. Adults with very high levels of psychological distress, 2018. 2018.
[57] In this case, the analysis is based on participants with both pre- and post-episode K10 scores (n=1,411).
[58] Australian Government Department of Health. Primary Mental Health Care Minimum Data Set – Scoring the Kessler-5. September 2018.
[59] People seen in primary care who score 12 and over on the K5 are likely to have high or very high psychological distress.' This is, however, a screening instrument, and practitioners are expected to make clinical judgements. Australian Institute of Health and Welfare. Adults with very high levels of psychological distress, 2018. 2018.
[60] The analysis is based on participants with both pre- and post-K5 scores (n=183).
[61] A K5 score of 5-11 indicates a low to moderate level of psychological distress. A score of 12-25 indicates a high to very high level of psychological distress.

Figure 31 | Boxplot of K10 and K5 scores from pre- to post-episode



Demographic and service factors do not typically impact outcomes of participating in HeadtoHelp

Outcome measures correlated with explanatory variables

We generated a regression model to estimate the effect of several factors on the change in K10 scores from pre- and post-episode. Data included in this analysis were only for participants who had both pre- and post-episode K10 scores[62]. A multiple linear regression was used[63]. Service and demographic factors included in the regression model include:

Service[64]

- number of service contacts
- PHN where the episode occurred
- main modality of service contacts
- main type of service contact type.

Demographic

- labour force status
- main language at home
- homelessness
- gender
- age.

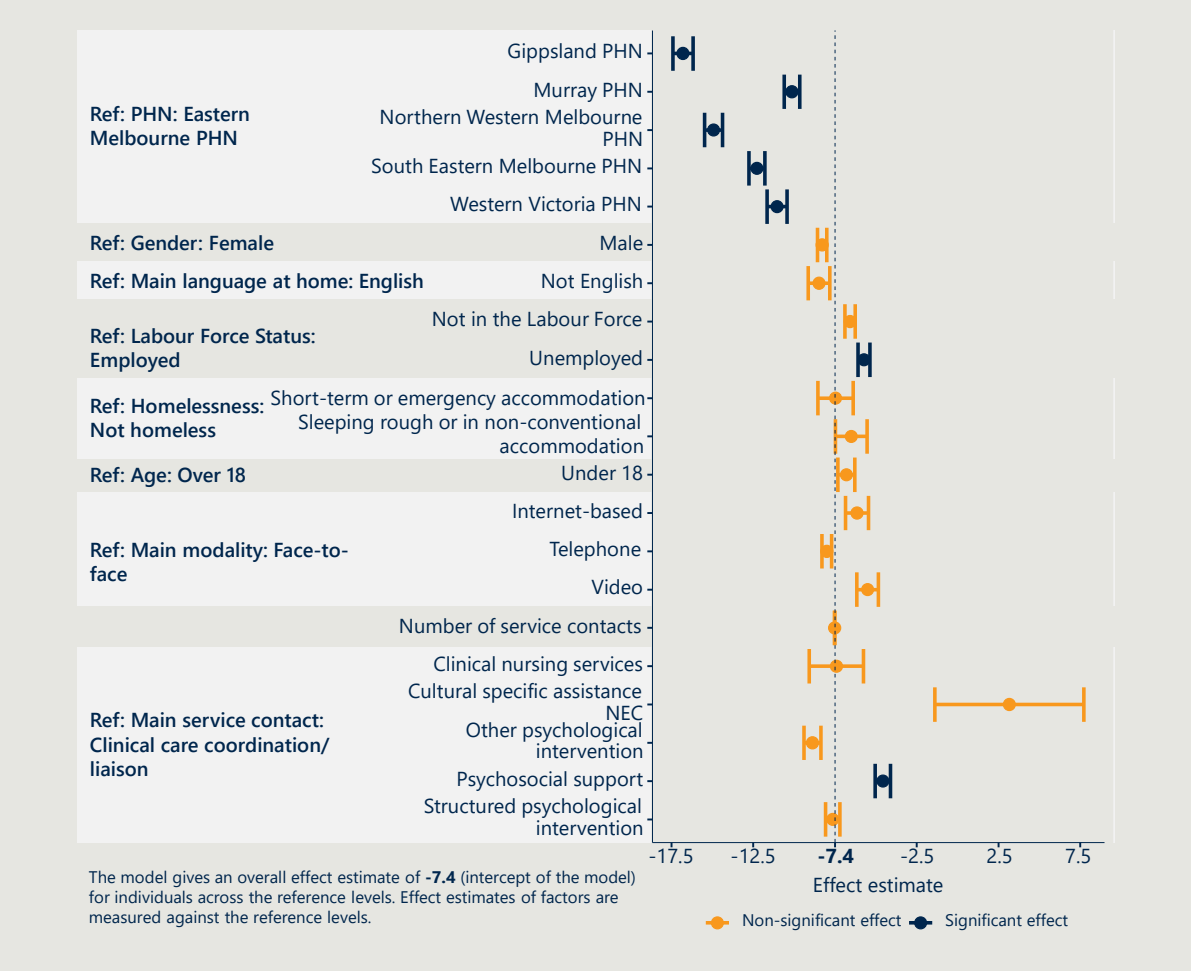
The regression model (with demographic and service factors) explains about 11 per cent of the variability in the data.[65] This figure is meaningful to this evaluation as it indicates that demographic

[62] The regression analysis is based on 1,113 participants.
[63] Appropriate tests were used to ensure that key assumptions in the regression were met such as low or no collinearity across the factors and constant variance of residuals.
[64] IAR DST-level of care was not considered because participants in GPHN did not have their IAR DST-level of care data in the PMHC-MDS.
[65] Regression models generate an R^2, which is a coefficient that measures how close the data is to fitting the regression line. An R^2 of zero per cent indicates that the model explains none of the variability of the response data around its mean, whereas an R^2 of 100 per cent indicates that the model explains all the variability of the response data around its mean. An R^2 of 12 per cent indicates that the factors analysed do not really impact the outcomes and that there is high variance in K10 scores, reflecting the fact that there are many factors affecting mental health.

and service factors do not have a strong relationship with the outcomes of participating in *HeadtoHelp*. It also reflects a high variance in K10 scores and reinforces that there are many factors which can influence an individual's mental health outcomes. The linear model also has with an intercept of -7.4. This value indicates that an individual across the reference levels in the model (see Figure 32) will most likely see an average change of -7.4 in their K10 score from pre- to post-service.

Of the factors considered, the PHN where the episode took place was statistically significant at the 99 per cent significance level, and both labour force status (unemployed) and main service contact type (psychosocial support) were all statistically significant at the 95 per cent significance level[66].

Figure 32 | Effect size of factors correlated with change in K10 scores from pre- to post-service[67]



All other factors in the model held constant, the PHN where the service was conducted had a relationship with outcomes. While the relationship between PHNs and change in K10 scores varied among PHNs, with EMPHN having the weakest relationship and GPHN having the strongest, it should be noted the model shows unambiguously that regardless of PHN, participants tended to have better outcomes after engaging with *HeadtoHelp*.

Similarly, all other factors held constant, people who were unemployed tended to experience positive outcomes at the end of service, but not to the same degree as people who were not in the labour

[66] Detailed regression outputs are given in the Final Evaluation Report appendices.

[67] To consider the overall effect of a factor, we add the effect estimate to the intercept. For example, consider a participant across the reference levels except Labour Force Status where they are unemployed. The model then estimates that the overall effect is -7.4 (intercept effect) add 1.77 (the effect estimate from the factor Labour Force Status: Unemployed) for an overall effect of -5.63. Noting that all effect estimates are no greater than 7.4, this indicates that across all statistically significant factors, the overall impact to the individual is positive.

force or held employment. An objective of the 'free service' component of the model is to increase access for those who may not otherwise be able to access services; removing that barrier helps to improve the chances of those facing other stressful life circumstances, such as unemployment and poverty, to experience positive outcomes. A further rationale for this finding is that over their engagement with *HeadtoHelp*, an individual's time unemployed may have increased, together with their experience of rejection from potential job options, which could result in worsening mental state.

Finally, participants whose main service contact type in their episode was psychosocial support tended to have less positive outcomes at the end of service. This suggests that *HeadtoHelp* hubs may have concentrated capability on psychological therapies but have less capability in other evidence informed services and support that build capacity and connectedness, and/or connections with other services such as housing, finance and education.

Interestingly, this analysis has shifted since the Interim Evaluation Report, where the regression model identified two alternate factors that were statistically significant: homelessness (sleeping rough or in non-conventional accommodation) and age (people under 18).[68] In relation to homelessness (sleeping rough or in non-conventional accommodation), the sample size on which the initial finding was drawn was very small, and this variation was not further proved by the larger dataset. In relation to age, concern about capability to provide appropriate services to people under 18 was frequently raised by PHNs and hubs in consultation – it may be possible to infer that this dedicated attention has resulted in better service provision and outcomes for people under 18.

5.1.2 Qualitative benefits

Participant and support person interviews also identified many qualitative benefits of participation in *HeadtoHelp*.

In total, 77 per cent of participants reported experiencing some benefit for themselves and 46 per cent of support people reported positive impacts of *HeadtoHelp* for their loved one. A summary of the benefits experienced are shown in Figure 33.

[68] Running the regression with the same factors as those used in the interim evaluation does not give homelessness and age as statistically significant factors. On the other hand, running the regression on the interim dataset and controlling for PHN shows that homelessness and age remain statistically significant at the 95 per cent significance level while PHN is only statistically significant 90 per cent significance, signifying that homelessness and age had a stronger relationship at the time of the interim evaluation. A possible explanation for this is that over time PHNs have a larger effect than homelessness status and age combined. Additionally, the regression model using the same factors in the Interim Evaluation on the final dataset has an R2 of only two per cent, compared to 12 per cent in the interim evaluation, suggesting that over time the relationship between the factors has changed significantly and accounting for only two per cent of the total variance down from 12 per cent.

Figure 33 | Benefits experienced by HeadtoHelp participants

HAVING MORE STRATEGIES IN MY TOOLBOX

- Ideas and strategies to handle problems and deal with life circumstances.
- Ongoing strategies and techniques to maintain mental health.
- Techniques to improve thinking patterns.
- Techniques to use when feeling distressed or overwhelmed.

"[HeadtoHelp has] given me a lot of ways to help him with his anxiety. I'd say it's made a really big difference."

32 service users and six support people

ACTING IN MY OWN BEST INTERESTS

- Taking a more active role in maintaining and improving mental health.
- Other changes, for example, being more assertive, not tolerating disrespect, giving up smoking, "not abusing myself as much".

"Now I can actually say 'no' to different people… Whereas in the past… I'd just get walked over."

27 service users and five support people

THINKING DIFFERENTLY

- More confident in their ability to manage mental health.
- Better understanding of their mental health situation.
- Sense of hope and a positive future.

"I believe that I'm worthy of a better life and that I deserve better."

42 service users and five support people

USING THE SERVICES I NEED

- More actively engaging with the services they feel they need and taking mental health more seriously.
- More able and willing to reach out for help for mental health in future.
- Better connected with important community supports.
- More knowledgeable about services available or how to navigate the system.

"I don't particularly like making all these phone calls. So, to have… somebody call me… it was a lot easier to actually continue to get [help]. I wouldn't have continued to speak to people otherwise."

24 service users and six support people

IMPROVED LIFE SITUATION

- Better relationships, for example, with parents and/or partners and more social engaged.
- Getting or changing work.
- Finding safer, more positive accommodation.

"After the sessions I found out that I came back to the original version of me where I enjoy going out with [my family] and playing with them."

15 service users and two support people

IMPROVED MENTAL HEALTH AND WELLBEING

- Feeling calmer and less stressed.
- Feeling like they are on the right track.

"I'm incredibly glad that I went in and gave it a chance, because HeadtoHelp probably saved my life in that window. If I hadn't gotten in contact with them, then yeah, I don't know."

"I feel like it's a good start."

26 service users and seven support people

As illustrated above, most participants described positive impacts of *HeadtoHelp* on their lives. Interestingly, these tended to relate less to alleviation of specific symptoms and more to having hope, better management strategies, and new ways of thinking and 'doing' – a greater ability for people to take control of their own lives going forward. These recovery-focused (rather than clinically-focused) outcomes are hopeful and should be a focus of *HeadtoHelp* going forward. While more difficult to measure, these types of outcomes are more sustainable and personally meaningful than traditional clinical outcome measures like reduced symptomatology and hospital presentations.

Those people whose experiences were less positive often still reported some benefits, such as knowing a bit more about available services, or making some progress. Support people often also experienced benefits for themselves, including feeling calmer or more at peace, and experiencing a new sense of hope. However, a few participants reported feeling disappointed or 'disheartened' by the outcome of their attempts to get help, wondering whether they would ever get the support they needed. Some described feeling they had wasted their time and that their interaction with *HeadtoHelp* had delayed getting the services they needed.

5.2 What has been and is the likely impact of the implementation of the HeadtoHelp?

Key findings: The majority of participants and support people were satisfied with the service they have received, as well as with their intake experience, with some occasions where participants reported they were as satisfied with this intake experience as they were with the intake experience of other services. Factors determining high satisfaction included a client-centric system, staff competence, timeliness and the ease with which clients were able to access *HeadtoHelp*. However, intake experiences depended on the intake clinician, and where clients indicated dissatisfaction with intake this was usually due to what they felt was a superficial intake conversation and an intake staff member who lacked experience.

There were slight differences in satisfaction depending on whether the client received a service at the hub or only a referral, as well as differences in service experience ratings between PHNs.

Interviews with both service partners and participants indicated that integration between *HeadtoHelp* and other services could be improved, and the importance of this for achieving positive outcomes was emphasised by participants. Where service integration was achieved, some success factors included co-location and establishing genuine partnerships to build trust in *HeadtoHelp*.

5.2.1 Participant experience

Service satisfaction was largely high, with only a small difference in satisfaction levels depending on service type, and between support people and participants

Figure 34 and Figure 35 illustrate the satisfaction ratings from expressions of interest (EOI) survey data of participants and support people respectively, according to the type of service received. The data shows that whether participants or support people received support at the hub or a referral only, satisfaction ratings in the higher score categories were the dominant result.

Those who received referrals only appeared slightly less satisfied than those receiving service at the hubs. This may have been due to a participant or support person requiring support in the moment of contact and thus a referral at that time was not helpful to them. Additionally for support people this may have been due to parents being disappointed with the lack of child-specific services in the hubs.

Figure 34 | Satisfaction rating by service type: Participants

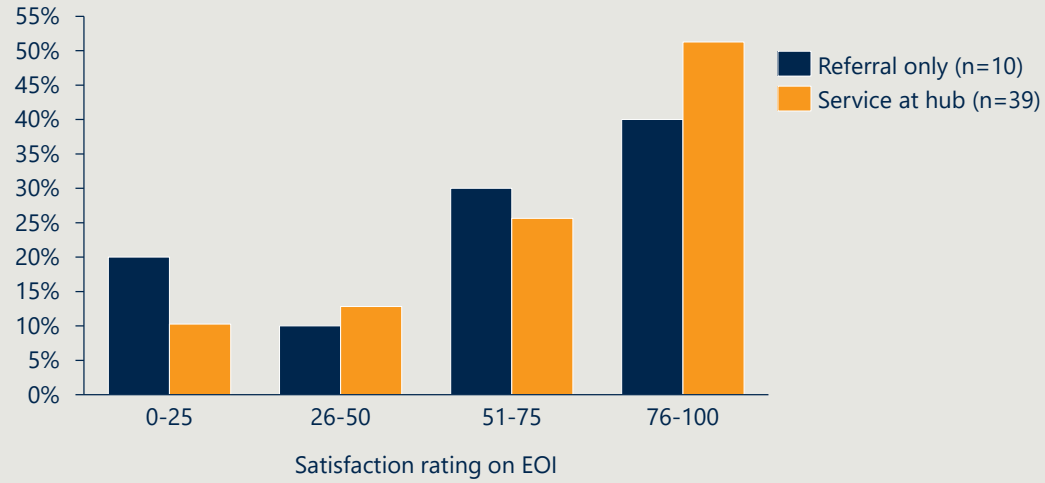
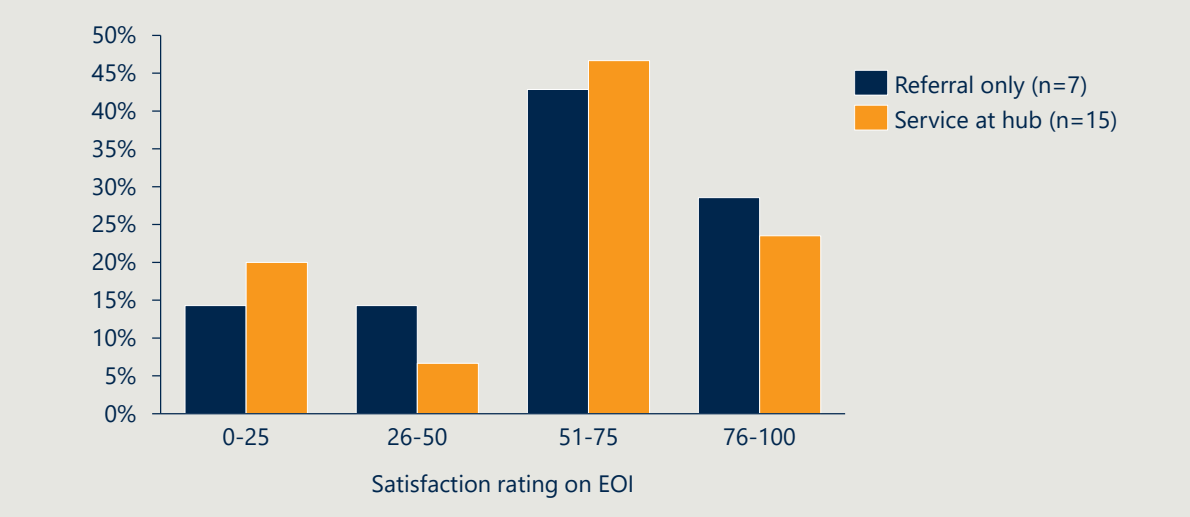


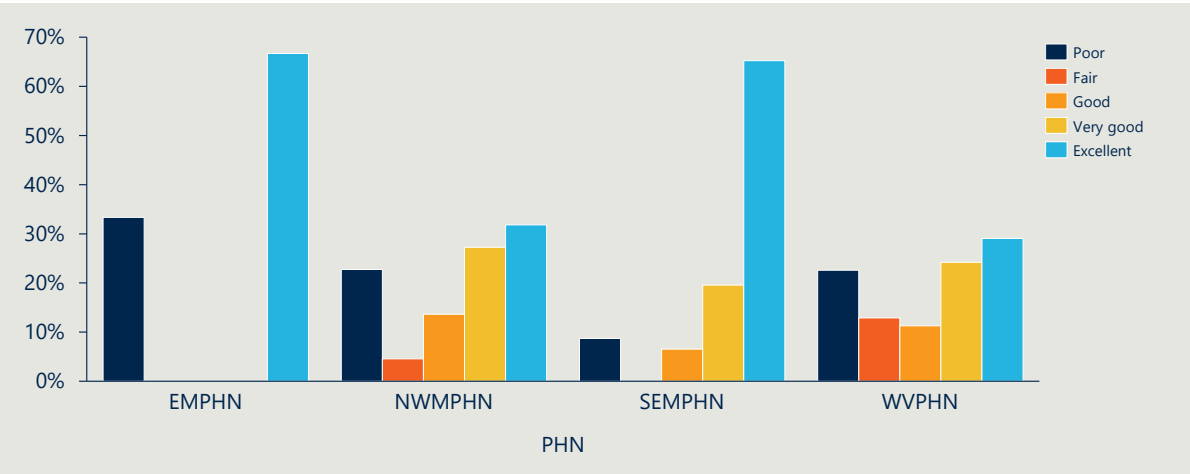
Figure 35 | Satisfaction rating by service type: Support people



YES survey results on overall service experience varied across PHNs, noting that reasonable data was only obtained from NWMPHN, SEMPHN and WVPHN. Figure 36 shows the distribution of answers to the YES survey question "Overall, how would you rate your experience with this service in the last three months or less?" Interestingly, SEMPHN respondents had a median rating of 'Excellent' for their service experience (with over 60 per cent of respondents selecting this rating), which is in contrast with the views of service partners from that region, who cited clarity on the model/risk profile and low engagement as major barriers to referrals.

WVPHN and NWMPHN both had over 20 per cent of respondents rating their service experience as Poor, however, the majority of respondents from these PHNs did rate their experience as Very Good or Excellent (with the Excellent ratings being significantly lower than for SEMPHN).

Figure 36 | Overall service experience in last three months by PHN (YES survey results)



Almost all participants would recommend HeadtoHelp

Overall, 76 per cent of participants asked said that they would recommend *HeadtoHelp* and a further 12 per cent said they might, depending on the circumstances, or with some reservations. However, this rate may have been higher in a representative sample, as less satisfied people were oversampled interviews.

When asked whether they would use *HeadtoHelp* again if the need arose, most people said that they would. Even people who said that they would not use *HeadtoHelp* to seek services for themselves or their loved one often said that they would still recommend it to other people, depending on the

circumstances. One participant noted that *HeadtoHelp* might be useful for someone newer to the mental health system, while a couple of support people said that they would not use it for a child, however, would recommend it for an adult. A few people acknowledged that a lack of comparable options influenced their willingness to recommend *HeadtoHelp*.

Supporters of children were the least satisfied with the service, with their satisfaction lower than that of the supporters of adults. This fits with the service provider feedback regarding difficulties of providing child and adolescent services within the current model and aligns with other findings in this report.

HeadtoHelp appears to be relevant and acceptable to other diverse, minority groups

Limited data from the YES survey appeared to indicate that satisfaction with *HeadtoHelp* was lower for Aboriginal and Torres Strait Islander people. However, those who were interviewed indicated that they found *HeadtoHelp* to be culturally sensitive once they engaged with the service. This was also the case for other diverse, minority groups, including CALD groups and the LGBTQI+ community.

Timeliness and staff competence and personal qualities were the most commonly cited factors in determining a positive experience with HeadtoHelp

Important features that determined participant satisfaction with their experiences are described below[69]. YES, survey data is included where relevant.

- **Staff competence and personal qualities**. It was extremely clear that the qualities of individual clinicians and participants' interactions with them was of primary importance to people's experiences. This was implied in nearly every story and the personal qualities highlighted included competence, professionalism, empathy, kindness and respect. Empathy was valued highly, and people appreciated the opportunity to talk to someone and feel they were 'heard and not judged.' Often people were not only describing their psychologist or clinician, but also the person who spoke to them at intake or organised their appointments. YES, survey results showed that the majority of participants felt safe and welcome in using the services. However, there were some people who mentioned interacting exclusively with staff who were not empathetic and were perceived as lacking training and competence, appearing not to understand participants' issues and/or making them feel uncomfortable. Sometimes while staff may have been generally competent, people described a poor match between themselves and a clinician, for example, if the staff member lacked training and experience with specific issues such as trauma, autism or substance issues. While the Department does not directly influence the quality of intake staff, there are levers the Department can use to ensure the quality of intake clinicians – such as ensuring appropriate staff funding to enable hubs to hire experienced staff.
- **Timeliness**. YES, survey results showed that around 75 per cent of respondents found they were usually or always able to access the service when they needed it, something that delighted and often surprised participants, as with other services they would likely have had to wait for months for a first appointment. This was a consistent and very strong theme. Most were able to see a clinician within a couple of weeks, sometimes in a matter of days. Several had resorted to contacting *HeadtoHelp* after discovering that appointments for a psychologist or a community mental health team were not available for at least several months. Some participants, however, reported distressing delays with *HeadtoHelp* due to calls not being returned, appointments cancelled, or long waits for appointments at the hubs. Participants also found it important that the frequency of appointments was based on need, without long delays in between. YES survey results showed that around 75 per cent of respondents found they were usually or always able to access the service when they needed it.

[69] For details of the frequency with which each of these factors were mentioned, both positively and negatively, please refer to the University of Sydney Voices of Lived Experience report.

- **Cost**. The fact that services were provide free of charge was important to most people. For some, the free service was the deciding factor in whether they would seek help or not. A number of people mentioned that a critical feature was having services for as long as needed rather than being limited to six or eight appointments or therefore perhaps being withdrawn before they were ready, as would be the case with a mental health plan. Participants also found it important that *HeadtoHelp* took their financial status into account when making tailored referrals.
- **Client-centredness (41)**. One of the other things that were most appreciated by participants was when a client-centric approach was taken by the *HeadtoHelp* hub workers. Examples of client-centredness included:
  - choice around which therapist they saw and/or the option to change therapists if they were not suitable
  - choice around face to face, phone or zoom sessions
  - the length and frequency of services being determined by need, rather than pre-defined criteria
  - enough time to explain themselves and their needs
  - having a flexible and accommodating booking service to suit the participant's schedule
  - going 'above and beyond' their assigned duties, such as spending extra time with participants outside appointments
  - focusing on what the participant wanted to work on and achieve and asking for feedback to improve the process.

The YES survey found that it was important to people that they were able to make decisions around their treatment and that these decisions were respected.

While most participants were happy with the client-centredness of the service, some reported negative experiences, including clinicians asking situation-inappropriate questions and not engaging in appropriate language; experiencing difficulties and system problems with booking appointments and not being able to find appropriate times (e.g., weekends) to fit into their schedule. Some people also reported not having enough information to make a decision on which therapist to select and others felt uncomfortable to ask for a different therapist or type of professional. The YES survey indicated that whilst nearly all participants felt that their right to make decisions was respected, only 66.1 per cent reported that their treatment plan took all their needs into account.

> "If I want to talk about my Aboriginality, they're fine with that but they don't bring it up unless you want to, which is good." – *Participant*

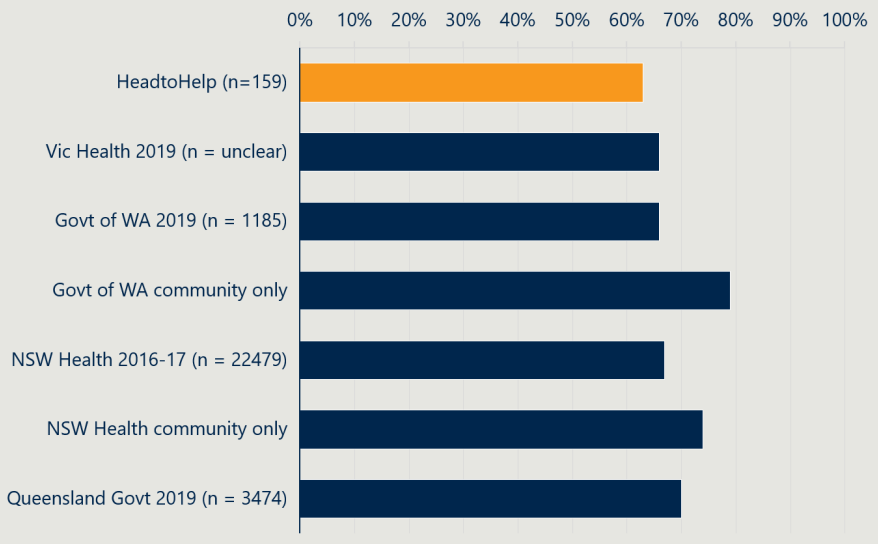
- **Responsiveness to diversity**. Almost all participants from diverse backgrounds felt that their cultural background was respected in all their interactions with *HeadtoHelp*, even if their cultural heritage was not specifically mentioned or discussed in detail. One participant highlighted the importance of making space for conversations around cultural identity and heritage but allowing the participant to raise these issues and direct the conversation, rather than asking pointed questions. Some of the specific strategies that were noted as demonstrating awareness and respect for cultural diversity included: performing an Acknowledgement of Country during counselling sessions, offering access to an Aboriginal and Torres Strait Islander service provider, or asking for a person's preferences in relation to service provider (e.g., gender). A few Aboriginal and culturally diverse participants commented on the benefit of having a service provider from a similar background, though this was sometimes not possible.
- **Proactive communication and follow up**. Participants really appreciated when *HeadtoHelp* staff followed-up with them proactively to see how they were getting along, or to check on them if they missed appointments. This kept them engaged with the service and made them feel supported. However, other participants reported the opposite experience, where staff failed to

return calls or contact them in agreed-upon timeframes and did not follow up with or check in on people. Participants who had disengaged from the service due to worsening mental health issues reflected that they would have liked some follow up. Other communication issues included lack of clarity around treatment timeframes, lack of communication during waiting periods and services finishing before the person was ready with no other support in place.

HeadtoHelp overall service ratings are high, but do not stand out compared to other state services

To provide some perspective, a comparison of *HeadtoHelp* participant ratings of "How would you rate your experience with this service in the last three months or less?" has been compared to YES survey results for the same question for four state services. The graph below shows the percentage of participants who responded "very good" or "excellent" to the question.

Figure 37 | Comparison of HeadtoHelp service ratings with other state services



This comparison shows that *HeadtoHelp* service ratings are fairly high at 66 per cent but slightly lower than for those reported in other surveys, particularly when compared to community-based services, reported separately in WA and NSW. Further to this, 19 per cent of *HeadtoHelp* clients rated their service experience as poor, whereas this was only four per cent for both QLD and NSW, and 2.7 per cent for WA.

5.2.2 Intake-specific experience

Participants and support people generally found the service easy to access

The vast majority of participants have described *HeadtoHelp* as very easy and straightforward to access. Most participants heard about *HeadtoHelp* via a cold referral (i.e., they were given the 1800 phone number to call). In considerably fewer cases did the referrer contact *HeadtoHelp* on behalf of the participant or support person.

Twelve participants and two support people mentioned being initially reluctant, anxious, or hesitant to call.

This suggests the possibility that other people who would have benefited from *HeadtoHelp* may not have accessed the service.

> "It was really straightforward. They gave me the number, I rang and I spoke to someone straightaway." – *Participant*

Of the ten participants who had difficulty accessing the service, four from SEMPHN who called the 1800 number commented that being triaged through the central phone line added extra steps to the process of obtaining help.

> "I think because it is a quick response and when you're in … a crisis or when your mindset is in crisis mode, that's really important. And often, just having someone hear you is enough to dissipate that crisis feeling and you can get more into the active space." – *Support person*

One of these participants mentioned being told the number they had called was for country Victoria and it is unclear what the end result was for the other three. The other seven participants who had difficulty accessing the service cited issues with phone calls or warm referrals not being followed up promptly or at all.

However, overall, the use of a simple 1800 contact number was seen as a benefit. A few participants reported finding it more comfortable to contact someone they did not know to discuss their problems by phone, than to approach someone in-person, for example, their GP.

Regardless of any initial reluctance, most participants were able to access *HeadtoHelp* easily and quickly. People sometimes reported being surprised either that someone answered the phone or that their call was returned promptly, sometimes within the hour.

This was a real strength of *HeadtoHelp* that was acknowledged even by some participants whose experiences were not positive overall. The promptness with which they were able to speak to the intake worker was highly appreciated and some participants emphasised the importance of these, with one stating that ease of access 'could be the difference between continuing to seek services or giving up again.'

Intake experiences were largely positive, although highly clinician-dependent

The majority of participants and support people described the initial interview with *HeadtoHelp* as a positive experience and finished the call believing that *HeadtoHelp* had helped or would be able to help them.

Each of the support people initially spoke to the intake clinician without their loved one being present. Parents of children provided background information about their child and progressed to the next step. The relative of an adult participant was advised to have them call but felt that the intake clinician had been receptive to her advice to be 'a bit delicate and careful with her to try and get her to come around', so they called again together for intake. The mother of an 18-year-old particularly mentioned that *HeadtoHelp* were very respectful of her as a parent and willing to work with her rather than dismissing or diminishing her role just because her daughter was 18.

Apart from the promptness of contact (as above) some of the most commonly reported features that made the experience of intake positive were:

- It was **client-centric**: "The assessment interview with *HeadtoHelp* was based really on what it is that I was talking about and … not focussing on stuff that I didn't see as an issue at the time." – *Participant*
- The assessment was relatively **brief**: "It was very quick. I remember she just sped through everything, but still managed to keep it really personable and friendly, which was really, really nice." – *Participant*
- The intake clinician was **caring, understanding and respectful**: "So the intake was great. They were really good, they listened to the issue. They were totally non-judgemental." – *Support person*
- The intake clinician was **knowledgeable**: "I felt like she knew what she was doing." – *Participant*
- The intake clinician helped them **to identify what was needed** if they were unsure: "I didn't really know the direction I was looking for. So, I felt like they were really good in asking me questions to get me to be able to put a label on the outcome." – *Support person*
- The process was **easy and efficient**: "It was really, really easy to communicate and deliver what I'm stressing about… [They] provided help immediately, so I didn't have to contact them again at all. It was really efficient and useful." – *Participant*
- **Supportive** of support people: "I wasn't belittled or [told] 'oh, you need to do this, you can't do that because you're not, they're over this age'… it was 'you're coming from a place of care and we're here to help you care for them and here we go'." – *Support person*

Participants who did not report a good intake experience had a number of common reasons:

- They found the assessment to be **superficial**, not comprehensive enough, or too standardised to be helpful: "It seemed very impersonal… it seemed very rushed and informal and just not like my best interest was in place." – *Participant*
- The intake clinician appeared to **lack experience in mental health**: "He mentioned that he's just only the intake person… [It would be better if] maybe someone they got trained… or someone they know more about maybe mental health." – *Participant*
- The intake clinician was **unable to build rapport**: "Honestly it felt like scripted empathy from someone who didn't know what to say." – *Support person*
- **Participants or support people were expected to know** what was required: "We present to places and they go, 'Oh, how can we help you?' … We're not the experts in the field. We don't know what is helpful and, you know, what we're supposed to do next." – *Support person*

> "I felt the *HeadtoHelp* was – yeah, like focused on – they're just dealing with my day-to-day stuff… it was almost like everything that I brought up she would just give me something to think about with it or just an alternate thought rather than the ones that I was on." – *Participant*

While most participants described the intake interview in a similar way – as a process of being asked questions, having their situation understood, then having a suitable course of action agreed upon – there were exceptions. One participant reported that she spent around an hour on that initial call, during which she was able to discuss her problems and receive wise advice (see left). Although this participant was so distressed when she called that if she had not reached *HeadtoHelp*, she said she might have phoned triple zero, she did not feel that she needed anything more from *HeadtoHelp* after that one extremely helpful phone call.

Other participants, however had the opposite experience. A participant phoned *HeadtoHelp* because she was distressed by problems in her life and found little assistance (see below).

> "I understand he couldn't give me any further advice that I wish at that time, [but I would have liked] a little bit comfort or at least like hear my story… even though they cannot provide a particular solution, but at least I feel being heard, whether they just ask me to do goals, or make another phone call to another organisation." – *Participant*

Around half of people who received referrals to other services felt that those referrals were appropriate

Where participants were not satisfied with their referrals, a range of issues were cited, including:

- The intake clinician had little knowledge about the services they were recommending (e.g., eligibility, specialties, wait times, costs, etc).
- Referred services had already been tried and had either closed their books or had long waiting lists.
- Referred services were well-known services that participants could have contacted in the first place, however, were hoping for something different.
- Referred services, when contacted, said that they could not help or had long waiting times.
- Referred services did not address the issue perceived by the participant.
- Being referred to services that were not appropriate to the person's needs. For example, one support person was referred to online services, which she saw as inappropriate for her young son.

> "We're always bouncing from person to person… what we're looking for is somebody who can actually help us with the problem." – *Support person*

- Warm referral not being carried through, requiring follow-up and delaying support.
- Being given no options – one recommended organisation with no Plan B for if that did not work out.
- Lack of follow-up from *HeadtoHelp* as to outcome of the referrals.

5.2.3 Impact on system integration

Integration with service partners, in particular AMHSs, has had mixed success

The amount of collaboration, awareness and communication between local AMHSs and other service partners, and *HeadtoHelp* hubs is mixed, although often not occurring to the extent that the model envisioned.

> 'It's important for them to collaborate – look, all these services are great they're brilliant, they're awesome. [But] can we be honest and not rush and just call it for what it is?... I just feel the government of the day are just putting a band-aid approach to all of this and just throwing money for the sake of throwing money at it. Really not thinking about it from a collaborative approach.' – *Participant*

AMHS managers noted that some opportunities for collaboration such as the development of referral pathways were missed. AMHS staff who were unaware of the service or did not refer many participants to the service noted that the purpose and level of risk taken on by the hubs was unclear. Some staff were also sceptical of the service and the capability of hub staff to appropriately service participant's needs. Some service partners also noted that *HeadtoHelp* staff did not participate consistently in regional planning and networking forums, or that there was no regular 'face' in *HeadtoHelp* participation. From the perspective of the *HeadtoHelp* hubs, many felt they did not have the resourcing to support integration through these channels. This indicates a lot of work remains to be done to develop greater trust and rapport between *HeadtoHelp* hubs and AMHSs, and successfully build the profile of *HeadtoHelp*. This may be further supported through the involvement and advocacy of the Victorian Government.

HeadtoHelp participants and formal support people are not aware of any communication between HeadtoHelp and other mental health services they use

Of 54 participants or formal supports who were asked whether there was any communication between *HeadtoHelp* and other services that they used, 23 answered 'I don't know' and 12 answered 'no'. Only four answered 'yes', and ten reported 'some level of communication'.

Those who did report a collaborative approach between their supports highly valued this approach, and several mentioned that they had strongly advocated for it themselves.

"When I do go to a doctor's appointment, they ask me whether I want them to be in the room with us... I get them to come in with me so the more they know about me and my problems, the more they can help me, that's my mentality."

Most participants who reported no communication either did not expect this to happen, did not think it was needed, or thought it would happen if required. However, ten participants thought that more communication would be helpful or was needed.

One type of collaboration experienced by only two people but seen as extremely beneficial, was between a *HeadtoHelp* psychiatrist and a GP around medication.

However, there are success factors that have improved integration

Deliberate and genuine partnerships, as well as co-location, has supported greater integration of *HeadtoHelp* hubs with the broader mental health system. Details on each success and the outcome

observed are outlined in Table 4. Two case studies illustrating how specific *HeadtoHelp* hubs and PHNs have adopted these approaches are detailed below (Figure 38). These success factors are likely not specific to *HeadtoHelp* and therefore are applicable to other mental health programs such as the AMHCs.

In addition to these specific factors, stakeholders also noted that it takes time for new services to be embedded and integrated within the broader system – particularly in a context of typically short-term funded initiatives – noting there is often a layer of scepticism as to how long new players will 'be around' – which can be a disincentive to engagement.

Table 4 | Integration success factors

Success factor	Details	Outcome observed in evaluation
Establishing genuine partnerships with LHDs and AMHSs to build trust in HeadtoHelp	Factors that have been critical to *HeadtoHelp* hub providers forming genuine relationships: • Awareness of changes within the service environment (e.g., restructures in AMHSs, new organisation executives, etc.). • Identifying how the IAR and state-wide mental health triage scale compliment each other. • Providing reciprocal opportunities for staff across organisations.	The evaluation found that some service providers in the MPHN and WVPHN regions have established closer working relationships with AMHSs in their region, which service providers reported anecdotally resulted in the majority of referrals to *HeadtoHelp* from AMHSs in these regions. This is validated through analysis of the PMHC-MDS and *HeadtoHelp* extension in Section 5.2.3.
Co-location with AMHSs, community health services and GP clinics improved the accessibility and awareness of HeadtoHelp	The majority of hubs are co-located with community or tertiary health services. Of the 15 hubs and nine satellites currently operating, services have been co-located in general practices (13), community health services (five), a hospital (one) and in a specialised mental health service (one). Co-location within an existing community service supported: • service awareness • access to existing infrastructure (e.g., clinic rooms, a phone line, medical software). However, some stakeholders raised concerns that co-locating hubs with GP services led to a perception of competition from referring GPs. The communications stream managed this on an ad-hoc basis, creating FAQ documents to inform referring GPs of the service. However, hubs should be mindful of the services they are co-located with as location with a tertiary service may be traumatic for some cohorts (e.g., Aboriginal and Torres Strait Islander people).	• Many hubs reported that co-location with a GP clinic, headspace and/or child and maternal services was important for visibility and accessibility of the service and improving care coordination. • Additionally, co-located hubs have benefited from referring participants to other existing services. • Hubs co-located with GP clinics over time have built partnerships with GPs to refer into the service, thus building confidence and trust in the hub model. Where *HeadtoHelp* is co-located in GPs or hospitals, staff have reflected that the access to the existing infrastructure and proximity to other medical services has worked very well.

Figure 38 | Integration case studies

The NWMPHN hubs partnered with RCH creating a range of reciprocal opportunities for staff	

Case study included with permission from the RCH	During COVID-19, RCH was funded to deliver against specific initiatives, including secondary consultation and the provision of outreach services. As a result of this funding, the RCH partnered with the NWMPHN to provide expert advice on working with children and youth cohorts. This was viewed as critical in light of workforce shortages for child and youth mental health clinicians. The NWMPHN intake team, hubs and the RCH met regularly to establish key components of the partnership. As a result of the partnership a range of opportunities were identified to support the NWMPHN *HeadtoHelp* hub staff deliver services to children and youth. These opportunities include:
	• free access to RCH professional development for all hub staff
	• an RCH senior mental health clinician provides:
	  • secondary consultation and advice to hub staff up to three days per fortnight
	  • facilitates monthly reflective practice and case reviews with each hub
	• development of a joint referral pathway.

Gateway Health and local AMHS effectively collaborate by establishing a project control group	
Case study included with permission from Gateway Health	Gateway Health had a productive pre-existing relationship with the local AMHS, however, a restructure of the service provided them with a timely opportunity to refresh relationships. Gateway Health established a project control group to support the implementation of *HeadtoHelp* in Wodonga and the surrounding region. The group had representation from the local AMHS and other services in the region. Gateway Health and the AMHS report this project control group was an effective way to work together during the first months of service implementation. This approach supported them to: • make decisions in an efficient manner • establish a clear referral pathway into *HeadtoHelp* for the AMHS, including identifying ways the IAR and state-wide mental health triage scale fit together and support appropriate referrals into *HeadtoHelp* • identifying opportunities to build service capacity in the region, recognising workforce constraints.

5.3 How efficient is the program?

Key findings: Noting the limitations of the approach, analysis of costs per service contact and costs per episode of care indicate that while efficiencies are largely dependent on service volumes, some PHNs appear to be more cost efficient than others.

Comparison of overall *HeadtoHelp* efficiency with headspace costs per occasion of service indicates that despite differences in efficiencies between PHNs, *HeadtoHelp* is reasonably efficient across the board.

The slow uptake in service provision is also likely to have impacted this efficiency analysis. Repeating this analysis with data and service activity from the final December 2021 to June 2022 extension, where funding was distributed based on actuals from the preceding year, would address this limitation and likely to be more reflective.

5.3.1 The analysis used to measure efficiency is limited

This report has undertaken an analysis comparison of efficiency considering program costs and volume of activity – both distinct episodes and total service contacts. Volume data has been taken from the PMHC-MDS, financial data was provided by the PHNs and does not include the latest funding extension to June 2022. This analysis has been done at both the overall and PHN level.

Findings need to be interpreted with caution. This analysis is based purely on volume – it does not consider the quality or effectiveness of service (in either outcomes or experience of service), population factors in particular regions, or the complexity behind each episode or service contact. In addition, it has been done using the funding data from the first two stages of *HeadtoHelp* delivery, which was based on projected need only, and not on actual expenditure. It may be useful to repeat this analysis using the financial information and volume data from the final December 2021 to June 2022 extension, where funding was distributed based on actuals from the preceding year, and likely to be more reflective. This analysis should be used with the PHNs to promote learning and sharing of good practice, not as a sole driver of future funding allocations.

5.3.2 There appears to be efficiency variances between PHNs

Table 5 gives details on the investment into establishment and operations of the *HeadtoHelp* hubs, not including PHN flexible funding, from September 2020 to 31 December 2021[70]. It also shows service contact and episodes of care numbers over this period, which have been used to estimate the cost per episode of care and per service contact in each PHN and overall. Establishment costs were excluded from calculations for both metrics, as these costs are not costs incurred when offering care, and intake costs are excluded in calculations for service contact costs.[71]

Across all PHNs, the average cost per service contact was $194.45 and cost per episode of care was $1,509.94

What this data appears to show is that PHNs with higher volumes of service contacts have lower costs per service contact, for example, EMPHN which had 13,729 service contacts had an estimated cost per service contact of $194.45, compared to NWMPHN, which had the lowest number of service contacts at 9,055 at the highest cost of $307.97. There are a number of possible explanations for this. Over time, delivery of a higher volume of contacts is likely to result in lower cost per service contact (driven by the increased denominator). It may also reflect that hubs delivering a larger number of service contacts may have larger multi-disciplinary teams, thus relying less on relatively higher cost professions (e.g., psychologists).

However, the costs per service contact are not necessarily directly proportional. For example, EMPHN and MPHN both have higher volumes of service contacts than GPHN, but GPHN has the lowest cost per contact. This could suggest that GPHN may be operating more efficiently than the others.

The same pattern in costs versus volumes can be seen in episodes of care. These findings are heavily influenced by the average number of service contacts per episode of care – see analysis included in Section 4.1.6. EMPHN and SEMPN have the lowest volume of episodes of care and the highest costs per episode. MPHN has the lowest costs per episode, reflecting earlier analysis that this PHN has typically shorter length of stay and number of contacts. There are some small exceptions to this pattern – for example WVPHN has the fourth highest volume of episode of care but is the third most efficient – indicating some greater efficiency, however what can be taken from these insights is limited. The high correlation between number of service contacts per episode and efficiency of episodes of care suggests that the analysis of cost per service contact is the more useful.

Table 5 | HeadtoHelp funding and activity data

PHN	Total allocated	Total minus establishment	Total minus establishment and intake	Total episodes of care	Total service contacts	Cost per episode of care	Cost per service contact

[70] PHN flexible funding was excluded in these calculations to best reflect hub operation rather than PHN administration and management.
[71] As intake contacts are not included in the count of service contacts from the PHMC-MDS dataset.

PHN	Total allocated	Total minus establishment	Total minus establishment and intake	Total episodes of care	Total service contacts	Cost per episode of care	Cost per service contact
EMPHN	$3,317,552.99	$2,909,779.44	$2,669,583.68	1,131	13,729	$2,572.75	$194.45
GPHN	$2,584,774.01	$2,271,559.17	$1,998,244.32	2,158	12,688	$1,052.62	$157.49
MPHN	$2,254,186.01	$1,980,843.57	$1,787,610.74	2,194	13,972	$902.85	$127.94
NWMPHN	$3,513,160.99	$3,082,847.24	$2,788,656.72	1,608	9,055	$1,917.19	$307.97
SEMPHN	$3,264,752.99	$2,863,608.65	$2,634,563.58	1,188	10,422	$2,410.44	$252.79
WVPHN	$2,294,008.01	$2,013,243.09	$1,826,821.41	1,226	10,778	$1,642.12	$169.50
Total	$17,228,435.00	$15,121,881.16	$13,705,480.46	9,505	70,644	$1,590.94	$194.01

5.3.3 Comparison to other services shows that HeadtoHelp appears relatively efficient overall

To try and quantitatively assess the efficiency of *HeadtoHelp*, we have considered a comparison with both headspace and single service contact costs for psychology. **Overall, this evaluation finds that HeadtoHelp has been operating with appropriate efficiency, especially considering the time taken for the hubs to ramp up operation early on.**

Comparison to headspace: available funding data for headspace's 'communities of youth services' or integrated service hubs and networks, which were established between 2006 and 2009 shows that $34.2 million was received[72] by 30 of these integrated service hubs and networks across Australia over this time period. Within this time frame, 13,917 young people had been seen and over 95,000 occasions of service provided, which equates to roughly $360 per occasion of service. In the 2013/2014 financial year, the cost per occasion of service was similar, at $339[73]. Comparing this with the estimated cost per service contact for *HeadtoHelp* overall, which is $194.01, it appears that *HeadtoHelp* is operating at reasonable efficiency, noting that headspace is operating with a younger cohort (which could be expected to increase costs), but an often less clinically complex group (which could be expected to decrease costs).

Comparison to single service costs: the Australian Psychological Society National Schedule of Recommended Fees 2021-2022 sets a standard 46 to 60-minute consultation fee at $267. Anecdotally, single service contacts for a psychologist are typically approximately $200. Again, this demonstrates that *HeadtoHelp* is operating at a lower cost per service contact, however it is important to note that while psychological services were the most common primary service type, not all service contacts at *HeadtoHelp* are or need to be delivered by a psychologist.

5.3.4 A slow uptake in service provision is likely to impact efficiency analysis.

Most *HeadtoHelp* hubs had low intake numbers in their first few weeks of operation. Low client numbers means that staff are not fully utilised which increases the cost per episode and service contact early in the establishment and implementation phases.

[72] headspace Evaluation Report, Kristy Muir et al., Social Policy Research Centre, University of New South Wales, 2009.
[73] Is headspace making a difference to young people's lives? Final report of the independent evaluation of the headspace program, Hilferty et al., Social Policy Research Centre, University of New South Wales, 2015.

6 Establishment of AMHCs

This section addresses KEQ 8 (How effective has the establishment of the AMHC program been to date and what can we learn from it?), KEQ 9 (How appropriate is the IAR intake process that has been developed?) and KEQ 10 (How efficiently were AMHCs established?).

6.1 How effective has the establishment of the program been to date and what we can learn from it?

Key findings: There has been a thorough and robust commissioning process, with appropriate levels of co-design and funding in place to support effective establishment. While PHNs generally found timelines appropriate, this did not necessarily extend to service providers, many of whom could not meet PHN expectations to open by December 2021. Most major delays to establishment resulted from difficulty in securing the right physical location – recognising an appropriate space as a key feature of the AMHC model.

Workforce recruitment throughout the establishment phase has been effectively managed, with innovative models being adapted for the peer workforce. AMHCs do however, remain concerned about ability to manage future demand and system-level integration in a complex service and funding environment, particularly in Victoria.

There are opportunities to improve collaboration as a complete 'network' of AMHCs.

Where appropriate, this section incorporates learnings from both the direct establishment of the AMHCs, and relevant parallels from the establishment and operational experience of *HeadtoHelp*.

6.1.1 PHN commissioning

Commissioning for all AMHCs was completed by November 2021, with AMHCs now in varying stages of service delivery commencement

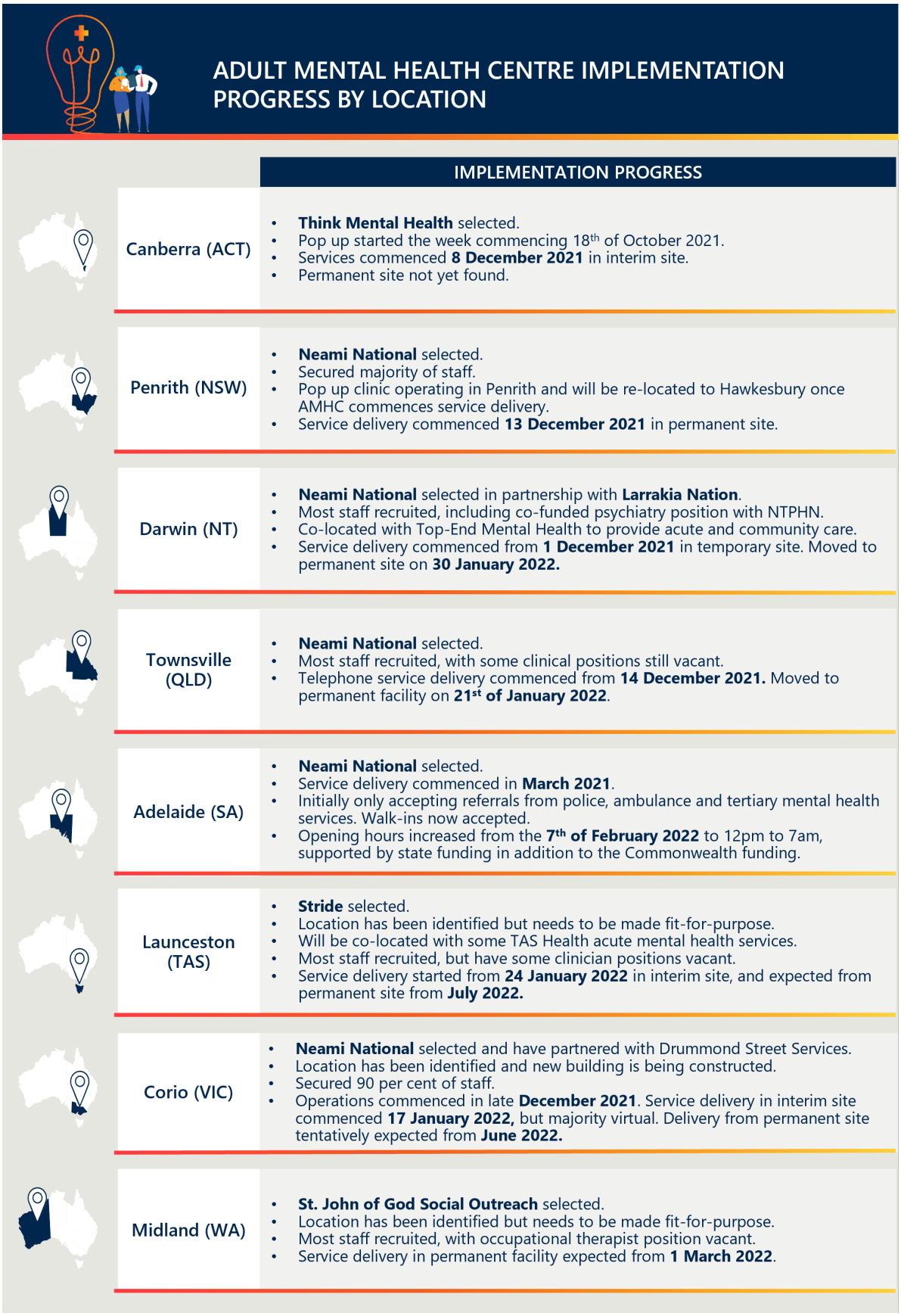
Figure 39 provides a summary of commissioning and establishment progress of each AMHC. Seven of the eight centres were operational by January 2022, with three offering services from their permanent facility and four operating from an interim site. For those delivering services from an interim site, transitions to permanent sites are expected during the first half of 2022. Only two centres (including SA which began operations in the first half of 2021) were operational in their permanent facility by the original proposed start date of December 2021.

The majority of PHNs reported the 'full commissioning process' set out by the Australian Government Department of Health as a positive experience. Specifically, PHNs provided positive feedback on the timeframe provided, noting that it:

- allowed for a full process recognising some inevitable challenges (i.e., staff availability)
- allowed for market development, preparing local providers for future responses and brokering strong relationships
- (for one PHN) gave the ability to execute a provider contract ahead of schedule.

All PHNs identified practices that worked well in their commissioning process and some of these can be used to inform future commissioning of services – see in particular the case studies included in Figure 40 and Figure 41.

Figure 39 | Summary of AMHC implementation progress by location



Local alignment, partnerships and ability to secure a workforce were key determinants in commissioning decisions

In addition to experience and delivery capacity, PHNs were concerned with ensuring commissioned provider had the right vision, values and contextual knowledge for their region. Five of the eight AMHCs have Neami National as their selected provider, and this is due to their connections with local services and extensive experience in the sector, as well as their demonstrated ability to secure staff and establish robust governance structures.

Across the board, some common reasons for commissioning decisions were reported:

- **Appropriateness of NGOs to meet service need**. Most of the commissioned service providers are NGOs, with reflections from stakeholders being that NGOs share strong service delivery experience and the ability to deliver multidisciplinary services, both psychosocial and clinical.
- **Partnerships that reflected specific local requirements and values**. NGOs are strong candidates to meet community needs and preferences, in particular when combined with local partnerships that respond to particular community need. For example, Northern Territory PHN (NTPHN) commissioned Neami National in partnership with Larrakia Nation, which will enhance the ability to meet the needs of their Indigenous community. They also included interviews as part of the tender process to specifically assess values alignment. Neami National in Victoria have partnered with Drummond Street Services to employ a staff member to provide services appropriate for diverse cohorts, such as LGBTQIA+, and for those requiring extra support such as AOD clients.
- **Ability to secure workforce.** The selected provider in WA, St John of God Social Outreach, is part of St John of Healthcare, which operates the existing high-acuity state tertiary service (AMHS) and a complementing community treatment service in the North Perth area, and so will have access to a clinical workforce as well as established care pathways with the ability to step participants up and down from services as needed. Part of the rationale for the AMHC in ACT selecting Think Psychology as the provider was due to their ability to engage and possibly recruit and train university students as staff for the AMHC. As stated above, this was also a driver behind Neami National being selected for five services.

Figure 40 | Case study on the commissioning process of the AMHC in Northern Queensland

The commissioning approach of Northern Queensland PHN (NQPHN) allowed achievement of market development within the process and gave the PHN confidence in the integrity of their commissioning. This has led to an exemplary establishment process in conjunction with the selected provider.

ACHIEVING MARKET DEVELOPMENT

In commissioning a provider for the AMHC, NQPHN used a two-stage, transparent and competitive dialogue commissioning process, which consisted of EOIs, interactive feedback and then select requests for tender (RFT). The rigour of the tendering process was well communicated in advance and allowed for the safeguarding of the clinical maturity required for both implementation and operationalisation of the service model on the ground. The evaluation criteria prioritised providers demonstrating local expertise. Decision making was conducted by a largely independent evaluation panel made up of people with lived experience, mental health clinicians, experienced commissioners and human services professionals, First Nations people, former Australian Defence Force personnel and digital health professionals.

This approach enabled market development within the North Queensland region, as unsuccessful providers were provided with substantial feedback in tandem with providers progressing from EOI to RFT. One local provider competed very strongly with the selected provider (Neami National) and NQPHN feel that as a result this provider is now ready for the next opportunity to apply their learnings. The process strengthened the provider's clinical and governance frameworks which will be beneficial to the PHN as they partner with this provider in other areas. This is a positive outcome as there is a strong push for using local providers in Queensland, and by partnering with this provider and increasing their capabilities, it increases their chances of being commissioned for future projects.

TIMELY ESTABLISHMENT

Despite commenting that the timeline was challenging, NQPHN executed the contract with their chosen provider one week ahead of schedule, with community co-design commencing on the 22nd of October and expected to continue weekly for five weeks.

SERVICE AND SYSTEM INTEGRATION

During the commissioning and establishment process, NQPHN positioned themselves in conversations between other mental health clinics in Townsville and the Queensland crisis support onsite at Townsville Hospital. This was to ensure that the AMHC will integrate well with the other mental health services in the region, that investments will complement each other, and so there can be shared learnings between all the services.

IT infrastructure integration has been a priority, and in commissioning, the ability to integrate systems such as MyHealthRecord in the AMHC were mandated so that once the service is operational, clinical decisions are made with a full picture of the consumer journey.

INCLUSIVE WORKFORCE

As exemplified by their chosen provider and local co-design, the AMHC will have a peer-led workforce, with approximately 50 per cent of staff consisting of lived experience roles, as well as clinical staff including, but not limited to, registered nurses, a senior clinical lead and a clinical services manager. There will also be specialist roles provided by consortium partners, including CALD workers, AOD clinicians and counsellors, and a tenancy housing support officer. Discussions are being held with Aboriginal Community Controlled Health Organisations (ACCHOs) to offer social and emotional well-being specialist roles for First Nations people. At the time of interview, roles had been advertised by the lead provider with a strong response of applicants, and no impacts on the state service and other PHN service workforce had been identified.

NQPHN have mitigated workforce challenges by requiring potential providers to demonstrate their relationships with training and building in reporting measurements of people who are undergoing training, supervision or credentialing within the AMHC. They also provided specialist worker opportunities through partnerships with consortium members, and providers were required to demonstrate how they would create regional sustainability and manage local resourcing across both clinical and peer workforce. Neami National has subsequently met the training and local resourcing requirements by suggesting a partnership with TAFE which has been formalised, establishing a local reference group, and collaborating with GPs to provide joint training, making this a reciprocal arrangement such that as well as delivering training, GPs also receive a development opportunity.

PERFORMANCE MEASUREMENT

Mandatory minimum requirements expected for performance measurement as identified in an indicative outcomes framework designed by PHNs were communicated to the market before tendering, as well as the requirement for innovative additions such as including a system and quality and safety domain to address system coordination, consumer risk management and overall service integration specifications. Mental health literacy and YES framework requirements were also embedded into the framework. Neami National have also fortified the framework using their own tools and maturity – the ability for the provider to do this was included in the RFT process. NQPHN will capture PMHC-MDS data through RediCase, and money has also been put aside from the project budget to conduct an external evaluation.

Most AMHCs were operational by December 2021, though many from interim sites

As illustrated in Figure 39, five of the eight centres had commenced service delivery by December 2021 (with the AMHC in SA having been operational since March 2021). The major delay to the planned opening date of other AMHCs related to challenges securing facilities (see further Section 6.1.3). While the NSW AMHC commenced operations from its permanent location, AMHCs in ACT and NT were operating from interim sites, and QLD and VIC operating via a telephone service. VIC began offering services from an interim site from 17 January 2022, however the majority of their service was still virtual due to COVID-19 and maintenance issues with the interim site. NT moved into their permanent facility in January 2022, as did QLD. ACT had not yet sourced their permanent site by February 2022.

Two AMHCs were not in a position to commence operations as planned in December:

1. The AMHC in WA is expected to start offering a full service by March 2022, with the major reason for delay being the securing and fit-out of a permanent site. A facility has been found, but approval from the local council for a change in business type for the building is reported to have inhibited the commencement of renovations and thus delaying the service commencement.
2. The AMHC in TAS commenced service delivery from an interim start on 24 January 2022 and will reportedly commence full service delivery from a permanent site in July 2022 or later. A location for the service has been identified and this will include co-location with an acute team from the state health service.

Service providers have felt well supported by PHNs

Overall providers have reported positive relationships with their PHN. A number of service providers have referred to relationships with PHNs as a true 'partnership' and highlighted this relationship as one of the critical success factors for establishment. AMHCs have particularly highlighted the quality, collaborative approaches and adaptiveness of PHN staff.

While AMHCs have reported communication directly between AMHCs and PHNs to be effective, some have noted challenges with information flow – describing the PHN's role 'as a middleman' which could result in some confusion and inefficiencies (particularly in relation to requirements for performance measurement – see further Section 6.3.2).

6.1.2 Co-design and local tailoring

Co-design approaches differed across AMHCs, but were positively received by PHNs, service providers and communities

Co-design approaches differed across AMHCs, with overall feedback very positive. Many PHNs noted that the approach conducted for the AMHCs was the best experience of co-design they had ever been involved in. NQPHN and Nepean Blue Mountains PHN (NBMPHN) in particular reported brilliant co-design processes with Neami National. People have recognised the importance of and embraced the co-design process and early indications are that clients and communities are appreciative of the outcomes.

Six of the eight PHNs completed co-design by November 2021, prior to service commencement. NTPHN's co-design process was longer than that for other AMHCs, while co-design for the ACT AMHC was delayed due to the announcement of a Head to Health pop-up clinic that began offering services in late October. The pop-up, as well as consultations from the Safe Haven Café[74], were expected to inform the establishment of the AMHC in ACT.

[74] The Safe Haven Café in Canberra is located at the Belconnen Community Health Centre and is intended to be a safe space for people experiencing mental health problems or emotional distress to access support more easily than through a clinical emergency room. It is

Co-design engagement involved people of lived experience, support people and family members, people involved in service delivery and Elders in the Aboriginal and Torres Strait Islander communities. Some AMHCs reported greater engagement with state and territory governments in the design process than others. For example:

- NTPHN reported strong engagement with the NT Government Commissioning Body for Health, and substantial support from the Minister. State data on emergency and acute consumers was used to understand the type of consumers who might access the service. The case study shown in Figure 41 describes the effective use of this partnership, as well as with the Aboriginal Organisation, Larrakia Nation, to design and establish an AMHC closely tailored to local needs.
- NQPHN engaged with state and regional mental health providers to ensure investments complemented each other, and so learnings for all parties could be shared and used in service design.
- WVPHN reported limited involvement of the state government in the co-design process, however the Department of Health and Human Services (DHHS) came on board later for the provider procurement process.

PHNs either conducted co-design themselves or in partnership with commissioned service providers. Where service providers were commissioned early enough in the establishment process, they were heavily involved in co-design. NBMPHN reported working closely with Neami National in co-design and engagement with different organisations across their region and had a 20-person advisory committee set up that included representatives from relevant organisations as well as six consumers, to assist in initial decision making. In WA, the service provider led the co-design process. Co-design underpinned location selection in both NSW and WA.

Co-design insights have been reflected in the peer-led staffing models developed for the AMHCs – a model that has been well received by AMHC consumers in SA. Another major area where co-design outcomes are reflected is in the physical design of the building. AMHCs in NSW and NT have reported positive feedback from clients on their space, with the AMHC manager in NSW commenting that the centre has 'the perfect layout', and the community expressing that everything they wanted has been incorporated into the physical design of the space as well as into the staffing model. The centre manager of the AMHC in NT also indicated that their space reflects nearly all the co-design outcomes, however they also mentioned that service delivery requirements should have been given more consideration in the physical design, as there are some problems with technicalities such as where administration staff should sit.

intended for people who do not have the level of distress that requires emergency attendance but who require more support than what is provided by community organisations. People have access to peer workers who can help them to manage their distress.

Figure 41 | Case study on the effective use of partnerships for co-design and establishment of the AMHC in NT

The AMHC in Northern Territory skilfully employed partnerships to overcome challenges and meet unique local requirements.

COLLABORATION WITH STATE GOVERNMENT

NTPHN recognised that they were not in a position to do market analysis surrounding mental health staff, and are acutely aware of the shortages in this space in the Territory. Thus, they engaged with the state government to overcome this challenge and ensure that the process helped to develop the mental health sector in the region. Engagement with the Minister and NT Commissioning Body for Health was strong, with some variability in the success of relationship building, however the Minister for Health provided substantial support. A clinical governance, tripartite agreement was established with NT Government, NTPHN and the Aboriginal Medical Alliances (AMSET) who were all involved in decision making in the commissioning and establishment process.

By working with the state government, the AMHC has been able to access state data, including emergency and acute data, to predict and prepare for what kind of clients they may expect to see accessing the service. There has also been collaboration with the state government to implement a single digital intake system for all services and thus avoid confusion for clients wishing to access mental health services. The AMHC intake tool will be developed first and then work will be done to integrate state services into this system.

PARTNERSHIP WITH AN ABORIGINAL ORGANISATION (LARRAKIA)

To incorporate cultural appropriateness for the region, Neami National was engaged as the provider in partnership with the Aboriginal Community Controlled Organisation (ACCO) Larrakia Nation. The partnership will help to ensure that all levels of the organisation will prioritise relations with First Nations people, and that cultural appropriateness for First Nations people is part of the success, and not a late addition to the AMHC.

Larrakia Elders and traditional healers may also work in the building, and the communication about the centre to the public has been tailored to reflect Aboriginal culture, with the centre described as 'A place to Rest, Yarn and Heal' and a Larrakia artist was commissioned to develop artwork for use in the centre and on marketing products.

Service models appear to have the right balance between model fidelity and local variation

The AMHC model of care provides guidance for the centre-level operational model, including approaches to intake. PHNs were generally very supportive of the core service model which they see as based on best practice principles and collaboration paired with the ability to adapt the core Commonwealth model to suit local context. There were not instances where either PHNs or AMHC providers sought to redesign the model completely (with the exception of the SA AMHC – see below).

PHNs were pleased to have advocated for the guidance and ability to localise through co-design, fearing that if they had to standardise the service as was done with *HeadtoHelp* it would not have been suitable for all areas. Instead, this approach appears to have enabled the right balance between fidelity and variation. Specific areas important to individual PHNs included the need to safeguard the clinical maturity required to implement and operationalise the service model, and the need to be as client-centric as possible (while not straying from the core aspects of the original model).

Model similarities include opening times, and the role of a peer workforce; variations include length of service delivery and co-location

Similarities include:

- **Opening hours**: centres have similar planned opening times, in response to high volume 'avoidable' ED presentations, which are typically later in the day. For example, the AMHCs in the NT and VIC are open from 11am to 11pm and the AMHC in WA will be open from 10am to 10pm on weekdays and 12pm to 8pm on weekends and public holidays. The AMHC in SA extended

their opening hours to be open 19 hours a day from 31 January 2022, with state funding supplementing Commonwealth funding to make this possible. The AMHC in TAS offers face-to-face services from 9am to 10pm, with an overnight digital support line that will be operated by a contracted service provider.

- **Role and prominence of a peer workforce:** all AMHCs are committed to embedding a substantive peer workforce. This is discussed further in Section 6.1.4.

Key variations included:

- **Expected length of service episodes**: most AMHCs have characterised their services as short-medium term (a few weeks to a few months). Uniquely, SA Health has characterised their services as 'urgent mental health care through brief episodes of care' (four to five hours), with main referrers being acute services, police and ambulances. However, many stakeholders have expressed concerns about the need for services to provide interventions for longer periods (several months). This was also reflected by participants and support people.
- **Approach to co-location**: only two PHNs have co-located the AMHC with another service. The AMHC in the NT have co-located with a community mental health team (noting that the community mental health actually relocated to the new AMHC building) and the AMHC in TAS will be co-located with an acute state-mental health service once they move into their permanent facility.

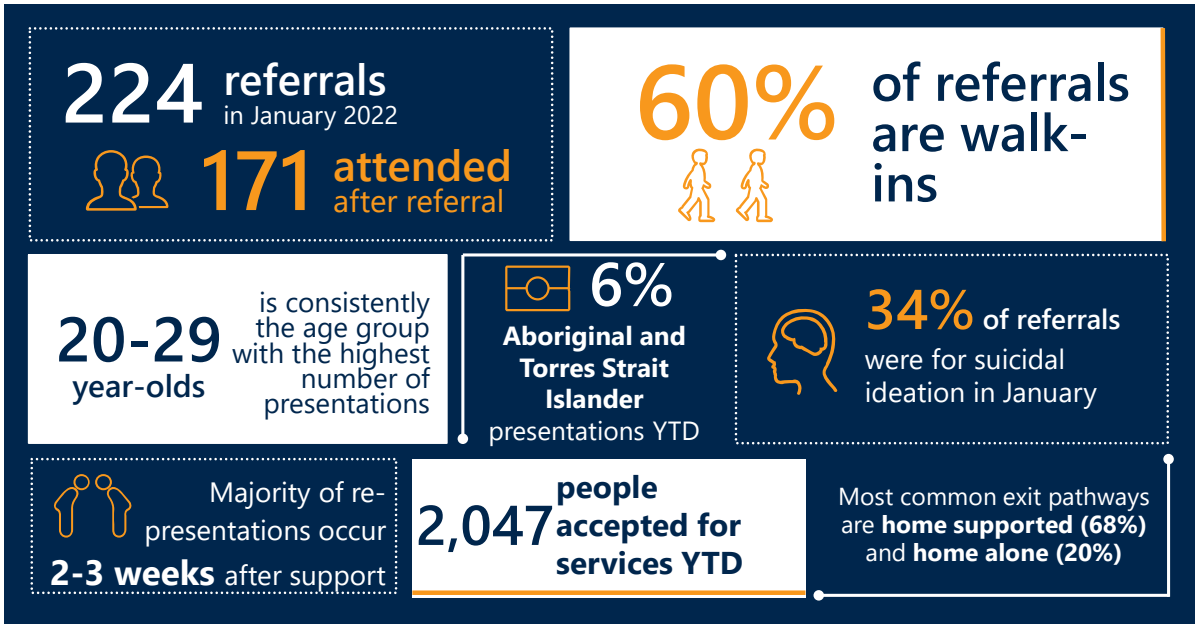
The SA AMHC is a notable departure from the core model, but recent changes are more closely aligned

The AMHC in SA is the only centre that commenced service delivery with a model that was significantly different to that proposed by the Department. However, they have now transitioned some elements of the model to be more aligned to the core model. Specific changes that have been made to date include:

- **Transition from referral only to mixed referral/walk in centre.** As a result of this change, which occurred in June 2021, between 50 per cent and 60 per cent of presentations have consistently come through this pathway[75]. Introducing the walk-in service has had a substantial impact on the cohorts serviced and has reduced the acuity levels (i.e., referred clients tended to be more unwell than walk in clients). This has resulted in an increase of IAR level two and three clients than had been previously seen in the service.
- **Opening hours.** Using supplementary state funding, the SA AMHC adjusted their opening hours from 7 February to be from 12pm to 7am every day, in response to observations that the twelve-hour timeframes limited service provision. Modelling on urgent care models in other jurisdictions, particularly overseas, has shown that a model with these extended hours will allow for better relationship establishment and rapport with people with different profiles (e.g., people who are considering committing suicide will be able to stay for longer periods of time). The longer opening hours will allow for more time to support and assess clients and direct them to the right service. The extended-hours model has added complexity to the workforce, particularly for peer workers, psychologists, nurse practitioners and mental health GPs.

[75] Urgent Mental Healthcare Centre Monthly Report January 22, provided by SA Health

Figure 42 | Key statistics from the January 2022 report on the Urgent Mental Healthcare Centre (UMHCC) in SA



Other key insights to note from the UMHCC report:

- Results of a service feedback survey provided to clients upon leaving indicates that clients are very pleased with the centre staff, with 90 per cent responding 'agree' or 'strongly agree' to the statement 'I feel cared for by the staff' in January 2022. However, the results of the questions related to wellbeing are not as positive, with only ten per cent of clients answering 'excellent' to their wellbeing level, and 30 per cent of respondents rating their wellbeing as 'terrible'.
- In January 2022, 63 per cent of clients were female, 26 per cent were male and 11 per cent identified as other. This distribution of genders has remained consistent since the opening of the AMHC and is consistent with what has been observed in the *HeadtoHelp* hubs.

6.1.3 Establishment challenges

Most major delays to establishment resulted from difficulty in securing the right physical location

The physical environment for a mental health service has implications on its efficacy as a therapeutic space.[76] The physical environment includes both the internal fit-out and the surrounding area. AMHCs needed to balance placing the location in an area that both meets the needs of the population (e.g., good transport links, in an area of need), and is safe, ideally near other services where participants may be referred to or from.

Most PHNs had difficulty finding an accessible, affordable and suitable facility located in an area of need, however, of those who have started operating out of their permanent facility (NSW and NT), there has been very positive feedback about the space. Some AMHCs have noted concerns surrounding the safety of their locations after-hours (potentially posed by intoxicated, or aggressive clients in later hours). This raises a need for appropriate management and de-escalation plans to be embedded in each centre, with staff trained on these strategies. Operational relationships with police, crisis teams and EDs will also support management of these concerns.

AMHCs highlighted challenges related to operating out of an interim site. The most commonly cited of these was that being in an interim site limits their ability to promote the service, as it is likely to

[76] Pressly, P and Heesacker, M. The Physical Environment and Counseling: A Review of Theory and Research. Journal of Counseling & Development. Page 149.

confuse clients and potential clients when they move. The AMHC in the NT also commented that when they were in their interim site, they were not able to keep to their planned opening hours. The interim sites in TAS and ACT are too small to offer a full suite of services, so cannot yet operate to full capacity.

One positive of the interim arrangements was the ability to stage staff recruitment as capacity scales, and opportunity to observe what does and does not work in the facility before signing a lease on a permanent one.

Timeframes and short-term contracts have proved challenging for providers

While PHNs found the commissioning timeframes appropriate, this was not reflected by all providers. Most commonly, timeframes provided by the PHNs for AMHC establishment impacted providers' ability to find a suitable permanent location and recruit staff, however the impact varied depending on when providers were commissioned by the PHN:

- Where providers were commissioned earlier in the process, such as in NSW, there were minimal complaints about the time available for establishment, as these providers had sufficient time to recruit and onboard staff. Securing a suitable location was still a challenge, but there was sufficient time for this to be overcome.
- Providers commissioned later in the process cited the short timeframes as the major reason they were unable to commence services as scheduled. For example, the TAS AMHC provider was only advised of the tender outcome on 11 November 2021, giving them just over a month to recruit and onboard their workforce if they were to open in December 2021. The frustration with the short timeframe available for recruitment was echoed in other jurisdictions. It was noted that a standard recruitment phase tends to take at least 12 weeks, and this should be considered for the establishment of future centres.

Contract length and uncertainty also raises the issue of future job security for staff, with some AMHCs highlighting concerns that their most valuable staff will be the first to leave if they feel jobs are not secure. While not yet an issue in the establishment phase, one stakeholder suggested that written confirmation of contracts extensions are needed at least six months before current contracts end to prevent this loss of staff.

Contract uncertainty has also increased risk for providers in securing appropriate facilities

Contract length and uncertainty has also resulted in challenges to securing a permanent facility, due to provider concerns with the risk associated with signing a lease on a large facility with a minimum leasing period without contract security. Current contracts run until 30 June 2023 (noting there has been verbal communication regarding a one-year extension, but this is yet to be formally confirmed).

There remains confusion as to data and performance management expectations

During the commissioning phase, PHNs had different approaches to data and reporting plans for performance measurement, with some being more robust than others. While some of the data and reporting plans developed by the PHNs were commendable, AMHC providers have experienced frustration pertaining to a lack of clarity around data collection and reporting requirements. The level of concern differs substantially between providers, but most have commented that the basic reporting template provided by the Department has been vague, and one stating that some data points would not be possible to record. One AMHC described the lack of guidance on reporting requirements as 'stressful', stating that they were not clear on which minimum data set they should be using, and that they required two FTE to assist with the work for the first report. Another AMHC has gained access to two minimum data sets from other programs that they anticipate may be similar to what the Department requires in the future and are collecting data based on this to avoid having to collect retrospectively. Other centres, while still not clear on requirements, are not prioritising data collection, primarily due to having more pressing matters on hand in getting the

service up to steady state operations, with one relying on a program run by their PHN to collect the data.

This confusion and concern from AMHCs providers regarding performance management reporting indicates misalignment between the Department, PHNs and centre managers in this space. It also creates a risk that initial data collected through the establishment phase will be inconsistent or incomplete, which will be difficult and resource intensive to rectify retrospectively. As well as demonstrating a need for the Department to provide clearer guidance on the approach to, and expectations of, performance reporting, this issue raises the necessity to significantly improve information flow from the Department to the AMHC providers, whether this is done directly or through PHNs.

The impact of COVID-19 varied

The impact of the coronavirus pandemic has varied across jurisdictions, with some of the effects including:

- WA Primary Health Alliance (WAPHA) found that hard border closures have compounded the issue of mental health staff shortages.
- The provider for the AMHC in TAS highlighted that border closures made it difficult to travel to TAS (as they are based interstate) to develop partnerships with brokered service providers. The difficultly in developing these relationships has continued due to many staff members of service provider partners contracting COVID-19 at the start of service delivery. The AMHC centre manager also commented that their service delivery partners are struggling to recruit, due to the impact of the pandemic on the temporary workforce.
- Capital Health Network (CHN) found the virtual engagement necessitated by lockdowns resulted in lower engagement with stakeholders during the establishment phase.
- The volatile COVID-19 situation in Melbourne has meant that staff cannot attend the clinic full time, however this has not been the primary issue in their establishment, as many clients prefer to meet via video conference where masks are not required and they can see the clinician's face.

Other PHNs and centre managers did not report any adverse effects from the pandemic, and were able to successfully complete the commissioning and establishment process, despite the severe lockdowns in NSW and VIC. Thus, while COVID-19 did have some impacts on specific AMHCs, it should not be considered an insurmountable factor in the timely establishment of the AMHCs.

6.1.4 Workforce

Peer workers are a core component of the service model

Most AMHCs have recruited a workforce that consists of approximately 50 per cent peer workers. It was important that this workforce model was carefully planned and not considered as a 'cheap' substitute for clinical workforce but as a valuable complement to enhance client experience. Peer workforces experience unique challenges related to stigma, discrimination and lack of infrastructure (e.g., professional supports or development, legitimacy)[77] and thus it was important that AMHCs were prepared with effective governance, supervision and support to unlock the potential of these workforces, and to 'promote, support and empower lived experience workforces'. [78]

Prior to the commencement, SA Health and PHNs reported high confidence in Neami National's governance structure and their ability to enable a peer workforce. Where providers had less experience in this area, peer workforce governance has been identified as an area that will require close attention. Stakeholder consultations have not identified any key concerns to date. There is an

[77] Australian Institute of Health and Welfare. National Mental Health Workforce Strategy. Page 8.
[78] Ibid.

opportunity here to share governance models, lessons learnt and supervision frameworks across AMHCs to facilitate capability development in this area.

Overall, AMHCs have reflected positively on workforce operations to date, though they remain attuned to potential operational and culture tensions as both clinical and peer staff adapt to new ways of working. The Victoria AMHC is particularly focused on this issue. The AMHC has introduced a peer-lead to elevate the role of peer workers in leadership positions and provide a clear career path for peer workers. The AMHC is focussed on avoiding hierarchy between peer and clinical workers, by encouraging the different roles to work together and learn from each other. Two initial issues that the AMHC is grappling with are:

1. The pay gap variance between the two roles.
2. Appropriately matching and managing risk involved in certain client decisions, for example surrounding a client who may be suicidal, in which cases the decisions of the clinical worker are paramount.

Nation-wide staffing constraints were effectively navigated in the establishment phase

During the establishment phase, PHNs consistently noted the pressure of workforce shortages, including concerns about the 'poaching' of staff from other local services. Similarly, many state and territory stakeholders raised workforce as their greatest concern in the standing up of the AMHCs, due to the number of competing mental health services and the very limited numbers of staff available, a situation that has been compounded by hard border restrictions.

Impressively, AMHCs successfully navigated the challenge of recruitment in a complex market in a number of ways, including:

- **Using a peer-led workforce to complement clinical and allied professional staff.** As outlined above, most AMHCs have recruited a workforce that consists of approximately 50 per cent peer workers to enhance the experience of clients and provide them with a safe and effective therapeutic relationship and guide them through their journey with the service. In this regard, the peer workers are able to provide a service experience that clinical and allied professionals cannot, thus helping those professionals to achieve improved mental health outcomes for clients.
- **Selecting a lead provider who could utilise existing clinical staff.** As noted above, ability to secure workforce was a key factor in commissioning decisions. Specific examples include:
- In WA, St John of God Health Care WA have been able to share staff with their existing inpatient services at the local hospital.
- Think Psychology in the ACT have repurposed staff from their local clinic, including administrative staff. Repurposed staff included part-timers who left their other part time jobs to work at the AMHC – Think Psychology – attribute their staff's willingness to do this to their efforts to make themselves an 'employer of choice' as well as the community's excitement about the new service. The provider feels that without their ability to repurpose staff, recruitment would have been very difficult.
- The NSW AMHC is sharing Penrith AMHC staff with their pop-up centre in Hawkesbury, as it is easier to recruit staff in Penrith than it is in Hawkesbury.

Co-locating with other services. This approach was taken by both the NTPHN and Primary Health TAS, however the implications of co-location had to be carefully considered. Learnings from *HeadtoHelp* indicate that physical co-location with other mental health service providers, community health, or general practice can support access to clinicians (e.g., a psychiatrist). Co-location with other services must be underpinned by clear clinical governance and safety measures for participants and support people. Co-location with other service providers, particularly those delivering services to participants with higher acuity, may require security protocols and staff. Some stakeholders have reflected that the presence of extensive security measures can undermine a therapeutic space and have the potential to re-traumatise participants who have had negative experiences in acute care. Establishing safety in a therapeutic space is critical.

Stakeholder consultations to date have reflected positively on co-location, with no negative impacts expected from having clients of higher acuity in a different part of the building. Both facilities have been designed to ensure that the co-located services are in separate areas (i.e., on different floors) which reflects the 'stepping up and down' of clients between the services.

- **Workforce development strategy.** The Tasmanian AMHC has partnered with the University of Tasmania to support development of a pipeline of staff for their AMHC.

There are certain positions that AMHCs have struggled to fill, including some clinical roles – particularly occupational therapists and Aboriginal health workers. For example, despite being the first to open, the SA AMHC has had an Aboriginal health worker role advertised but remaining vacant for some time. Where this is the case, rather than recruiting individual Aboriginal health workers, PHNs might consider partnering with ACCHOs, as has been done in the NT (see the case study on the AMHC in NT in Figure 41) as may be more effective and feasible than hiring service specific Aboriginal health workers.

6.1.5 Implementation risks

AMHCs remain concerned about ability to manage demand

Despite some AMHCs are not yet operating at capacity, ability to manage future demand was consistently highlighted as a major concern. Specific concerns include:

- inability to refer out from AMHCs for a range of needs due to other services being at capacity
- the lack of multi-year services available for those who need extended care, suggesting these individuals may keep returning to the AMHC due to longer term needs not being met
- continuing to receive overflow from other services that are at capacity, in addition to their own new clients
- uncertainty about how future AMHCs will be established to support demand management (location and timeframes)
- not being able to recruit and retain all the staff they will need to care for increasing client numbers.

These concerns are enhanced by emerging evidence that pressure on *HeadtoHelp* hubs (in particular length of stay is increasing). As referrals grow, there is a clear risk that AMHCs could become another oversubscribed service that is unavailable to community members when they need immediate, accessible, no cost support. Availability and rapid access for all, regardless of economic status is critical and these must remain essential design features, with concomitant funding. There is an urgent need for better collection and use of data to understand and analyse need at a system level, understand gaps, potential areas of underutilisation and inform future design, delivery and location decisions for the next tranche of AMHCs, as well as other funded mental health services.

A lack of localised communications may impact ability of AMHCs to connect with communities

Some AMHCs have raised concerns about the constraints imposed on running their own websites and social media pages to engage with local community. Service providers understand the Department's concern about mixed messages and multiple, inconsistent entry points. However, they feel that having localised channels to connect with their communities is critical, and that a solution needs to be found to allow for this so that centralised communication and intake via a single 1800 number need not be at the exclusion of complementary localised communication and promotion channels.

One AMHC highlighted that having local social media pages and websites will help with brand awareness and allow for targeted marketing through geo-tagging particular information and promotional material, helping to ensure that the right cohorts for the AMHC are reached. Another explained that it would allow them to promote practical aspects of the AMHC such as available services and capacity, and any planned or unanticipated changes to opening hours, or if there were events or other activities being hosted. They considered this an important aspect of promoting social

engagement, inclusion and connection for their clients. They also viewed it as an important mechanism to promote other services and supports in their local area.

The establishment phase has provided some evidence as to the importance of localised marketing and communications. For example, one AMHC experienced a significant rise in walk-in clients after a social media post on their services was made by their local MP and another experienced the same after an advertisement on the local radio. This is reinforced by *HeadtoHelp* findings that broader promotion using a range of advertising channels, including social media, is needed to achieve more equitable access. This collectively indicates there is likely to be significant value in a multi-pronged but aligned approach.

There is confusion around the role of AMHCs in a complex service and funding environment, particularly in Victoria

There have been substantial investments announced for mental health services by both the Commonwealth and state and territory governments. This reflects the high level of service need as well as significant planned reforms. However, the range of announcements and different funding arrangements has the potential for further fragmentation of the system and creating difficulty in navigating to the right services as more services are established. Table 6 contains a summary of the different mental health related funding announcements, primarily from 2021-22 budget announcements.

Victoria faces additional confusion around the difference between the *HeadtoHelp* centres and the AMHCs, and this may be further exacerbated by the establishment of the new Local Adult and Older Adult Mental Health and Wellbeing Services clinics. Clarification is required via deliberate communication of the AMHC scope, intent and position within the service system. To enable this, clarity is also required as to who is responsible for leading this communication. Having this clarity and communication in place will avoid some of the ongoing confusion about the service's purpose and capability that has been experienced with the *HeadtoHelp* services.

Table 6 | Summary of mental health funding

Australian Government	$114.5 million over five years to trial eight AMHCs (May 2019), $26.9 million for 15 *HeadtoHelp* hubs in Victoria (March 2020) and $487.2 million for additional Head to Health AMHCs, $54.2 million for the establishment of Head to Health kids (May 2021) and $7.1 million to extend the operation of at least 12 *HeadtoHelp* clinics until 30 June 2022 (August 2021).
ACT	$15.8 million to extend a range of mental health programs and services initially funded by the COVID-19 Mental Health Support Package in May 2020 and $3.156 million for Child and Adolescent Mental Health Services (CAHMS) (February 2021).
NSW	$109.5 million over four years to develop 25 Safeguards – Child and Adolescent Mental Health Crisis Teams (2021-22 budget) and $10.6 million to establish pop up clinics in seven PHNs in NSW (August 2021).
NT	$31.8 million to continue expansion and upgrade of the mental health inpatient unit at Royal Darwin Hospital and $7.5 million to establish a mental health stabilisation assessment and referral area at Royal Darwin Hospital (2021-22 budget).
QLD	$11.4 million for mental health service projects at Hervey Bay and Maryborough hospitals (2021-22 budget).
SA	$163.5 million package of mental health initiatives over four years, including crisis stabilisation centres, community mental health centres and an older persons' mental health facility (2021-22 budget).
TAS	$56 million to transform the mental health system, alcohol and drug services, and boost preventative health measures, and an additional investment of $26 million to support delivery of CAHMS (2021-22 budget).
VIC	$264 million for the first 20 of up to 60 new Local Adult and Older Adult Mental Health and

	Wellbeing Services and $196 million for dedicated services to support families through 13 new Infant, Child and Youth Area Mental Health and Wellbeing Services (2021-22 budget).
WA	$1.9 billion in health and hospital services to recruit additional staff and create more available beds (details are to come in September 2021).

A further risk to AMHC operations more broadly is the perception by some stakeholders that the AMHCs are an alternative to the ED. While it is true that the AMHCs provide an alternative to many individuals who may have previously presented to emergency where this was not clinically required, the AMHC model and staffing profile is not equipped to deal with clients in severe crisis. It is essential that this is well-communicated to other services and the general public to avoid placing the AMHCs in situations that they are unable to manage, negatively affecting both them and their clients.

6.1.6 Collaboration across AMHCs

PHNs recognise the value of collaboration, but supporting mechanisms could have been more structured and effective

Some sharing amongst PHNs took place during the establishment phase and several PHNs found the national PHN Steering Committee organised by the Department useful for sharing challenges and discussing progress. However, most PHNs have not had the level of engagement or information sharing with other PHNs that they would have liked. SA Health reported that during the tendering stage of the other AMHCs, there was good information sharing with the PHN network, however this decreased as the other PHNs progressed with the establishment of their centres. Victorian PHNs noted that they felt there was an opportunity for them to provide more learnings to other PHNs from their *HeadtoHelp* experience.

Strong collaboration occurred between Neami centres, but did not extend to other providers

Stakeholders are strongly of the view that it would be beneficial to share intelligence across AMHCs, such as lessons learnt, barriers to implementation and solutions identified. Many stakeholders also indicated it would be valuable to combine elements of the co-design process, such as the testing of service models for different cohorts.

Conversations with AMHC managers in the first few weeks of operation highlighted that the five AMHCs who have Neami National as their provider have been collaborating strongly, with weekly meetings to share learnings and solve problems. However, there has been no collaboration between the three centres who do not have Neami as their provider (WA, ACT and TAS), either with each other or with the Neami centres. While the non-Neami centres have not expressed a strong desire to work with other centres, the Neami centres have found working together to be extremely useful. The Department should consider organising for collaboration to extend beyond only Neami centres, to ensure that all centres can experience the benefits of shared knowledge and avoid a 'Neami versus non-Neami' scenario.

A barrier to sharing operational successes is that, in some cases, materials will be competitive intellectual property of providers – however, this could be overcome by the Department providing some requirement or incentive that such material is available to share more broadly. This is appropriate and recognises that there needs to be specific funding to support collaboration – it is not enough to rely on this always occurring organically.

6.2 How appropriate is the IAR intake process that has been developed?

Key findings:

The IAR-DST will be adopted by all the AMHCs in some form, with some states having plans to adopt the system across state mental health services. Where IAR has already been implemented, for example in the pop-up clinic in NSW, it has received positive feedback. To improve the intake

process and ensure consistency for clients, there needs to be further awareness of and training in the use of the IAR, as well as consolidation of the intake pathways (phone lines and walk in processes) across AMHCs. The effectiveness of the IAR would increase significantly if supported by an up-to-date directory of services as this would improve the experience of clients and staff attempting to navigate the mental health system.

6.2.1 Uptake of the IAR-DST

All AMHCs are using or proposing to use the IAR-DST in some form

With the exception of the SA AMHC, all AMHCs have indicated they will be using the IAR-DST from the outset, with a degree of local adaptation expected. In addition, different versions of the IAR-DST are now being produced for particular cohorts such as children, Aboriginal and Torres Strait Islander peoples, elderly people, CALD populations, veterans and people with a disability. A number of states are also planning, or will be required through bilateral agreements, to use the IAR across all of their mental health services. SA Health has been using state triage tools compatible with the primary referrers, however consultations in late 2021 indicated considering using the IAR-DST.

While some PHNs and AMHCs have noted the need for more staff training on the use of the IAR-DST, there has already been some positive feedback on the tool:

- In NSW, where a pop-up clinic has been operating, it was reported that the IAR service and the accompanying level of customer service is 'almost as therapeutic as the mental health services offered.'
- WAPHA has found the IAR-DST to be highly effective as a service navigation and decision tool, and its expanded implementation has the potential to transform how clients enter and navigate the mental health service system.
- In Victoria, GPs perceive elements of the IAR to be equally important to the program as the buildings and the people, and Victoria's new state hubs will be using the IAR, although it was mentioned by the AMHC in Victoria that they were not confident on when to use and how to report on client information using the IAR.

While some AMHCs have had the opportunity to learn from the HeadtoHelp hubs and 'pop-ups', this was not reflected equally across stakeholders, suggesting learnings could have been more deliberately distributed.

AMHCs are operating individual intake phone lines and walk-in processes which will need to be unified

Many AMHCs have reported operating their own intake telephone lines for the centres, with some having offered a telephone-only service for their first weeks of operations while waiting to move into physical facilities. However, having multiple intake lines for AMHCs and other mental health services is likely to cause confusion for clients (as has already been seen in some cases for *HeadtoHelp*).

To avoid this confusion and ensure a consistent intake experience for all AMHC clients, the individual phone lines will need to be reviewed and planning undertaken for how these will fit into/be transitioned to the national mental health IAR telephone service which is planned for release by the Department in July 2022.

AMHCs also have different walk-in intake processes for their clients, and to maintain the consistency of client experience regardless of how they enter the service, there needs to be consideration of how the walk-in client details will be collected and stored in the same way as the telephone intake clients. Ideally this process will be the same across all the AMHCs and other mental health services using the national IAR telephone service.

Best practice use of the IAR-DST relies on a supporting directory of services

If the IAR-DST is to support coherent and streamlined service navigation, there needs to be a common and up-to-date directory of services that intake clinicians can refer to. Without this, intake experience will not be uniform across clients, as it will depend entirely on who the intake staff member is and the knowledge they have. A real-time directory including information such as wait times, billing, eligibility criteria and opening hours of other services will also ensure that clients are referred to services that have capacity and avoid the 'bouncing around' between different services that has often been the experience for clients attempting to navigate the current mental health system.

6.3 How efficiently were AMHCs established?

Key findings:

Funds allocated for the establishment of AMHCs varied across states and territories at the discretion of the Department, appearing to be made on the basis of population size. The fit out and other costs associated with making facilities fit-for-purpose was similar across AMHCs, ranging from $1 million to $1.5 million. Compared with other similar services commissioned, this appears reasonable. In general, PHNs found that establishment funding for the AMHCs was adequate to meet these and other establishment costs such as staffing.

Interviews with AMHC service providers and managers in the early stages of operation have revealed some inefficiencies, partly due to delayed information flow between the Department and service providers. Slow intake numbers also limit efficiency, however, many AMHCs have developed strategies to mitigate this, and it is expected to become less of an obstacle as the service becomes more embedded in the community and intake numbers increase.

It is too early in the roll-out of AMHCs to draw any definitive findings on efficiency. For those services that have commenced operations, initial activity data from December 2021 and January 2022 is both incomplete and inconsistent across centres and is of a too small sample size to draw meaningful conclusions.

6.3.1 Establishment costs and funding

Distribution of costs differed across AMHCs

Of the $114.5 million over four years allocated by the Department for the AMHCs, $87.8 million has been distributed between PHNs in the first three years of the rolling agreement. Each AMHC was allocated flexible funding, to cover the establishment and operational costs of the centre, and operational funding, for the administrative, governance and core functions of the PHNs. Distribution of funding between AMHCs and PHNs is relative to the size of the population AMHCs are expected to service, with ACT and TAS receiving the lowest funding amount.

Variances to note on the AMHC funding and establishment costs are:

- the AMHC in SA was block-funded, with no contractual distribution between flexible and operational funding
- the NT received a greater portion of their total funding in their first year to cover higher than average costs of establishment than experienced by AMHCs in other states
- it is expected that there will be underspend in operational funding of AMHCs in the 21/22 financial year due to only having operated for six months during this period.

Funds allocated appear to have met service needs

The fit out and other costs associated with making facilities fit-for-purpose ranged from approximately $630,000 (QLD) to $1.4 million (WA). The AMHC in North Queensland had substantially lower fit-out costs than other centres and had savings of $74,000 from the funding allocated for establishment.

Compared with other similar services commissioned, these fit out costs appear reasonable. In general, PHNs found that establishment funding for the AMHCs was adequate to meet these and other establishment costs such as staffing. However, one AMHC commented that the fit-out costs for their desired facility have been challenging, and in WA, the spend on fit out costs was above the amount provided by the Department, and this extra cost has been covered by the provider. In contrast, one centre manager highlighted that the budget available for their space has made a significant difference, and that this is the first project of this kind they have been involved in where the money was available to ensure the needs of the community could be met to such a large extent.

The requirement for interim sites introduced cost inefficiencies

Of the eight AMHC sites, four had to pay for interim facilities. The use of interim sites is inefficient, as any funding for building adjustments or maintenance required to make them fit for purpose (which ranged from $5,000 to $85,000) cannot be recouped for the permanent site. There are also additional costs associated with both the initial sourcing of two sites, as well as movement of staff and equipment between the interim and permanent site. Of greater concern, there is the risk of confusion or lack of clarity for clients as to the nature, location and duration of the service. For the AMHCs who were only in interim facilities for a short time, it may have been more cost efficient and client effective to run a virtual or telephone service, which was the approach adopted by some other AMHCs.

6.3.2 Operational efficiency

Protracted information flow between the Department, PHNs and providers has resulted in some inefficiencies

Interviews with centre managers during early stages of centre implementation highlighted that information flow between AMHCs and the Department could be improved, however this depended on the relationship of the AMHC provider with their local PHN. The PHN acts as a 'middleman' between the Department and the AMHCs, and some conversations with AMHC service providers have indicated that the efficiency of this process has depended on the skills of individual PHN staff. While this has enabled strong relationships and smooth information transfer for some AMHCs, there needs to be a system change to improve information flow across all PHNs, as the skills of PHN staff and their personal relationships with service providers cannot be guaranteed for each PHN.

Particular inefficiencies due to this system reported by PHNs included the frustrations with guidance on data collection and reporting requirements, and communication of national mental health objectives and initiatives (which hinders the planning of service promotion and marketing).

A further inefficiency reported by one service provider was the Department's decisions to outsource processes such as developing client experience surveys, which took much longer than required and delayed the opportunity to collect data at the start of operations. In one instance, the AMHC provider reverted to developing their own survey, noting this was a duplication of effort, just to be able to commence collection.

Efficiency is likely to improve as referrals build and the service model becomes more embedded

Most AMHCs had low intake numbers in their first few weeks of operation. Low client numbers means that staff are not fully utilised which increases the cost per occasion of service. AMHCs have found ways to mitigate the effects of low service numbers, including by:

- using this time as an opportunity for staff training (e.g., on the use of the IAR) and implementing ways of working, such as developing how the peer-clinical worker relationship will function
- staging staff recruitment to be in line with the number of presentations
- accepting clients from the waitlists of other PHN services rather than relying on walk-ins and referrals from other local services.

As the service becomes more established as part of the mental health services available in each area, the number of referrals and walk-in clients will increase, improving staff utilisation and thus reducing cost per occasion of service and increasing centre efficiency.

Many of the lessons identified in this evaluation are not limited to the operation of *HeadtoHelp* and the AMHCs – rather they have wider implications. In light of this, the recommendations set out in the following Section 7 include a fourth category of broader system-focused recommendations for supporting establishment and implementation of future programs.

7 Recommendations

The purpose of this evaluation was to understand what has been achieved to date to inform future Commonwealth Government decisions. To this end, this evaluation has identified a number of specific recommendations for action for the Australian Government Department of Health, PHNs, *HeadtoHelp* hubs and AMHCs going forward. These recommendations draw on the combined insights and lessons learnt across all components of this evaluation. These recommendations build on and update those provided in Nous' Interim Evaluation Report.

Recommendations have been organised into four overarching categories, with details surrounding the rationale and expected outcomes of implementing each recommendation described below.

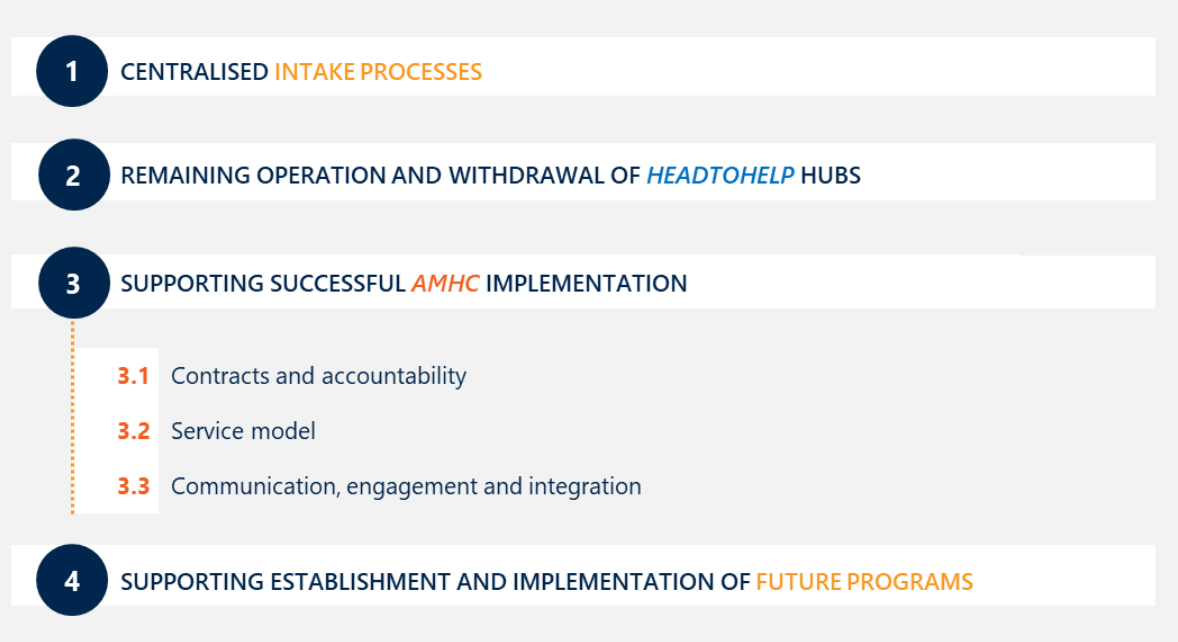


Table 7 | 1. Recommendations regarding the centralised intake process

#	Recommendation	Details
1.1	**Ensure that training is available to support other services in awareness and effective utilisation of the IAR in the context of their service.**	It is important that all services that interact with the AMHCs are trained to understand the IAR and how it is used, to ensure smooth integration between different systems and services. Training should be carried out by PHNs, who will need to identify potential users and share the required information. This clarity of understanding of the purpose and content of the IAR-DST will help minimise the extent to which a client has to retell their story.
1.2	**Maintain core fidelity of the IAR-DST tool but allow tailoring at the margins for local context.**	PHNs should be explicit when rolling out the IAR-DST in different services that the core fidelity of the tool needs to be maintained, however it can be adjusted at the margins (e.g., 20 per cent) to suit local context and provide a client-centred experience.
1.3	**Evaluate effectiveness of the IAR-DST.**	The Department should proactively and consistently invest in the evaluation and reviews of the IAR-DST, including seeking regular feedback on the tool requirements for service providers.
1.4	**Prioritise investment into continual revision of the IAR-DST, including tailoring for specific cohorts.**	Utilising data from regular review and evaluation of the IAR-DST, along with feedback from service providers, the Department should continue developing tailored versions of the tool to suit different cohorts such as children, CALD communities, Aboriginal and Torres Strait Islander peoples and the elderly, as well as revising the core tool as required.

1.5	**The IAR-DST should be amended to include sub-categories of assessments to support the referral of clients assessed as level five.**	The current default for clients assessed as a level five is to refer directly to the ED. However, there is a number of alternative services that clients assessed as level five could be referred to (e.g., ED, inpatient admission, community treatment teams, Prevention and Recovery Care services (PARCs)). To assist in deciding which service to refer them to, sub-categories with level five could be developed to support the decision as to which state service a level five client should be referred to.
1.6	**IAR-DST assessment/patient record should be shared with GPs, other referrer and services receiving referrals.**	The Department should fund IAR-DST system development to enable access by GPs and other service providers. This would help to avoid double-handling of patient data, as well as give GPs and other referrers line of sight of where their clients are in the system and what mental health treatment services they are receiving. This information sharing will help minimise the extent to which a client has to retell their story. To deliver this integration, the first priority is to ensure GPs are aware of and understand the IAR and can access assessments.
1.7	**The Department should require, and PHNs should ensure, that all continuing HeadtoHelp hubs are promoting use of the Victorian single intake contact number only.**	The addition of local service phone numbers to local communications is confusing for service providers to refer to *HeadtoHelp* and draws away from the intent of the centralised intake model. The Department should ensure contractual terms require the use of the single 1800 number (and no additional numbers).
1.8	**The Department should invest in a plan for the integration of individual AMHC intake processes with the national IAR-DST telephone service when it is implemented in July 2022.**	A national mental health IAR telephone service is expected to be in place by July 2022. As AMHCs will be operational before this, the Commonwealth needs to plan for how the AMHC intake processes (including phone lines) will transition to the national approach. This is critical to ensure consistency of experience and reduce confusion for clients. Consideration also needs to be given as to how the details of walk-in clients will be collected and stored in the same system as those being captured through the phone line. This will also need to be integrated with the intake processes of the continuing *HeadtoHelp* hubs and ideally adopted as part of the roll out of Local Mental Health and Wellbeing hubs in Victoria.
1.9	**Centralising intake at the PHN regional level should be continued and adopted nationally.**	There is a tension between centralisation and localisation of intake processes. Findings from *HeadtoHelp* indicate that the PHN regional level provides an appropriate balance. Geo-routing incoming calls to the IAR-DST line to a PHN-level intake team allows clients to be assigned to operators with a building/strong knowledge of the area that the client is calling from which will enable better informed referrals.
1.10	**The IAR service needs to be supported by a digital comprehensive service and community resources database that is developed by PHNs as a clinician support tool.**	Participants highlighted that some referrals were neither personal to their needs, appropriate or accessible, suggesting that service providers may not be fully aware of the range and options available. There needs to be greater system-level support for clinicians to access and use this information. The Commonwealth should fund PHNs to develop a robust and up-to-date service and community resource directory as part of IAR implementation, which should contain real-time information such as wait times, billing, eligibility and opening hours to support referrals. This will more easily guide providers to give locally appropriate and responsive referrals.

Table 8 | 2. Recommendations regarding the remaining operation and withdrawal of HeadtoHelp hubs

#	Recommendation	Details

2.1	**The Department should extend the operation of existing HeadtoHelp hubs until the Victorian Local Mental Health and Wellbeing Centres and subsequent tranches of AMHCs are operational.**	The Department should consider the following process to avoid a service gap between the decommissioning of *HeadtoHelp* hubs and the establishment of both further AMHCs and the Victorian Local Mental Health and Wellbeing Services: • Urgently confirm locations for the next tranche of AMHC clinics/ satellites. • Where an AMHC will be located, consider if novation of contracts, as well as transfer of staff and clients from current hubs to new centres is possible and appropriate. • Where a Local Mental Health and Wellbeing Service is planned, the *HeadtoHelp* hub in that location should be extended until the new local service is operational and the transition planned in conjunction with the Victorian Government. • By the time the proposed 50 to 60 Local Mental Health and Wellbeing Services are established, all existing *HeadtoHelp* hubs should either be transitioned or decommissioned. The transfer of staff will allow for the retention of local and service knowledge and combined with the transition of clients this may enable smooth continuity of care. Consideration will also need to be given to how client records will be transferred safely from *HeadtoHelp* hubs to the new centres. The agreed process and timing for the above needs to be communicated early and effectively to PHNs, providers, staff and clients.
2.2	**Length of stay and impact on access should be closely monitored throughout remaining operation of the hubs.**	Evidence from this evaluation suggests that length of stay with the *HeadtoHelp* hubs is increasing, but the number of initial service contracts (i.e., new clients) is decreasing. This needs to be actively monitored as ease of access is core to both the *HelptoHelp* and AMHC service model and value proposition. If this trend continues it will be necessary to expand capacity of the services to which clients are being referred and /or the AMHCs. The interaction between length of stay, access and outcomes needs to be closely monitored and analysed on an ongoing basis.
2.3	**Evaluation findings should be broadly distributed to PHNs, hubs and intake services. This should include an accompanying guide of best practice features influencing satisfaction.**	A summary version of this evaluation should be developed and distributed to all PHNs to share with their *HeadtoHelp* and AMHC service providers. The summary should also be shared with intake phone service providers who are not within the PHNs. Inclusion of an accompanying best-practice guide incorporating the features identified in this report as influencing participant and support person satisfaction would enhance consistently positive participant experiences and facilitate measuring of fidelity to best practice. A full version of both this evaluation report, as well as the supplement 'Voices of Lived Experience' report, should be made available on the Australian Government Department of Health's website.
2.4	**HeadtoHelp PHNs and hubs should review AMHC recommendations and implement where practicable and benefits will be realised in remaining operation.**	There are a number of recommendations provided in relation to the AMHCs that will also be relevant for ongoing *HeadtoHelp* hubs, when the longevity of their remaining operation is confirmed. *HeadtoHelp* PHNs and hubs should review all recommendations in this evaluation closely and consider on a case-by-case basis where it would be practical and appropriate to make these changes, and where there is an opportunity to benefit clients during remaining operation.

Table 9 | 3. Recommendations to support successful AMHC implementation

#	Recommendation	Details

3.1 Contracts and accountability

3.1.1	**The Department should provide greater guidance on the approach to, and expectations of performance measurement and data collection, and reporting requirements should be a clear contractual requirement.**	The Department should ensure that commissioning PHNs have clarity on their accountability to measure and manage performance of the AMHCs. PHNs should ensure service provider contracts clearly outline the requirements for data collection using the PMHC-MDS as well as an agreed way of capturing this information for streamlined reporting.
3.1.2	**The Department should set an expectation of collaboration among both PHNs and commissioned service providers to enable information sharing and continuous improvement.**	The Department should facilitate collaboration between PHNs, either directly or through resourcing a PHN to act on their behalf, so that PHNs can share information that will enable continuous improvement during the establishment and implementation of the AMHCs. Two levels of collaboration should be established: 1. Between PHNs and SA Health. 2. Between AMHC centre managers and/or service providers – this will help to mitigate the risk of Neami AMHCs not engaging with other AMHCs. Nationally agreed mental health indicators would benefit PHNs and AMHCs as they would a provide a benchmark for measuring centre performance.
3.1.3	**Performance and outcomes monitoring needs to include specific recovery-oriented and individual outcome measurements, including attention to client wellbeing and experience of service.**	The emphasis of the AMHCs (in line with broader Mental Health policy and reform around the country) is on both mental health and wellbeing. Current outcomes monitoring has a strong clinical focus and initial evidence from the SA AMHC is that changes in individual's wellbeing are not as positive. This warrants consideration of an appropriate metric and further monitoring to understand any underlying trends across the country and adopt the model as appropriate. This will assist in gauging whether *HeadtoHelp* is fostering personal agency, resilience recovery and mental flourishing. The currently used K10 measure is inadequate to measure the recovery-oriented outcomes that participants and their families highlighted as important to them, as it measures the frequency of specific symptoms only. There are a range of suitable individual recovery and recovery-oriented service measurement tools available, such as the RAS-DS (well-used internationally), the Recovery STAR tool, and The Warwick-Edinburgh Mental Well-being Scale (WEMWBS).
3.1.4	**PHNs' contracts with AMHCs should include specific KPIs measuring integration to increase accountability.**	Integration needs to be understood as core to the role and successful functioning of AMHCs. Measures of success include forming genuine and collaborative relationships with local health services and AMHSs early, ongoing contact and communication, and identifying and actioning opportunities to improve access to joint services through co-location.
3.1.5	**The Department can support timely AMHC establishment through clearer guidance on allocation of time between PHNs and service provider.**	The majority of planning time for the establishment of the initial AMHCs was used by the PHNs, leaving in some cases extremely tight (and sometimes unmeetable) timeframes for the AMHCs to recruit and commence operations. Moving forward there is a need to ensure both PHNs and service providers have sufficient time to plan and implement their respective roles in centre establishment. This could be achieved through inclusion of an indicative time schedule in accompanying specification documents. Broadly, time for PHN commissioning should be at least 12 weeks and establishment for service providers at least 16 weeks.

3.2 Service model

3.2.1	**Ensure all operating AMHCs have access to appropriate senior clinical expertise.**	All AMHCs should have access to appropriate senior clinicians (e.g., psychiatrist) to ensure the right supports and resources are available to support needs and complexity of the missing middle and enable clinical decision making. For example, if AMHCs do not have enough expertise in their core team, arrangements for secondary consultation or liaison with more experienced staff may be a suitable alternative.
3.2.2	**Ensure adequate training in, and expectations around, use of warm referrals and follow up.**	Drawing on the lessons from *HeadtoHelp* it is important that AMHCs ensure that referrals they make are 'warm' (active) rather than 'cold' (passive) referrals. This means contacting potential services with and for the person, advocating for the person, and even attending the referred service/program with them initially if appropriate. Follow up is also needed with participants to ensure they have managed to connect with the service, they have been accepted by that service, and that it is meeting their needs.
3.2.3	**Where existing clinical governance frameworks exist, these should be shared across the AMHC networks.**	Sharing of existing tools and frameworks will support more efficient and effective implementation. While tailoring to local context may be required, this avoids a wholly inconsistent approach and reduces the need for every provider to 'start from scratch'. This might require the Department to consider appropriate compensation for use of this intellectual property.
3.2.4	**Funding of AMHCs should seek to maintain accessibility through short waitlists, free services and sufficient capacity.**	The AMHC centre-level operational model needs to retain short or no waitlists and the ability for participants to access services quickly. To achieve this, capacity needs to be sufficient to manage demand, which can be achieved through: • ensuring AMHCs are adequately resourced • ensuring services to which the AMHC refers clients have sufficient capacity (i.e., monitor demand for services being referred to) and are at least partly covered by Medicare/affordable for clients being referred; if services the AMHC needs to refer to are not affordable for clients this may require additional investment to subsidise. • close monitoring of length of service, and impact of changes on ability for new clients to access the AMHCs, and participant outcomes. Mental health services provided in the AMHCs should continue to be freely accessible to clients (this emerged as a key benefit of *HeadtoHelp*). Efficient processes to support service delivery (e.g., booking systems) will help to reduce the level of stress participants feel.
3.2.5	**AMHCs should actively monitor clinical need as the services move more fully into the implementation phase.**	As new services, the distinct clinical needs of individuals presenting to AMHCs (separately and collectively) remains untested. AMHCs should actively monitor and review clinical need and outcomes as they move from establishment into implementation and use this information to inform service and workforce models and development.
3.2.6	**Ensure all AMHCs have the willingness and capacity to offer and deliver therapeutic digital services where that responds to participant preferences.**	Telehealth (phone and video) was valued by many participants and should be offered to all participants as a choice to increase accessibility and availability. Going forward, AMHCs should have the capacity and skill set to deliver a range of digital services (video, phone, online) in line with individual preferences. Digital services may provide wider choice and opportunities for participants to engage with service providers who are able to meet specific needs but are not located within their local area (e.g., cultural needs, gender specific, age related or specialty needs). Further, AHMC resources may be more fully utilised through digital services across areas, for example, if one area is under and one over-subscribed. Support and training should be provided to service providers to maximise the benefits of working therapeutically using digital platforms and hubs should be set up to accommodate and therapeutic digital service provision.

3.3 Communication, engagement and integration

3.3.1	**Develop a co-designed, comprehensive communications strategy to be adopted by all AMHCs.**	The need for more effective communication is a key learning from *HeadtoHelp*. Development of a comprehensive communications strategy, with clear roles and accountabilities between the Department, PHNs and AMHC lead agencies will support both expectation management and awareness raising of the new centres. Methods of communication and messaging should be developed through co-design with individuals with lived/living experience and tested in different settings to ensure they are effective for different local communities.
3.3.2	**As part of an overall communications strategy, individual AMHCs should be permitted and encouraged to utilise broadcast and social media to connect with local communities.**	Having a centralised single point of promotion and intake via a single 1800 number need not be at the exclusion of complementary localised communication and promotion channels. It is important that individual AMHCs have a channel through which to promote the service, provide service updates (i.e., address, changes to location, opening times or centre closures, events, etc.) and connect with local communities. Use of social media, radio or television may be appropriate for different communities. This complements rather than replaces the national communications approach. Methods of communication and messaging should be developed through co-design to ensure they are effective for local communities.
3.3.3	**Clarify and clearly communicate the purpose and intent of AMHCs to manage expectations and ensure there is the capacity and capability to meet those expectations.**	It is essential AMHCs clarify their purpose and clearly communicate the service's intent, capacity, intake functions, services within the centre and staff capability to GPs, other service partners and relevant stakeholders to ensure there is a consistent understanding of: • the level of acuity AMHCs will service • the service offering of AMHCs. This is the responsibility of the Department and PHNs in their communication with lead agencies, and the responsibility of lead agencies in relation to the communications with local service partners. Furthermore, once those expectations are set, it is critical that the service has the capacity and capability to deliver on those expectations. The service is not just about a 'front door', but also what sits behind that.
3.3.4	**AMHCs need to be provided with technical support for system integration.**	To counter the issue of poor system integration, particularly between the IAR and existing services, the Department should provide funding and/or technical support to PHNs/AMHCs to integrate these systems during establishment. This will remove the need for double entry of client information and reduce the administrative burden on staff.

Table 10 | 4. Recommendations to support establishment and implementation of future mental health programs

#	Recommendation	Details
4.1	**HeadtoHelp and the AMHCs have trialled a valuable model for delivering care, that should continue to be delivered and evolved.**	*HeadtoHelp*, despite being established to be responsive to mental health needs resulting from COVID-19, appears to also fill a gap for many people who are otherwise unable to access timely and affordable non-COVID related mental health help, suggesting that this type of service model (also exhibited by the AMHCs) warrants a permanent place in the mental health landscape.
4.2	**The Department needs to think strategically about how best the Victorian AMHC(s) can interact with the Local and Area Wellbeing hubs, and any**	*HeadtoHelp* and AMHCs do not exist in a vacuum and success is linked to wider issues, including the availability and integration of other mental health services. Noting the current state of uncertainty, significant attention still needs to be given by the Victorian AMHC(s) as to how both the existing, and future planned services will interact

#	Recommendation	Details
	changes that may be required to the planned roll-out of AMHCs in that jurisdiction.	with the proposed local Adult and Older Adult Mental Health and Wellbeing Services and the infant, child and family hubs.
4.3	**Future programs should adopt longer minimum contract durations and adequate minimum periods for renewal prior to contract expiry.**	Services need longer minimum contract durations to ensure participants receive safe and high-quality care, and to assist in retention of staff. Longer contracts will allow services to remain competitive in a landscape with significant demand for a qualified mental health workforce by providing staff with greater job security. Longer operating periods give participants much needed consistency in a fragmented mental health system; for example, if they require services for longer periods of time or require additional services at a later time. Greater duration and certainty in employment contracts will assist in recruiting and retaining appropriately skilled and experienced staff. Greater stability in staffing will also assist client experience through stable therapeutic relationships.
4.4	**Future contracts should include dedicated resourcing for relationship building, service integration and promotion and clinical governance.**	Services require relationship building, promotion and clinical governance to be explicitly resourced as part of effective service establishment. The Department should require through its contract terms that dedicated resources/roles are allocated for driving and maintaining service integration process and that there is explicit funding allocated to this role (for example a nominated AMHC contact for other services who can act a consistent representative at service integration discussions).
4.5	**Future AMHC locations should be planned in collaboration with state health departments.**	To ensure that AMHCs are being located in regions where they will provide the most benefit, and to foster collaboration and productive relationships between the Commonwealth and state governments, the Department should consult state health departments when deciding on locations for AMHCs. This can be done through PHNs, who the Department should hold accountable for collaborating with state health departments. The identification of future AMHC locations should be based on evidence of need (e.g., using the National Mental Health services Planning Framework).
4.6	**Realise opportunity to inform mental health service system design through data.**	Data that collected through the PHMC-MDS brings an important opportunity to better inform system design and identify areas of priority for investment in new and/or expanded services. This is a level of granularity of the client journey that has not previously been examined. By monitoring and analysing data including referral destinations, capacity (e.g., wait times, number of service contacts, episode length), and referral uptake, the analysis will identify blockages in the journey that could suggest long term areas of need in the service expansion or new service development. In addition, monitoring of return clients, will enable a deeper understanding of what referrals these people are needing but not getting due to service constraints.

Appendices

The Full Appendices are contained in a companion document: *HeadtoHelp* and AMHCs Final Evaluation Report: Appendices.

Appendices included are as follows:

Appendix A: *HeadtoHelp* Service Pathway

Appendix B: KEQs

- **7.1** Part A KEQs
- **7.2** Part B KEQs

Appendix C: Program logics

- **7.3** *HeadtoHelp* program logic
- **7.4** AMHCs program logic

Appendix D: Data ecosystem

Appendix E: Detailed methodology

- **7.5** Program theory
- **7.6** Data collection and analysis
- **7.7** Data sources
- **7.8** Primary sources
  - **E.1.1** *HeadtoHelp* sources
  - **E.1.2** AMHCs sources
- **7.9** Secondary sources
- **7.10** Limitations
- **7.11** Methodology for participant and support person interviews
- **7.12** PMHC-MDS data methodology

Appendix F: List of stakeholders consulted

- **7.13** *HeadtoHelp* stakeholders
- **7.14** AMHC stakeholders

Appendix G: *HeadtoHelp* KPIs

- **7.15** Original KPIs (14 September 2020 to 13 September 2021)
- **7.16** Recast KPIs for extended *HeadtoHelp* hub contracts (from 14 September 2021)